

# Public Document Pack

## Health and Wellbeing Board Agenda

Thursday, 19 September 2013  
**1.30 pm,**  
Committee Room 1 - Civic Suite  
Civic Suite  
Lewisham Town Hall  
London SE6 4RU

For more information contact: Kalyan DasGupta (Tel: 020 8314 8378)

### Part 1

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

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# Health and Wellbeing Board Members

Members of the committee, listed below, are summoned to attend the meeting to be held on Thursday, 19 September 2013.

Barry Quirk, Chief Executive  
Wednesday, 11 September 2013

Councillor Chris Best	Community Services, London Borough of Lewisham
Aileen Buckton	Directorate for Community Services, London Borough of Lewisham
Mayor Sir Steve Bullock	London Borough of Lewisham
Elizabeth Butler	Lewisham Healthcare NHS Trust
Jane Clegg	NHS England South London Area
Tony Nickson	Voluntary Action Lewisham
Dr Simon Parton	Lewisham Local Medical Committee
Marc Rowland	Lewisham Clinical Commissioning Group
Dr Danny Ruta	Public Health, London Borough of Lewisham
Elaine Sammarco	Lewisham HealthWatch
Frankie Sulke	Directorate for Children and Young People

# Agenda Item 1

## **MINUTES OF THE HEALTH AND WELLBEING BOARD**

**Thursday, 11 July 2013 at 1.00 pm**

**PRESENT:** Sir Steve Bullock (Chair), Councillor Chris Best, Aileen Buckton (Executive Director for Community Services), Elizabeth Butler (Chair of Lewisham Healthcare NHS Trust), Tony Nickson (Director, Voluntary Action Lewisham), Simon Parton (GP), Danny Ruta (Director, Public Health), Elaine Sammarco (Chair of Lewisham Healthwatch), David Sturgeon (NHS SE England, representing Jane Clegg), Warwick Tomsett (representing Frankie Sulke), and Helen Tattersfield (Chair of Lewisham CCG).

**IN ATTENDANCE:** Mark Drinkwater (Health Inequalities and Social Care Officer, Voluntary Action Lewisham), Brid Nicholson (Health Protection Programme Manager), Ian Smith (Director, Children and Young People), Katrina McCormick (Joint Deputy Director, Public Health), Donal O'Sullivan (Consultant in Public Health Medicine), Sarah Wainer (Head of Strategy, Improvement and Partnerships) and Kalyan DasGupta (Assistant Policy Officer and Clerk to the Board).

Apologies for absence were received from Jane Clegg (NHS SE England) and Frankie Sulke (Executive Director for Children & Young People).

### **1. Minutes of the meeting held on 30 May 2013**

**RESOLVED:** That the minutes of the meeting of 30 May 2013 be agreed as an accurate record.

### **2. Declarations of Interest**

There were no declarations of interest.

### **3. Disabled Children's Charter for Health and Wellbeing Boards**

Ian Smith, Director of Children's Services, presented the report summarising the key points in the Disabled Children's Charter. He recommended that the Board sign up to the Charter, delegating responsibility for implementation as appropriate to the Children and Young People's Strategic Partnership Board (CYPSPB).

It was noted that the Charter would not lead to any unplanned or unanticipated financial commitments and that the Children and Young

People's Directorate has a good understanding of the future demand for disability services and support. Future plans have been developed based on analysis of robust data.

**RESOLVED** that:

- i) The Health and Wellbeing Board agrees to sign the Disabled Children's Charter;
- ii) The Health and Wellbeing Board delegates the production and sign-off of the implementation plan to the CYPSPB;
- iii) Regular updates on the Charter will be scheduled and included in the Health and Wellbeing Board work programme.

#### **4. Clinical Commissioning Group Commissioning (CCG) Strategy**

Dr Helen Tattersfield, Chair of Lewisham Clinical Commissioning Group, presented the report, which provided an update on the development of Lewisham CCG's five-year commissioning strategy. She advised that the document will be further refined.

The discussion highlighted the following points:

The priorities fit well with the strategic priority areas identified by the Health and Wellbeing Board.

As with the priorities of the Health and Wellbeing Strategy, it would be important for all members to support the CCG's strategic direction. Members of the Board will play a key role in monitoring progress against the identified priorities.

**RESOLVED** that:

- i) The Board agrees that consideration and review of the CCG Strategy should remain on the Board's work programme.

#### **5. Health Protection in Lewisham and proposed future arrangements**

Dr Donal O'Sullivan, Consultant in Public Health Medicine, presented a report to brief the Health and Wellbeing Board and to seek its support on the recommended actions to address health protection issues in Lewisham.

Members noted:

- A Lewisham Health Protection Strategy Group would be established, reporting to the Health & Wellbeing Board. The terms of reference should be consistent with the outline provided in Appendix A of the submitted papers and agreed by the group.
- A workshop will be arranged for September 2013 on the issues covered in the report. Membership of the Health Protection Strategy Group will be finalised at that workshop.
- Top challenges within health protection include Tuberculosis and Sexual Health.
- Health Protection is a crucial area that offers an opportunity for further synergy between Health and the Local Authority.
- Where appropriate, other groups will be set up to address specific issues. For example, the Immunisation Group, which already exists, will be reporting to the Health Protection Group.
- Duplication of work across groups needs to be pre-empted and avoided.
- The first key task of the new Health Protection Strategy Group would be to review health protection plans already in place locally and identify any additional plans needed.
- A TB action plan for Lewisham would be developed, based on recommendations in the TB Joint Strategic Needs Assessment (Autumn 2013).

**RESOLVED** that:

- i) To schedule further discussion on Health Protection at a future Board meeting.
- ii) Public Health to be invited to present an item on Resilience at a future Board meeting.

**6. Recruitment of additional member from the voluntary Sector**

Tony Nickson, Director of Voluntary Action Lewisham, presented a report demonstrating that Voluntary Action Lewisham (VAL) has given consideration to the methods of recruitment for an additional member from the voluntary sector to the Health & Wellbeing Board. It was proposed that the additional member would:

- represent the voluntary and community sector and have a leadership role, such as that of a trustee or a director, in an organisation that is a member of VAL;

- have an active interest in health and social care provision in Lewisham and be able to represent a wide and diverse range of communities at the Health & Wellbeing Board;
- be responsible for liaising with, and feeding back to, the Health and Social Care Forum (which is co-ordinated by VAL);
- serve a term of one (1) year.

In discussing the proposal, members of the Board raised the following points:

- On the term to be served, it would be preferable to have continuity of the member, since annual membership might disrupt their cycle of work and contribution.
- On appointment through VAL, it would be more democratic to include non-VAL members, though any nominated person would require the endorsement of their organisation.
- On representation, the specification should be clear that the person should not simply represent their own organisation, but be able to bring a wider Third-Sector perspective to the table.

**RESOLVED** that:

- i) VAL be requested to run an election process to secure a representative of the Third Sector for the Health & Wellbeing Board, being mindful of the points raised by the Board during their discussions.
- ii) To schedule an agenda item for further update of Health and Wellbeing Board membership for the 19 September Board.

## **7. Work Programme**

Sarah Wainer, Head of Strategy, Improvement and Partnerships, introduced the Work Programme for comments.

**RESOLVED** that

- The item on Smoking should be taken to the 19 September Board.
- The Evaluation of Warm Homes should come for information to the 19 September Board.
- To postpone the item on CCG Commissioning to the 21 November Board.
- To postpone the item on the Public Health Budget to the 21 November Board.
- The Integrated Health & Care item should include information and guidance on what the Board needs to do, and by when.
- The Forward Plan needs to indicate, where possible, the progression path of each item by stating, briefly, where each report has been presented and where it will be presented next.

## **8. Membership changes**

Helen Tattersfield, Chair of Lewisham CCG, informed the Board that, owing to the pressure of her professional duties, she intended to stand down as the Chair of the CCG (and, therefore, also as the Board's Vice-Chair). The Chair thanked Helen for her significant contribution during her involvement with the Health and Wellbeing Board, as well as with the CCG and the former Shadow Health and Wellbeing Board.

Helen responded with thanks and reassured the Board that the election of her replacement would take place as soon as possible and that the CCG would continue to support the work of the Board.



HEALTH AND WELLBEING BOARD			
<b>Report Title</b>	Declarations of interest		
<b>Contributors</b>	Chief Executive – London Borough of Lewisham	Item No.	3
<b>Class</b>	Part 1	Date:	19 September 2013

## 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)

# Agenda Item 3

Health and Well Being Board			
<b>Title</b>	Lewisham Health and Social Care Scrutiny Protocol (Revised)	<b>Item No</b>	3
<b>Contributors</b>	Healthier Communities Select Committee		
<b>Class</b>	Part 1	<b>Date</b>	19 September 2013

## 1. Purpose of paper

- 1.1 To invite the Board to consider the Health and Social Care Scrutiny Protocol, which sets out how the Healthier Communities Select Committee will exercise its scrutiny responsibilities, and which also forms an agreement between the Committee and the Health and Wellbeing Board, healthcare commissioners and providers in Lewisham as to how they will interact.

## 2. Recommendations

- 2.1 The Board is recommended to:

- note the role of the Healthier Communities Select Committee
- to be a signatory of the Lewisham Health and Social Care Scrutiny Protocol

## 3. Health and Social Care Scrutiny Protocol

- 3.1 In 2008, the Healthier Communities Select Committee (HCSC) developed and agreed a Health and Social Care scrutiny protocol with local commissioners and providers as to how the various bodies would interact with the Committee as it exercised its statutory health scrutiny duties. The protocol included specific agreement about regular and routine interaction, how potential services variations would be dealt with and how interaction with the Lewisham Involvement Network (LINK) would also be maintained, in part through the attendance of two LINK members at every HCSC meeting.
- 3.2 The introduction of the agreements set out in the protocol have led to closer working relationships with local provider trusts and commissioners over the last 4 years and much earlier engagement with proposed service developments, as well as collective agreement on an agreed template for assessing whether a proposed variation might be considered substantial by the Committee. Regular attendance at the Committee meetings and routine engagement with the Chair has benefitted both the Committee and the local organisations by the effective communication it supports, enabling interaction to be targeted and appropriate.
- 3.3 With the changes brought in by the Health and Social Care Act 2012 being implemented from April 2013, it was recommended to the Committee and the relevant partner organisations that the protocol be updated in light of these changes, to ensure ongoing effective relationships with local commissioners and providers and Lewisham Healthwatch.
- 3.4 On 16 April 2013, the Committee agreed that the Protocol be revised, in discussion and agreement with the appropriate local organisations and bodies. On 4 September 2013 the Committee considered a draft of the revised protocol and agreed that the

Health and Wellbeing Board be asked to agree to the protocol, specifically to the inclusion of the commitments that the Board will:

- ensure that the health and wellbeing strategy and resultant delivery plan are made available to the Committee for pre-decision scrutiny before they are finalised and agreed by the Board,
- provide appropriate representation at Committee meetings when requested to attend in relation to a specific item being scrutinised

3.5 The Health and Social Care Scrutiny Protocol is attached at Appendix A.

## **5. Legal Implications**

5.1 As set out in the Constitution, the Healthier Communities Select Committee is required to:

- “fulfill all of the Overview and Scrutiny functions in relation to the provision of service by and performance of health bodies providing services for local people. These functions shall include all powers in relation to health matters given to the Council’s Overview and Scrutiny Committee by any legislation but in particular the Health and Social Care Act 2001, the NHS Act 2006 as amended, the Health and Social Care Act 2012 and regulations made under that legislation, and any other legislation in force from time to time.
- review and scrutinise the decisions and actions of the Health and Wellbeing Board and to make reports and recommendations to the Council and/or Mayor and Cabinet.
- To review and scrutinise in accordance with regulations made under Section 244 NHS Act 2006 matters relating to the health service in the area and to make reports and recommendations on such matters in accordance with those regulations
- Require the attendance of representatives of relevant health bodies at meetings of the select committee to address it, answer questions and listen to the comments of local people on matters of local

### **Background documents:**

Minutes of Healthier Communities Select Committee 16 April 2013 and 4 September 2013.

## Appendix A

# Lewisham Health and Social Care Scrutiny Protocol September 2013

### 1. Purpose of protocol

- 1.1 Local Authorities have an important statutory role in monitoring the performance and the development of health services in their area through Overview and Scrutiny. The Overview and Scrutiny process should also help to develop a positive working relationship between the Council and the wider health community.
- 1.2 The Health and Social Care Act 2012 has made some changes to the process of the scrutiny of health services. The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002, and 2004, are revoked and replaced by The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.
- 1.3 The local authority retains the role of scrutinising and reviewing any matter relating to the planning, provision and operation of the health service in its area. The local authority holds the statutory power of health scrutiny and determines how those functions are discharged, which is consistent with the principles of localism. While they may choose to retain a Health Overview and Scrutiny Committee arrangement, there will be no obligation to do so and the authority may choose to undertake health scrutiny through another committee or other suitable arrangement. In Lewisham the health scrutiny responsibilities have been devolved to the Healthier Communities Select Committee (HCSC).
- 1.4 This protocol seeks to set out how the Healthier Communities Select Committee (hereafter “the Committee”) will fulfil this role and should be read in conjunction with the Committee’s Terms of Reference, the Council’s Constitution and Member Code of Conduct.
- 1.5 This protocol will provide detailed guidance as to how the Committee will discharge its responsibilities, and how the Committee will interact with local NHS bodies, the Local CCG, Lewisham Healthwatch and the Health and Wellbeing Board when they are discharging those of their responsibilities that require interaction between the Committee and those bodies. It further outlines what is expected of local NHS bodies within those interactions.

### 2. Effective Scrutiny

- 2.1 The Centre for Public Scrutiny (CfPS) Good Scrutiny Guide defines four principles of effective public scrutiny.

These propose that good scrutiny:

- provides “critical friend” challenge to executive policy makers and decision makers
- enables the voice and concerns of the public and its communities
- is carried out by “independent minded governors” who lead and own the scrutiny process





regulations made under that legislation, and any other legislation in force from time to time.

- review and scrutinise the decisions and actions of the Health and Wellbeing Board and to make reports and recommendations to the Council and/or Mayor and Cabinet.
- To review and scrutinise in accordance with regulations made under Section 244 NHS Act 2006 matters relating to the health service in the area and to make reports and recommendations on such matters in accordance with those regulations”<sup>1</sup>

3.2 Under Section 7 of the Health and Social Care Act 2001, a duty was placed on local NHS organisations to consult overview and scrutiny on any proposal for a substantial development or substantial variation in the provision of services.

3.3 In 2010, the Secretary set out four key tests against which NHS service reconfigurations (significant changes to services) have to be assessed. These tests were set out in the Revision to the Operating Framework for the NHS in England 2010/11<sup>2</sup>. This requires reconfiguration proposals to demonstrate:

- support from GP commissioners;
- strengthened public and patient engagement;
- clarity on the clinical evidence base; and
- consistency with current and prospective patient choice.

3.4 Neither the legislation nor the guidance defines what constitutes a substantial development or variation in service. NHS bodies and overview and scrutiny committees are advised to aim for a local understanding of the definition, taking into account:

- a) changes in accessibility
- b) the impact of the proposal on the wider community
- c) patients affected
- d) methods of service delivery
- e) evidence based best practice

3.5 The final decision as to what constitutes a substantial variation sits with the body exercising the Overview and Scrutiny functions, in this instance the Committee.

3.6 Confidential or exempt information will be treated in accordance with the Local Government Act 1972 (as amended), and the requirements of the Data Protection Act, Freedom of Information Act and the Health and Social Care Act 2001.

3.7 Report to the Secretary of State

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<sup>1</sup> The Constitution of the London Borough of Lewisham

Lewisham “Full Council” has the power to report to the Secretary of State where it believes that:

- a consultation has been inadequate in relation to the content or time allowed
  - the reasons given for not consulting, in cases where there is a perceived risk to the safety or welfare of patients or staff, are inadequate
  - the proposals are not in the interests of the health service in the area
- 3.8 When a responsible health authority has under consideration any proposal for a substantial development , or substantial variation in the provision of the health service in the area of the local authority, the local authority, in Lewisham through the Healthier Communities Select Committee, must be consulted; the proposed date for making the decision provided, and the date by which the responsible health authority requires a response from the Committee.
- 3.9 If there are any changes to these dates, which are published, the Committee must be informed.
- 3.10 The Committee can comment, or make a recommendation, on the proposals.
- 3.11 Following the consultation exercise the health authority shall consider the outcome and notify the Committee of its decision on the proposal.
- 3.12 Where a recommendation is made, and there is a disagreement between the Committee and the relevant health authority over that recommendation, both the Committee and the health authority must take such steps as are reasonably practicable to try and reach agreement in relation to the subject of the recommendation.
- 3.13 Only if this requirement is disregarded by the health authority, or is not possible within a reasonable amount of time, is the Committee able to recommend to Full Council that it make a report to the Secretary of State.

#### **4. Conduct of Meetings**

- Meetings of the Committee will be open to the public except where confidential information may be disclosed.
- Reports will be presented as appropriate. Representatives from the NHS Trusts, the local Clinical Commissioning Group, Health and Wellbeing Board and the Council will be expected to answer the questions of the Committee.
- Different approaches and locations may be used for some meetings depending on the circumstances of the matters on the agenda
- Agendas will be circulated as public documents five clear working days before meetings in line with the Council’s Constitution and legal requirements. Copies will be sent to all local NHS Trusts, the local Clinical Commissioning Group, Health and Wellbeing Board and Lewisham Healthwatch.
- As with all Scrutiny Committees in Lewisham, the Committee will produce an annual work programme that is discussed and shared with local health bodies and Lewisham Healthwatch. The plan will identify priority issues

for the year and also build in capacity for the Committee to respond to consultations on service reconfigurations.

- The outcome of scrutiny exercises will be passed directly to relevant health organisations and such organisations will be expected to consider any recommendations and report back the outcome of such consideration.

#### **5. The Committee will:**

- maintain a positive style of questioning and treat witnesses with courtesy.
- familiarise itself with the subject under review prior to calling witnesses. Members will be prepared to undertake training if it is deemed necessary.
- ensure scrutiny of service changes and wider topics takes account of the national policy and government directives driving the service changes, yet focus on the local implementation of the national policy/directive and the areas of implementation to which the Committee can have a positive impact for local people.
- maximise public accessibility to the scrutiny process.
- hold regular agenda planning meetings with Council officers and nominated officers from all local NHS trusts and the CCG to discuss and agree the items to be scrutinised and the requirements of the Committee in terms of reports and consultation.
- provide details of dates and venues for all agenda planning meetings throughout the municipal year to all local NHS trusts and the local CCG at the start of each municipal year or as soon as available.
- carry out its responsibilities in line with members obligations in the Members Code of Conduct.
- provide all local NHS Trusts, the local CCG, Health and Wellbeing Board and Lewisham Healthwatch with the proposed dates of all Committee meetings at the beginning of the municipal year.
- ask Lewisham Healthwatch for their views on items they are considering, allowing enough time for responses to be pulled together.
- provide an acknowledgement of Lewisham Healthwatch referrals within five working days of receipt, advising the Lewisham Healthwatch of the date of the Committee meeting that the matter will be discussed at and inviting Lewisham Healthwatch to make representations at that meeting.
- provide a formal response to Lewisham Healthwatch referrals, outlining the action the Committee will take, and the reason for that action, within seven working days of the Committee meeting at which the referral was considered.
- invite local NHS Trusts and the local CCG to propose topics for inclusion in the annual work programme.
- ensure that when making a written report to an NHS body (other than responses to consultation on proposed substantial variations/developments in NHS services), the report shall include:
  - an explanation of the matter reviewed or scrutinised

- a summary of the evidence considered
- a list of the participants involved in the review or scrutiny
- any recommendations on the matter reviewed or scrutinised.
- circulate final reports and recommendations to Mayor and Cabinet, other Council committees and relevant organisations as the Committee determines relevant.

**6. Local NHS Trusts and the local Clinical Commissioning Group will:**

- ensure a designated senior officer attends every Committee meeting
- where the CCG is either leading on or has an interest in an agenda item a relevant member of the governing body (including GP commissioners) will attend the committee meeting to give evidence and answer questions
- regularly attend agenda planning meetings with the Chair to:
  - provide early notification of any upcoming service developments
  - provide completed Impact Assessments for consideration
- discuss the items planned on the work programme to be scrutinised at the upcoming meeting and ensure a clear understanding of the Committee's requirements of the Trust/CCG in terms of information required
- produce reports as requested by the Committee that address the area of concern as outlined at agenda planning
- ensure all reports include information regarding Equalities Impact Assessments carried out where relevant
- ensure all reports clearly advise the Committee of what patient and public involvement has been carried out in relation to the area being scrutinised
- provide reports to the Committee's scrutiny manager at least six working days before the Committee meeting at which the item is to be scrutinised
- maintain a positive and objective style of discussion and answer questions honestly and openly
- use jargon-free language as far as possible
- respond within a period of 4 weeks to reports and recommendations received from the Committee.

**7. The Health and Wellbeing Board will:**

- ensure that the health and wellbeing strategy and resultant delivery plans are made available to the Committee for pre-decision scrutiny before they are finalised and agreed by the Board
- provide appropriate representation at Committee meetings when requested to attend in relation to a specific item being scrutinised

**8. Lewisham Healthwatch will:**

- nominate 2 members to attend Committee meetings

- share its work programme with the Committee annually
- share the contents of its annual report, for information, with the Committee, prior to it being made public and submitted to the Secretary of State
- provide formal referrals to the Chair of the Committee and the Committees Scrutiny Manager 8 working days in advance of the next scheduled Committee meeting
- set up a process that allows it to represent participants' views to the Committee

## **9. Substantial variations or developments to services**

- 9.1 In reaching the agreement outlined in this protocol as to how substantial variations will be dealt with locally, the Committee, local NHS Trusts and the local CCG undertake to:
- Ensure that this is a clear and transparent agreement, easily understood by all the parties.
  - Maintain a common threshold of what determines a substantial variation or substantial development and to enable that threshold to be reviewed on a periodic basis.
  - Simplify the process of assessment and consultation.
  - Ensure the involvement of patients and the public in the process through the appropriate patient groups and Lewisham Healthwatch

The parties accordingly agree the following:

### **9.2 Principles governing Consultation and Assessment**

- 9.2.1 The CCG and/or NHS bodies shall notify the Committee and the relevant Patient group and Lewisham Healthwatch at a formative stage of any proposals for service change. The purpose being to provide early notice of possible changes and to obtain any preliminary views on whether the proposal is likely to amount to a significant change or variation.
- 9.2.2 The NHS bodies will follow Cabinet Office guidelines on good practice for consultation in all consultation exercises, and will follow Department of Health "Changing for the Better" guidance when undertaking major changes to NHS services, unless otherwise agreed by the parties. NHS bodies will make the Committee aware of any government guidance issued superseding these documents.
- 9.2.3 The Committee and local NHS bodies and the CCG all note the duty to consult and involve patients and the public (including relevant user/carer/patient or voluntary groups) conferred on NHS bodies by Section 242 of the National Health Service Act 2006. Furthermore the parties acknowledge that focusing consultation solely with the Committee would not constitute good practice.
- 9.2.4 The relevant NHS Trust(s) and/or CCG shall:
- Ensure awareness within their organisation of the need to consult.

- Identify a lead manager or clinician to co-ordinate the process.
- Ensure that patients and the public are involved in the planning, development and operation of services, as required under S.242 of the NHS Act (2006)
- Ensure that any proposals for variations or developments in service include the Impact Assessment detailed below.
- Where the variation or development in service covers more than one NHS Body, ensure that one of those bodies shall lead the assessment process on behalf of the others and only one assessment will be undertaken in that the impact is assessed from the perspective of all affected persons, including patients and carers and the NHS Bodies and local authority.

### **9.3 Substantial variation or development - Impact Assessment**

- 9.3.1 The determination of what constitutes a substantial variation or substantial development in service will be informed by a scored impact assessment process (scored evaluation matrix template at Appendix A) carried out by the NHS body and applying the criteria set out in section 8.4 and ensuring that the impact is assessed from the perspective of all affected persons, including patient and carers, the NHS bodies and local authorities concerned.
- 9.3.2 In determining whether or not a proposal amounts to a substantial variation or substantial development all parties will have regard to guidance issued by the Secretary of State and the impact of the change as assessed in accordance with the criteria set out in section 8.4 and as outlined in the completed Impact Assessment

### **9.4 Assessment Criteria**

- 9.4.1 The Impact assessment will be undertaken having regard to the following criteria;
- a) changes in accessibility
  - b) the impact of the proposal on the wider community
  - c) patients affected
  - d) methods of service delivery
- 9.4.2 Changes in Accessibility includes consideration of:
- Reductions and/or Increases in services on a particular site
  - Local provision/accessibility
  - Relocation of Services (e.g. moving a ward from one place to another)
  - Withdrawal of Service, (e.g. closing a well-established service, in-patient, day patient or diagnostic facilities)
- 9.4.3. The impact of the proposal on the wider community includes consideration of:

- Transport, e.g. the movements of the public, patients, staff and goods/supplies
- Community Safety, (e.g. on crime (fear of), domestic violence)
- Local Economy, (e.g. such as shops)
- Environment
- Regeneration (e.g. the potential to inhibit and/or contribute to regeneration of the area)

9.4.4 Patients affected includes consideration of:

- Number of Patients/Carers to be affected by the change
- Proportion of Patients/Carers Affected (the magnitude of the patients/carers affected compared to the service overall)
- Equality and Diversity (the impact on issues such as ethnicity, gender, age)
- Social Exclusion (the impact the change will have on access, life expectancy)
- views from the relevant Patients Forums, Healthwatch or other relevant carer/patient/voluntary groups

9.4.5 Methods of Service Delivery includes consideration of:

- Change in Setting, (e.g. moving a service from the hospital setting to the community setting or vice versa)
- Change in technology, (e.g. advances in technology permitting conditions to be treated with drugs instead of surgery)
- Change in Practitioner, (e.g. expanding/extending the role of nurses to provide care previously provided by doctors)
- Change in Care Process, (e.g. moving to one stop clinics from multiple visits to the surgery or hospital)

9.4.6 The financial implications for both the NHS trust and the Local Authority and other organisations should also be considered, as well as the cumulative effect of the proposed changes taken with other variations or developments, (whether or not they were originally viewed as "substantial" in themselves) which have been implemented within the previous 2 years

9.4.7 The parties acknowledge that the scored evaluation matrix shall be used to inform any decision as to substantial variation or change, but shall not necessarily be conclusive, and that the relevant professional advisers of the NHS body, local authorities and HCSC shall use their professional judgement in reaching and advising HCSC on any conclusions and decisions they make as to whether a change is substantial.

9.4.8 For the avoidance of doubt it is acknowledged that this agreement is not intended to apply to minor/routine operational/day to day decisions, or to variations or changes which are of a temporary nature (for example to address short term resource issues) unless early assessment of the proposed changes indicates that there may be a significant impact on one, or more, of the four assessment criteria areas.

## **9.5 Executing the Impact Assessment**

9.5.1 The relevant NHS body shall:

- arrange for the impact assessments to be carried out by or on behalf of both itself and the relevant Patients forum (or user/carer/patient/voluntary group to offer view on its behalf), and/or Lewisham Healthwatch.
- be responsible for consulting with all other agencies (including relevant departments of local authorities) insofar as necessary to address the Assessment Criteria
- Where an impact assessment indicates that the proposed service variation or development could be substantial, refer the proposal for consultation to the Committee together with:

the NHS Bodies plan or business case for the service development or variation

a copy of the impact assessment and supporting evidence

9.5.2 In the event an NHS body concludes, following an impact assessment, that a proposal does not amount to a substantial change or variation, the NHS Body (while under no statutory duty to do so) shall nonetheless notify the Committee at the earliest opportunity of the proposal and supply a copy of their assessment, (together with any assessment carried out by a relevant user/carer/patient/voluntary group).

## **9.6 Responding to Impact Assessments and proposed variations**

9.6.1 Upon receipt and consideration of an impact assessment the Committee (either itself or through the authorised member at agenda planning) shall (without prejudice to its rights under Regulations 2(1) and 4(7)) determine the following;

- whether or not it considers all relevant issues have been properly addressed
- if not, what further matters should be considered or considered further
- whether or not it agrees with the conclusion of the impact assessment
- if not, where it disagrees, and
- the nature and extent of consultation to be undertaken

9.6.2 For the avoidance of doubt, where the Committee, upon receipt of an impact assessment, and contrary to the views of the NHS body, forms a view that the



proposal amounts to a substantial variation or development, the NHS body shall;

- carry out the consultation required under Regulation 4 in respect of that proposal, and
- defer any action on the implementation of the proposal pending the conclusion of the said consultation and the proper consideration of its outcome.

9.6.3 The Committee has authorised the Chair, in consultation with the Vice-Chair and any relevant non-voting advisory members, to express a view on the above matters on behalf of the Committee, at agenda planning meetings. Such discussions will be supported by the relevant Scrutiny Manager (and legal officer as appropriate) and will be reported to the next meeting of the Committee.

9.6.4 In all circumstances where it is agreed that a proposed service variation/development is substantial, the NHS body/bodies will allow sufficient time for the Committee to be convened and for the members of the Committee to have adequate time in which to construct a response. The consultation period will normally be three months unless otherwise agreed between the NHS body and the Committee.

9.6.5 The Committee shall:

- ensure that effective supporting arrangements are in place to deal with referrals from NHS Bodies.
- Ensure that any necessary Joint Committee arrangements are in place following notification of an issue which requires a joint committee to be established
- Identify a lead officer and member of the Committee to co-ordinate the process.
- Respond to referrals within 31 calendar days with an indication of whether or not the NHS body's conclusion is agreed and the further action (if any) it proposes
- Respond to NHS consultation within the stipulated timescale, and if it does not support the proposals, it will provide reasons and evidence for its view
- Sign off the service variation if it is satisfied with the information it has received from the NHS body and no additional information is required.
- Request additional information/request the length of the consultation period to be extended if necessary to fully understand the potential implications of the proposed changes
- Refer the matter to the Secretary of State, should the Committee be minded to, based on the legal reasons set out at section 3.7. The relevant NHS body will be given the opportunity to respond to the Committee's comments and an effort at local resolution will be made.

## **Appendix A**

### **Impact Assessment – scored evaluation matrix template**

#### **Appropriateness and exceptions**

The impact assessment is a tool which should be used to demonstrate that due consideration has been given to service development. Its intended use is in circumstances where clarity is required to demonstrate whether a change requires or does not require public consultation and could be considered a substantial variation.

#### **The impact assessment should not be used in cases where there is to be -**

- No impact on services
- Re-provision of the same services on same site or equally accessible site
- Incontestable improvement to services and is in line with local and national NHS policy
- Temporary service relocation due to environmental or health and safety grounds.

Changes which occur as a result of the above will be notified to the Committee on a meeting by meeting basis.

#### **The impact assessment should be used in cases of**

- Uncertainty whether a change is “substantial” or not
- Where the service move has an impact on accessibility
- Where a temporary relocation becomes a permanent change of location

This Impact Assessment forms a significant part of the process used by the NHS and the Committee to help decide whether changes proposed constitute a “substantial variation” of service.

If a decision is made that the changes do constitute a “substantial variation” of service, formal consultation with the Committee (and with service users/the wider public) is necessary.

The Impact Assessment needs to be completed at an **early and formative** stage in the development of the proposals or discussion around service change - not at a stage when it is too late to make changes to the process.

The NHS Trust or CCG needs to score the form below to support the Impact Assessment - there is also an opportunity to comment on the issues this creates.

A score is also required from a group of people affected by the changes (eg patients, users or carers) before it can be submitted. The NHS Trust will need to identify and agree who will do this - for example it may be the local user group they are working with on the proposed changes, an involved voluntary group or the Healthwatch.

This is to demonstrate that the views of some of those affected by the change are incorporated in this part of the process. This is consistent with the NHS legal responsibility to involve and consult people who use services in the planning, operation and delivery of services.

This form and the Impact Assessment scores will be forwarded to the Committee for consideration.

**Impact Assessment Form**

<b>1. Impact Assessment Details:</b>	
Lewisham Healthcare NHS Trust / South London and Maudsley NHS Trust / Lewisham Clinical Commissioning Group	
<b>Name of proposal or service development:</b>	
<b>Name of person completing the form:</b>	
<b>Name of Patient Forum, Healthwatch or other patient/user/carer/voluntary group completing supporting Impact assessment:</b>	
<b>Date Impact Assessment scores completed:</b>	
<b>2. Please briefly describe the scope of the proposal or service development:</b>	
<b>3. Comments from the Service Provider on the Impact Assessment scores:</b>	
<b>4. Comments from the Healthwatch, patient/user/carer/Patient Forum or voluntary group on the Impact Assessment scores:</b>	
<b>Submitting NHS contact point for the Committees support officer:</b>	
<b>Tel no -</b>	<b>E Mail -</b>
<b>Date Impact Assessment forms submitted to the Committee:</b>	

*The scoring shall be undertaken on a seven point scale, ranging from major negative impact (-3) to major positive impact (+3), using the matrix set out below.*

A service variation or development shall be considered substantial where any aspect is deemed to have a major negative impact (i.e. scored -3) or where there are two medium impact scores in the same numbered section.

**Scoring chart**

<b>Impact Range</b>	-3	Major negative impact
	-2	Medium negative impact
	-1	Minor negative impact
	0	No impact
	+1	Minor positive impact
	+2	Medium positive impact
	+3	Major positive impact

1. Changes in Accessibility

Ref	Aspect	Healthwatch/Patient Perspective	Organisational Perspective	Impact
A	Reduction/Increase on particular site, or opening times			
B	Local Provision Accessibility esp disadvantaged or hard to reach groups			
C	Relocation of Service due to medical development, efficacy or efficiency			
D	Relocation of aspects of specialist care			

## 2. Impact on the Wider Community

Ref	Aspect	Healthwatch/Patient Perspective	Organisational Perspective	Impact
A	Economic impact			
B	Transport			
C	Regeneration			

## 3. The Patient Population affected

Ref	Aspect	Healthwatch/Patient Perspective	Organisational Perspective	Impact
A	Does it affect the whole community?			
B	Is it a small group accessing specialist services			
C	Is it a group requiring continual access over significant periods of time?			

## 4. Method of Service Delivery

Ref	Aspect	Healthwatch/Patient Perspective	Organisational Perspective	Impact
A	Change in Setting – e.g. hospital based to community			

HEALTH AND WELLBEING BOARD			
<b>Report Title</b>	Lewisham Hospital - Outcome of the Judicial Review and subsequent Government appeal		
<b>Contributors</b>	Executive Director for Community Services	Item No.	4
<b>Class</b>	Part 1	Date: 19/9/2013	

## 1. Purpose

- 1.1 This report informs Members of the Health and Wellbeing Board on the outcome of the judicial review heard in the High Court on 2-4 July 2013 and of the subsequent appeal lodged by the Government.
- 1.2 This report also updates Members on the proposed merger of Lewisham Healthcare with Queen Elizabeth Hospital and on the provision of services at Lewisham Hospital.

## 2. Recommendation

- 2.1 Members of the Health and Wellbeing Board are recommended to:
  - Note the outcome of the Judicial Review which found that neither the recommendations of the TSA nor the decision of the Secretary of State to reduce the facilities at Lewisham Hospital fell within their powers;
  - Note the appeal by the Secretary of State for Health which was lodged on 21 August against the decision;
  - Note that the planned merger of Lewisham Healthcare with Queen Elizabeth Hospital is unaffected by the outcome of the judicial review or the appeal and will take effect on 1 October 2013; and
  - Note that there has been no change to current services at Lewisham Hospital and all services are running as normal.

### **3. Policy Context**

- 3.1 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 *Shaping our future’s* priority outcome that communities in Lewisham should be *Healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and wellbeing.*

### **4. Background**

#### **4.1 The TSA report**

- 4.1.1 South London Healthcare NHS Trust (SLHT) was formed on 1 April 2009, as the result of the merger of three NHS trusts. The SLHT operates out of three main sites; Queen Elizabeth Hospital in Woolwich, Princess Royal University Hospital in Farnborough and Queen Mary’s in Sidcup.
- 4.1.2 Due to the SLHT being in severe financial difficulty, the Secretary of State for Health appointed Matthew Kershaw in July 2012 as Trust Special Administrator, under the Unsustainable Providers Regime (UPR). As TSA, Mr Kershaw took on the functions of the chairman and directors of the SLHT and was required to make recommendations to the Secretary of State in relation to the Trust.
- 4.1.3 Mr Kershaw produced a final report in January 2013 *Securing Sustainable NHS Services: The TSA’s Report on South London NHS Healthcare Trust and the NHS in South-East London.*
- 4.1.4 In his report, the TSA made a number of recommendations in relation to Lewisham Hospital. Lewisham Hospital was to lose its fully admitting A and E service, its 24/7 surgical and medical inpatients’ service, its inpatient paediatric service, its critical care and obstetric led maternity units and its complex inpatient surgery unit. It was proposed that Lewisham Hospital become a centre for elective surgery.
- 4.1.5 Following the submission of the TSA’s report to the Secretary of State, the Council made representations to the Secretary of State. In those representations the Council disputed the legal powers of the TSA/Secretary of State to make the service changes proposed at Lewisham Hospital, and the basis for doing so.



4.1.6 The UPR regime required the Secretary of State to make his decision in relation to the TSA's recommendations by 1 February 2013. On 31 January 2013, the Secretary of State accepted the TSA's recommendations, with modifications suggested by Sir Bruce Keogh. The Secretary of State agreed the TSA recommendations in respect of Lewisham Hospital as outlined above. The Secretary of State said his decision would be implemented over a three year period.

## **5. The Judicial Review**

- 5.1 On 20 February, the Mayor agreed that the Head of Law be authorised to pursue judicial review proceedings.
- 5.2 Two separate judicial review applications were brought and heard together in the High Court from 2-4 July 2013; in the first case by the London Borough of Lewisham and in the second case by Save Lewisham Hospital Campaign. Both claimants contended that the decision was *ultra vires* because the powers of the TSA and the Secretary of State are confined to the particular NHS Trust in relation to which the TSA was appointed, and that the tests for reconfiguration were not met. In addition, both parties claimed that the proposals did not have the support of the GP commissioners.
- 5.3 In his judgment, Mr Justice Silber concluded that neither the recommendations of the TSA nor the decision of the Secretary of State reducing the facilities at Lewisham Hospital fell within their powers. He also agreed that support from the Lewisham's CCG should have been obtained as they used most of the services at Lewisham Hospital. As a result, Mr Justice Silber quashed the decision of the Secretary of State insofar as it related to Lewisham Hospital, along with the recommendations of the TSA insofar as they related to Lewisham Hospital
- 5.4 Mr Justice Silber did give the TSA and Secretary of State for Health permission to appeal though on the basis that the issues on which they seek permission are important issues as to when and how Chapter 5A of the National Health Services Act 2006 can be used and because there has been no previous authority on this.
- 5.5 A full transcript of the judgment can be found at the following link:

<http://www.judiciary.gov.uk/Resources/JCO/Documents/Judgments/Lewisham-v-SSH310713.pdf>

## **6. The Appeal**

- 6.1 Although the decision of the Secretary of State was quashed at Judicial Review, along with the recommendations of the TSA insofar as they related to Lewisham Hospital, the Government lodged a formal application on 21 August (the last day on which it could do so) to

appeal the decision of Mr Justice Silber at the Court of Appeal. At the time of writing this report, no further information on the detail or timescale of the appeal is available.

## **7. The Merger**

- 7.1 In developing his recommendations for the final report, the TSA undertook a market engagement process to seek input from other organisations on the best organisational solution to deliver clinically and financially sustainable services.
- 7.2 During this process, Lewisham Healthcare NHS Trust proposed coming together with Queen Elizabeth Hospital in order to establish a new NHS Trust. This merger was supported and recommended by the TSA in his final report. The merger is unaffected by the judgment or by the appeal and will proceed on 1 October 2013. The business plan for the new Trust is being finalised and will cover a two year period. It does not include any proposals for changes to emergency or maternity services.

## **8. Current Position**

- 8.1 At the time of writing this report, the substantive grounds on which the Government has appealed are unknown. The Council has issued an application for the appeal to be expedited and for the hearing to take place before the end of October 2013 but this is subject to judicial approval.
- 8.2 If further information is obtained before the meeting of the Health and Wellbeing Board, a verbal update will be provided by the Executive Director for Community Services.

## **9. Financial implications**

- 9.1 The Council has not incurred any costs as a result of the Judicial Review process. In the event of the Council incurring any costs following the Government's appeal against the High Court ruling, then a call against the Council's available corporate resources would be made to cover these costs.

## **10. Legal implications**

- 10.1 In pursuing the Judicial Review, the Council relied on the general power of competence which is a power available to local authorities in England that allows them to do "anything that individuals generally may do". It was provided for in the Localism Act 2011 and replaces the well-being powers in the Local Government Act 2000. The general power of competence does not remove any duties from local authorities.

10.2 As part of their statutory functions, Members are required 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, and to encourage persons who arrange for the provision of health-related services in its area to work closely with the Health and Wellbeing Board.

## **11. Crime and Disorder Implications**

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

## **12. Equalities Implications**

12.1 There are no specific equalities implications arising from this report or its recommendations

## **13. Environmental Implications**

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

## **14. Conclusion**

14.1 At Judicial Review, Mr Justice Silber decided that the TSA did not have vires to make his recommendations and that the Secretary of State did not have vires to make his decision. The Government has appealed against the High Court ruling. Officers will inform Members of the Health and Wellbeing Board of the outcome of the appeal as soon as it is known.

### **Background Documents**

*Approved Judgement – Judiciary.gov – Neutral citation number:{2013} EWHC 2329 (Admin) Case CO/2744/2012 AND CO/2930/2013 Royal Courts of Justice, Strand London. Date:31 July 2013 Before Mr Justice Silber, Between London Borough of Lewisham and Save Lewisham Hospital Campaign and Secretary of State for Health and the Trust Special Administrator appointed to South London Hospitals NHS Trust*  
<http://www.judiciary.gov.uk/Resources/JCO/Documents/Judgments/Lewisham-v-SSH310713.pdf>

*Securing sustainable NHS services: the Trust Special Administrator's report on South London Healthcare NHS Trust and the NHS in South East London, Final report , Volume 1 of 3, 7 January 2013*  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213341/TSA-VOL-1.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213341/TSA-VOL-1.pdf).

If there are any queries on this report please contact Dr Petula Peters, Consultation and Research Officer, London Borough of Lewisham, on 020 8314 6575, or by email at [petula.peters@lewisham.gov.uk](mailto:petula.peters@lewisham.gov.uk)

HEALTH AND WELLBEING BOARD			
<b>Report Title</b>	Preventing the uptake of smoking among children and young people and reducing the number of people smoking		
<b>Contributors</b>	Jane Miller, Deputy Director of Public Health	Item No.	5
<b>Class</b>	Part 1	Date: 19 September 2013	

## 1. Purpose

1.1 The purpose of this report is to:

- update the Board on progress against this priority outcome
- inform the Board of future plans
- seek approval on proposed future actions by Board members

## 2. Recommendation/s

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

- Consider this report on progress regarding this priority outcome
- Ensure everyone in Lewisham knows how to access help to stop smoking by making a commitment to identify workforce members to be trained to deliver smoking brief interventions;
- Ensure sign up and representation on Smoke Free Future Delivery Group from all partners
- Champion ongoing initiatives to tackle illicit tobacco including enforcement and social marketing.

## 3. Policy Context

3.1 Reducing smoking prevalence was identified in Healthy Lives, Healthy People: A Public Health Strategy for England, (which informed the Health and Social Care Act 2012) and as an indicator in the Public Health Outcomes Framework, which sets out a vision for public health, desired outcomes and the indicators to measure improvement (1).

3.2 The Lewisham Smokefree Future Delivery Plan contributes to the following Lewisham Sustainable Community Strategy priorities: ambitious and achieving; safer; clean, green and liveable; healthy, active and enjoyable; empowered and responsible; and dynamic and prosperous and to the overarching aim of reducing inequality.

Smoking is one of the nine priority outcomes, identified in the draft Health and Well Being Strategy for Lewisham and the vision is that:

- In three years' time, there will be a reduction in the numbers of children and young people taking up smoking by 10%, more children living in smoke free homes, and a reduction in the use of illicit tobacco.
- In five years' time, the number of adults smoking will drop to less than 15%, and the numbers of children and young people taking up smoking will be reduced by 20%.
- In ten years' time, there will be very few smokers and very few children will live with smokers. It will be socially unacceptable to smoke indoors or in cars and very few young people will start smoking.

3.3 The Lewisham Children and Young People's Plan 2012-15 (4) identifies intervening early to reduce the numbers of children and young people starting smoking is an area of focus. There are a range of actions identified within the plan, which will reduce the impact of smoking and tobacco on children's lives. The outcomes identified for 2015 are:

- Staff can provide good quality, consistent and appropriate messages on the impact of tobacco
- Reduced levels of tobacco-related illness in children and young people.
- Even greater participation of children's centres and schools in tackling this issue.
- More homes will be smoke-free so that more children are kept safe from exposure to second-hand smoke
- Increased numbers of parents will stop smoking
- Fewer children and young people will start smoking.

#### **4. Background**

4.1 Smoking is the primary cause of preventable morbidity and premature death (2). Compared to England Lewisham had significantly more smoking attributable deaths in 2008-10 and hospital admissions in 2010/11 (3).

4.2 Currently about 20% of people over 18 smoke in England and about 22% of people smoke in Lewisham (approximately 43,000 smokers). This has fallen since a peak in the 1940s, but shows signs of levelling off more recently. Two thirds of smokers want to stop.

4.3 Reducing smoking is a priority for the Board this year, along with alcohol and obesity.

- 4.4 Reducing smoking prevalence and preventing the uptake of smoking among young people remains a challenge in Lewisham.
- 4.5 An estimated 710 young people in Lewisham started smoking in 2011 which is more than twice the national rate. Nationally, 12% of 15 year olds smoke, equivalent to 338 in Lewisham.
- 4.6 It is important to tackle youth take up because 80%+ of adult smokers start by the age of 19. Delaying onset may mean a young person does not start at all. The younger people are when they start to smoke, the greater the damage to health in later life and risk of premature death.
- 4.7 Young people overestimate prevalence and think about half the population smoke. The tobacco industry targets young people to maintain their customer base. It is estimated that they have to recruit 500 young people per day in the UK to do this. Smoking is over represented in relation to current prevalence in the media and the images do not reflect the reality of smoking.
- 4.8 Cigarettes are carefully marketed to young people and as a way to suppress appetite and stay slim, taking advantage of the desire to have the perfect body. Brands and flavours of cigarettes are specifically aimed at young people. Brands are an important form of advertising in countries like the UK where other forms of advertising have been regulated.
- 4.9 Children and young people are much more likely to smoke if their parents, siblings and friends smoke.
- 4.10 NICE recommends a comprehensive, multi layered approach to preventing uptake of smoking by children and young people. Ideally, there should be a combination of universal and targeted approaches and at different 'trigger points' at different ages and stages of a young person's development.
- 4.11 There is a significant market in illicit tobacco within SE London. The illicit tobacco market represents around 15% of the tobacco consumed and is a trade worth over £20 million p.a., above the UK average levels predicted by Her Majesty's Revenue & Customs (HMRC) (5). In Lewisham, 10% of the tobacco consumed by those surveyed was illicit. Thirteen out of every twenty smokers surveyed had been offered illicit tobacco. Around three in ten smokers reported that they bought illicit tobacco at least once in the last year, which implies a very high degree of acceptance of the illicit trade. The scale and value of the trade is likely to be supporting the presence of organised criminal gangs in the area and supporting other criminal activities ranging from drug trafficking to people trafficking, which has been confirmed in a 2011 report by HMRC.

- 4.12 The estimates for the scale and value of the illicit tobacco trade contrast markedly with confirmed reports of illicit tobacco sales, which imply it is neither easily nor openly available. The market is largely covert in SE London, with 80% of smokers who bought illicit tobacco stating they were known to or introduced to the seller. Buying from someone's home now appears to be the most significant source of illicit tobacco in Lewisham, both in terms of frequency of purchases and volume of tobacco, followed by buying from a pub.
- 4.13 A delivery group, chaired by public health, with representation from a broad range of agencies has been meeting for the last couple of years, with an action plan focused on the following three strands:
- Preventing the uptake of smoking by children and young people
  - Reducing exposure to second hand smoke
  - Motivating smokers to quit

These are based on the national tobacco control strategy, maximise the use of the current evidence base and pilot initiatives and evaluate them where the evidence is less well developed.

## **5. Preventing the uptake of smoking among young people**

- 5.1 In line with NICE guidance, Lewisham's approach is multi-layered.
- 5.2 **Tobacco regulation & enforcement:**  
Lewisham Trading Standards ensure that the controls and restrictions upon the lawful supply of tobacco are complied with (such as the advertising and display of tobacco products, the sale of single cigarettes and the sale of tobacco to persons under 18).
- 5.3 They also play a key role in detecting and eliminating the availability of illicit tobacco (counterfeit, smuggled/ bootlegged, inadequately labelled etc) including so called 'niche products' such as shisha & non smoked tobacco items. This has recently been informed by findings of the recently commissioned survey on illicit tobacco intelligence findings.
- 5.4 Cheap tobacco undermines the pricing policy which aims to protect young people from taking up smoking. The cost of smoking is important to young people who have less disposable income. Tackling the illegal trade in tobacco products to protect children has been prioritised and is identified in the CYP Plan. Key future actions a social marketing campaign aimed at smokers and building capacity to detect and prevent the sale of illicit tobacco.
- 5.5 **Peer education:** Involving young people and using the influence of peers has been shown to be an effective method of changing their



behaviour. Evidence shows that giving young people information about health on its own does not change their behaviour.

- 5.6 Some of the young people who are looked up to by their peers may be the more extrovert and risk taking young people who are more likely to take up smoking themselves. Involving them as advocates against the tobacco industry is a way to keep them from smoking and to use their popularity to influence others.
- 5.7 In 2012/13 there were two specific peer education initiatives within the Lewisham delivery plan to influence young people not to take up smoking, informed by The Truth Campaign in the USA (6): training Year 8 students to be peer educators in 5 schools and using film-making about tobacco with young people.
- 5.8 The Year 8 peer education programme is based on the ASSIST programme (7) in the UK. It is designed for Year 8 students, an age when many young people start trying out smoking. It offered training about tobacco and skills students to pass on their knowledge to peers and to influence them not to take up smoking. Everyone in Year 8 completed a simple questionnaire to identify the students who were most influential with their peer group. A group of 12 to 16 students were selected to take part in the project. They were trained and talked to and presented to their peers in Year 8.
- 5.9 In 2012/13, Cut Films were commissioned by Lewisham Public Health to work with 4 groups of young people (Abbey Manor Pupil Referral Unit, Lewisham College 14-16s group, Young Carers and Bellingham Gateway Youth Centre) to involve them in making films to enter into their national anti tobacco film making competition. These groups were chosen as young people excluded from school are much more likely to take up smoking. The 4 groups learned about tobacco and smoking and made 5 films about tobacco use to enter into the competition. All were involved in decision making throughout the project.
- 5.10 LeSoCo group was supported by Cut Films to attend a reception at the House of Lords, after the 2013 AGM of the British American Tobacco with ASH (Action on Smoking and Health). They asked questions and met 2 Lewisham MPs, Joan Ruddock and Heidi Alexander.
- 5.11 In 2013/14 schools will be offered a tobacco peer education programme for young people to influence their peers not to start smoking alongside a menu of other initiatives including the Cut Films Competition. Cut Films will build on the work they started and continue to support targeted groups to take part. They will also contact every secondary school and college to integrate the Cut Films anti tobacco film making into the mainstream curriculum to involve many more young people in every school and college in Lewisham.

- 5.12 Staff working with children and young people will have training on preventing uptake of smoking.
- 5.13 **Reduce exposure to second hand smoke:** The CYP Plan includes the provision of training on smoke-free homes and cars to staff working with children and families.
- 5.14 The proportion of homes that are smoke free is one of the outcomes proposed for inclusion in the new outcomes frameworks for health visiting and children's centre services. This will ensure that promotion of smoke free homes is a key element of the work of these services.
- 5.15 **Motivating smokers to quit:** People trying to stop smoking are 4 times more likely to succeed with treatment which combines behavioural support and medication than if they 'go it alone'. (8)
- 5.16 The Stop Smoking Service in Lewisham was set up in 2000 and provides smoking cessation support in a variety of settings (including GP surgeries, pharmacies, community centres and hospital) through its network of over 100 trained advisers. The quit target of 1800 was reached in 2012/13 after two years of not achieving the target.
- 5.17 From April 2007 to March 2012 almost 18,000 quit dates were set by 13,000 smokers and 46% of those resulted in a successful quit. The number of quit dates set per year has increased, but the success rate (the proportion of the quit dates set that result in a successful quit) has fallen, this is in line with the situation nationally. The majority of quit dates were set in GP practices, followed by pharmacies, with the highest success rates in GP practices and specialist services (more intensive support to heavily addicted smokers, including pregnant smokers and people with mental health problems).
- 5.18 The CYP plan has prioritised a number of actions to promote the Stop Smoking Service (SSS) including: children's services promoting the service to parents; proactively offering support to pregnant women and their partners to help them stop smoking; Primary schools sending information on the SSS to parents/ carers and inviting the service into schools.
- 5.19 In addition to this, the Stop Smoking Service has plans to raise awareness among other providers of the support available to help smokers quit through brief intervention training. This training will enable front line workers to be confident about discussing smoking and signposting service users to the Stop Smoking Service.

## 6. Financial implications

- 6.1 It has been estimated that the cost to Lewisham of smoking is between £51.2- £62m per annum based on an estimated 42,600 smokers (9,10).

NHS	Over 50,000 GP visits each year Almost 10,000 outpatient clinic visits Over 28,000 prescriptions Almost 1,700 hospital admissions	£9-13m
Societal Costs	Smoking-related litter in the borough	£1.7m
	Smoking related fires in Lewisham homes	£3m
Smoking-related productivity losses cost Lewisham businesses	short term as a result of smoking breaks	£14m
	additional smoking-related sick days (on average two additional days per smoker per year)	£3.5-£12m
	long term as a result of premature smoking-related mortality	£20m
Total		£51.2-62m

6.2 The expenditure on tobacco interventions is less than £1m, excluding the cost of prescribed medication, such as nicotine replacement therapy. Most of the tobacco control budget is spent on commissioning Stop Smoking Services (£529k at a cost of £294 per quit). More recently £100k has been allocated to prevention such as tackling the sale of illicit tobacco, peer education with 12 to 13 year olds in Year 8 and using film with young people to raise the issue of smoking. A part time Tobacco Control Programme Manager, with responsibility for leading the programme and commissioning Stop Smoking and Tobacco Control services is also funded (£40k).

6.3 The key benefits of stop smoking services, preventing premature morbidity and mortality, are seen in the longer term; where as the financial cost in providing services is required in the short term.

6.4 In the first 2 years of investing in a local stop smoking services<sup>1</sup> the following savings<sup>2</sup> would be made in Lewisham;

- £400,000 (NHS and business costs)
- 1200 sick days
- 50 hospital admissions
- 1600 GP visits

6.5 In the short term (2 years) the cost of each smoking death averted is £140,000. However when viewed over a lifetime providing stop smoking services both saves money and lives (that would have been lost to smoking).

6.6 Similarly in the short term the cost of each Quality Adjusted Life Year (QALY)<sup>3</sup> gained is £28,000 but over the course of a lifetime providing

<sup>1</sup> Includes NHS Stop Smoking Service, GP brief interventions (brief, opportunistic advice and information to raise awareness and support behaviour change) and other interventions such as text to stop, phone and internet support and self help books.

<sup>2</sup> Gross

stop smoking services reduces premature morbidity and saves money (in the treatment of smoking-related illness).

- 6.7 Over a lifetime local stop smoking services provide an additional 10 QALYs, or years of perfect health per 1000 smokers in the borough.
- 6.8 In the short term local stop smoking services would cost<sup>4</sup> £19 per smoker<sup>5</sup> in the borough but save £3 per smoker over a lifetime solely in NHS costs. Taking into account the savings in health gain<sup>6</sup> local stop smoking services would cost £6 per smoker in the short term and save money by 5 years; providing a net saving of £216 per smoker over a lifetime.
- 6.9 The benefits (including both healthcare savings and health gains) of local stop smoking services outweigh the costs within 5 years; over a lifetime the benefits outweigh the costs almost ten times (benefit:cost ratio of 9.83).
- 6.10 Providing local stop smoking services would provide a saving of £1.64 and £9.83 within 5 years and a lifetime respectively considering both NHS savings and the value of health gains.

## **7. Legal implications**

- 7.1 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.

## **8. Crime and Disorder Implications**

- 8.1 The concerns associated with the sale of illicit tobacco and criminal gangs have been described previously in this report.

## **9. Equalities Implications**

- 9.1 Increasingly smoking is one of the most significant causes of health inequalities. There is a strong link between cigarette smoking and socio-economic group, with those in lower socio-economic groups being more likely to smoke, least able to afford it and least able to give it up. Currently smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups.

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<sup>3</sup> One QALY is equal to one year of life in perfect health

<sup>4</sup> Net

<sup>5</sup> All smokers in the borough (not just those who access services or quit)

<sup>6</sup> Health gain calculated by assigning a monetary value to a QALY and multiplying by the number of QALYs gained.

Smoking is also strongly associated with mental health, it is estimated that psychiatric patients have a smoking prevalence of two to three times higher than the general population.

In 2010 Marmot highlighted tobacco control as central to any initiative looking to reduce health inequalities.

- 9.2 A Health Equity Audit of the Stop Smoking Service was recently undertaken. It considered the use and success of the service from April 2007 to March 2012 by age, gender, ethnicity, socioeconomic group and location. In addition the views of service users and advisers were sought on factors that may affect the use and success of the service.
- 9.3 It showed that although more women than men set quit dates men were more likely to quit successfully. Contrary to popular assumption men were more likely to use GP-based stop smoking advisers than women. Men were also more successful in quitting than women when using a GP-based service, though women were more successful than men when using pharmacy-based services. Older women seem to be underrepresented in users of the service when taking into account their smoking prevalence.
- 9.4 Over the last five years the rate of increase in the number of smokers using the SSS has been highest in those from most deprived areas. The importance of the role of specialist level three stop smoking advisers in reducing inequalities is evident as smokers from deprived areas and black African smokers are more likely to quit with their support in comparison to other providers of support.
- 9.5 Smokers from ethnic minorities are overall better represented amongst users of the service than in 2000-2005. Indian men, Chinese men, white Irish men and black Africans of both genders are least represented amongst users of the service currently. White Irish male smokers have a higher success rate than other ethnicities.
- 9.6 As is the case nationally younger smokers are both less likely to use Lewisham's Stop Smoking Services and less successful. Smokers aged 50-59 are five times more likely to quit (using the SSS) than those aged 15-19.

## **10. Environmental Implications**

- 10.1 The main environmental implications from smoking are smoking litter (estimated at 40% of all litter) and indoor pollution, leading to passive smoking. Reducing smoking prevalence would lead to a decrease in both indoor pollution and outdoor smoking litter.

## **11. Conclusion**

11.1 In summary, whilst smoking prevalence in Lewisham is reducing, there are still some groups with high rates of heavily addicted smokers. It is clear that reducing smoking prevalence and reducing the uptake by young people remains a challenge in Lewisham. The Tobacco Control programme in Lewisham includes a number of evidenced based initiatives and cost effective services, in line with best practice, with clear targets and indicators. The amount spent on tobacco control initiatives in Lewisham has increased over the past few years however the costs of smoking to Lewisham are much higher. As outlined in the recommendations there are a number of actions which the Board can take to continue and strengthen the work programme being taken forward by the Lewisham Smokefree Future Delivery Group.

### **Background Documents**

- (1) Healthy Lives, Healthy People: A Public Health Strategy for England 2012, DH
- (2) Lewisham JSNA [www.lewishamjsna.org.uk](http://www.lewishamjsna.org.uk)
- (3) London Health Observatory, Tobacco Profiles: [www.lho.org.uk](http://www.lho.org.uk)
- (4) London Borough of Lewisham, Lewisham Children and Young People's Plan: It's Everybody's Business, 2012-15
- (5) A survey commissioned in 2012 by Trading Standards & Public Health teams across South East London
- (6) R Campbell, F Starkey, J Holliday, S Audrey, M Bloor, N Parry-Langdon, R Hughes, L Moore, 2008 An informal school-based peer-led intervention for smoking prevention in adolescence (ASSIST): a cluster randomised trial [www.thelancet.com](http://www.thelancet.com) Vol 371 May 10, 2008
- (7) [www.protectthetruth.org/truthcampaign](http://www.protectthetruth.org/truthcampaign).
- (8) Robert West et al National Centre for Smoking Cessation and Training 2010
- (9) NICE tool 2012
- (10) Action on smoking smoking cost tool 2011

If there are any queries on this report please contact Jane Miller  
Deputy Director of Public Health, Community Directorate, London Borough of  
Lewisham on 020 8314 9058, or by email at: [Jane.miller@lewisham.gov.uk](mailto:Jane.miller@lewisham.gov.uk)

HEALTH AND WELLBEING BOARD			
<b>Report Title</b>	Lewisham's Health and Wellbeing Strategy		
<b>Contributors</b>	Director of Public Health	Item No.	6
<b>Class</b>	Part 1	Date:	19.09.13

## 1. Summary

- 1.1 The Health and Social Care Act 2012 introduced a statutory requirement for Health and Wellbeing Boards to prepare Health and Wellbeing Strategies (HWS) for their local areas. The Act states that joint Health and Wellbeing Strategies should provide an over-arching framework to ensure a strategic response to the health and social care needs of the local population.
- 1.2 Lewisham's Health and Wellbeing Strategy is a 10 year strategy whilst the delivery plan is initially for three years. A review will be undertaken at the end of the three years and this will inform the development of a subsequent delivery plan for the remaining years.

## 2. Purpose

- 2.1 This report seeks approval of Lewisham's Health and Wellbeing Strategy and asks the Board to note the accompanying draft delivery plan that sets out actions for addressing the priorities identified in the strategy.

## 3. Recommendations

Members of the Health and Wellbeing Board are recommended to:

- Approve the final version of the Health and Wellbeing Strategy – attached at Annex A;
- Note the current draft Delivery plan – attached at Annex B.
- Agree that the responsibility for further development of the plan and the monitoring of the plan will be undertaken by the Delivery Group, who will provide regular updates on progress to the Board.

## 4. Policy Context

- 4.1 The development and publication of a Health and Wellbeing Strategy is a statutory duty under the Health and Social Care Act 2012. The purpose of the Strategy is to inform commissioning decisions across

local services focusing on the needs of service users and communities, based on evidence provided in the Joint Strategic Needs Assessment (JSNA).

- 4.2 Local authorities, Clinical Commissioning Groups (CCGs) and the NHS Commissioning Board are required to take the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy into account when producing commissioning plans so that their plans are fully aligned with the jointly agreed priorities in the Health and Wellbeing Strategy.
- 4.3 Lewisham's Health and Wellbeing Strategy has been developed in the context of the Lewisham JSNA and other local strategies that aim to improve the lives of Lewisham's residents. These include:
  - Lewisham's Sustainable Communities Strategy
  - Lewisham's Children and Young People's Plan
  - Lewisham's CCG Commissioning Strategy
  - Joint Health and Care Commissioning Plans
  - Other strategies and plans (e.g. Housing, Safer Lewisham)

## **5. Background**

- 5.1 In its shadow form, the Health and Wellbeing Board initiated the development of a new Health and Wellbeing Strategy, building on the JSNA and the strengths and successes of existing plans and Strategies, whilst being more wide-reaching and ambitious in its scope. An officer group that supports the Board, with representation from the local authority, public health and other parts of the NHS, steered this process.
- 5.2 Through a review of the key evidence in the Lewisham JSNA, a review of existing intelligence from users, carers and 'less heard' groups including community engagement activities with key groups, the following key priorities for the Health and Wellbeing Strategy were identified:
  - 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.



- 5.3 The priorities cover those areas by which Lewisham Council and its partners can collectively:
- a) make the biggest difference to health and wellbeing at all levels of our health and social care system
  - b) take actions that will enable change and integration across social care, primary and community care, and hospital care
  - c) take early action now, that will improve quality and length of life in the future, and reduce the need for additional health and social care interventions later on.
- 5.5 The draft Health and Wellbeing Strategy has been revised following feedback from key partners. The Strategy – attached at Annex A - also includes ideas from people across the voluntary and community sector who have taken part in the development of the strategy. During a series of community engagement activities the sector was asked what issues it would like considered in order to improve health and wellbeing in Lewisham.
- 5.5 A delivery plan has also been developed and a draft is attached at Annex B. The draft Delivery Plan sets out the high level activities (deliverables) to achieve the improvements and outcomes required in each of the Health and Wellbeing Strategy priority areas. The next steps in its development is to ensure clarity on the individual contributions of each partner and to translate the plan into action in 2014/15. Whilst the Strategy covers 10 years the delivery plan is initially for three years. The Delivery Board will review progress and will consider if any additional steps need to be taken to ensure there is measurable and effective improvement. The Delivery Board will provide feedback to the Health and Wellbeing Board on a regular basis.
- 5.6 The draft Strategy and the draft Delivery Plan were presented to the Healthier Communities Select Committee on 4 September 2013.
- 6. Financial implications**
- 6.1 The actions identified in the delivery plan will be delivered by Lewisham Council and its partners on the Health and Wellbeing Board within the constraints of their existing budgets and future years' budget strategies.
- 7. Legal implications**
- 7.1 The Health and Social Care Act 2012 introduced a statutory requirement for Health and Wellbeing Boards to prepare joint Health and Wellbeing Strategies (HWS) for their local areas.

- 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 the area.

## **8. Crime and Disorder Implications**

- 8.1 Actions relating to Alcohol Harm Reduction e.g. underage sales test purchases, and also action for Tobacco Control e.g. work with Trading Standards to reduce access to illicit tobacco will contribute to reducing crime and disorder in the borough.

## **9. Equalities Implications**

- 9.1 In line with requirement in the Equality Act 2010, an Equality Analysis Assessment was undertaken on the Health Inequalities Strategy by assessing the possible impact that each of the priorities might have on each of the 9 protected characteristics. Census, GLA Population Projections and various other local and national data sources were used to assess the potential impact across the protected characteristics.
- 9.2 There was no clear evidence that the Health and Wellbeing Strategy as a whole will have a negative impact on any of the protected characteristics. In some cases there was likely to be a positive impact on one or more of the protected characteristics as they are the target of particular interventions under the strategic priorities. This is because of the JSNA process identifying a greater need as the result of worse outcomes or poorer use of healthcare, for example:
- Reducing alcohol harm amongst young women
  - Improving cancer survival amongst older people, through improved awareness of early symptoms and signs
  - Reducing rates of teenage pregnancy
  - Tackling obesity in children
  - Improving access to IAPT services amongst BME groups
  - Reducing emergency admissions for people with long term conditions.
- 9.3 In other cases people identified as having a protected characteristic may benefit more from some of the priorities as a result of an association with a target group, for example, older people are more likely to have complex healthcare and social support needs and are more vulnerable to crises that reduce their independence. They are therefore more likely to benefit from the strategy's priority to delay and reduce the need for long term care and support.

If there are any queries on this report please contact Dr Danny Ruta, Director of Public Health on 020 8314 9094.

**LEWISHAM'S HEALTH AND WELLBEING STRATEGY:  
HEALTH AND WELLBEING FOR ALL BY 2023**

**Foreword from the Chair of the Health and Wellbeing Board**

Welcome to Lewisham's Joint Health and Wellbeing Strategy for improving the health and wellbeing of local people.

[To be completed].

## Appendix A

### Our Vision for Health and Wellbeing

This ten year strategy has been developed by Lewisham's Health and Wellbeing Board (HWB) and sets out the improvements and changes that we as a Board, in partnership with others, will focus on to achieve our vision of

#### *Achieving a healthier and happier future for all*

This strategy outlines the key health and wellbeing challenges that people in Lewisham face, as well as the assets, skills and services that are available locally to support people to stay healthy and be happier.

As members of the Health and Wellbeing Board, we know that beneath the overall picture of health that exists, specific inequalities need to be addressed. In implementing this strategy, we will look for action that not only ensures that Lewisham performs as well or better than other boroughs with similar levels of deprivation, but also that all parts of Lewisham, and all members of its diverse communities enjoy the same quality of services and opportunities to maintain and improve their health and happiness.

In order to achieve long-term improvements in health and wellbeing, individuals, communities and organisations will need to work collaboratively. This collaboration starts with a joint commitment to ensure that people are at the heart of decisions about their care, that they are able to make choices over the care and support they receive and that there should be 'no decision about me, without me.'

We will also ensure that our work contributes to the objectives of Lewisham's Sustainable Community Strategy to reduce inequality, by narrowing the gap in outcomes for citizens; and to deliver together efficiently, effectively and equitably – ensuring that all citizens have appropriate access to and choice of high-quality local services

In taking forward action to achieve our vision we have three overarching aims

**To improve health** – by providing a wide range of support and opportunities to help adults and children to keep fit and healthy and reduce preventable ill health.

**To improve care** – by ensuring that services and support are of high quality and accessible to all those who need them so that they can regain their best health and wellbeing and maintain their independence for as long as possible.

## Appendix A

**To improve efficiency** –by improving the way services are delivered; streamlining pathways; integrating services so ensuring that services provide good quality and value for money.

### Our local area

Lewisham is a part of London, the largest, most culturally diverse and vibrant city in the European Union and home to over 7.5 million people. Lewisham’s future is shaped by the growth and success of London.

Lewisham covers an area of 13.4 square miles stretching from the Thames at its most northerly point to Bromley in the south. There are good transport links to the rest of London and the wider region. The West End, Canary Wharf, London City Airport and the new international rail terminal at Stratford are all within easy reach. Lewisham citizens can take full advantage of the opportunities available in London, one of the few world cities with strong global connections.

Some 275,000 people live in Lewisham. The borough has a young population, with a quarter of residents aged between 0 – 19. By contrast, just under 10% of the population is aged over 65. By 2021, Lewisham’s population is expected to increase to 321,121, an increase of over 44,000 residents in a 10 year period. The number of residents aged over 65 is projected to be 9%.

There is no common definition of disability, but 14% of residents identify themselves as being limited in carrying out day-to-day activities. Just over 8% of residents identified themselves as providing unpaid care to a friend or relative. This percentage has remained the same since the 2001 Census.

As a locality, Lewisham is the 15th most ethnically diverse local authority in England. Two out of every five Lewisham residents are from a black or minority ethnic background. There are over 170 languages spoken in the borough.

Lewisham is the 31st most deprived local authority in England, and relative to the rest of the country its levels of deprivation are increasing.

### Our Assets and Opportunities

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Within Lewisham, we are fortunate to be able to call upon many resources and assets that exist within our local communities and across the borough to support and promote health and wellbeing. Within Lewisham we have:

- the highest proportion of green space in London
- strong and active communities, able to mobilise their efforts and support each other to make changes
- a vibrant voluntary and community sector which provides tailored support and assistance to people
- an existing strong base of partnership working which has already established joint commissioning arrangements and integrated services
- 7 sports and leisure centres, 12 libraries and 21 children's centres. There are also 89 primary and secondary schools in Lewisham.

### What do we mean by 'health and wellbeing'?

Good health and wellbeing mean different things to different people. Any definition needs to reflect the fact that health isn't just about being free from illness or disease. It also needs to encompass how people feel in themselves and in the communities in which they live. And wellbeing means not only extending people's lives but also improving the quality of their lives. So for the purposes of this strategy, we have used the World Health Organisation's (WHO) definition to define health as *a state of complete physical, mental and social wellbeing* and chosen an approach to wellbeing as having *the capability to do and be what you want in your life*.

### What we know about the health and wellbeing of people in Lewisham

In developing this strategy we have considered all the information contained in Lewisham's Joint Strategic Needs Assessment (JSNA). The online JSNA ([www.lewishamjsna.org.uk](http://www.lewishamjsna.org.uk)) brings together in one place a wealth of information on the health and social care needs of Lewisham's citizens, complemented by information on the social, environmental and population trends that are likely to impact on people's health and well-being. The JSNA also includes the community and patient perspective.

## Appendix A

From this information, we know that, in general, people in Lewisham feel healthy. 83% of residents identify themselves as having good health or fairly good health. However, 5% identify themselves as having bad health or very bad health.<sup>1</sup>

We know that Lewisham residents are not as healthy as they could be:

- Men and women in Lewisham have a relatively low life expectancy compared with the England average.
- The three most important causes of this gap between Lewisham and the rest of the country are premature deaths below the age of 75, from circulatory diseases (mainly heart attacks and stroke), cancer (mainly lung, breast and bowel), and respiratory diseases.
- More people smoke than the national average and reducing the number of people in Lewisham who smoke would make a major impact on all three causes of premature death.
- Increasing numbers of people have long-term conditions such as diabetes or COPD and the numbers will increase with an ageing population as will those who have more than two conditions.
- Lewisham's black and minority ethnic communities are at greater risk from long-term conditions such as diabetes, hypertension and stroke.
- Prevalence of mental illness is high in Lewisham and there are inequalities within the borough: wards in the south of the borough (Downham, Bellingham and Whitefoot) have higher needs for services than some other areas.
- With increasing life expectancy, the number of people with dementia will increase, particularly in those aged 65 and over.
- There are high rates of teenage conceptions, sexually transmitted infections and obesity compared with England.
- The percentage of low birth weight babies is falling but still significantly higher than the England average, though now comparable to London as a whole.

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<sup>1</sup> Census 2011



## Appendix A

- Medical advances are helping people to live longer but, in line with this, more people can expect to live for some time with a care and support need.

We also know that people in Lewisham have different life expectancy depending on where they live. Men living in the most deprived areas in the borough live on average 6.5 years less than men in the least deprived areas. Women in the most deprived areas live 3.3 years less than women in the least deprived areas. In the last five years, the gap has closed by about a year for both men and women but there is more work to do. Cancer mortality rates for example are much higher in Bellingham and New Cross.

There are also significant ethnic health inequalities in Lewisham. Uptake of breast cancer screening is lower in black women, whilst late diagnosis of HIV infection is more common in black African heterosexual men. Black teenage girls are 74% more likely to get pregnant than white teenage girls. White men and women have higher rates of admission for alcohol related problems.

In summary, health outcomes vary across the borough. While some parts of the borough experience relatively good health, others experience high levels of health deprivation and disability. This is illustrated on the map below:

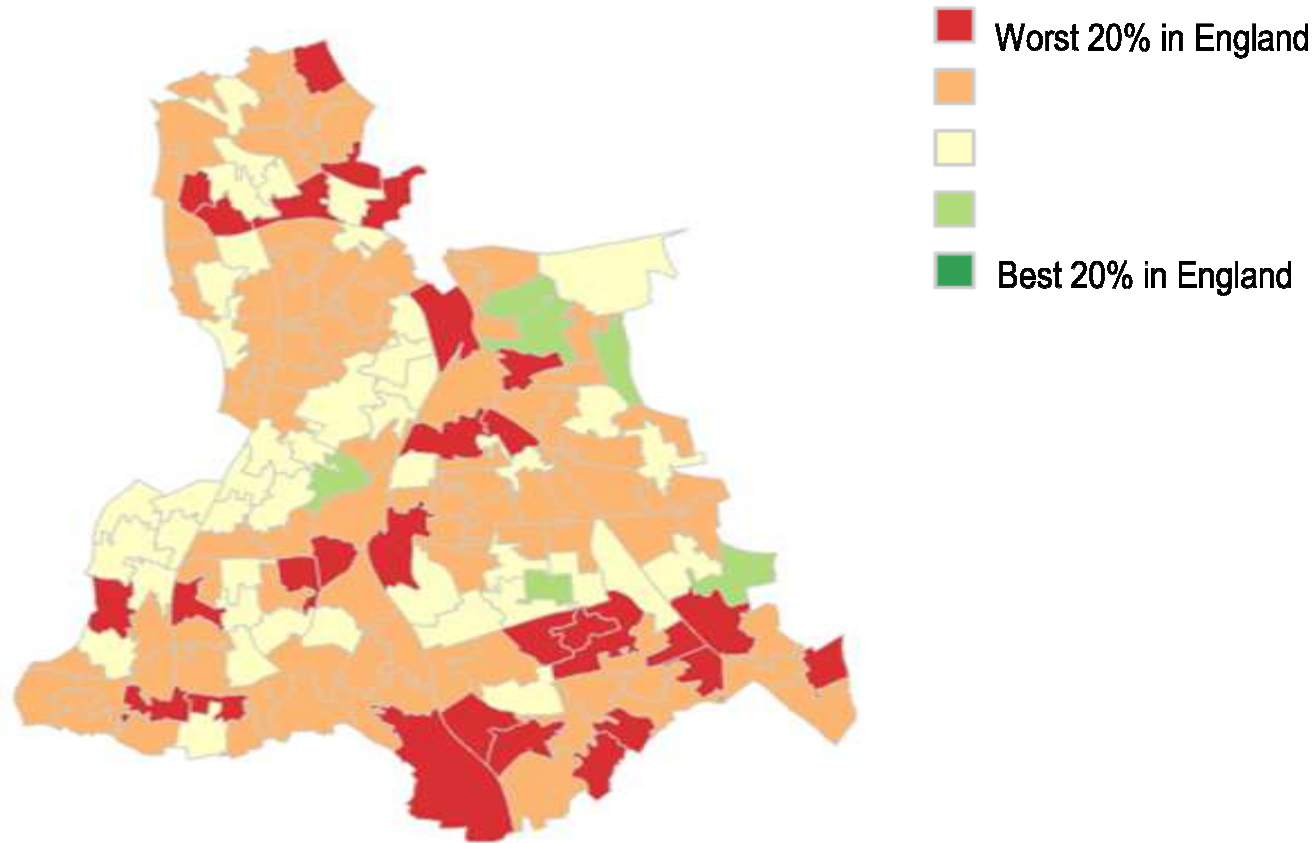


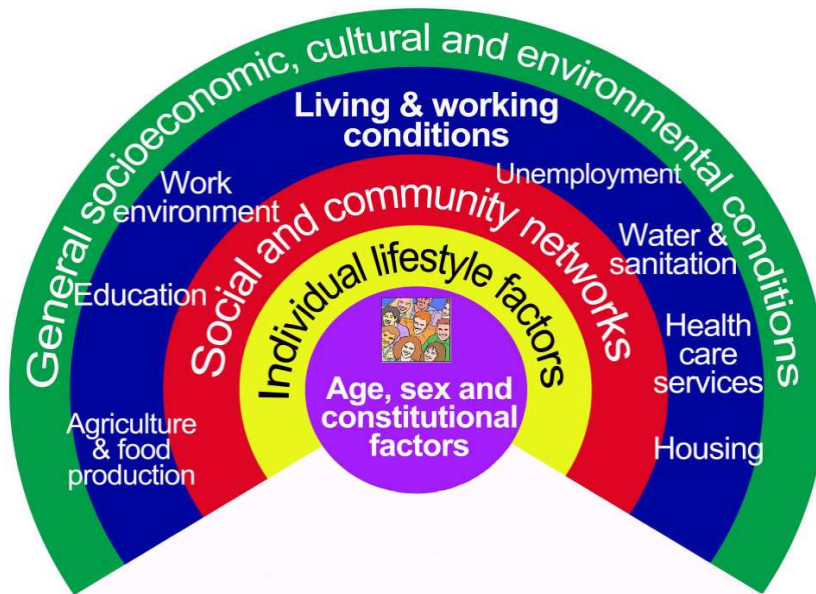
Fig 1. Indices of Multiple Deprivation 2010 – Health deprivation and disability

### Multiple Determinants of Health

We also know that health and wellbeing is affected by social factors as well as by the choices and actions taken by individuals. Such factors determine the quality and length of a person’s life. Some directly impact on health, and others shape the behaviours and thought processes that in turn affect physical and mental health and wellbeing.

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The following diagram summarises these multiple determinants of health:



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Given these wider determinants, it is important that this strategy connects with other strategies and plans across organisations as shown below:



## What you told us

We are grateful to people across the voluntary and community sector who have helped us develop this strategy. Voluntary and community organisations and groups across the borough provide extensive depth and reach into our communities and through their work provide intelligence on community needs, have knowledge about issues that affect health and wellbeing and represent the voice of our communities.

We asked the sector what issues we would need to consider in order to improve health and wellbeing in Lewisham and what the sector could contribute to delivering the strategy. They highlighted:

- The impact of social isolation on people's physical and mental health and wellbeing
- The barriers that hinder people from pursuing a healthy lifestyle, from cost and access to a lack of confidence to turn up and engage with existing activities.

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- The existence of a range of opportunities and activities, already provided within the community, that could support people to feel healthier and maintain their independence.
- The significant role played by Voluntary and Community organisations and Faith organisations in supporting people's engagement with their local community but also in acting as a trusted source of information.
- The importance of being able to easily access a wide range of cultural and leisure activities so that people could feel empowered and stimulated
- The value of combining traditional medical interventions with 'social' prescribing i.e. doctors and other health and social care professionals supporting people to access cultural, social and leisure opportunities in their local area
- How some groups are more at risk of poor health outcomes than others, for example carers, young carers and older people who do not have English as their first language
- Some of the key barriers to improving health and wellbeing: lack of organisational join-up, a lack of continuity between services, knowing what opportunities are available and having the time and space to consider which opportunities to access.

### **How will we work together to deliver improved health and wellbeing outcomes for Lewisham**

Alongside the statutory agencies, Lewisham enjoys the involvement and support of a diverse and vibrant voluntary and community sector. This sector is uniquely placed to complement statutory services and plays a vital role in providing expertise input into service design and delivery. We are also fortunate to have strong communities and neighbourhoods in which people actively take responsibility for the well-being of their area and those who live there.

We can strengthen and build on the strong networks and local connections that exist. We know can't expect everybody in Lewisham to be equally healthy and happy but we can work together to significantly improve people's health and wellbeing and reduce the inequalities in health and wellbeing that exist between different sections of our community, and between Lewisham and the rest of the country.

### Our Approach

## Appendix A

Informed by both the Marmot Review<sup>2</sup> and the Ottawa Charter Principles<sup>3</sup>, in commissioning, designing, developing and delivering the activities or services which will deliver our vision and aims the Board will look to an approach which:

*Empowers local people and communities to take control over their health and wellbeing*

Encouraging individuals to take control of and be responsible for their health and wellbeing as far as they want and are able to, by better equipping them to manage their own care. Providing timely information and advice so that people can make informed choices about the care and support they need.

*Creates supportive environments that help people to make positive changes*

Everyone will be empowered to be actively involved in their local neighbourhood area and be responsive to the needs of those who live there.

*Puts the patient at the heart of their care*

Putting the user at the heart of their care which is co-ordinated around the needs, convenience and choice of the individual and families. Patients and users taking the lead in how services are designed and being more involved in deciding the care and support they require.

*Recognises the health implications in everything we do*

Putting health on the agenda of policy makers in all sectors and at all levels.

*Is outcome focused*

Using the NHS, Public Health and Local Authorities outcomes frameworks and user and community feedback to measure success.

*Promotes integration and community based care*

Rearranging services in a way that provides the care and support people need, at the right time in the right place, and establishing neighbourhood-based delivery models where appropriate.

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<sup>2</sup> The Marmot Review in 2010 'Fair Society, Health Lives' <http://www.instituteofhealthequity.org/Content/FileManager/pdf/fairsocietyhealthylives.pdf>

<sup>3</sup> <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index1.html>

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### Priority areas

As partners, using the JSNA evidence and focusing on our three aims of improving health, care and efficiency, we have:

- looked at those areas which collectively are able to make the biggest difference to health and wellbeing at all levels of our health and social care system, from empowering people to make healthy choices to prevent ill health, through early intervention to prevent deterioration in health and wellbeing, to targeted care and support, right through to complex care for people with long term health problems;
- listened to the voice of Lewisham people and local communities, the voluntary and community sector, about the issues that affect their health and wellbeing;
- chosen those areas and actions that will enable transformative system level change and integration across social care, primary and community care, and hospital care;
- considered in particular those areas where early action now, for example by addressing the ‘causes of the causes’ of ill health and inequalities, particularly in the early years, or intervening to prevent dependency will improve quality and length of life in the future, and reduce the need for additional health and social care interventions later on.

In so doing, we have selected nine priority areas for action over the next ten years. These are:

#### **1: Achieving a Healthy Weight**

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

#### **3: Improving Immunisation Uptake**

#### **4: Reducing Alcohol Harm**

## **Appendix A**

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

**6: Improving mental health and wellbeing**

**7: Improving sexual health**

**8: Delaying and reducing the need for long term care and support.**

**9: Reducing the number of emergency admissions for people with long term conditions**



## Appendix A

For each priority area we describe why this area was chosen as a priority and what we want to achieve.

### Priority 1: Achieving a Healthy Weight

#### Why is this a priority?

- This has been identified as a priority because the prevalence of adult obesity is around 33% in Lewisham compared to 24.2% in England. Lewisham has a high prevalence of childhood obesity: 13.6% of reception children were obese as were 24.4% of children in year 6, significantly higher than the England average for the past three years. Over 40% of 10-11 year olds and over a quarter of 4-5 year olds were overweight or obese in 2009/10. Overweight and obesity is a major risk factor for cardiovascular diseases (mainly heart disease and stroke), diabetes; musculoskeletal disorders and some cancers (endometrial, breast, and colon).

#### What do we want to achieve?

Lewisham residents to take up opportunities to be physically active and for all children to engage in regular physical activity.

Help to be available to everyone who could benefit from weight management and to see a significant reduction in the percentage of children and adults who are obese.

The majority of fast food outlets to offer healthier food options, and now new outlets to open.

Children in Lewisham to have the same weight distribution as children living in England in 1990.

A significant reduction in the prevalence of type 2 diabetes and coronary heart disease.

## Appendix A

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

#### **Why is this a priority?**

Cancer survival rates in England are significantly poorer than in comparable countries. It has been estimated that if England was to achieve similar cancer survival rates to the European average, then 5,000 lives would be saved every year. If England was to achieve cancer survival rates of the European best, then 10,000 lives would be saved every year. Research suggests that a major explanation for poorer outcomes in England is that cancers are diagnosed at a later stage. It is known that there is greater delayed diagnosis for breast cancer amongst some groups such as older people and certain BME groups.

Lewisham does not reach the national coverage targets for the cancer screening programmes for Breast, Cervical and Bowel cancer. In Lewisham approximately 1,000 Lewisham residents are diagnosed with cancer each year. In 2011 there were 518 deaths from cancer in Lewisham.

#### **What do we want to achieve?**

- Reduce the prevalence of smoking as smoking is the single biggest avoidable risk factor for cancer.
- Men and women in Lewisham to be much more aware of signs and symptoms of key cancer types and to feel comfortable in visiting primary care settings with their concerns.
- Survival rates for cancer to be similar to the average survival rates in Europe and ultimately the best in Europe.

## Appendix A

### Priority 3: Improving Immunisation Uptake

#### Why is this a priority?

Immunisation is one of the most cost-effective health interventions available, saving millions of people from illness, disability and death each year. Effective and safe vaccines that protect against more than 20 serious diseases are available. Uptake of immunisation has been a problem in Lewisham for some time. Recorded uptake of indicator vaccines has been below target, and as a result, significant numbers of children in Lewisham have not been protected against potentially serious infections. Due to the low uptake of MMR vaccine, there was an outbreak of measles in Lewisham in 2008 with a total of 275 confirmed or suspected cases.

Uptake of many vaccines in adults is also short of achieving national targets. For example, though increasing numbers of the elderly are protected against influenza, and Lewisham achieved national targets for this group in the past two years, uptake of influenza vaccine in other groups remains an issue.

#### What do we want to achieve?

A significant increase in the uptake of all vaccines in Lewisham.

Herd immunity for all of the vaccine preventable diseases of childhood in Lewisham.

The incidence of all vaccine preventable diseases to have declined significantly and only sporadic cases of vaccine preventable disease to be seen in Lewisham.

## Appendix A

### Priority 4: Reducing Alcohol Harm

#### Why is this a priority?

This has been identified as a priority because alcohol use has a major impact on health, anti-social behaviour, crime and other important social issues, including the wellbeing and development of children. Deaths from liver disease have been increasing during the past 20 years, largely as a result of alcohol-related liver disease. In Lewisham over 11,000 drinkers are considered to be at at high risk, and over 31,000 drinkers are at increasing risk, of harm. Alcohol-related hospital admissions are high in Lewisham and are rising.

#### What do we want to achieve?

Practitioners to be skilled in identifying those at risk from alcohol harm and in delivering brief interventions.

Fewer drinkers at increased or higher risk of harm from alcohol and a decrease in the number of alcohol-related hospital admissions.

More people accessing and completing treatment services.

Young people exiting treatment in a planned way

A decrease in alcohol use by young people across the borough.

No increase in early deaths from liver disease in Lewisham and, to achieve the same or lower levels as England.

## Appendix A

### **Priority 5 : Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking**

#### **Why is this a priority?**

Tobacco use is the biggest single factor contributing to the gap in healthy life expectancy between Lewisham and England. There are still between 40-50,000 smokers in Lewisham. Over 700 11-15 year olds take up smoking each year and nearly half of Lewisham children say that someone smokes in their home on most days.

#### **What do we want to achieve?**

Practitioners to be skilled in delivering brief interventions on smoking

Very few children or young people taking up smoking.

A significant reduction in the number of adults who smoke and more children living in smoke free homes

Very little use of illicit tobacco.

For it to be socially unacceptable to smoke indoors or in cars.

## **Appendix A**

### **Priority 6: Improving mental health and wellbeing**

#### **Why is this a priority?**

Common mental illnesses such as anxiety and depression affect nearly 1 in 5 (19.8%) people in the Lewisham population. This is higher than London (18.2%) and England (16.6%). Seventy-five percent of people with common mental illnesses go undiagnosed. Rates of severe mental illness such as schizophrenia and bipolar disorders are also higher than the national average. Around 50% of mental disorders occur by the age of 14 years and 75% by the mid 20s. Identifying risk factors and early presentation of mental health problems can prevent escalation and help recovery.

#### **What do we want to achieve?**

For BME representation accessing psychological therapies to be representative of the local population.

Families to receive support from Child and Adolescent Mental Health Services or an alternative service to prevent the escalation of mental health issues and prevent more severe mental health problems.

All children who would benefit from support to protect their mental health to be identified at a younger age.

For mental wellbeing to be recognised as a key component of good health.

People with mental illness to be physically healthy through better access to screening and by receiving support for behaviour change in relation to smoking, physical activity and healthy weight management.

Suicide rates to be below the national average

An improvement in under 75 mortality for those with mental illness.

## **Appendix A**

### **Priority 7: Improving sexual health**

#### **Why is this a priority?**

Sexual health is a local priority due to high rates of teenage pregnancy, abortion, sexually transmitted infections and HIV. Although the teenage conception rate has fallen significantly in Lewisham it remains amongst the highest nationally. One in 10 young people aged 15-24 have chlamydia infection, a further 1 in 50 have gonorrhoea and HIV prevalence is amongst the highest in the UK.

#### **What do we want to achieve?**

All young people to know where and how to access free condoms and emergency contraception.  
A significant reduction in the teenage pregnancy rate.

All schools to receive SRE support.

All GPs to routinely offer HIV testing and late diagnosis of HIV to be a rare event.

Long Acting Reversible Contraception (LARC) to be widely available in most GP practices and at weekends and for LARC to become the preferred method of contraception for women over 20 years old.

## Appendix A

### Priority 8 – Delaying and reducing the need for long term care and support.

#### Why is this a priority?

Research suggests the provision of intensive short term interventions (enablement), at times of crisis, can reduce the demand for institutional and long term care and improve outcomes for service users. In addition, evidence suggests that people's need for ongoing social care support is reduced by 60 per cent compared to those who used conventional home care provision. Furthermore over 60 per cent of people who receive enablement services required no more than six weeks of intervention and support.

#### What do we want to achieve?

For any resident discharged from hospital and identified as needing health and social care support, to receive enablement services to regain their independent living skills.

For more people with complex health and social care needs to be supported to live at home and to receive integrated care and support from multi-agency teams working closely with their GP.

For people to be able to manage effectively their own conditions at home.



## Appendix A

### Priority 9: Reducing the number of emergency admissions for people with long term conditions

#### Why is this a priority ?

A long –term condition (LTC) is a health problem that can't be cured but can be controlled by medication or other therapies. Examples of long-term conditions are COPD, diabetes, depression, dementia and arthritis.

Chronic Obstructive Pulmonary Disease (COPD) is the third leading cause of disease burden in Lewisham. Only 40% of expected cases in Lewisham are recorded on GP registers. Lewisham residents are more than twice as likely as residents in the local authority with the lowest admission rate to be admitted to hospital for COPD. The prevalence of diabetes is expected to rise by 23% over 10 years. It is estimated that in Lewisham in 2009 there were 14,124 people aged 16 years or older who have diabetes (diagnosed and undiagnosed).

Cardiovascular Disease is a major contributor to the life expectancy gap between Lewisham and England. Lewisham identifies less people than expected on all GP cardiovascular disease registers, and performs below the England average in identifying and managing cardiovascular disease (coronary heart disease, stroke and transient ischaemic attack, hypertension, heart failure and atrial fibrillation) in primary care.

#### What do we want to achieve?

The systematic identification, diagnosis and risk profiling of COPD, diabetes and cardiovascular disease to be implemented across all GP practices.

All patients to be managed within care pathways that meet NICE quality standards.

The majority of patients with LTCs to be actively engaged in self care, and to have good co-ordination of all aspects of their care by a key worker.

Patients to be effectively managed in the community.

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Lewisham to have amongst the lowest rate of admissions for LTCs in England, and premature mortality rates below the age of 75 years for Lewisham residents to be amongst the lowest in the country.

## Appendix A

### Our Delivery Plan

This strategy is accompanied by a Health and Wellbeing Delivery Plan which sets out the activities to achieve the improvements and outcomes required in each priority area. It will identify the activity delivered by various agencies on the Health and Wellbeing Board, as well as the contributions and support that will be sought from local communities. As Members of the Health and Wellbeing Board, we will continually review the progress that is being made and will consider any additional steps that need to be taken to ensure there is measurable and effective improvement.

### Governance and delivery

Lewisham's progress towards improving the health and wellbeing of its residents will be monitored by the Health and Wellbeing Board.

Lewisham's Health and Wellbeing Board will be responsible for developing and delivering the actions that underpin this strategy and for making sure that objectives are met. The Board brings together individuals from the key organisations that deliver health and care services as well as representation from the borough's voluntary and community sector. The perspective of citizens and patients is provided by Healthwatch Lewisham.

The Board comprises:

- The Directly Elected Mayor of Lewisham
- The Cabinet Member for Community Services
- The Director of Adult Services
- The Director of Children's services
- A representative of the Lewisham Clinical Commissioning Group
- The Director of Public Health
- A representative of Healthwatch Lewisham
- A representative of NHS England
- A representative of Local Medical Committee

## **Appendix A**

Supporting the Health and Wellbeing Board, the Children and Young People's Strategic Partnership will ensure that there is clear leadership and specific engagement in relation to tackling health inequalities experienced by children and young people and will oversee delivery of those actions relating to children.

Furthermore, Lewisham's Healthier Communities Select Committee and the Children and Young People's Select Committee will continue to take a major interest in the work of the board and in the activity and progress in relation to this strategy.

**DRAFT HEALTH AND WELLBEING BOARD DELIVERY PLAN**

This Delivery Plan underpins the Health and Wellbeing Strategy and set out the actions that will be taken to achieve the improvements and outcomes required in each priority area. This work will be undertaken in partnership by strategy agencies, the voluntary and community sector and by individuals themselves.

## Appendix B

Priority Area	Objectives	Activity and actions	Timescale	Indicator	Lead
1. Achieving a healthy weight	<ul style="list-style-type: none"> <li>Capacity building/training-development of knowledge and skills around nutrition, physical activity and healthy weight to deliver effective brief interventions</li> </ul>	To deliver training for midwives on maternal obesity and introducing solids for health visitors	annual	Number of staff attending training	PH
		To deliver training to frontline staff on weight and nutrition guidelines	annual	Number of staff attending training	PH
		To deliver Let's Get Moving Physical Activity Care Pathway training to primary care staff and the wider community	annual	Number of staff attending training	PH
		To deliver Fitness for Life training programme to primary school teachers	annual	Number of teachers attending training	PH
	<ul style="list-style-type: none"> <li>Breastfeeding support services-providing easier access to breastfeeding and infant feeding support</li> </ul>	To improve staff skills on infant feeding by delivering training and audit staff skills	Feb 2014	Achieve UNICEF stage 2	PH
		To expand number of local breastfeeding cafes and peer supporters reaching women ante natal and post natal	March 2015	Increase prevalence of breastfeeding at 6-8 weeks	PH
		To develop Infant Feeding Care Pathway incorporating all UNICEF Baby Friendly Practice Standards	March 2015	Mother's audit of infant feeding support report experience of care in line with UNICEF standards	PH
	<ul style="list-style-type: none"> <li>Healthier catering - working with early years settings, schools and fast food outlets to increase the range of healthy food options available</li> </ul>	To roll out Eat Better, Start Better training for early years settings	March 2015	50% of early years settings signed up to voluntary food and drink guidelines	PH

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Priority Area	Objectives	Activity and actions	Timescale	Indicator	Lead
Page 76		To work with school caterers to improve the uptake of school meals	March 2014	Increase uptake of free and paid school meals	PH
		To implement the Healthier Catering Commitment (HCC) scheme with eligible fast food businesses	March 2016	75% of all eligible fast food outlets awarded HCC certificate	PH
	<ul style="list-style-type: none"> <li>Healthier built environment - working with others to create spaces and homes that support health and wellbeing</li> </ul>	Restrictive policy on new hot food take-away in Development Management Local Plan	December 2014	No new hot food take-away approved	LBL (Planning)
		To support development of community gardens and community food growing initiatives	March 2015	Increase number of community gardens and food projects	PH
		To ensure health perspective incorporated into large scale Housing developments	March 2016	Increased active travel	PH
	<ul style="list-style-type: none"> <li>Physical activity programmes - providing access to a range of activities in schools and in the community.</li> </ul>	To develop Healthy lifestyle programmes promoting healthy eating and physical activity and offer them to all primary schools.	March 2015	Increased participation in extra curricular physical activity. Increased number of chane4life clubs.	PH
		To work with School to encourage Fitness for Life sessions to be incorporated into school curriculum	March 2015	Increased fitness of primary school aged children	PH
		To support children and adults to participate in physical activity through subsidised courses	March 2015	Number of children and adults who access swimming, cycling	PH
		To support uptake of targeted activity programmes e.g. Exercise on Referral, Active Heart, NHS Health Checks Get Moving and walking for health	March 2015	Increase proportion of adults who participate in activity	PH

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Priority Area	Objectives	Activity and actions	Timescale	Indicator	Lead
Page 77	<ul style="list-style-type: none"> <li>Nutrition initiatives- working with communities to improve healthy eating and cooking skills of residents</li> </ul>	To implement universal free vitamin D scheme to pregnant women, one year post natal and children under 4 years	March 2014	Uptake increases to 25% of all those eligible (from baseline of 10%)	PH
		To roll out healthy eating on a budget cooking courses	March 2014	Number of participants report improved healthy eating	PH
		To support community projects in development of cookery/healthy eating	March 2014	Number of participants (DNP, 170 project, participatory budgeting)	PH
		To monitor access to food banks in Lewisham	annual	Number of participants accessing food banks	PH
		To work with partners to ensure evidence-based nutrition guidelines are adopted and disseminated	March 2015	Number of organisations signed up to nutrition guidelines	PH
	<ul style="list-style-type: none"> <li>Workplace health initiatives - assisting employers to help their own employees improve their health</li> </ul>	To work initially with the Council and partner agencies that are represented on the Health and Wellbeing Board to promote healthy eating and physical activity with their own employees.	March 2014	Evidence that employees have been given information on healthy eating and feedback from staff	Communications/ HR/ Occupational Health/ partner agencies
		To deliver workplace events where healthy eating / options are promoted, beginning with the Council and partner agencies that are represented on the Health and Wellbeing Board	March 2014	Feedback from staff	Occupational Health/ HR/ CHIS/ partner agencies



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Priority Area	Objectives	Activity and actions	Timescale	Indicator	Lead
Page 78		To develop agreements with the caterers to ensure that food supplied for Council and partner agencies that are represented on the Health and Wellbeing Board have healthy options labelled	March 2015	Copy of agreement and monitoring report on food supplied	Procurement / PH/ partner agencies
		To develop and implement Nutrition guidelines, which demonstrate the Council's and its partners commitment to healthy eating and provide an outline of what is expected from catering providers.	March 2015	Copy of the Nutrition guidelines monitoring report on food supplied	Procurement/ PH/ partner agencies
	<ul style="list-style-type: none"> <li>Obesity surveillance – monitoring levels and trends of overweight and obesity in the population<sup>1</sup></li> </ul>	To increase the participation in National Child Measurement Programme (NCMP)	annual	Over 90% of eligible children measured	LHNT (SANS)
		To produce annual data set on BMI in pregnancy at booking appointment	annual	Determine prevalence of maternal obesity	PH/LHNT
		To record and monitor overweight and obesity in adults aged 40-74 as part of the NHS Health Check programme	annual	Determine prevalence of excess weight in adults aged 40-74 years	PH
	<ul style="list-style-type: none"> <li>Weight management programmes - targeting those adults and children already identified as overweight or obese</li> </ul>	To follow up proactively all children identified as very overweight in the NCMP by school nurses	annual	Number advised and attending appointments	LHNT (SANS)
		To develop targeted weight management programmes in community settings	March 2015	Increased number of referrals and positive outcomes	PH
		To develop borough wide specialist community weight management services for children and adults	March 2015	Increased number of referrals and positive outcomes	PH

<sup>1</sup> This reflects the work of a number of strategies and plans. Detailed action plans are available for Breastfeeding, Promoting Healthy Weight in Children and Families Strategy, Physical Activity Plan, Food Strategy and Workplace Health

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Priority Area	Objectives	Activity and actions	Timescale	Indicator	Lead
	<ul style="list-style-type: none"> <li>Streamline healthy lifestyle referral pathways following NHS Health Check</li> </ul>	To commission a Lifestyle Referral Hub for those identified at high CVD risk after NHS Health Check	March 2014	Increased referrals to weight management and physical activity programmes	PH
2. Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years	<ul style="list-style-type: none"> <li>Improved awareness of early signs and symptoms of key cancers such as bowel cancer, lung cancer and breast cancer.</li> </ul>	To develop a cancer awareness raising programme in collaboration with the community and health improvement practitioners.	March 2014	Programme developed with appropriate activity indicators and incorporated into the work of the health improvement provider	PH/CHIS
		To deliver cancer awareness raising programme in collaboration with the community and health improvement practitioners.	March 2015	Cancer Collaborative with local communities developed and involved in targeted cancer awareness programme in at least 2 wards and identified population groups with worse outcomes for cancer	PH/CHIS
		To review and expand cancer awareness raising programme implemented in collaboration with the community and health improvement practitioners.	March 2016	Cancer Collaborative and cancer awareness programme expanded to other wards with poor outcomes for cancer	PH/CHIS
	Improved awareness of cancer screening programmes	Bowel, Breast and Cervical Cancer Screening training developed as part of the Lewisham Health Improvement Training Programme aimed at improving the skills and knowledge of individuals with paid or unpaid health promotion role in	March 2014	Two training courses developed	PH

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		Lewisham			
		Work with the health promotion specialist for the South East London boroughs to promote the Bowel Cancer Screening Programme, providing resources and training for primary care and community and voluntary groups	March 2014	Course on Bowel Cancer Screening delivered to at least 12 key individuals from primary care and community and voluntary groups who have a health promotion role	PH/ SE London boroughs health promotion specialist
		Delivery of Bowel, Breast and Cancer Screening training delivered as part of the Lewisham Health Improvement Training Programme aimed at improving the skills and knowledge of individuals with paid or unpaid health promotion role in Lewisham	Nov 2015	At least 2 training courses for a total of 24 individuals with health promotion role in Lewisham	PH/ SE London boroughs health promotion specialist
		Work with NHS England to promote uptake of cancer screening for cervical, bowel and breast cancer	Oct 2015	Improved uptake of cancer screening in Lewisham	PH/NHS England
	<ul style="list-style-type: none"> <li>Greater awareness within primary care on the signs and symptoms of cancer and the appropriate management of patients presenting</li> </ul>	Distribution of Cancer profiles to each GP practice in Lewisham providing information on incidence and mortality, cancer screening uptake, 2 week referrals and emergency presentations for cancer.	March 2015	Improved 2 week GP referral figures	London Cancer Commissioning Team
		Application to Macmillan to fund GP lead for Cancer and if successful to work with practices on education for primary care to improve cancer awareness and early diagnosis,	2013-15	Successful application Work programmes developed with appropriate activity	PH/CCG

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		screening uptake and improved survivorship.		indicators and incorporated into the work of the Lead Cancer GP	
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Priority Area	Objective	Activity and Action	Timescale	Indicator	Lead
3. Improving immunisation uptake	<ul style="list-style-type: none"> <li>Further development and implementation of care pathways – active management of individual children to ensure that they are immunised is key to success</li> </ul>	To ensure HV pathway, similar to that in MMR pathway, becomes an integral part of the preschool booster pathway	April 2014	Pathway agreed and reports on implementation submitted to Immunisation Strategy Group	PH
		To agree with SANS and with NHS England a care pathway for immunisation of school aged children in Lewisham	April 2014	Pathway, and relevant contracts, agreed.	PH
		To develop and disseminate care pathway for immunisation of all children under one.	April 2015	Pathway agreed and reports on implementation submitted to Immunisation Strategy Group	PH
	<ul style="list-style-type: none"> <li>Support for GPs in aiming for best practice, in implementing care pathways fully and to ensure good flow of data. Support to include feedback of information to practices.</li> </ul>	To agree and deliver a training programme for GP facilitators so they can support practices in maximising the uptake of vaccines	Sept 2013	Training Programme Delivery.	PH
		To produce monthly dashboard mail-out for GP practices, detailing individual surgery performance on uptake of MMR and quarterly performance on uptake of preschool booster	Monthly for MMR Quarterly for PSB	Dissemination of Dashboards	PH
		To support GPs in introducing changes to national immunisation schedule through providing training for practice nurses, advice on formulation of patient group directives, and promoting new vaccines.	Respond as soon as possible as changes are announced.	Uptake of newly introduced vaccines.	PH

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Priority Area	Objectives	Activity and actions	Timescale	Indicator	Lead	
		To agree annual action plan aiming to improve uptake of influenza vaccine. Those at risk require immunisation each year, against the predicted prevailing types of the virus for that year.	Annual	Plan Agreed	CCG	
		<ul style="list-style-type: none"> <li>Working with children’s centres and schools to ensure their full engagement.</li> </ul>	To review arrangements for schools BCG and for provision of BCG to others who require the vaccine as part of TB needs assessment	Sept 2014	Completed Report	PH
			To ensure incorporation of collection of information on immunization status into school entry procedures	Sept 2015	%Return of Health Checklists	PH
		<ul style="list-style-type: none"> <li>Identifying, and attempting to remove barriers to successful completion of immunisation</li> </ul>	To conduct survey on parental perceptions of barriers to immunisations	Sept 2014	Completed Report	PH
			Annual workplans to include measures to minimise barriers	Annual	Uptake of vaccine	PH
4. Reducing Alcohol Harm	<ul style="list-style-type: none"> <li>Strengthening population based approaches to prevention through effective enforcement of regulations relating to alcohol supply</li> </ul>	Strengthen and Review LBL licensing policy	March 2014	New policy agreed	LBL (Licensing)	
		To ensure Licensing Law and Regulations are used whenever possible	ongoing	Evidence of license reviews and refusal	LBL (Licensing)	
		To develop a system for the Director of PH to consider and respond to Licensing applications	March 2013	Clear process established and being used	PH/LBL	

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Priority Area	Objective	Activity and Action	Timescale	Indicator	Lead
4. Reducing Alcohol Harm		To develop a rolling programme for test purchasing operations by Trading Standards for 'off sales' and Under Age Sales	ongoing	Number of test purchases per annum	LBL (Trading Standards)
	<ul style="list-style-type: none"> <li>Improving referral pathways and expand interventions to support those most at risk</li> </ul>	To review and improve locally defined referral routes and care pathways for alcohol (to include referral procedures), including specific groups such as vulnerable adults, young people and those 40-74 having health checks)	March 2014	<p>No. of people accessing and completing treatment services will increase.</p> <p>Implementation of Lewisham hospital Alcohol CQUIN</p> <p>No. of people aged 40-74 accessing and completing treatment services will increase.</p> <p>No. of young people exiting treatment in a planned way being maintained at 90% or better each year up to 2016</p> <p>Number of people aged 40-74 accessing and completing treatment services will increase.</p> <p>The number of young people exiting treatment in a planned way being maintained at 90% or better each year up to 2016</p>	DAAT/SP and Alcohol Treatment Provider, LHNT, CCG
		To monitor, review and develop the capacity of the alcohol	Oct 2014	Review implemented	DAAT

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		treatment system for Lewisham			
		To provide satellite and outreach provision from alcohol services into partnership agencies, the community and targeted specific areas	March 2015	Decrease in the number of alcohol-related hospital admissions.	DAAT/ SP and Alcohol Treatment Provider
Page 85	<ul style="list-style-type: none"> <li>Training for practitioners working in Lewisham to deliver effective screening and brief interventions for alcohol misuse.</li> </ul>	To deliver Alcohol Identification Brief Advice (IBA) Training to partnership agencies and front line staff	March 2016	By 2016, most practitioners will be skilled in identifying those at risk from alcohol harm and in delivering brief interventions.	PH/DAAT/ SP/CCG
		To deliver alcohol IBA training sessions for the GP Protected Learning Time Event.	Aug 2013	50% practices have trained staff in IBA	PH/DAAT/ SP/CCG
		To undertake an evaluation of alcohol IBA Training to be undertaken and produce recommendations for the future.	Oct 2013	Evaluation report	PH/DAAT/ SP & Alcohol Delivery Group Members
	<ul style="list-style-type: none"> <li>Co-ordination and enforcement of existing powers against alcohol-related crime, disorder and anti-social behaviour</li> </ul>	Responsible Retailers Agreements to be signed with off licences in drinking hotspots to remind them of their licensing responsibilities and identify problem premises.	March 2014 & ongoing	No. of agreements No of problem premises	NCSS
		To review the needs of street drinkers/street communities/Rough Sleepers	March 2015		DAAT/SP, NCSS/PH
		Audit offenders with alcohol related offences once a year to ensure appropriate support has been offered and review how Probation clients access alcohol services and embed Alcohol	ongoing		Lewisham Probation, Alcohol treatment provider



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		Treatment Requirements with alcohol care pathway			
	<ul style="list-style-type: none"> <li>Workplace health policies – assisting employers in developing policies and schemes that promote consistent messages about alcohol harm</li> </ul>	To work with partners to review and/or develop workplace alcohol policies to support improvement of health of the working population and reduce sickness absence	2014	Evidence of policies demonstrated	PH/DAAT/ SP & Alcohol Delivery Group Members
	<ul style="list-style-type: none"> <li>To produce and widely distribute consistent alcohol messages &amp; signposting to support services.</li> </ul>	Communications strategy including websites, posters, twitter, Lewisham Life, press and bus stops & billboards	March 2014	Awareness raised of the physical and mental short-term and long-term effects of drinking alcohol	PH/DAAT/ SP
		To raise awareness of alcohol harm amongst children & young people through SE Lesson, Health Days and Junior Citizens.	ongoing	Increase in knowledge, development of skills and attitudes to support making informed choices and decisions	DAAT Training Team/PH
		To develop partnerships between community groups, including those in Bellingham Well London & North Lewisham and alcohol treatment agencies.	March 2014	Numbers of residents reached	DAAT/ SP and Alcohol Treatment Provider
		To develop a social marketing campaign to include raising awareness of alcohol harm amongst young women and a mobile one application aimed at those most at risk to reduce alcohol related harm	March 2014	Usage of application Alcohol related admissions among young women	DAAT/ SP
		<ul style="list-style-type: none"> <li>Share intelligence to ensure a targeted approach to tackling alcohol related violence.</li> </ul>	To establish a process that allows alcohol related assault data to be collected by UHL A&E and shared with the police and public health to inform a targeted response.	2014	Data shared

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					LHNT
		To collate and analyse UHL A&E and Police Data on quarterly basis, to Map Alcohol Related Issues	2015	Quarterly reports	PH, MPS & Reducing Reoffending
		To identify key hotspots and produce action plan for response	2015	Action plans	PH, MPS & Reducing Reoffending
Priority Area	Objective	Activity and Action	Timescale	Indicator	Lead
Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking <sup>2</sup>	<ul style="list-style-type: none"> <li>Vision for tackling tobacco use is understood and shared across the Health and Well Being Board partners</li> </ul>	To develop a clearly articulated and shared vision.	March 2014	All partners report demonstrate an shared understanding of the vision	PH/LBL
		To ensure shared understanding across all partners on the effective methods for reducing tobacco harm and progress.	March 2014	Partners demonstrate a shared understanding of how to reduce tobacco harm	PH/LBL
		To disseminate evidence to inform and engage strategic groups	ongoing	Dissemination by each partner	PH/LBL
	<ul style="list-style-type: none"> <li>Motivate and assist smokers to quit</li> </ul>	To promote and deliver <i>Very Brief Advice</i> training as widely as possible. (including all health visitors & all school nurses) and primary care	Annual and ongoing	Frontline staff trained from a range agencies including all member agencies of Smokefree Future Delivery Group	SSS

<sup>2</sup> This is part of the Smokefree Future Delivery Plan 2013/16. The overall indicators for actions in delivery plan are:

Reduce smoking prevalence to 15% by 2016

Reduce the number of primary smoking related fires (those that cause harm to people, damage property or require five or more fire engines)

Reduce the number of secondary smoking related fires being all other (less serious) fires such as rubbish fires.

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				Increased numbers of referrals to stop smoking services, including following NHS health check	
		To target smoking parents of asthmatic children and work with CCG, primary care and others on identification and developing action plan	2014-15	Implementation of Action plan	SSS CCG
Page 88		To ensure that service spec and action plan of SSS incorporates recommendations from health equity audit 2013.	annual	50 quits x pregnancy 40 quits x acute patients 20 quits x mental health 5% increase in routine and manual quitters 10% increase in quitters aged 30-35 10% increase in women quitters over 60 5% increase in Black African quitters	SSS, PH, LBL
		To contact people who have received service and to re-engage them in service if they have relapsed.	ongoing	All service contacts called at 52 weeks to establish status	SSS
		To develop communications plan for Stop Smoking service .	Ongoing	Systematic and planned response to national and local campaigns	SSS/LBL (Comms)

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		To improve referral pathway to stop smoking services	annually		PH
<ul style="list-style-type: none"> <li>Engage schools and colleges in 'tobacco free' agenda and commission education programmes to influence young people not to start smoking.</li> </ul>		CYP Forum to promote tobacco free agenda	2013/16	Evidence demonstrated	VAL
		To offer a minimum of 5 secondary schools will be offered a tobacco peer education programme .	2013/14	Reduce the % of smokers at 15 years 5 schools 50 peer educators trained 1000 pupils reached	PH
		Cut Films to work with LeSoCo on design/ film making curriculum to involve young people in tobacco peer education.	2013/14	Workplan agreed and implemented	PH/Cut Films
<ul style="list-style-type: none"> <li>Regulate tobacco products effectively</li> </ul>		Trading Standards to reduce access to illicit tobacco through gathering intelligence, targeting suppliers and enforcement.	2013/15	Minimum of 250 retail premises visited. Evidence of action against covert sources of supply where detected	Trading Standards , LBL
		To appoint dedicated officer to work on tobacco regulation and continue monitoring compliance with legislation.	Sep 2013	Officer Appointed and work plan delivered	Trading Standards , LBL
		To undertake a Shisha (tobacco) users survey in Lewisham	March 2014	Survey completed	Trading Standards , LBL
<ul style="list-style-type: none"> <li>Communicate tobacco free agenda effectively.</li> </ul>		To raise awareness of the risk of cheap illicit tobacco, including the use of social marketing tools such as Twitter/Facebook	2013/14	SE London social marketing campaign	LBL (Comms)
		To promote images of 'Smokefree' and align local comms to national	Ongoing	Range of outlets utilised; min of 1 item	LBL (Comms)

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		campaign on Smokefree	Dec 2013	in Lewisham Life per annum Website pages completed		
		To contribute to Bellingham Well London, North Lewisham Health Improvement programme & other local initiatives by providing information about SSS, developing creative projects and training staff and volunteers	March 2014	Evidence demonstrated	PH	
	<ul style="list-style-type: none"> <li>Reduce exposure to second hand smoke</li> </ul>	To engage animal organisations to promote smokefree homes	March 2014	Increase in number of homes that are smokefree	PH	
		To promote smokefree homes and cars systematically with all staff working with pregnant women, children and families and housing staff through publicity & training	March 2014	Increase in number of homes that are smokefree Evidence demonstrated	PH/CYP SSS/LHN T	
		To commission training on smokefree homes and prevention of CYP uptake of smoking.	March 2014	20% staff trained in CYP trained each year	PH/CYP	
	<ul style="list-style-type: none"> <li>Workplace health</li> </ul>	To ensure brief advice provided to all staff smokers by all partners	ongoing	Numbers referred to SSS	SSS All	
		To work with organisations to enforce no smoking policy outside entrances and in grounds	On going	No smoker smoking outside buildings of partner agencies	Human Resources in all organisations	
6.	Improving mental health and	<ul style="list-style-type: none"> <li>Ensuring those in BME groups and at high risk of anxiety and</li> </ul>	To actively promote IAPT services through GP practices in BME	April 2014	Percentage of IAPT referrals from BME	SLAM

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		To work with organisations to enforce no smoking policy outside entrances and in grounds	On going	No smoker smoking outside buildings of partner agencies	Human Resources in all organisations
wellbeing	depression get access to IAPT services	groups		groups	
		Patients with long term conditions from BME groups to be assessed for anxiety and depression & referred where appropriate	April 2015	Percentage of patients assessed for depression with diabetes (QOF)	SLAM
		To encourage self referral to IAPT from BME communities through active promotion of services	April 2014	Increase in the number of BME referrals which come through self referral route	SLAM
	<ul style="list-style-type: none"> <li>Targeting those individuals and families at high risk of long term mental health problems through early intervention and parenting support delivered in schools and childrens centres</li> </ul>	To implement CYP IAPT model in Lewisham improving the quality of service delivered to child and their families in Lewisham	December 2014	2 staff trained from Voluntary sector in accredited parenting therapy programmes (specifically for families of 3 - 10 year olds, with behaviour and conduct issues)	CYP
		Targeted Family Support to work with 400 families a year.	April 2015	Demonstrated improvement in 3 key outcomes; improved child and family resilience; improved school participation and engagement; and prevention of escalation	CYP

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Priority Area	Objective	Activity and Action	Timescale	Indicator	Lead
Page 92		Lewisham schools to be offered the opportunity to participate in place2be or similar models of psychological support to school age children	April 2015	Number of schools offering Place2be or similar intervention	CYP
	<ul style="list-style-type: none"> <li>Supported discharge – those who access mental health services will be supported at discharge to prevent relapse</li> </ul>	To develop care pathways which support individuals as they transition through care services eg. Inpatient to community mental health services, community mental health services to primary care.	October 2015	Percentage of people discharged to primary care with a recovery and support plan in place.	SLAM
	<ul style="list-style-type: none"> <li>Improve recognition of poor mental health by front line workers (statutory and voluntary sector) and equip them to support individuals experiencing mental illness.</li> </ul>	To offer a programme of mental health first aid training to all front line public and voluntary sector workers to support them to respond to the needs of people with mental health needs.	Reviewed annually from April 2014	4 mental health first aid training courses to be offered 'free' to front line workers in Lewisham  Number of course participants completing courses	PH
		Youth Mental Health First Aid training courses to be delivered prioritising those working with vulnerable young people	April 2014	Number of courses run and participants completing the course.	PH
		To offer tier 1 mental health awareness training to all front line staff working with children and young people	March 2015	Uptake of tier 1 training across the borough	CYP

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Priority Area	Objective	Activity and Action	Timescale	Indicator	Lead
	<ul style="list-style-type: none"> <li>Improve the physical health of those with poor mental health.</li> </ul>	To offer support to all patients seen by SLAM identified as smokers to stop smoking	April 2014	Percentage of service users involved in developing their smoking cessation care plan	SLAM
		To offer Annual physical health checks to all patients on GP SMI registers		Uptake of physical health checks	CCG
Page 93 Improving sexual health	<ul style="list-style-type: none"> <li>We will continue to develop new and innovative ways to deliver sexual health services to the population, including through pharmacies, GP practices, online as well as clinic settings</li> </ul>	To increase access to sexual health services in pharmacies including: <ul style="list-style-type: none"> <li>Emergency contraception</li> <li>Condom distribution</li> <li>Pregnancy testing</li> <li>Chlamydia and gonorrhoea screening</li> </ul>	April 2015	Number of pharmacies offering sexual health services; number of individual visits to pharmacies for these services	PH
		To increase access to online STI screening through promotion of the services available	October 2014	Number of online screening requests	PH
		To review sexual health clinic provision across Lewisham in partnership with stakeholders	October 2014	Re-specification of Sexual health services in Lewisham	PH/ LSL sexual health commissioners
	<ul style="list-style-type: none"> <li>We will ensure that all young people know how to access and use free condoms, and are</li> </ul>	To develop a Lewisham Sex and Relationships Education curriculum and lesson plans with	April 2015	Development of lesson plans which can be used in all schools	Public Health



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	equipped with negotiation skills through the SRE programmes to use them to protect themselves.	school nursing and sexual health			
		To ensure that all Lewisham secondary schools are offered access to SRE lessons from local services	April 2014	Number of schools taking up offer of SRE lessons	Public Health
		To continuously improve the quality of SRE provision in Lewisham	October 2014	Feedback from pupils and teachers on content	Public health
		To ensure young people are able access sexual health services in a variety of settings in a timely manner	April 2014	Feedback from young people on local services Numbers of young people accessing different types of service provision	LHNT
	<ul style="list-style-type: none"> <li>Will ensure all our GP practices have the opportunity to be trained in sexual health and HIV</li> </ul>	To deliver a sustainable programme of Sexual Health in Practice (SHIP) training across Lambeth, Southwark and Lewisham	April 2014	Number of GPs and practice nurses attending Sexual Health in Practice Training; number of practices who have at least 1 GP and practice nurse who have completed training	PH
	<ul style="list-style-type: none"> <li>We will continue to expand the opportunities to promote and access LARC</li> </ul>	To develop and commission pathways for Long Acting Reversible Contraception for primary care	April 2014	Re-commissioned LARC contracts across primary care	PH
		To improve the experience of women accessing LARC across Lewisham	October 2014	Feedback from women in LARC providers reported annually	PH

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		To ensure all women accessing emergency contraception and abortion services are offered rapid access to LARC	April 2014	Proportion of women under going TOPs who choose LARC as a method	PH
	<ul style="list-style-type: none"> <li>We will increase the offer and uptake of HIV testing in primary care (GP practices) as part of routine practice</li> </ul>	To provide all practices with rapid HIV tests following attendance at SHIP training	April 2014	Increase in the number of positive HIV tests performed in primary care	PH
		Offer a rolling programme of HIV training and updates for all primary care staff	Sept 2014	Increase in the testing rate per 1,000 patients per practice	PH
<p>Delaying and reducing the need for long term care and support</p>	<ul style="list-style-type: none"> <li>Providing timely and appropriate enablement services</li> </ul>	To develop co-ordinated information and advice services to enable people to secure appropriate advice and support at an early stage	March 2014	User survey	ASC
	<ul style="list-style-type: none"> <li>Providing support for people with complex needs to live at home</li> </ul>	To work with Housing services to develop appropriate housing which can be a home for life, including for those people with complex needs.	By July 2016		ASC/LBL (Housing)
	<ul style="list-style-type: none"> <li>Providing integrated care and support</li> </ul>	To further enhance enablement service to reduce unnecessary hospital admissions and ensure timely and effective hospital discharge	March 2014		ASC/LBL (Housing)
	<ul style="list-style-type: none"> <li>Enabling people to manage their own conditions at home</li> </ul>	To undertake an analysis of unmet needs in relation to supporting people to remain at home and to influence joint commissioning intentions eg night care	March 2014	Patient survey indicator - how supported patients feel to manage their own condition	ASC/LBL (Housing)

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		To establish community development posts to work in the community and local neighbourhoods, alongside health and social care staff, to develop alternatives to statutory care and support and improve communication and referral lines.	Dec 2013		ASC/LBL (Housing)	
	<b>Priority Area</b>	<b>Objective</b>	<b>Activity and Action</b>	<b>Timescale</b>	<b>Indicator</b>	<b>Lead</b>
Page 96	Reducing the number of emergency admissions for people with long term conditions	<ul style="list-style-type: none"> <li>Developing a shared vision and strategy for 'integrated primary, hospital and social care across the health economy in Lewisham.</li> </ul>	Building on the foundations of the Neighbourhood Network Model/Networks to develop practical and pragmatic solutions to enable integrated working across those providing care to patients	2015/16	Patient Feedback Feedback from health care professionals Programme evaluation	LBL/CCG
		<ul style="list-style-type: none"> <li>Implementing the key principles for treatment and care for all people with long term conditions; Risk profiling, Integrated Care Teams and Self Care.</li> </ul>	To ensure the implementation of the Register, Recall and Review (3Rs) used to support the management and treatment Diabetes in partnership with patients is embedded in Primary Care (GPs)	Ongoing	Patient Feedback Peer to Peer Review & Evaluation	CCG
			To ensure the outcomes of Risk Profiling in Primary Care interfaces and support the Integrated Care Teams	2015/16	Patient Feedback Quality Innovation Productivity and Prevention (QIPP) Programme	CCG/LBL/ LHNT

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		To develop the mechanisms to enable Collaborative Care Planning with patients to support multi-disciplinary working integrated across whole system	2015/16	Patient Feedback Quality Innovation Productivity and Prevention (QIPP) Programme	CCG/LBL/LHNT	
	<ul style="list-style-type: none"> <li>Encouraging more independence and healthier lifestyles</li> </ul>	To promote self-care for patients through the use of patient led groups and education programmes (E.g. Developing Community Champion Programmes for all LTCs and supporting the Expert Patient Programme)	2015/16	Patient Feedback	CCG	
<b>Page 97</b>	<b>Priority Area</b>	<b>Objective</b>	<b>Activity and Action</b>	<b>Timescale</b>	<b>Indicator</b>	<b>Lead</b>
			To implement the Proactive Primary Care Programme	2015/16	Patient and GP Practice Feedback Evaluation of programme	CCG
			To empower patients to access their own data to support self-care	2015/16	Patient survey indicator - how supported patients feel to manage their own condition	CCG
	<ul style="list-style-type: none"> <li>Encouraging GPs to identify undiagnosed COPD, Diabetes and CVD (hypertension, atrial fibrillation, arrhythmia, heart failure, CHD) among their patients</li> </ul>	To encourage uptake of NHS Health Checks by GP practices in order to identify people age 40 to 74 with undiagnosed diabetes and CVD	March 2014	Numbers of health checks provided by GP, pharmacy and community outreach providers will increase	PH	
		To utilise national schemes to support practices (E.g. QP QOF: Quality and Productivity – Quality Outcomes Framework, Direct Enhanced Schemes; Dementia – DES)	Ongoing	GP Disease Prevalence Registers (CMS)	CCG	

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		To support practices in order to standardise processes and share best practice in identifying the undiagnosed	Ongoing	GP Disease Prevalence Registers (CMS) Patient feedback (Breatheasy, Diabetes Forum and LTC Group)	CCG
	<ul style="list-style-type: none"> <li>Providing support, training and development to primary care in the management of long term conditions.</li> </ul>	To continue GP Education and Training Programmes	Ongoing	GP Feedback	CCG
		To support workforce development for primary care in partnership with the South East London Community Based Care Strategy	2015/16	GP Feedback	CCG
<b>Priority Area</b>	<b>Objective</b>	<b>Activity and Action</b>	<b>Timescale</b>	<b>Indicator</b>	<b>Lead</b>
Page 98	<ul style="list-style-type: none"> <li>Redesign of all key LTC pathways</li> </ul>	To continue to integrate the diabetes pathway, including primary care, community care and self care aspects	2014/15	Quality Innovation Productivity and Prevention (QIPP) Programme Patient Feedback	CCG
		To review the asthma pathway to ensure that it is efficient, effective and provides quality outcomes for patients	2014/15	Quality Innovation Productivity and Prevention (QIPP) Programme Patient Feedback	CCG
		To undertake an Holistic review CVD pathways from diagnosis to treatment.	2014/15	Quality Innovation Productivity and Prevention (QIPP) Programme Patient Feedback	CCG

Key to Leads	
ASC	Adult Social Care

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CCG	(Lewisham) Clinical Commissioning Group
CHIS	CHIS
CYP	Children Young People
DAAT	Drugs And Alcohol Team
LBL	London Borough of Lewisham
LHNT	Lewisham Healthcare NHS Trust
MWM	Midwifery Department
MPS	Metropolitan Police Service
PH	Public Health
PHE	Public Health England
SANS	School Age Nursing Service
SLAM	South London and Maudsley NHS Trust
SP	Supporting People
SSS	Stop Smoking Service
VAL	Voluntary Action Lewisham
LHNT	Lewisham Hospital
NCSS	Neighbourhood Community Safety Service

## Equalities Analysis Assessment – Health and Wellbeing Strategy

Department:	Community Services
Service area:	Public Health
Lead for EAA:	Alfred Banya
Author:	Ellen Pringle

### Introduction

The Lewisham Health and Wellbeing Strategy is a commitment to improve the health and wellbeing of local people over the next ten years, specifically with a vision of:

***“Health and wellbeing for all Lewisham residents by 2023”***

In order to achieve this, it focuses on three overarching aims:

- 1. To improve health;*
- 2. To improve care; and*
- 3. to improve efficiency*

Nine priority objectives have been selected as areas that, with continued focus, give the best chance of achieving both these three aims and the overall vision of health for all Lewisham residents by 2023. These priorities were selected on the basis of evidence from the Joint Strategic Needs Assessment on local health needs:

- 1. Achieving a healthy weight*
- 2. Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years*
- 3. Improving immunisation uptake*
- 4. Reducing alcohol harm*
- 5. Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking*

## Appendix C

6. *Improving mental health and wellbeing*
7. *Improving sexual health*
8. *Delaying and reducing the need for long-term care and support*
9. *Reducing the number of emergency admissions for people with long-term conditions*

This will provide the basis for commissioning plans within the reformed health and social care system. The overarching aim of the strategy is to reduce health inequalities, and it is essential that the strategy is fair and does not discriminate against any protected groups of people. In order to meet equality legislation set out in the Equality Act 2010, a public body must, in the exercise of its functions, have due regard to the need to:

- (a) *Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*
- (b) *Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*
- (c) *Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

Equality law (Equality Act 2010) is clear that there are particular characteristics intrinsic to each individual, against which a person should not discriminate. Section 149 (the Public Sector Equality Duty) lists the goals of the Act and the characteristics, known as 'protected characteristics', against which we have to test for discrimination. These characteristics are gender, race/ethnicity, religion and belief, sexual orientation, age, gender reassignment, pregnancy and maternity, marriage and civil partnership and disability.

### **Lewisham's Joint Health and Wellbeing Strategy**

The development and publication of a Joint Health & Wellbeing Strategy is a statutory duty under the Health and Social Care Act 2012. The purpose of the Strategy is to inform commissioning decisions across local services focussing on the needs of service users and communities based on evidence provided in the Lewisham Joint Strategic Needs Assessment (JSNA).

Local authorities, Clinical Commissioning Groups (CCGs) and the NHS Commissioning Board will need to take the Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy into account when producing commissioning plans so that their plans are fully aligned with the jointly agreed priorities in the Joint Health and Wellbeing Strategy.



## Appendix C

The Draft Joint Health & Wellbeing Strategy will be signed off by the Health & Wellbeing Board in September 2013.

The Health and Wellbeing Board, as a statutory body, must show due regard to the Equality Act 2010 and demonstrate how it meets the Public Sector Equality Duty through the process of producing, publishing and updating both the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy. This equality analysis report is part of that process.

### **How we developed the Draft Health and Wellbeing Strategy for Lewisham**

The process of developing the Health and Wellbeing Strategy recognised that the complexity of health and care can best be tackled if organisations and individuals work in partnership. The approach therefore built on the long history of partnership working in Lewisham, which often provides different perspectives, different resources and different levels of expertise to problems and recognises that the best solutions are developed together with those who the services affect. The overall responsibility for developing the strategy was that of Lewisham's Health and Well-being Board. The Board brings together individuals from the key organisations that deliver health and care services as well as representation from the borough's voluntary and community sector. The Board comprises:

- Lewisham Council
- Public Health Lewisham
- Lewisham Clinical Commissioning Group
- South London and Maudsley NHS Trust
- Lewisham Healthcare Trust
- Lewisham GP Federation
- Lewisham Local Medical Committee
- Voluntary Action Lewisham
- Lewisham Health Watch

The Board maintained an overview of the development of the Strategy, whilst the operational aspects of the process, including the public and community engagement activities were delegated to the Senior Officer Group that supports the work of the Board. The community and public engagement process, including its outcome, are reported in Section Two of this document.

## Equalities Analysis Assessment

### Section one: Assessment of data and research

*List the data and research used to analyse the potential impacts across the protected characteristics.*

#### General

Census 2011 (various elements)

Greater London Authority (2012) Population Projections 2012 Round, SHLAA

Office of National Statistics (2011) General Lifestyle Survey

#### Age

APHO (2012) Health and Wellbeing of Older People's Atlas

Lewisham Joint Strategic Needs Assessment (alcohol, tobacco control, sexual health, mental health, long term support, cancer, immunisations and healthy weight chapters)

Health Equity Audit of the Stop Smoking Service in Lewisham, May 2013

Health Survey for England 2009

Department of Health (2012) Long Term Conditions Compendium of Information

Purdy S, King's Fund (2010) Avoiding hospital admissions - what does the research evidence say?

Department of Health (2011) The likely impact of earlier diagnosis of cancer on costs and benefits to the NHS.

NHS Lewisham Health Equity Audit of Breast Cancer Screening 2010

K Robb, S Stubbings, A Ramirez, U Macleod, J Austoker, J Waller, S Hiom and J Wardle (2009) Public awareness of cancer in Britain: a population-based survey of adults (British Journal of Cancer 2009 101(Suppl 2): S18–S23)

Lewisham Public Health Performance Dashboards: Immunisations

#### Disability

Lewisham Joint Strategic Needs Assessment (alcohol, adults with learning disabilities and healthy weight chapters)

NHS Yorkshire and the Humber (2010) Healthy Ambitions for People with Learning Disabilities

Department of Health (2012) Long Term Conditions Compendium of Information

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Child and Maternal Health Observatory (2011) Disability and obesity: The prevalence of obesity in disabled children

### **Gender**

Lewisham Joint Strategic Needs Assessment (alcohol, tobacco control, sexual health, mental health, long term support, cancer, immunisations and healthy weight chapters)

Health and Social Care Information Centre (2013) Statistics on Obesity, Physical Activity and Diet, England.

Department of Health (2012) Long Term Conditions Compendium of Information

Health Equity Audit of the Stop Smoking Service in Lewisham, May 2013

London Health Improvement Board (2011) Alcohol

Hospital Episode Statistics (various years)

### **Pregnancy/Maternity**

Lewisham Joint Strategic Needs Assessment (tobacco control, sexual health, immunisations and healthy weight chapters)

NHS Information Centre (2012) Statistics on Smoking in England

Lewisham Public Health Performance Dashboards: Immunisations

Kelly y et al (2009) Why does birthweight vary among ethnic groups in the UK? Findings from the Millennium Cohort Study (J Public Health (2009) 31 (1): 131-137)

### **Race**

Lewisham Joint Strategic Needs Assessment (alcohol, tobacco control, sexual health, mental health, long term support, cancer and healthy weight chapters)

Health Survey England (2004) (special focus on ethnic minority health)

Hospital Episodes Data (2011)

Selten, J-P, Cantor-Graae, E & Kahn, René S (2007) Migration and Schizophrenia (Current Opinion in Psychiatry: March 2007 - Volume 20 - Issue 2 - p 111-115)

Kelly y et al (2009) Why does birthweight vary among ethnic groups in the UK? Findings from the Millennium Cohort Study (J Public Health (2009) 31 (1): 131-137)

British Heart Foundation Health Promotion Research Group (2010) Ethnic Differences in Cardiovascular Disease

Diabetes UK (2010) Diabetes in the UK 2010: Key statistics on diabetes

Health Equity Audit of the Stop Smoking Service in Lewisham, May 2013

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NHS Lewisham Health Equity Audit of Breast Cancer Screening 2010

K Robb, S Stubbings, A Ramirez, U Macleod, J Austoker, J Waller, S Hiom and J Wardle (2009) Public awareness of cancer in Britain: a population-based survey of adults

(British Journal of Cancer 2009 101(Suppl 2): S18–S23)

Public Health England (2013) HIV Epidemiology in London: 2011 Data

### **Religion/Belief**

Department of Health (2009) Religion or Belief: a practical guide for the NHS

### **Gender Re-assignment**

Department of Health (2007) Reducing health inequalities for lesbian, gay, bisexual and trans people

Gender Identity Research and Education Centre (2011) The Number of Gender Variant People in the UK - Update 2011

### **Sexual Orientation**

Lewisham Joint Strategic Needs Assessment (demography, sexual health and mental health chapters)

Public Health England (2013) HIV Epidemiology in London: 2011 Data

### **Marriage/Civil Partnership**

Derbyshire County Council (2013) Equality Impact Analysis of Health and Wellbeing Strategy

### **Deprivation**

Lewisham Joint Strategic Needs Assessment (alcohol, tobacco control, sexual health, mental health, long term support, cancer and Lewisham profile chapters)

Health Equity Audit of the Stop Smoking Service in Lewisham, May 2013

### Section two: Consultation and data used for the analysis

*Give details of the consultation and results. List the data and sources.*

A series of engagement activities took place in Lewisham around the Health and Wellbeing Strategy. Between December 2012 and April 2013 nine events were held; a total of over 500 people took part. The activities were designed to allow a broad range of stakeholders to contribute to the strategy's development and specifically to identify the role that non-statutory organisations and individuals can play in improving outcomes and reducing inequalities. Participants included: residents, older people, children and young people, carers, voluntary and community sector organisations, arts and leisure groups, faith groups and housing providers.

Each engagement exercise adopted an asset-based approach, in which participants were given information on Lewisham's most pressing needs and challenged to think about what already exists locally that could help meet these needs. Participants were asked to draw upon their local knowledge and experience to explore practical methods of improving people's health as well as providing a more detailed picture of the opportunities and barriers that local people experience. This allowed gaps in provision and other areas of inequality to be more easily identified. The outcomes and key messages of this engagement fed directly into the Health and Wellbeing Strategy, in the consideration which the strategy gives to some of the wider determinants of health and wellbeing.

The key messages from the engagement activity include:

- The impact of social isolation on people's physical and mental health and wellbeing
- The numerous barriers that hinder people from pursuing a healthy lifestyle, from cost and access to a lack of confidence to turn up and engage with existing activities
- The existence of a range of opportunities and activities, already provided within the community, that could support people to feel healthier and maintain their independence.
- The significant role played by Voluntary and Community Organisations and Faith organisations in supporting people's engagement with their local community but also in acting as a trusted source of information.
- The importance of being able to easily access a wide range of cultural and leisure activities so that people could feel empowered and stimulated

## Appendix C

- The importance of social prescribing\*
- Some of the key barriers to improving health and wellbeing: lack of organisational join-up, a lack of continuity between services, knowing what opportunities are available and having the time and space to consider which opportunities to access.

As well as feeding into the Health and Wellbeing Strategy these messages, in particular the practical recommendations, will be important in the formulation of the action plan for implementing the strategy.

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\* Linking people to sources of non-medical help and support in the community

Section three: Impact Assessment

Protected Characteristic	Findings / local context	How the findings/local context aligns with the strategy / strategic objectives
<b>Age</b>	<ul style="list-style-type: none"> <li>• Lewisham has a relatively young population:                             <ul style="list-style-type: none"> <li>○ 25.4% of residents are under 19 (compared to an England average of 25%)</li> <li>○ Children under 5 make up 8% of the population, compared to 6.3% in England</li> <li>○ Only 10.5% of the population are over 65 (compared to an average of 11% for London and 16% for England)</li> </ul> </li> <li>• There is a higher proportion of older residents in the south of the borough (7% of residents of the northern wards of the borough (Evelyn, New Cross and Brockley) are aged 65 years and over compared to 14% in the southern wards of Grove Park, Downham, Sydenham and Catford South). (There is not a similar geographical pattern for younger residents.)</li> <li>• Lewisham’s younger population is more ethnically diverse; 73% of residents aged 65 and over are white, compared to 61% of those aged 16-64 years.</li> </ul> <p><b>Older People</b></p> <ul style="list-style-type: none"> <li>• Both healthy and disability adjusted life expectancy at age 65 are significantly lower in Lewisham than both the England and London averages.</li> </ul>	<p>The strategy includes some priorities that are equally relevant to all ages, and others that are more targeted at the differing needs of younger or older residents:</p> <p><b>Older People</b></p> <ul style="list-style-type: none"> <li>• Reducing unplanned admissions for long term conditions and reducing people’s need for long term support are strategy priorities.</li> </ul>

	<ul style="list-style-type: none"> <li>• The rates of all and emergency admissions for those aged 65 and older are significantly higher in Lewisham than England.</li> <li>• Lewisham has a directly standardised all cause mortality rate for the over 65s that is significantly worse than England as a whole.</li> <li>• Health declines with age; 16% of Lewisham residents aged 35-49 report not being in good health compared to 71% of over 85s.</li> <li>• England-wide figures show that long term conditions become more common with increasing age. Three times as many over 75 year olds report having at least one long term condition compared to those aged 16-44.</li> <li>• The prevalence and hospital admission rates for COPD (Chronic Obstructive Pulmonary Disease) are higher in Lewisham than in England as a whole. 88% of admissions for COPD are amongst people aged 60 years or over. Similarly rates of admissions for heart failure are higher in Lewisham than England as a whole.</li> <li>• Emergency readmission rates within 28 days of discharge for residents aged over 75 are significantly worse than England.</li> <li>• The rates of admission of over 65s to residential and nursing homes in Lewisham was 560 per 100,000 in 2011/12; this is lower than the England average, though higher than the London average. The rates of over 65s returning home to their usual place of residence following a hospital admission for hip fractures is worse for Lewisham residents than the England average.</li> <li>• 89% of those aged 65+ in Lewisham discharged to rehabilitation services are still at home 91 days after</li> </ul>	<p>The main focus of these objectives will be older people; as reflected in the findings, they are more affected by long term conditions and hence need for long term support.</p> <ul style="list-style-type: none"> <li>• Improving cancer survival will also target older people, aiming to improve their awareness of early symptoms and healthcare seeking behaviour (both of which were found to be lower amongst older Lewisham residents).</li> <li>• The immunisations priority targets those most at risk of vaccine preventable diseases, both children and older people.</li> </ul>
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	<p>admission.</p> <ul style="list-style-type: none"> <li>Standardised cancer mortality rates amongst the over 65s are significantly higher in Lewisham than England. However, those for 35-64 year olds are lower than England.</li> <li>In 2011/12 70% of over 65s year olds were vaccinated against influenza. This is below both the London and England rates.</li> </ul> <p><b>Children and Young People</b></p> <ul style="list-style-type: none"> <li>Obesity amongst children in Lewisham is a significant problem. The prevalence of obesity amongst both 4-5 year old and 10-11 year olds is higher in Lewisham than the England average; 37% of 10-11 year olds are either overweight or obese.</li> <li>Lewisham has a high proportion of children and young people from ethnic minorities; national data has shown a higher prevalence of overweight (including obesity) in Black African and Caribbean children.</li> <li>England has one of the highest death rates from chronic liver disease, used as a marker for alcohol-related harm, in Western Europe. And importantly for young people it is the only disease in which deaths amongst the under 65s are increasing. Hospital admissions related to alcohol are high and increasing in Lewisham. Binge drinking is more common amongst young people, and there is evidence of a rise in alcohol harm amongst young women in particular (see gender section for further details)</li> <li>The earlier children or young people start smoking the greater their risk of developing lung cancer and heart disease later in life. Children who live with parents or siblings who smoke are</li> </ul>	<p><b>Children and Young People</b></p> <ul style="list-style-type: none"> <li>Unhealthy behaviours, such as obesity, smoking and excess alcohol consumption increase in prevalence with age. However the long-term consequences are greatest for younger people, hence the tobacco, alcohol and healthy weight priorities of the strategy focus on children (whilst including all residents).</li> <li>In addition to the HWB strategy Lewisham's Children and Young People's Plan identifies priorities and actions to improve the health and wellbeing of children in the borough.</li> <li>The mental illness strategy priority focuses on addressing the needs of children and young people with mental health problems, recognising that many people who go on to have long-term mental health problems will</li> </ul>
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	<p>two to three times more likely to take up smoking. There is evidence that smokers who started at an early age smoke more and are less likely to be able to quit. In Lewisham smokers aged 15-19 using the Stop Smoking Service were less likely to successfully quit than older smokers.</p> <ul style="list-style-type: none"> <li>• Rates of mental illness are higher in Lewisham than England and London. Most mental disorder begins before adulthood with 50% of lifetime cases of diagnosable mental illnesses beginning by age 14 and 75% of disorders starting by the mid-20s.</li> <li>• The under-18 conception rate in Lewisham is significantly higher than rates in both London and England. In Lewisham abortion rates are highest amongst 18 and 19 year old women, and overall the abortion rates in the borough are higher than both London and England.</li> <li>• Uptake rates of MMR2 and pre school booster vaccination for Lewisham children are amongst the lowest in London. There was an outbreak of Measles in Lewisham in 2008.</li> </ul>	<p>already be experiencing them as children or young people.</p> <ul style="list-style-type: none"> <li>• Given the high rates of unplanned pregnancy amongst teenage girls in Lewisham they are a target for the sexual health priority.</li> <li>• The strategy recognises, that although uptake of some routine childhood immunisations has improved, progress is still required to increase uptake to avoid outbreaks of infections such as Measles.</li> </ul>
<p><b>Disability</b></p>	<ul style="list-style-type: none"> <li>• In 2011 14% of individuals in Lewisham reported having a long-standing health condition or disability that limited their day to day activities. Half of those reported that it limited them “a lot”.</li> <li>• Individuals with a long standing disability or health condition may be more vulnerable to minor illnesses or accidents. These may also have a greater impact on their wellbeing and ability to live independently in the short or long term.</li> <li>• Similarly those with a long standing disability or health</li> </ul>	<ul style="list-style-type: none"> <li>• The strategy focuses on reducing the number of emergency admissions for those with long term conditions, acknowledging the higher level of admissions and readmissions experienced by those individuals in Lewisham.</li> <li>• The strategy also aims to reduce the</li> </ul>

	<p>condition are more likely to require long term care and support.</p> <ul style="list-style-type: none"> <li>• The rates of admission for people with COPD and heart failure are higher in Lewisham than the England average.</li> <li>• Individuals with learning disabilities are more likely to be admitted to hospital than the general population (26% per year and 14% per year respectively). They are also four times more likely to die of preventable causes and are significantly more likely to die under the age of 50.</li> <li>• Lewisham is currently a pathfinder in a national programme for children with disabilities and special educational needs.</li> <li>• People with long term conditions are 2 to 3 times more likely to suffer from depression than those in good health. Amongst those with two or more chronic physical conditions, the risk of depression is seven times higher.</li> <li>• The proportion of people achieving recommended levels of physical activity is lower amongst those with disabilities than the able-bodied. The prevalence of obesity is higher in children with long-term health conditions or disabilities.</li> <li>• In Lewisham 17% of people accessing alcohol treatment services have a disability.</li> </ul>	<p>need for long term care by improving individuals' independent living skills, and enabling more people with complex health and social care needs to live at home.</p> <ul style="list-style-type: none"> <li>• The strategy priorities that focus on unhealthy behaviours look to promote healthy behaviours to all individuals in an appropriate manner, including for those with disabilities. (For example the Stop Smoking Service is considering how best to reach out to disabled smokers, in particular those who struggle to leave their home).</li> </ul>
<p><b>Sex / Gender</b></p>	<ul style="list-style-type: none"> <li>• 15.5% of males living in Lewisham of all ages reported not being in good health, compared to 17.7% of women.</li> <li>• Emergency admissions for Lewisham residents vary across the borough. Rushey Green and Ladywell have the highest standardised rates for men and Rushey Green and Evelyn for</li> </ul>	<ul style="list-style-type: none"> <li>• The strategy does not directly address gender differences in all the health priorities identified. In some cases they will be addressed at service delivery level, for example:</li> </ul>

	<p>women.</p> <ul style="list-style-type: none"> <li>• Men are twice as likely to die from alcohol related harm as women.</li> <li>• Alcohol harm is an increasing problem amongst women and in particular young women; although alcohol-specific admissions are higher for men than women, over the past few years rates have levelled off in men but continue to rise in women. In the case of under 18s the alcohol-specific admission rates for women are twice those of young men (though in the over 18s the rates for men are three times higher)</li> <li>• The premature mortality rate for all cancers for men (under 75) in Lewisham was 24% higher than the England-wide rate, the same rate for women in Lewisham was 10% higher than the rate for England.</li> <li>• Physical activity is higher amongst men than women at all ages. A higher proportion of women than men in England have a healthy<sup>†</sup> body mass index (BMI) (34% and 39% respectively), but more women are obese than men (26% and 24% respectively) In the case of women (in England) rates of obesity increase with increasing levels of deprivation; this relationship with deprivation is weaker for men.</li> <li>• In the UK smoking prevalence is slightly higher in men than women and smoking-related mortality is higher amongst men. In Lewisham more women than men seek support to quit smoking through the Stop Smoking Service, but men are more successful in quitting using the service than women.</li> <li>• Women are more likely to suffer from common mental illnesses than men, though men are twice as likely to suffer</li> </ul>	<ul style="list-style-type: none"> <li>○ Providing a range of activities to improve physical activity should help ensure there are activities that appeal to both genders aiming to reduce the gap in physical activity rates.</li> <li>○ Targeted promotion of cancer screening, for example bowel cancer screening to men.</li> </ul> <ul style="list-style-type: none"> <li>• Some of the priority areas are only/more relevant to one gender as a result of the health differences, for example some elements of the sexual health objectives and specific cancer screening programmes.</li> <li>• In the case of reducing alcohol harm, the rise in alcohol harm amongst young women has been recognised and hence this is a particular focus.</li> </ul>
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<sup>†</sup> BMI between 18.5 and 25

	<p>from schizophrenia.</p> <ul style="list-style-type: none"> <li>• Women have more long term conditions on average than men, particularly with increasing age.</li> <li>• On the average, women receive more social care services (8.2%) than men (3.6%) in Lewisham, though this is presumably because on average women live longer than men.</li> </ul>	
<p><b>Pregnancy &amp; Maternity</b></p>	<ul style="list-style-type: none"> <li>• The general fertility rate (number of live births per 1000 women aged 15-44) in Lewisham is higher than the London and England averages. In 2011 the wards with the highest rates were Crofton Park and Rushey Green; Brockley and Telegraph hill had the lowest.</li> <li>• Abortion rates in Lewisham are higher than the England average and almost half of abortions are performed on women who have had at least one previous abortion. The highest rates of abortion in the borough are for women aged 18-19 years old.</li> <li>• The low birth weight rate for Lewisham births is higher than the England average, though not significantly different to London. Low birth weight can be associated with some ethnicities, including black Caribbean and black African, alcohol use, smoking and deprivation.</li> <li>• Smoking by mothers at time of delivery is lower in Lewisham than the UK average.</li> <li>• Local maternal obesity data show there are more women overweight (31%) or obese (24%) in Lewisham compared with England as a whole (28% and 17%).</li> <li>• Influenza vaccine rates amongst pregnant women in</li> </ul>	<ul style="list-style-type: none"> <li>• The strategy recognises the need to reduce the high rate of unplanned teenage pregnancy in the borough.</li> <li>• Maternal obesity and immunisation against influenza will also be included in the broader immunisation and healthy weight priorities.</li> </ul>

	Lewisham are below the London average.	
<b>Race</b>	<ul style="list-style-type: none"> <li>• Lewisham is an ethnically diverse borough, with only 41.5% of the population describing themselves as white British. The largest BME groups in the borough are black Caribbean and black African.</li> <li>• In Lewisham self reported health at the 2011 Census was worse in white British and black Caribbean residents than other ethnic groups. However, this may simply reflect the age profiles of these ethnic groups.</li> <li>• Obesity prevalence varies between ethnic groups. In England the prevalence of obesity is higher in women of Black Caribbean, Black African and Pakistani groups compared to the general population.</li> <li>• In Lewisham the majority of people accessing alcohol treatment services are white British; the Health Survey England in 2004 found that harmful drinking was less prevalent among ethnic minorities, including black Caribbean and Africans.</li> <li>• There is evidence nationally that some ethnic minorities have a higher prevalence of some mental illnesses, most notably black African and Caribbean men and schizophrenia; it is thought migration and other factors play a part in this association. In Lewisham there are high numbers of admissions amongst people whose ethnicity is reported as black other.</li> <li>• Smoking prevalence varies between ethnic groups. Taking this into account proportionately fewer black African smokers</li> </ul>	<p>The strategy includes some priorities that are equally relevant to all ethnicities, and others are more targeted to specific communities, on the basis of greater need or lower healthcare use:</p> <ul style="list-style-type: none"> <li>• The priorities addressing health behaviours and long term conditions include all ethnicities. However some BME groups have greater need, for example greater prevalence of obesity and diabetes, and hence ensuring these services are relevant and adapted to their needs will be important during planning and implementation.</li> <li>• The higher prevalence of mental illnesses amongst some BME groups is recognised and a focus for the local Improving Access to Psychological Therapies Programme (IAPT).</li> <li>• Similarly BME groups will be a target for improving attendance at</li> </ul>

	<p>are using the local Stop Smoking Service.</p> <ul style="list-style-type: none"> <li>• Some long term conditions are more prevalent amongst ethnic minority communities, including diabetes and cardiovascular disease.</li> <li>• There is evidence nationally to suggest that emergency admissions are higher amongst ethnic minority groups.</li> <li>• Cancer incidence in general is lower amongst ethnic minority groups, although there are some important exceptions. For example, prostate cancer incidence is greater amongst Black African and Black African-Caribbean men.</li> <li>• Levels of public awareness of early symptoms and signs of cancer have been found to be lower amongst ethnic minority groups. In Lewisham breast cancer screening attendance was lower amongst BME women than white British women.</li> <li>• Pregnancy rates are 74% higher amongst black ethnic groups than white ones; similarly, abortion rates are higher.</li> <li>• New diagnoses of HIV are higher amongst black Africans in Lewisham, and Lewisham as a whole has one of the highest prevalences of HIV in England. About a third of new diagnoses of HIV in South East London are in Black Africans.</li> </ul>	<p>cancer screening, noting lower attendances and awareness of cancer signs and symptoms and that early diagnosis improves survival.</p> <ul style="list-style-type: none"> <li>• Actions to roll out HIV testing in primary care, increasing HIV testing in other settings, and undertaking targeted work with Black African communities to understand barriers to accessing sexual health services are a focus of the strategy.</li> </ul>
<p><b>Religion or belief</b></p>	<ul style="list-style-type: none"> <li>• Christianity is the most widely reported religion in the borough, with 53% of residents identifying themselves as Christian, 6% identify as Muslim and 27% have no religion.</li> <li>• At the last census rates of self reported poor health were significantly lower than average amongst those with no</li> </ul>	<ul style="list-style-type: none"> <li>• The strategy recognises the need for an individual approach to lifestyle interventions. At the planning and implementation stage the relevance, appropriateness and sensitivity of services to all</li> </ul>

	<p>religion and Hindus and higher than average amongst Christians, Buddhists, and those of “Other Religions<sup>‡</sup>.</p> <ul style="list-style-type: none"> <li>• Religious and cultural views can influence attitudes towards reproductive medicine, abortion, contraception, neonatal care and death. They may also determine the types of treatment and drugs used, for example blood transfusions, porcine or alcohol-based drugs.</li> <li>• In Lewisham there are a number of successful health projects run alongside religious groups. For example, the Community Health Improvement Service conduct health drop in sessions in a variety of faith centres, including the Hindu temple. Similarly, services have worked alongside religious groups at key times, such as the Stop Smoking Service at Ramadan.</li> </ul>	<p>religious and non-religious groups needs to be taken into account.</p>
<p><b>Gender reassignment</b></p>	<ul style="list-style-type: none"> <li>• There is very limited information on the prevalence of gender reassignment. The most recent estimate suggests that 25 per 100,000 individuals have received treatment for gender variance; 60% of those have undergone transition surgery. The majority (80%) of those undergoing surgery were born male and transitioning to female.</li> <li>• A national survey of transgender people found that a third of adults had attempted suicide.</li> <li>• Rates of substance misuse have been found to be higher amongst transgender communities.</li> <li>• 30% of transgender people have experienced discrimination from healthcare professionals, including with regard to cancer screening.</li> </ul>	<ul style="list-style-type: none"> <li>• There is little information available about the transgender community in Lewisham. At planning and implementation stages for services, in particular mental health and cancer screening, the needs of these individuals will need to be considered.</li> </ul>

<sup>‡</sup> Excluding Hinduism, Christianity, Buddhism, Islam, Judaism and Sikhism



<p><b>Sexual orientation</b></p>	<ul style="list-style-type: none"> <li>• There are no accurate statistics available regarding the profile of the lesbian, gay, bisexual and transgender (LGBT) population either in Lewisham, London or Britain as a whole.</li> <li>• The Greater London Authority based its Sexual Orientation Equality Scheme on an estimate that the lesbian and gay population comprises roughly 10% of the total population.</li> <li>• At the 2011 census 2% of over 16 year olds were cohabiting with someone of the same sex or were in a civil partnership, this is higher than both the England and London averages (0.9 % and 1.4% respectively).</li> <li>• There are higher rates of mental illness amongst individuals who describe themselves as lesbian, gay, or bisexual. Young gay men have been found to have a 5 fold increase in the risk of depression compared to heterosexual men. Suicide risk is 12 times higher.</li> <li>• Men who have sex with men (MSM) are at increased risk of acquiring HIV; just over half of new diagnoses of HIV in 2011 in South East London were in MSM. In London as a whole rates of new HIV infection amongst the MSM community are increasing, despite falling amongst other groups.</li> </ul>	<ul style="list-style-type: none"> <li>• The differing and changing needs of LGBT residents and in particular MSM (noting the recent rise in HIV incidence) around sexual health services are recognised. These will be considered as part of the sexual health priority.</li> <li>• Similarly, it will be necessary, during the implementation stage, to ensure that other health improvement services are relevant and appropriate for LGBT residents.</li> </ul>
<p><b>Marriage and civil partnership</b></p>	<ul style="list-style-type: none"> <li>• About half of Lewisham residents over 16 have never been married or in a civil partnership. This is higher than England as a whole.</li> <li>• A third of over 16s in Lewisham are currently married or in a</li> </ul>	<ul style="list-style-type: none"> <li>• The strategy’s priority to delay and reduce the need for long term care and support will enable more individuals to manage their conditions at home. This is likely</li> </ul>

Appendix C

	<p>civil partnership (0.5% in civil partnership)</p> <ul style="list-style-type: none"> <li>• 17% of residents (aged 16 and over) have been married or in a civil partnership but are now separated, divorced<sup>§</sup> or widowed<sup>**</sup>.</li> <li>• Married people’s physical and mental health tends to be better than that of single people. However the health of single people is usually better than that of people who are widowed, separated or divorced.</li> </ul>	<p>to have more of an impact on residents currently living alone, who may be isolated.</p> <ul style="list-style-type: none"> <li>• Engagement events on the strategy highlighted the importance of social isolation.</li> </ul>
<b>Non-Statutory</b>		
<b>Deprivation</b>	<ul style="list-style-type: none"> <li>• Lewisham is the 31<sup>st</sup> most deprived local authority in England and deprivation is increasing in the borough relative to the rest of the country.</li> <li>• The highest levels of deprivation are found in Evelyn ward, in the north of the borough and Downham ward, in the south of the borough.</li> <li>• Deprivation is quantified using the Index of Multiple Deprivation, which takes into account the following components: income, employment, health and disability, education, skills and training, housing and services, crime and the living environment.</li> <li>• Increased deprivation is associated with worse health and wellbeing outcomes across many domains: <ul style="list-style-type: none"> <li>○ In Lewisham alcohol specific admissions are higher amongst residents of more deprived wards. The admission rates in Lewisham central for the period from</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• An overarching priority of the strategy is reducing health inequalities. In tackling some of the wider determinants of health, these include many of the elements that are included in deprivation measures: education, living environment and housing. This wider perspective was also highlighted as important during the engagement events.</li> </ul>

<sup>§</sup> Or were in a civil partnership that has now been legally dissolved

<sup>\*\*</sup> Or are the sole surviving partner of a civil partnership

	<p>2005 to 201 were three times higher than the ward with the lowest rates of alcohol specific admissions.</p> <ul style="list-style-type: none"> <li>○ Obesity is higher amongst those from more deprived areas. National figures have shown obesity levels amongst 4-5 year olds in the most deprived areas to be double that of the least deprived.</li> <li>○ It has been estimated that the need for mental health services is 25-40% higher amongst residents of the least affluent wards in the borough compared to the most affluent.</li> <li>○ Cancer incidence and mortality are generally higher in deprived groups compared with affluent groups. Although breast cancer has higher incidence in more affluent groups, its mortality is higher in less affluent women.</li> <li>○ Smoking prevalence is higher amongst those from lower socio-economic groups. Additionally, smokers from lower socio-economic groups are more likely to have started earlier, smoke more and find it harder to quit than smokers from higher socio-economic groups.</li> </ul>	
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### **Section four: Decision / Result of analysis**

*Make an assessment as to whether the strategy will negatively or positively impact any protected characteristics. Take into account all factors including finance and legal issues.*

There is no clear evidence that the HWB strategy as a whole will have a negative impact on any of the protected characteristics. In some cases there is likely to be a positive impact on one of more of the protected characteristics as they are the target of particular interventions under the strategic priorities. This is because of greater need as the result of worse outcomes or poorer use of healthcare, identified through the JSNA process, for example:

- Reducing alcohol harm amongst young women
- Improving cancer survival amongst older people, through improved awareness of early symptoms and signs.
- Reducing rates of teenage pregnancy
- Tackling obesity in children
- Improving access to IAPT services amongst BME groups
- Reducing emergency admissions for people with long term conditions.

In other cases protected characteristics may benefit more from some of the priorities as a result of an association with a target group, for example:

- Older people are more likely to have complex healthcare and social support needs and are more vulnerable to crises that reduce their independence. They are therefore more likely to benefit from the strategy's priority to delay and reduce the need for long term care and support.

Consultation with stakeholders in the borough highlighted the importance of addressing the multiple and wider determinants of health to reduce health inequalities. Most of the priorities involve the provision of services to Lewisham residents. These services will be open to residents from all the protected characteristics<sup>††</sup>. During the implementation stages, it will be important to ensure they are relevant and accessible to all. Similarly, monitoring this once services are running and in those services that are already in existence will be important; this monitoring may be carried out by, for example, health equity audits. In addition it will be important to understand the barriers met by

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<sup>††</sup> Except where not relevant, for example cervical screening only available to women.

**Appendix C**

residents in pursuing a healthy lifestyle, particularly those highlighted by the engagement events, and implementing the recommendations made to overcome these.

**Section five: EAA Action Plan**

- 1. Feedback to those involved in the engagement events, including the outcome of the events, the final strategy and ongoing progress against the strategy.**
- 2. Ensure that due regard is given to the protected characteristics throughout the implementation of the strategy; particularly when planning, reviewing and designing programmes and services and as highlighted by the impact assessment.**
- 3. During the three yearly review and action planning process ensure that the impact of the implementation of the strategy on the protected characteristics is reviewed and fed into the cycle of implementation.**

Health & Wellbeing Board			
<b>Report Title</b>	An Evaluation of the North Lewisham Health Improvement Programme and the Transfer of Learning		
<b>Key Decision</b>	Yes	Item No.	7
<b>Ward</b>	Mainly Evelyn, New Cross, Bellingham but applicable across Lewisham.		
<b>Contributors</b>	Jane Miller, Deputy Director of Public Health Alfred Banya, Assistant Director of Public Health		
<b>Class</b>	Part 1	Date:	19 September 2013

## 1. Summary

1.1 This report highlights an evaluation undertaken of the North Lewisham Health Improvement Programme (NLHIP). It describes the approach, and the methodology used to evaluate it, and the evaluation findings (with examples from individual projects). It concludes that the programme has been successful in raising awareness, changing behaviour and improving health outcomes for a proportion of the target population living in Evelyn and New Cross wards in a cost effective way. It has also provided valuable learning, which can inform future activity, particularly in relation to the integrated prevention agenda.

1.2 The evaluation report is on the Lewisham Joint Strategic Needs Assessment website, [www.lewishamjsna.org.uk](http://www.lewishamjsna.org.uk) and hard copies are available from Public Health Lewisham.

## 2. Purpose

2.1 This report provides evidence on the impact of the North Lewisham Health Improvement Programme – an area based health initiative in Evelyn Ward and New Cross Ward.

1.2 The report seeks the Health and Wellbeing Board's support for this approach to health improvement, based on partnership working with communities and key agencies in defined geographical areas that have poor health outcomes.

## 3. Recommendations

3.1 It is recommended that the Board:

- Notes the health impact of the North Lewisham Health Improvement Programme and progress made in transferring the learning to Bellingham.

- Endorses the approach as a way of contributing to the implementation of the Lewisham health and wellbeing priorities at a local level and as part of the integration of health and social care activity at a local level.

#### **4. Policy context**

4.1 The Health and Social Care Act became law in March 2012 and provided the legal basis for the transfer of public health functions from the NHS to local authorities as part of the wider NHS Transformation Programme

4.2. Under the Act, the majority of Public Health responsibilities and functions transferred to the Council on 1 April 2013. These functions range from the more specific programmes e.g. NHS Health Checks to broader ones e.g. Public Health aspects of local initiatives to tackle social isolation.

4.3 Public health interventions contribute to the overall health and wellbeing of populations. In Lewisham the interventions support the delivery of the Sustainable Community Strategy's priorities, specifically *Healthy, active and enjoyable – where people can actively participate in maintaining and improving their own health and wellbeing* and the corporate priority, *Active, healthy citizens*. The North Lewisham Programme, whose evaluation findings are presented here, is an example of a public health programme contributing to this priority.

4.4 NICE Guidance on Community Engagement to Improve Health (Feb 2008) states that 'Area-based Initiatives (ABI) focus on geographic areas of social or economic disadvantage'. The recommendations identified that more evidence is still required on the impact of ABI on individuals, but acknowledged the usefulness of community engagement approaches and recommended that these could be used to address a range of issues with different communities.

#### **5. Background**

5.1 In 2007, in response to recommendations by the Lewisham Strategic Partnership and what was at the time the Healthier Lewisham Partnership Board, and the Lewisham Primary Care Trust Board, Public Health developed an outline of a 5-year North Lewisham Health Improvement Programme (NLHIP) as part of the implementation of the health inequalities strategy.

5.2 North Lewisham was defined as New Cross and Evelyn wards in the north of the borough. The rationale for choosing these wards was that they were two of the four in the borough with the lowest life expectancy for both men and women; two of the five with the highest death rates for people under 75; and had the highest death rates for people under 75 from cardiovascular disease (CVD).

5.3 The objectives for the NLHIP were:



- To undertake a detailed health needs assessment of New Cross and Evelyn wards and comparing these with Lewisham as a whole and England
- To increase partnership working with key stakeholders to identify ways to reduce health inequalities in North Lewisham.
- To establish effective initiatives which promote health and reduce health inequalities in North Lewisham.
- To increase community engagement to raise awareness of health and promote the uptake of services.
- To increase uptake of primary care services and screening, including the identification of risk factors in patient populations, and the diagnosis of illness.
- To increase resource allocation and opportunities to target additional investment towards Evelyn and New Cross wards.
- To identify mechanisms for partners working in a different way.
- To develop local targets and indicators, and evaluate the health impact of the plan.

A further intention was that the NLHIP would also provide learning that could be applied to future community based programmes.

5.4 The evaluation reported here has been undertaken by Public Health officers in order to assess the impact of the NLHIP as it neared the end of its 5 year implementation period.

## **6. Evaluation methodology and framework**

- 6.1. The NLHIP is a complex intervention involving community-based activities. Complex interventions are widely used in public health practice, but are difficult to evaluate because of their complexity, size, and the multiple problems they try to address. Overall, the diverse nature of NLHIP interventions requires a range of qualitative and quantitative methods to evaluate them.
- 6.2. An embedded evaluation was undertaken. This entailed assessing how far the constituent parts of a programme met their individual objectives, and then assessing their contribution to the process and outcomes of the whole programme. This design is particularly suitable here, as five years is not a long enough period of time to achieve aims such as reducing cardiovascular morbidity and mortality, but changes that contribute to these may still be observed.
- 6.3. Taken as a whole, the embedded evaluation was designed to answer four main questions:
- What projects or initiatives were established?
  - What objective[s] of the programme did they meet?
  - What was learned about the process of the projects or initiatives?
  - What were the outputs and outcomes of the projects or initiatives, and how did they contribute to improvements in the four overarching

areas of the plan: knowledge, behaviour, disease prevalence and premature death?

6.4 The impact of this complex public health intervention on health and wellbeing in North Lewisham was further assessed by a panel of four public health specialists. The panel reviewed independently the findings and results for each of the NLHIP projects reported in the evaluation and gave an overall assessment.

6.5 Each panel member assigned a rating to each project against each relevant outcome, on a whole number scale from 0 to +3, where a score from >0 to 1 indicates a small effect, a score from >1 to 2 indicates a moderate effect, and a score from >2 to 3 indicates a large effect.

## **7.0 Summary of Evaluation findings of the Programme**

7.1 Using a community development approach within a strategic framework to reduce health inequalities was an important feature of the NLHIP. The DH National Support Team on Health Inequalities described the programme as unique and innovative. Furthermore, Lewisham has been recognized nationally by the Department of Health (DH) for the ground-breaking approach of one of the initiatives of the programme; the Cardiovascular Disease (CVD) Healthy Communities Collaborative; especially for involving local communities and also for its participatory budgeting grant scheme in which local people made decisions on funding for community health activities. The NLHIP was the first example in this country where a participatory budgeting approach was taken to allocating funds to community groups to promote healthy lifestyle.

7.2 The approach used in the NLHIP enabled sharing of knowledge about the evidence base on the health of the population and the effectiveness of interventions as well as the key strategic priorities. These were shared with local communities, front line staff and statutory and voluntary organisations so that they could use that knowledge to inform their practice. Likewise the knowledge about local communities was harnessed and has informed how the programme was delivered.

7.3 Most projects explicitly used a community development approach to health improvement. The programme was effective at building social networks and social capital. At least 10,000 people benefitted directly from the programme and many more benefitted from the programme indirectly through families and friends.

7.4 The programme successfully targeted people from black and minority ethnic populations living in north Lewisham. All the projects were successful at reaching women. Some projects were more successful than others at reaching men and disadvantaged communities with poorer health. The numbers of people with disabilities accessing projects were low initially, but action was taken to address this and higher numbers of people with disabilities accessed projects in later years. A broad spectrum of ages

benefitted from the programme although the predominant age of people participating in projects were adults aged between 30 and 75.

7.5 A return on investment of a ratio of 1.8:1 to 3.0:1 suggests good value for money. This is particularly true as the only value included is value to the client/patient. Potential 'longer term cost' savings to the NHS and others are not included. A lack of longitudinal data also means that benefits are often only counted for the short term, and in some cases there may be longer term value that is not incorporated into this evaluation.

7.6 The programme has developed a rich knowledge base about how to reach communities, raise awareness, change behaviour and improve health outcomes. The innovative nature of the programme allowed projects to try new and different ways of working and there are many practical examples of what works and what does not work that can inform similar health improvement programmes and projects. Below are the findings from some of the initiatives established under the NLHIP. The projects and initiatives range from needs assessments and stakeholder participation, to those aimed at promoting lifestyle change and uptake of health checks.

#### 7.6.1 North Lewisham Health Needs Assessment

a. The health needs assessment confirmed the estimated pattern and level of deprivation and poor health of north Lewisham, with a high proportion of under 75 year olds reporting a long term illness, comparatively low levels of life expectancy, high rates of premature death and lower than expected diagnosis of chronic diseases.

b. The needs assessment report was added to the Lewisham Joint Strategic Needs Assessment (JSNA) website and presentations were made to the North Lewisham Health Improvement Stakeholder Group, the GP Neighbourhood 1 Clinical Commissioning Group and the Lewisham Adult Joint Commissioning Group.

c. The needs assessment informed the North Lewisham programme and its priorities and most of its recommendations have been addressed.

#### 7.6.2 Vietnamese Focus Groups

a. The focus groups and subsequent report provided comprehensive information about the Vietnamese community, including key concerns and issues as well as providing insight into barriers to behaviour change, which informed the programme.

b. Most of the issues raised related to the wider determinants of health, such as income, social status, education, physical environment, social support networks, housing, unemployment and gender. Other issues included difficulty in learning and communicating in English; family

relationships; safety; addictions; mental health, health services; the influence of culture and background and access to services.

c. A number of changes were made in terms of public health commissioning. The uptake of NHS Health Checks and the Stop Smoking Services increased among the Vietnamese community, which could lead to some reduction in smoking prevalence and more people at cardiovascular risk being identified. However, not all of the recommendations from the report were taken forward because the working group did not meet after a couple of meetings.

### 7.6.3 The Mental Health and Well Being Impact Assessment (MWIA)

a. The MWIA served three key purposes:

- identified indicators to use to measure mental wellbeing;
- raised awareness of how the programme was contributing to mental well being, the gaps in the programme, and how these gaps were to be addressed;
- strengthened the mental well-being element of the programme through making the promotion of well-being more explicit in the criteria for small grants funding, as well as in the referral pathways between the Improving Access to Psychological Therapies service and community groups funded through the programme.

b. The methodology used was an inclusive way of enabling stakeholders to assess the actual and potential impact of the programme, leading to concrete ways to improve the mental well being focus of the programme.

### 7.6.4 Evelyn Stop Smoking Social Marketing Project

a. The use of social marketing techniques to obtain an insight into smokers' views enabled the Stop Smoking Service to improve the way the service was provided and led to an increase in the number of smokers accessing the service, setting quit dates and stopping smoking.

b. There was a notable increase in the number of Evelyn and New Cross residents (53% and 103%, respectively) entering the Lewisham Stop Smoking Service throughout 2008 and 2009, and this was far greater than the 23% increase across Lewisham as a whole. The number of successful quitters also increased during that time period (by 30% in Evelyn and by 62% in New Cross), compared with a 7% increase in the numbers quitting in the rest of Lewisham.

### 7.6.5 Cardiovascular Disease Healthy Communities Collaborative (CVD HCC)

a. Social capital was built through the recruitment and training of local volunteers. Volunteers reported that the project raised their own awareness of CVD, its prevention and risk factors, and influenced their willingness to change their behaviour.

b. Overall, 2,247 health checks were undertaken by the project, with 1,389 people aged 40 to 75 years old, exceeding the target of 1,300. The project was successful in reaching women (70%), people from black and minority communities (70%) and those not registered with GPs (4%), but less successful in reaching residents living in the catchment area (40%) and men (30%). Lessons were learnt about how to successfully reach and engage communities with poor health outcomes.

c. In addition, prescribing of most medicines for hypertension increased more rapidly in North Lewisham than in the rest of Lewisham, and rates of increase were lower in the rest of Lewisham after the programme began, but higher in North Lewisham. The prescribing data are consistent with improved diagnosis and management of CVD, but the changes are not statistically significant at the usually accepted level. This is probably because of the small number of data points available for the period before the programme began.

d. It is reasonable to conclude that the step change improvement in recording the blood pressure of those with hypertension and increased prescribing in the management of hypertension, compared with the rest of Lewisham, were linked to the establishment of the CVD Healthy Communities Collaborative and the increased focus on CVD and the engagement of GPs in the North Lewisham Health Improvement Programme, its stakeholder group and events.

#### 7.6.6 Cancer Healthy Communities Collaborative (Cancer HCC)

a. The outcomes of this collaborative were very similar to the CVD collaborative in that it built social capital through recruiting and training more than 20 volunteers from local communities, and raised awareness of the importance of cancer prevention and the early diagnosis of cancer, with a fourfold increase in those presenting with symptoms.

b. It also led to a change in practice within primary care leading to a trebling of the number of cancer referrals per month and a dramatic improvement in the numbers referred within two weeks for breast, bowel and lung cancer.

#### 7.6.7 Stakeholder Involvement (Bi-Monthly Stakeholder Group, Stakeholder Events, New Cross & Evelyn Ward Assemblies)

a. Chaired by the voluntary sector, the stakeholder group introduced a different way of working on health inequalities, by bringing together a wide range of partners to take responsibility for the programme under a

strategic framework to address health inequalities, but informed at a local level.

b. The inclusive nature of the stakeholder group and the community development approach used to develop and to implement the programme allowed many projects to flourish. There are many examples of an increase in social capital, whether through volunteering, training opportunities or community group activities.

c. Grassroots involvement through stakeholder events, meetings and ward assemblies has ensured that the priorities and direction of the programme have been informed by local communities and are therefore delivered in a way that is effective and relevant to people's lives.

#### 7.6.8 Small Grants programmes (Evelyn Chooses Health Fund, Supporting Communities Fund, Deptford and New Cross Choose Health)

a. Allocating funding to community organisations has been demonstrated as an ideal way to reach and respond to the needs of different communities. Small grants programmes have been effective at raising awareness about health, and in changing the lifestyle behaviour of not only their participants, but also their friends and families.

b. The various small grants schemes have been amended and improved by incorporating the learning from the previous schemes. Community groups are more effective at delivering health promotion interventions when they receive advice and training and development from public health specialists and when they have opportunities to network with each other.

#### 7.6.9 Community Development for Health – Nutrition Worker (170 Community Project)

a. The project worker provided community development support to 92 community groups and organisations in New Cross and Deptford to develop themselves into social enterprises and obtain funding for growth. A total of 21 workshops were completed and nine health events held between 2009 and 2010.

b. Individuals who completed the external evaluation questionnaires stated that the greatest influence of the project was a positive change in their attitudes to nutrition and healthy eating. They also said they benefited from the project through: mapping information on the range of services; addressing health related issues; information on funding opportunities; networking and support; capacity building and health related training; and networking to enable better collaboration. Most groups rated the information, support, accessibility and effectiveness that they received from the project as either good or very good.

## **8.0 A Public Health Specialists' Panel Overall Assessment of the Impact of the North Lewisham Plan**

Large health impacts were observed for all outcomes except reducing premature deaths in at least one individual project within the North Lewisham Plan. Large improvements were observed in: knowledge in 3 projects; behaviour in 5 projects; disease prevalence in 1 project; health needs assessment in 4 projects; increased partnership working in 7 projects; increased health promotion initiatives in 5 projects; increased community engagement in 10 projects; increased primary care uptake in 3 projects; increased resource allocation in 8 projects; improved working in a different way in 10 projects; and increased identification of targets in 3 projects.

## **9.0 Transfer of Learning**

9.1 Learning has been transferred to other parts of the Borough. A particular example in the south of the borough (similar to the NLHIP), is the locally focussed Bellingham Well London (a partnership initiative with the Greater London Authority and the Big Lottery). It uses an integrated, community action approach that aims to improve community health and well-being in ways that are effective and sustainable. It works through co-production by engaging and empowering people to build and strengthen the foundations of good health and wellbeing in their communities using community action, capacity building and development.

### **9.2 Phase 1 of the Bellingham Well London Programme**

This ran from 2008 to 2011 in South Bellingham. Out of a sample of 501 participants:

- 393 people reported an increase in healthier eating.
- 365 people reported increased access to affordable healthy food.
- 367 people reported an increase in levels of physical activity.
- 419 people reported that they felt more or much more positive.

9.3. Phase 2 of the Bellingham Well London Programme began in September 2012 and will run initially up to March 2015. So far, the programme has involved the creation of a Delivery Team made up of local volunteers and youth apprentices. The volunteers have been trained to deliver key messages around public health e.g. healthy eating, sensible drinking and benefits of physical activity to residents. The Youth Apprentices work specifically with young people and an example is that Bellingham won the Lewisham Cut Films Award on tobacco and young people from Bellingham attended the national award ceremony. Furthermore, 12 small community groups, through a participatory budgeting process borrowed from the NLHIP, have been awarded up to £5k to run activities that contribute to these the public health messages.

9.4 This programme is currently being evaluated by University of East London in conjunction with Well London and Public Health Lewisham.

9.5 The intention is for similar programmes to be supported in Downham and in Lewisham Central, in addition to North Lewisham and Bellingham, which will form part of the integration of health and social care, specifically the joint work with GPs and neighbourhoods, where the aim is to make better use of existing community resources, improve the range of services available within communities and increase access to services to support people to maintain independent living and a high quality of life.

9.6 The learning from the evaluation of these programmes could also inform the implementation of 'Fulfilling Lives, Better Start', funded by the Big Lottery, (led by the Children's Society and the London Borough of Lewisham). This is particularly pertinent as this new programme has a commitment to partnership working and engaging and involving communities in taking the work forward.

## **10. Financial implications**

During the first three years (2008/11) the NLHIP cost a total of £570,000 public health/PCT funding, supplemented with additional resources of £310,000 from DH. A return on investment of a ratio of 1.8:1 to 3.0:1 for the North Lewisham Health Improvement programme suggests good value for money.

The Phase 1 of the Well London Programme was commissioned and managed directly by Well London and the Big Lottery and it cost £100k per annum. The current Phase of the Bellingham Well programme is commissioned through Public Health Lewisham. The cost is also approximately £100k per annum. However, for the year 2012-13 matched funding of 50% was provided by Public Health Lewisham and the other 50% was funded by Well London and the Big Lottery.

Any future financial implications from taking the learning forward will be met through the Public Health Allocation to the London Borough of Lewisham, in addition to any potentially available external funding.

## **11. Crime and disorder implications**

There are crime and disorder implications within some of the public health priorities being addressed at a local level, such as tackling underage sales of tobacco and alcohol; the supply of illicit tobacco and the reduction in crime and anti social behaviour arising from reduced alcohol consumption.

## **12. Equalities implications**

12.1 A key element of public health activity consists of the identification of health inequalities, notably the extent to which people with different protected characteristics can experience variations in health outcomes. Interventions, such as the NLHIP, which take a community



development approach are designed to deliver health improvement initiatives in ways that are appropriate to population groups that are often not reached in other ways.

### **13. Environmental implications**

13.1 Creating healthier environments are often central to encouraging healthier lifestyles and promoting health and well being and can also result from behaviour change .e.g. reduction in cigarette litter, safe open spaces which encourage physical activity.

### **14. Conclusion**

14.1 This programme has been successful in raising awareness, changing behaviour and improving health outcomes for a proportion of the target population living in Evelyn and New Cross wards in a cost effective way. Overall this large, ambitious and challenging programme has made good progress in achieving its objectives. It has also provided valuable learning about how this can be achieved and applied to other similar programmes.

**If there are any queries on this report please contact: Jane Miller, Deputy Director of Public Health, 0208 314 9058**

# Agenda Item 8

HEALTH AND WELLBEING BOARD			
<b>Report Title</b>	The role and responsibility of the Health and Wellbeing Board for Pharmaceutical Needs Assessments		
<b>Contributors</b>	Dr Danny Ruta, Director of Public Health	Item No.	8
<b>Class</b>	Part 1	Date:19.09.13	

## 1. Purpose

- 1.1 This report outlines the requirements and responsibilities of the Health and Wellbeing Board's (HWB) for maintaining and publishing a Pharmaceutical Needs Assessment (PNA).
- 1.2 The report provides an update on the actions undertaken to date by the Council's Public Health Unit and sets out a proposed process for updating the existing PNA and for developing a plan to ensure that a revised PNA is presented for approval by the Health and Wellbeing Board before April 2015.
- 1.3 The report also proposes that the Director of Public Health is given responsibility for considering and commenting on any local pharmacy applications within the statutory consultation period.

## 2. Recommendations

Members of the Health and Wellbeing Board are recommended to:

- 2.1 Note that from 1 April 2013 the Health and Wellbeing Board assumed responsibility for the existing Pharmaceutical Needs Assessment - previously published by Lewisham Primary Care Trust - and that the Board must publish its own Pharmaceutical Needs Assessment by April 2015.
- 2.2 Note that, in 2012, NHS South East London assessed the inherited Pharmaceutical Needs Assessment and supplementary statements and concluded that the current Pharmaceutical Needs Assessment and the four supplementary statements are fit for purpose.
- 2.3 As set out in paragraph 7.1 below, note that a working group will be set up to review and identify any changes needed in local pharmaceutical services and undertake the preparation of a revised PNA which will be presented for approval to the Health and Wellbeing Board in Autumn 2014.
- 2.4 Approve the proposed process for preparing any necessary supplementary statements to ensure the current PNA remains fit for purpose.

- 2.5 Agree that the Public Health Director be given responsibility to consider any forthcoming pharmacy applications within the 45 day prescribed time period and to make any written representations as necessary on behalf of the Board.

### **3. Policy Context**

- 3.1 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 *Shaping our future’s* priority outcome that communities in Lewisham should be *Healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and wellbeing*.
- 3.3 The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis and the full requirements of the Health and Wellbeing Board for developing and updating the Pharmaceutical Needs Assessment (PNA) together with the responsibility of the NHS Commissioning Board (now NHS England) in relation to market entry.

### **4. Background - Overview of Regulatory Framework**

- 4.1 The provision of NHS Pharmaceutical Services is a controlled market. If a person (a pharmacist, a dispenser of appliances or in some circumstances and normally in rural areas, a GP) wants to provide NHS pharmaceutical services, they are required to apply to the NHS to be included on a pharmaceutical list. Since April 2013 Pharmaceutical lists are compiled and held by NHS England. This regulation of pharmacy sites is commonly known as the NHS ‘control of entry’ system.
- 4.2 The NHS (Pharmaceutical Services and Local Pharmaceutical Services) (amendment) Regulations 2010 placed each Primary Care Trust (PCT) under a duty to prepare and publish a PNA by 1st February 2011. The PCT was also required to publish any necessary supplementary statements to ensure that the PNA remained fit for purpose. This requirement of publishing a PNA was a prelude to major changes in the control of entry arrangements for community pharmacies.
- 4.3 In September 2012, the NHS (Pharmaceutical Services) Regulations 2012 came in to effect. These regulations replaced the previous control of entry system with a new system of market entry control, where applications to open new pharmacies, move existing premises or change hours or provide additional pharmaceutical services must be considered, by the PCT (now NHS England), against the PNA for the area in which the application is made.
- 4.4 The Health and Social Care Act 2012 transferred the statutory responsibility for the development and updating of the Pharmaceutical Needs Assessment

to Health and Wellbeing Boards (and the determination of applications to the National Commissioning Board – now NHS England).

- 4.6 Thus under the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulation 2013 (the 2013 Regulations) a person who wishes to provide NHS pharmaceutical services must now apply to NHS England to be included in the relevant list by proving they are able to meet (fill a gap in) a pharmaceutical need as set out in the relevant Pharmaceutical Needs Assessment (PNA). There are two exceptions to this, one for services provided only by distant selling (internet or mail – order only) basis; the second is an application for needs not foreseen in the PNA.
- 4.7 NHS England must maintain up to date lists of persons within an area offering a pharmaceutical service. NHS England must consult, giving 45 days for a response, the relevant Health and Wellbeing Board when an application for a new pharmacy or change to existing pharmacy is received within 2km of the area served by a Health and Wellbeing Board.
- 4.8 Pharmaceutical Services covered by the Pharmaceutical Needs Assessment are those services listed within the NHS (Pharmaceutical Services) Regulations 2013.  
[The NHS \(Pharmaceutical and Local Pharmaceutical Services\) Regulations 2013](#)

## **5. Responsibilities of Health and Wellbeing Boards**

In summary, the Health and Wellbeing Board responsibilities are to:

### 5.1. Publish its first PNA by 1 April 2015

The Regulations set out the minimum information which must be included within the PNA: the matters which must be considered when making the assessment: and the process to be followed (including formal consultation with specific stakeholders for a minimum of 60 days) in preparation of the PNA.

In the interim period, the PNA published by a Health and Wellbeing Board's former PCT(s) will be used, by NHS England, to inform market entry decisions.

### 5.2. Maintain and keep up-to-date the PNA

In response to changes in the availability of pharmaceutical services, there is a requirement for the Health and Wellbeing Board to determine whether or not it needs to revise the PNA or, where this is thought to be a disproportionate response, to issue a supplementary statement setting out the change(s). As a minimum, a new PNA must be published every 3 years. In addition, the Health and Wellbeing Board is required to keep up-to-date a map of provision of NHS Pharmaceutical Services within its area.

### 5.3. Consultation by a neighbouring Health and Wellbeing Board

- 5.4 The Regulations require that, when consulted by a neighbouring Health and Wellbeing Board on a draft of their PNA, the Health and Wellbeing Board must consult with the Local Pharmaceutical Committee (LPC) and Local Medical Committee (LMC) for its area (unless the areas are served by the same LPC and/or LMC) and have regard for the representations from these committee(s) before making its own response to the consultation.

## **6. Current Position for Lewisham**

- 6.1 The Lewisham Health and Wellbeing Board has assumed responsibility for the PNA originally approved by Lewisham PCT (and with it 4 additional statements). The NHS Lewisham PNA 2011 is accessible on: <http://www.lewisham.gov.uk/myservices/socialcare/health/Pages/Pharmaceutical-Needs-Assessment.aspx>
- 6.2 A high level review of the PNA was commissioned by NHS South East London in 2012 for all its constituent PCTs. The purpose of the review was to ensure that each PNA was fit for purpose to inform market entry decisions and for subsequent transfer to the relevant Health and Wellbeing Board.
- 6.3 The review identified that Lewisham PCT's PNA either met or partially met all but two of the requirements set out in the 2010 Regulations (the Regulations prevailing at the time the document was written). One of the non-compliant areas (defining localities) has been resolved (to being met) by the preparation of a (clarifying) additional supplementary statement (supplementary statement 4). The second area is related to "benefits of reasonable choice" which was not explicitly addressed in the PNA. Recent guidance has outlined that a PNA should be explicit in defining benefits to the population (or part of the population), and as far as is reasonable when, for example the closure or relocation of a pharmacy would change significantly the availability of the service. The issue will be addressed in the H&WB PNA. The PNA was then assessed by NHS South East London as being a low risk in relation to potential complaints and/or judicial review in relation to market entry decisions made against future pharmacy applications. The review provides assurance to the Health and Wellbeing Board that it is not necessary to update the inherited PNA because of failure to comply with Regulations.

## **7. Process and Timetable for the Development of a new PNA**

- 7.1 Although the Health and Wellbeing Board does not have to publish its first PNA until 1 April 2015 and the assessment of the inherited PNA has concluded that the PNA with its supplementary statements is fit for purpose, a work group, chaired by the Director of Public Health, will be formed by end September 2013 to ensure the timetable for producing a new PNA can be met.
- 7.2 The group will be supported with pharmaceutical advice provided from NHS Lewisham Clinical Commissioning Group and input as necessary from NHS England.

7.3 The group will create a timetable to:

- Assess current pharmaceutical services; updating the current information as necessary and preparing any supplementary statement.
- Use the updated assessment of current services, with relevant information in the JSNA and the local strategic directions for the health and wellbeing of the Lewisham population to develop a new Pharmaceutical Needs Assessment.

7.4 Once prepared, the new PNA will be circulated for consultation as outlined in the Regulations. A final version will be presented for consideration of approval at the Health and Wellbeing Board in autumn 2014.

## **8. Supplementary Statements and PNAs of Neighbouring Boroughs**

8.1 In relation to the Health and Wellbeing Board's responsibilities as set out in 5(b) and 5(c) above, it is proposed that the Health and Wellbeing Board delegate to the Director of Public Health responsibility to:

- Approve supplementary statements which ensure that the current PNA remains fit for purpose;
- Respond to any consultations on PNAs being developed by neighbouring Health and Wellbeing Boards; and
- Respond, as necessary, on any consultations received from NHS England on changes to existing pharmacies or application for new pharmacies within the Borough and within 2 km of the borough boundary.

8.2 The Director of Public Health will ensure that significant risks and/or issues are escalated to the Health and Wellbeing Board, as appropriate, and will, in Autumn 2014, submit with the new PNA a summary report of any actions that were undertaken.

## **9. Financial implications**

9.1 The development work to produce the new PNA the administration, any management time required to ensure that the PNA remains fit for purpose and the production of any additional statements will all be undertaken within existing Public Health budgets.

9.2 The financial implications of any changes to services proposed as a result of the needs assessment will be considered in future reports.

## **10. Legal implications**

10.1 As highlighted in the body of this report, the Health and Wellbeing Board has a number of statutory duties and responsibilities in relation to PNAs. Failure to comply with the regulatory duties and to produce a robust PNA following the 2013 Regulations could lead to legal challenges because of the PNA

relevance to decisions about issues such as the opening of new pharmacies, the commissioning of (pharmaceutical) services etc. For example a party may believe that they have been disadvantaged following a decision made by NHS England based on the information within the PNA and may consider challenging the process ( if not robust) of preparation, consultation and approval of the PNA.

- 10.2 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 the area.

## **11. Crime and Disorder Implications**

There are no specific implications arising from this report.

## **12. Equalities Implications**

- 12.1 The Regulations require Health and Wellbeing Board to have regard (in so far as is practicable) to the outcome of its assessment of compliance with its duties under Chapter 1 of Part 11 of the Equality Act 2010(a) specifically in relation to the protected characteristics.
- 12.2 The assessment undertaken by NHS South East London assessed the current PNA as partially meeting these specific areas.
- 12.3 The PNA to be presented in Autumn 2014 will have regard ( as far as is practicable) to being fully compliant with duties under Chapter 1 of Part 11 of the Equality Act 2010.

## **13. Environmental Implications**

There are no specific implications arising from this report.

## **14. Conclusion**

- 14.1 The Health and Wellbeing Board assumed responsibility for the PNA on the 1 April 2013. The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 - effective from 1 April 2013 - requires the Health and Wellbeing Board to publish a revised assessment where it identifies changes to the need for pharmaceutical services which are of a significant extent and to publish its first PNA by 1 April 2015. Failure to comply with the regulatory duties and to produce a robust PNA as detailed in the 2013 Regulations could lead to legal challenges.
- 14.2 This report outlines the requirement and responsibility of the Health and Wellbeing Board's to maintain and produce a PNA, and outlines the actions to be undertaken on behalf of the Health and Wellbeing Board by the Director of

Public Health, both in relation to maintaining the existing PNA and in preparing a new PNA by Autumn 2014.

Background Documents

[Lewisham PNA and 4 supplementary statements](#)

[The Lewisham Heat map assessment](#)

[The NHS \(Pharmaceutical and Local Pharmaceutical Services\) Regulations 2013](#)

If there are any queries on this report please contact Danny Ruta, Director of Public Health on 020 8314 9094



HEALTH AND WELLBEING BOARD			
<b>Report Title</b>	Integrated health and social care – an update		
<b>Contributors</b>	Executive Director for Community Services	Item No.	9
<b>Class</b>	Part 1	Date: 19 September 2013	

## 1. Purpose

- 1.1 This report informs Members of the Health and Wellbeing Board on the progress on Lewisham's Integration Programme, in particular the update on the Pioneer bid. It also asks Members to note that proposals for current and future programme management support will be submitted as part of the plans for the use of funding that is to be transferred to local government from the NHS to support transformation in 2013/14 and 14/15. From March 2015, similar funding to support the integration of social care and health will be known as the joint health and social care Integration Transformation Fund.

## 2. Recommendation

- 2.1 Members of the Health and Wellbeing Board are recommended to:
- Note the progress on Lewisham's bid for Pioneer Status and receive a verbal update on the Pioneer shortlist interview;
  - Agree the proposed governance arrangements and the role of the Health and Wellbeing Board in ensuring effective progress of the programme;
  - Note that proposals for project management support be included in the plans for the use of funding being transferred from the NHS England to the Council. These plans will be presented for approval by the Health and Wellbeing Board in November.

## 3. Policy Context

- 3.1 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 *Shaping our future's* priority outcome that communities in Lewisham should be *Healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and wellbeing.*

3.3 The Health and Social Care Act 2012 requires the Health and Wellbeing Board 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 May, the Government and other key national players launched 'Integrated Care and Support: our shared commitment'. This document stated that: '.....we need major change and we are determined to act. This means building a system of integrated care for every person in England. It means care and support built around the needs of the individual, their carers and family and that gets the most out of every penny we spend.'

4.2 The announcement included:

- An ambition to make joined up and coordinated health and social care the norm by 2018.
- The development of the first ever agreed definition of good integrated care and support – developed by the National Voices.
- The identification of ten new 'pioneer' areas around the country which will be looking for the innovative practical approaches needed to achieve changes as quickly as possible.
- The development of new measures of peoples' experience of joined up care and support, so change can be evaluated.

#### **5. Pioneer – Expression of Interest**

5.1 In response to the Government's invite, at the end of June, Lewisham submitted an expression of interest in becoming a pioneer in health and social care integration.

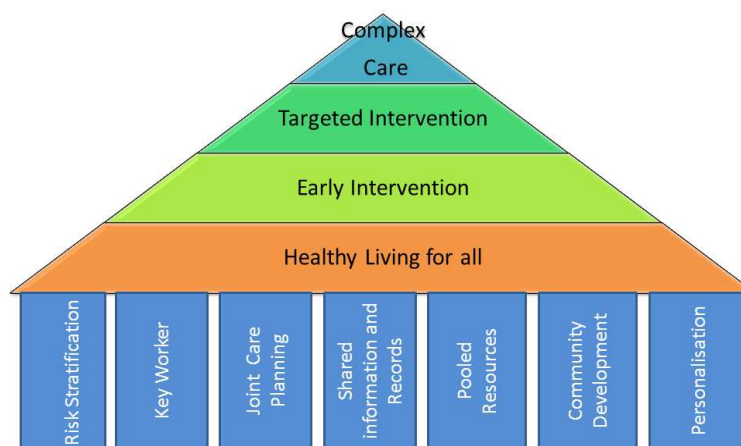
5.2 In the expression of interest, Lewisham highlighted the commitment of the Health and Wellbeing Board to increase the scale and pace of integrating working, building on:

- a basis of knowledge of what has worked to date and what has not;
- a local understanding of the cultural and organisational changes that are needed to bring different disciplines together; and
- Our experience of the action required to resolve issues and break down barriers

5.3 The submission set out in detail the work that has taken place to date in redeveloping the "intermediate tier" of care, and the establishment of multi-disciplinary teams around the GP neighbourhood clusters.

- 5.4 The submission further highlighted our commitment to a more ambitious model evolved, as shown below, based on the four different levels of advice, support and care any individual may receive during their life time.

### Lewisham's Integrated Delivery Model



- 5.5 Over 100 expressions of interest were received and on 8 August, Lewisham was informed that its application had been shortlisted for further consideration, subject to due diligence.
- 5.6 Prior to the final selection of pioneers taking place, Lewisham representatives will be interviewed by a selection panel to ensure the borough's plans for integration are fully understood and so that the panel can explore where those plans might be strengthened.
- 5.7 The interview will take place on 13 September. Attending the interview are Aileen Buckton, Executive Director for Community Services; Dr Helen Tattersfield, Lead GP, NHS Lewisham; Martin Wilkinson, Chief Officer, NHS Lewisham Clinical Commissioning Group; Tim Higginson, Chief Executive, Lewisham Healthcare Trust; and Joan Hutton, Head of Adult Assessment and Care Management.
- 5.8 As despatch of the Health and Wellbeing papers takes place before the date of the interview, no written feedback on the interview can be included in this report. However, members of the Board who attended the interview will give verbal feedback at the meeting.

## **6. Integration Programme**

- 6.1 Lewisham's adult integration programme of work already involves a number of different commissioning and provider organisations, from both the statutory and non statutory sector, working together in new ways. Poor governance arrangements are one of the most frequently cited organisational barriers to successful integration so it will be vitally important to the success of this programme that robust governance

arrangements are in place to oversee the delivery and evaluation of this complex work programme.

6.2 As highlighted to the board in previous papers, there are currently 6 major workstreams that are being progressed as part of the Integration Programme.

- **Work stream 1** – programme management and governance arrangements;
- **Work stream 2** – implementing and evaluating the neighbourhood delivery model; .
- **Work stream 3** – engagement with local communities and other stakeholders;
- **Work stream 4** – developing the workforce;
- **Work stream 5** – information sharing and information governance;
- **Work stream 6** – integrated commissioning and contractual arrangements.

6.3 In relation to **workstream 1**, the Health and Wellbeing Board will be the overarching body that monitors the progress of the programme. To ensure the programme remains on track in between Board meetings, officers propose that an Adults Integration Programme Board (AIPB) be established with representatives from health, social care, community development and housing who will ensure robust plans and delivery mechanisms are in place for the remaining five workstrands (and any additional workstrands that are established) and that regular progress reports are presented to the Health and Wellbeing Board.

6.4 It is proposed that the AIPB sits alongside, and work closely with, the existing Health and Wellbeing Delivery Group, the Adult Joint Strategic Commissioning Group and the Joint Public Engagement Group.

6.5 The AIPB will be accountable for the delivery and evaluation of the adult Integrated Care and Support work programme to the Health and Wellbeing Board. It will have specific responsibility to:

- Develop the Project Initiation Documents (PID), to be approved by the Health and Wellbeing Board;
- Oversee the implementation, monitoring and evaluation of the agreed work programme as outlined in the Project Initiation Document (PID);
- Coordinate the commissioning plans for the Integrated Transformational Funds
- Develop and recommend the local framework for commissioning of health care and social care;
- Identify further opportunities to develop a transformational agenda to improve the health & well being of the population of Lewisham.

- 6.6 Each of the remaining workstreams will have a project group which will report into the programme board. In the case of **workstream 2**, the project group will be supported by four neighbourhood committees who will assess progress and issues at the neighbourhood level.
- 6.7 In relation to **workstream 3**, the small project group will work closely with the Health and Wellbeing Board's Joint Public Engagement Group and other existing groups to develop a communication and engagement plan.
- 6.8 On **workstreams 4 and 5**, new project groups will be created pulling together relevant officers across health and social care to take this work forward.
- 6.9 Finally on **workstream 6**, the joint adult strategic commissioning group will take on the role of project group for this area of integration work.
- 6.10 A manager for the prevention and early intervention aspects of the programme has been recruited to assist in the development of the programme and the project groups. In addition, the Head of Strategy, Improvement and Partnerships in Community Services and the Corporate Director, NHS Lewisham Clinical Commissioning Group, supported by officers across the Council and the CCG are developing the PID and related documents. These will be presented to the November meeting of the Health and Wellbeing Board.

## **7. Funding to Support Integration**

- 7.1 In May 2013, the Department of Health issued Directions concerning the 13/14 transfer of funds from the NHS to local authorities. These funds must be used to support adult social care services which also have a health benefit and use of the funding must be agreed with the CCG. Plans for use of this funding are being developed in consultation with partners across health and social care and proposals will be brought to the Health and Wellbeing for approval in November.
- 7.2 Similarly the funding that will be provided in 14/15 to support transformation and that in 2015/16 via the Integration Transformation Fund will be focused on providing people with better integrated care and support. Plans on the proposed use of both years' funding will also be presented to the Health and Wellbeing Board.
- 7.3 As the PID is developed, the specific resources required to support the programme will be considered. Members are asked to note that, if further programme management support is required proposals for such support will be included in the use of funding proposals presented to the Health and Wellbeing Board in November.

## **8. Financial implications**

- 8.1 There are no specific financial implications arising from this report. All current activity to progress the development of the programme will be provided from existing resources within the CCG and the Council or, subject to approval by the Board in November, from the funding that is to be transferred from NHS England to the Council.

## **9. Legal implications**

- 9.1 As part of their statutory functions, Members are required 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, and to encourage persons who arrange for the provision of health-related services in its area to work closely with the Health and Wellbeing Board.

## **10. Crime and Disorder Implications**

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

## **11. Equalities Implications**

- 11.1 There are no specific equalities implications arising from this report or its recommendations

## **12. Environmental Implications**

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

## **13. Conclusion**

- 13.1 Officers will continue to progress the development of the detailed integration programme and the associated delivery plan. A further report will be presented to the Health and Wellbeing Board in November.

Health and Wellbeing Board			
<b>Report Title</b>	Report on membership issues		
<b>Contributors</b>	Health and Wellbeing Board	Item No.	10
<b>Class</b>	Part 1	Date: 19 September 2013	

## 1. Purpose

- 1.1 This report makes recommendations on the Health and Wellbeing Board's membership.

## 2. Recommendations

- 2.1 It is recommended that the Board agrees to:
- Review and approve the process through which an additional voluntary and community sector representative will be identified.
  - Note the appointment of a new CCG representative at the Board.
  - Appoint a new Vice-Chair of the Board.
  - Review and approve the recommendation for a Registered Social Landlord (RSL) representative

## 3. Policy context

- 3.1 The Health and Social Care Act 2012 establishes a duty on local authorities to convene Health and Wellbeing Boards for their areas.
- 3.1 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 *Shaping our future's* priority outcome that communities in Lewisham should be *Healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and wellbeing.*

## 4. Background

- 4.1 The Health and Social Care Act specifies that the Board's membership must, as a minimum, include:
- a) at least one Councillor of the local authority who is nominated by the Mayor and may include the Mayor
  - b) the Council's Director of Adult Services
  - c) the Council's Director of Children's Services
  - d) the Council's Director of Public Health
  - e) a representative of the Local Healthwatch organisation for the area
  - f) a representative of each relevant clinical commissioning group; and
  - g) such other persons or representatives of such other persons as the Council thinks appropriate.

- 4.2 In addition, the Health and Wellbeing Board can appoint such other persons as it considers appropriate.
- 4.3 At the Council AGM, held on 20<sup>th</sup> March, the Mayor reported that he was appointing himself and Cllr Chris Best as members of the Health and Wellbeing Board.
- 4.4 The Council, in the Constitution, has also made provision that two representatives of the voluntary sector will be appointed to the Board. These representatives will be appointed by the Council.
- 4.5 Regulation 6 of the Health and Social Care Act regulations modifies the Local Government and Housing Act 1989 (section 13(1)) to enable all members of Health and Wellbeing Boards or their sub-committees to vote unless the Council decides otherwise. This means that the Council is free to decide, in consultation with the Health and Wellbeing Board, which members of the Board should be voting members.
- 4.6 The Council proposed that its officers not be entitled to vote. In addition the Council proposed that where an organisation (Clinical Commissioning Group, Local Healthwatch, or otherwise) appoints an employee to the Health and Wellbeing Board, that employee will not be allowed to vote. The Council also proposed that this rule will not apply to representatives of the voluntary sector appointed by the Council.
- 4.7 At its first meeting, the Health and Wellbeing Board considered the Council's proposals for membership and voting rights and agreed with the Council's proposals and with the particular provisions that apply to the Health and Wellbeing Board as set out in the Council's Constitution.
- 4.8 The Health and Wellbeing Board approved the appointment of Tony Nickson, Director of Voluntary Action Lewisham, as a representative of the voluntary sector and asked Voluntary Action Lewisham to develop a process through which an additional representative for the voluntary and community sector could be identified.

## **5. Proposals on amendments to membership**

### **5.1 Voluntary and community sector representative**

- 5.1.1 Voluntary Action Lewisham have given consideration to recruiting an additional member from the voluntary sector to the Health and Wellbeing Board. This member will have an active interest in the health and wellbeing of the residents of Lewisham.
- 5.1.2 This role is intended to give a voice to an individual who does not already have a voice on similar boards (such as board member of a health care trust, clinical commissioning group, or a local councillor, etc.) The successful candidate would need to demonstrate an understanding that the role is to represent the wide range of communities in Lewisham (and not to represent just one single-interest group).
- 5.1.3 The new member will attend board meetings and will be responsible for liaising with and feeding back to the VAL-coordinated Health and Social Care



Forum in a timely fashion. Initially, the position will be for the period of one year.

5.1.4 Candidates will need to show they have the skills and experience of working in the voluntary and community sector. They will need to be prepared to make a time-commitment for the board and be able to prepare for board meetings. Candidates will be nominated by a voluntary sector organisation and will fill out a supporting statement (up to 200 words). Candidates will give a short presentation at a VAL event where a vote will take place.

5.1.5 Timeline for recruitment:

9 September - Contact members and contacts inviting nominations

19 September – information at VAL event about process

9 October - Deadline for nominations

17 October - vote will take place at a VAL-run event

## **5.2 CCG representation at the Board**

5.2.1 As noted at the Board meeting of 11 July 2013, the CCG representation at this Board will change following the resignation of Helen Tattersfield as chair of the CCG. It has been confirmed that Dr Marc Rowland will represent the CCG at future meetings.

## **5.3 Vice Chair of the Board**

5.3.1 As previously noted, Helen Tattersfield will no longer be representing the CCG at the Health and Wellbeing Board, which necessitates the election of a new Vice-Chair.

5.3.2 Members of the Health and Wellbeing Board are invited to nominate and agree on a new Vice-Chair.

## **5.4 Registered Social Landlord (RSL) representative**

5.4.1 The Housing Matters Programme was launched by the Mayor in July 2012 and responds to the priorities set out by the Mayor to:

1. Review the options for the ownership and management of the Council's housing stock
2. Increase the supply of affordable housing, including by building 250 new homes by 2017
3. Reviews the Council's approach to housing for older people and bring the existing stock of specialised housing for older people up to the required standard

5.4.2 An expert adviser has been commissioned jointly by Strategic Housing and Social Care to develop an Older People's Housing Strategy, which will be presented to Mayor and Cabinet in November 2013.

5.4.3 Housing is generally acknowledged as a determinant of health and wellbeing, therefore in light of this and the current workstreams detailed above, it is proposed that a Registered Social Landlord should be appointed to this Board

to represent this area and to ensure alignment and integration with the Health and Wellbeing agenda.

- 5.4.4 It is recommended that Brendan Sarsfield from Family Mosaic join the Health and Well Being Board as the Registered Social Landlord representative. Brendan Sarsfield has experience of working in the borough and is particularly interested in the link between housing and health.

## **6. Financial implications**

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

## **7. Legal implications**

- 7.1 The legal implications are reflected in the body of the report.

## **8. Equalities implications**

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

## **9. Crime and disorder implications**

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

## **10. Environmental implications**

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

## **Background documents**

None

If there are any queries on this report please contact Strategy, Improvement and Partnerships, Community Services, London Borough of Lewisham on 0208 314 9637 or by e-mail at [jo.barrie@lewisham.gov.uk](mailto:jo.barrie@lewisham.gov.uk)

HEALTH AND WELLBEING BOARD			
<b>Report Title</b>	Winterbourne View – Lewisham Health and Social Care Position Statement and Action Plan		
<b>Contributors</b>	Heather Hughes, Joint Commissioner Learning Disability	Item No.	11
<b>Class</b>	Part 1	19 September 2013	

## 1. Purpose

- 1.1 The purpose of this report is to present the Lewisham Action Plan to deliver recommendation 57 of the Department of Health's Final report "Transforming Care: a national response to Winterbourne View Hospital" (2012) into the abuse exposed at Winterbourne View Hospital for adults with a learning disability. Also to present a summary of Lewisham's response to the recent Department of Health's 'Winterbourne Stock take'.

## 2. Recommendations

Members of the Health and Wellbeing Board are recommended to:

- 2.1 Note the Lewisham 'stock take' summary position in Appendix A and
- 2.2 Agree the action plan attached to this report as Appendix B.

## 3. Policy Context

- 3.1 Following the exposure in 2011 of institutional abuse at Winterbourne View, a hospital for adults with a learning disability, the Department of Health commissioned the Care Quality Commission (CQC) to undertake an inspection programme of 150 learning disability services. The Department published the main findings in their 2012 interim report, which were:

- Too many people were placed in hospitals for assessment and treatment and staying there for too long;
- They were experiencing a model of care which went against published government guidance that people should have access to the support and services they need locally, near to family and friends;

- There was widespread poor quality of care, poor care planning, lack of meaningful activities to do in the day and too much reliance on restraining people;
  - All parts of the system have a part to play in driving up standards.
- 3.2 The report also referenced existing good practice guidance, in particular the Mansell Report (1993, updated 2007) which emphasised:
- The responsibility of commissioners to ensure that services meet the needs of individuals, their families and carers;
  - A focus on personalisation and prevention in social care;
  - That commissioners should ensure services can deliver a high level of support and care to people with complex needs or challenging behaviour; and
  - That services/support should be provided locally where possible.
- 3.3 In December 2012, the DH published a concordat, signed by the most significant providers of services for people with a learning disability which committed partners to “a programme of change to transform health and care services and improve the quality of care offered to children, young people and adults with learning disabilities or autism who have mental health conditions or behaviour that challenges to ensure better care outcomes for them”. In particular they pledged a rapid reduction in hospital placements for this group of people.
- 3.4 The Department’s final report on Winterbourne, “Transforming Care: a national response to Winterbourne View Hospital” also published in December 2012, set out a significant work programme of 63 timetabled actions for delivery required across the whole health and social care system, between 2012 and 2016, to transform care and support for people with learning disabilities and challenging behaviour. The DH is closely monitoring activity against these actions, and in July 2013 required every local authority area to complete a Winterbourne stock take.
- 3.5 This report particularly relates to recommendation 57, that “CCGs and local authorities set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour in their area. The Minister of State for Care and Support charged the Health and Wellbeing Board with responsibility for monitoring this recommendation in July 2013.
- 3.6 Delivery of this joint strategic plan reflects 2 key priorities of Lewisham’s Strategic Partnership priorities: Safer – keeping people safe from harm and abuse; and Health Active Enjoyable – supporting people with long term conditions to live in their communities and maintain their independence.

## 4. Background

- 4.1 The 2011 Panorama programme about Winterbourne View, a Castlebeck Group hospital, exposed, once again, the risk of abuse and inhumane treatment of adults with a learning disability whose behaviour challenges in institutional settings. Additionally, the programme also highlighted the failure of the system, including the care regulator CQC, to respond to attempts to 'blow the whistle'.
- 4.2 There have been many previous enquiries into poor and abusive hospital 'care' of people with a learning disability, from Ely Hospital (1969) and more recently Orchard Hill Hospital (2007). Ely was one of the scandals that drove the 'Care in the Community' hospital closure programmes not only for people with a learning disability, but also people with mental health difficulties. The then South East Thames Regional Health Authority (SETRHA) led the way on a large scale hospital closure programme and replacement with more locally based 'staffed housing' model.
- 4.3 As part of that programme SETRHA commissioned a staff training and systems consultancy service from the University of Kent. The outcome of that work informed the content of the Mansell report; good practice guidance into how to support people whose behaviour challenges in local services. The report looked at a whole systems approach from prevention through to the management of services for people with seriously challenging behaviour.
- 4.4 Despite the knowledge about what leads to cruelty and abuse in human services and a now significant body of literature and evidence about how to mitigate against it, Winterbourne View still happened. The series of investigative reports commissioned following this culminated in the Department of Health Report "Transforming care: A national response to Winterbourne View Hospital" (2012).
- 4.5 The report contains 63 recommendations for the Department itself, for CQC, the police, Royal Colleges, the Local Government Association and the National Commissioning Board among others. However, these recommendations collectively still signpost towards what the Mansell report contained in its original publication in 1993 and its revision in 2007 about best practice in supporting people with a learning disability whose behaviour challenges.
- 4.6 A first action following Winterbourne was the development of registers of NHS fully funded clients whose behaviour challenged, with a key focus on people in hospital beds. A key finding from the CQC reviews of 150 services post Winterbourne had been to highlight that some (then) PCTs did not know the people they were funding services for in long term hospital placements, and many had not been reviewed for a number of years. That register transferred to the new Clinical Commissioning Groups on 1<sup>st</sup> April 2013. There was a further requirement to ensure that all clients

in inpatient beds were reviewed, and an active planning process put in place to move people who were inappropriately placed in hospitals.

- 4.7 The DH continues to audit the number, and duration of stay, of people in hospital placements as a separate work stream. However, the July 2013 'stock take' audit has reinforced that service review and development must consider all people with a learning disability whose behaviour challenges, and not just for adults, but also for children and young people.
- 4.8 A summary of Lewisham's response to the July 2013 'stock take' is attached as Appendix A. Without reiterating its content here, it basically advises that Lewisham knows who it has placed in in-patient beds and where, and that the holistic reviews required have been carried out. Also noteworthy is that Lewisham's long standing history of partnership working, has served the authority well in that annual reviews, even of people in hospital inpatient beds, have been led by the social work team with support from clinical colleagues.
- 4.9 There are no more than 10 people in in-patient beds as at August 2013, the majority funded by the Lewisham Clinical Commissioning Group and others funded through NHS England contracts as the result of changes to recent NHS commissioning changes. There is a query over ordinary residence of a person not previously the responsibility of LCCG.
- 4.10 The 'stock take' also highlighted areas where pathways could be strengthened around supporting people whose behaviour challenges, particularly the need to improve transition pathways, and also delivering earlier intervention where people are challenging and living in the family home. Also, it has highlighted the need to review what services and service models are in place locally against what new service models may need to be put in place to better support people to stay in borough longer either as children and young people, or as adults.
- 4.11 The Action Plan attached as Appendix B outlines the work streams envisaged to develop an improved local service for people with a learning disability whose behaviour challenges. In particular, it highlights the need for Children and Young People and also Adult Health and Social Care commissioners, responsible for service to people with learning disabilities, to work closely together through the SEND pilot and to be clear about the Lewisham 'offer'. Also, the need for a Joint Strategic Needs Assessment across the population of both Children and Adults with a learning disability in order to (a) project demand and also (b) match existing service models against what will be required by the next generations. It also signposts a review of clinical pathways, particularly psychology support to ensure that young people are receiving appropriate behavioural interventions and support through their school lives and that local psychology support is directly targeting the support needs of families, as distinct from service providers, to help maintain this population locally.

## **5. Financial implications**

- 5.1 There are no specific financial implications relating to this report.

## **6. Legal implications**

- 6.1 There are no specific legal implications relating to the content of this report.
- 6.2 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 the area.

## **7. Crime and Disorder Implications**

- 7.1 There are no specific crime and disorder implications. However, the Winterbourne action plan attached to this report includes an action to review how health and social care can work in a more efficient and effective way with the wider criminal justice system to offer best support to people with a learning disability whose behaviour challenges.

## **8. Equalities Implications**

- 8.1 The Winterbourne View scandal highlighted the risk to people with challenging behaviour in long term service provision, particularly where that provision is in an inpatient hospital unit, and where the service is delivered at a distance from the person's borough of origin. This means that people can become invisible from their responsible local service systems. The local action plan developed as a response to Winterbourne and attached as Appendix B, will support a more equitable access for this group to local services, and ensure that local services more appropriately meet the needs of this group, thus seeking to prevent out of borough placements.
- 8.2 One of the actions outlined in the plan is the development of a Joint Strategic Needs assessment for learning disability. This will assist officers in assessing the equalities impact of existing service offers, which were developed out of the hospital closure programme, given the changing population of people with learning disabilities in the borough, in particular in terms of ethnicity, but also gender and long term health conditions.

## **9. Environmental Implications**

9.1 There are no specific environmental implications.

## **10. Conclusion**

10.1 This report has sought to remind members of the Health and Wellbeing Board of the scandal exposed by the Panorama documentary at Winterbourne View Hospital in 2011. Also to provide a summary of the Lewisham July 2013 'stock take' position. Finally, to present the action plan which officers are currently working to deliver which will review and improve the care pathway for people with a learning disability whose behaviour challenges in services for children, young people and adults.

### **Background Documents**

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213215/final-report.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf)

If there are any queries on this report please contact **Heather Hughes, Joint Commissioner, LBL/ LCCG**, on 020 8698 8133 or at [heather.hughes@lewisham.gov.uk](mailto:heather.hughes@lewisham.gov.uk)



## **Appendix A**

### **Summary of the Lewisham 'Stock take'**

This is a summary of the key areas included in The Department of Health's July Winterbourne 'stock take'. Questions were posed against 11 criteria.

**Partnership Working** – Lewisham has a strong history of working in partnership across health and social care and, in particular, has a Section 75 agreement in place for Joint Commission with the Council as the lead agency. There are good quality specifications in place with specialist learning disability clinical teams with SLaM and GSTT, and good links with the Council's Housing department and also third sector providers. Good governance arrangements are in place.

**Finance** - The cost of all Learning Disability services are known and reported in the appropriate level of detail through the governance systems in place. The change to funding arrangements for low and medium secure placements, which are now commissioned by NHS England, is a potential but not immediate concern for the CCG in terms of Winterbourne.

**Individual Case Management** – Lewisham has a strong 'virtual' Community Learning Disability Team which is value led and focussed on risk management and pathway planning. The low inpatient numbers reflect the successful support for people with complex behaviours in community settings. The team uses a 'team around a client' approach where there are particularly complex management issues, and where people are admitted to hospital from assessment and treatment, an outline plan for discharge management is developed.

**Current Review Programme** – Social worker have historically and continue to lead the review programme for hospital in-patients, with support and advice as required from clinical colleagues. This strengthens the 'person centred' whole life consideration of people's needs and wishes, and also the involvement of families in reviews and future plans. Of the current 7 people in in-patient beds, active discharge planning is happening for 2 and a medium term plan is being developed for 1. The remaining 4 people would require a legal decision making process to facilitate discharge planning.

**Safeguarding** - Lewisham fully complies and engages with the principles of the ADASS inter authority out of area Safeguarding Adults protocol and are active as required in safeguarding investigations led by other boroughs. Senior officers from Health and Social Care (including the Head of Assessment and Care Management, the Head of Joint Commissioning, Head of Community Safety, the Lewisham CCG Safeguarding lead) sit on Lewisham's Adult Safeguarding Board, along with senior officers from the emergency services and other key partners. The Lewisham Adult

Safeguarding Board held a special meeting to review the Winterbourne reports and their implications for local safeguarding.

**Commissioning arrangements** – Lewisham decommissioned its block contracted hospital assessment and treatment beds over two years ago to minimise hospital admission as an ‘automatic’ pathway. In general, there is a strong and highly competent local provider market who can deliver a wide range of service responses, including bespoke service packages as required for some very challenging people.

**Delivering local teams and services** – In addition to what has been said above regarding discharge planning for people in hospital placements, there is good advocacy support available which, where possible, will ‘follow people in’ to hospital, support them there and ‘follow them back out’. This helps with continuity of support and history for the person and also their family. Lewisham makes good use of Community treatment Orders to support the person and manage risks appropriately in the community.

**Prevention and crisis response** – A recent review of people admitted to hospital or placed out of borough because of challenging behaviour highlighted that this was not due to placement breakdown but complex family arrangements, where there is a ‘crisis’ event (e.g. the illness of a main carer) which upsets the equilibrium of the environment. Putting additional support into the family home (the strong provider market allows fast mobilisation of competent support), or placing the person in a local ‘interim placement’ can provide additional time to plan a long term local response in a person centred way.

**Understanding the population who need/receive services** – the market position statement is in draft form. Capital funding for accessible housing is a general issue to support people with complex needs to live locally. Better aligning the education and support pathways will form part of the SEND (special education needs and disability) pilot work. The number of people in hospital inpatient beds is too small to make an EAA a useful indicator. However, the development of a ‘register’ of people with challenging behaviour will support investigation of equalities issues in decision making and also consideration of the changing populations groups within Lewisham itself.

**Transition Planning** – The names of people coming into adult services from children’s services are known. However, it is less certain when any individual may need a particular service. A number of planned pathways have been redirected because of late presentation of education opportunities. Also, the placing of children and young people in residential schools and colleges can inhibit the consideration of local offers.

**Current and Future Market Development** – A review of what is available and a gap analysis was planned for August 13. However, this has been slipped back as a Joint Strategic Needs Assessment is required to deliver this more meaningfully.

**Winterbourne Joint Action Plan – 2013/14  
Lewisham Clinical Commissioning Group (LCCG) and London Borough of Lewisham (LBL)**

This joint action plan has been developed by the Joint Commissioning team on behalf of Lewisham CCG and LB Lewisham, working with other key partners, to support a joint approach to ensure people across all ages from Lewisham with learning disabilities / autism / challenging behaviour receive safe, appropriate, high quality care. This plan includes all the key actions required to deliver the Winterbourne View Concordat. This is a working document that details the work streams and progress against key milestones. Coordination of work will be the responsibility of the Joint Commissioner for Learning Disability. However, the table below identifies the department, agency or individual who will be the major contributors for each work stream

Objective	Key Actions/ Milestones	Time-scale	Key Contributors
<p><b>Review all current hospital placements and support everyone inappropriately placed in hospital to move to community based support as quickly as possible and no later than 1 June 2014</b></p>			
<p>Develop and maintain a register of all people with learning disabilities or autism who have mental health conditions or challenging behaviour in NHS funded treatment.</p>	<p>Lewisham has established and maintains a register of all people with learning disabilities or autism who are fully funded by the NHS for their care needs.</p>	<p>Achieved</p>	<p>Heather Hughes Joint Commissioner LD  Caroline Hurst Joint Commissioner CAMHS</p>

<p>Review the care of all people in hospital placements with learning disability or autism support. Everyone inappropriately placed in hospital to move to community-based support as quickly as possible and no later than 1 June 2014</p> <p>All people with challenging behaviour in inpatient assessment and treatment services are safe and receiving services or treatment which is actively promoting an effective discharge plan</p>	<p>Lewisham has historically managed its review processes through the adult social care team. Therefore all clients/ patients have received regular, at least annual reviews.</p> <p>Everyone inappropriately placed in hospital will be supported to move to community-based. No one in Lewisham is inappropriately placed at this time. That said plans are being developed to discharge 3 of the 8 Lewisham people in inpatient beds over the next year to 18 months.</p> <p>The majority of individuals are detained under the Mental Health ACT (MHA) and funding responsibility for some of these people is held by NHS England. Reviews continue to be undertaken by social care staff in partnership with SLaM clinicians. Mental Health Tribunals make decisions about whether the individual remains under the Mental Health Act, considering the right of the individual to receive necessary treatment, the loss of freedom that the individual experiences when they are treated involuntarily, and the interests of the community. It also considers</p>	<p>1 June 2014</p>	<p>Jacky Weise, Service Manager AWLD</p>
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	<p>the appropriateness of the current treatment plan and therefore these individual's will need to be remain within a registered hospital provision while detained under the Mental Health Act.</p> <p>Identify the local authority responsible for S117 after-care for patients detained under Section 3 and 37. Recent case law has confirmed that the local authority responsible is the authority in whose area the patient was actually resident immediately before they were detained. This may apply to one person currently counted in Lewisham's 'cohort'.</p>	September 2013	Sue Grose Joint Commissioner AMH
Review existing contracts with providers to ensure they include an appropriate specification (based on the national care model), an absolute expectation of clear individual outcomes, appropriate interventions and sufficient resource to meet the needs of the individuals, and appropriate information requirements to enable commissioners to monitor the quality of care being provided	<p>There are contracts in place for in-patient beds , which are the responsibility of Lewisham CCG to commission. The individual specifications clarifying expected outcomes are monitored as part of the review process by the Service Manager for the social work team. Specific concerns or requests for advice are made to SLaM or GSTT LD specialist clinical colleagues as required.</p> <p>The specifics of the contracts will be further reviewed once the</p>	Completed  tbc	Jacky Weise Service Manager AWLD

<p>The National Commissioning Board (NCB) is working with Association of Directors of Adult Social Services ( ADASS) to develop practical resources for commissioners of services for people with learning disabilities, including:</p> <ul style="list-style-type: none"> <li>• model service specifications;</li> <li>• new NHS contract schedules for specialist learning disability services</li> </ul>	<p>guidance from NCB/ADASS is issued (see below)</p> <p>It is assumed that NHSE have contracts in place for the services they commission. Clarification of this will be sought and the contracts /service specifications for low and medium secure units will be reviewed.</p> <p>Implement the guidance locally once available.</p>	<p>TBC. These specific schedules are delayed. Original timescale was March 2013</p>	<p>Tom Bird Joint Commissioning Manager LD</p> <p>NCB / ADASS</p> <p>Susan Grose Joint Commissioner AMH</p> <p>Tom Bird Joint Commissioning Manager LD</p> <p>Jacky Weise Service Manager AWLD</p>
<b>Locally agreed joint plan for high quality care and support services for people of all ages with challenging behaviour, that accords with the model of good care</b>			
<p>Ensure that from April 2013, health and care commissioners, set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of children, young people and adults</p>	<p>Plan in place which sets out the outcomes and work plan arising from the work streams below:</p> <p>LD JSNA which builds on the previous Health JSNA, the outcome of the 2012/13 LD SAF</p>	<p>1 June 2014</p> <p>1 February 2014</p>	<p><b>Heather Hughes</b> <b>Joint Commissioner LD</b></p> <p><b>Public Health</b></p>

<p>with challenging behaviour in their area.</p>	<p>(self assessment framework), and what is known about LD CYP trends and demands.</p> <p>Market position statement building on existing knowledge of commissioning activity and the Transition/ SEND pilot projections</p> <p>Working with SLaM and across Southwark, Croydon and Lambeth, develop a short and medium term programme of organisational development and redesign which (a) looks at pathway mapping between health and social care to maintain people in community settings and (b) strengthening the pre and post transition support to young people whose behaviour challenges and (c) managing a programme of pilot projects appropriate to the presenting borough specific hypotheses for out of borough/ hospital placements.</p>	<p>31 March 2014</p> <p>November 13</p>	<p><b>Keri Landau</b> <b>Joint Commissioning Manager</b> <b>LD</b></p> <p><b>Heather Hughes</b> <b>Joint Commissioner LD</b></p> <p><b>Joint Commissioning Leads for Lambeth Southwark, and Croydon</b></p> <p><b>Eleanor Davies</b> <b>Director Behavioural and Developmental CAG, SLaM &amp; GSTT clinical teams</b></p>
<p>Ensure that the right local services are available, for children, young people and adults with learning disabilities or autism who also have mental health conditions or behaviour that challenges</p>	<p>Review current service provision for younger adults with LD. Establish alternative pathways to out of borough education options and develop a commissioning plan for the same, including local cross borough options.</p> <p>Review specialist health services,</p>	<p>1 June 2014</p>	<p>Caroline Hurst Joint Commissioner, CAMHS</p> <p>Liz Bryan SEND Pilot Project Manager</p> <p>Ed Knowles</p>

	<p>particularly community psychology services, for young people in schools whose behaviour challenges.</p> <p>Develop competency framework across Lambeth, Southwark, Lewisham and Croydon to encompass the following:</p> <ul style="list-style-type: none"><li>• A multi-disciplinary approach to the assessment and treatment of challenging behaviour in order to meet the individual needs of a person</li><li>• A range of assessments to inform how individuals are supported with a clear focus on recovery and personalisation</li><li>• Staff adequately trained and supervised</li><li>• Good supportive environments</li></ul> <p>Commission the housing and support services/ stimulate the local market to deliver services identified through the Transition mapping process, as members of the 'Developing Care Markets for</p>	<p>1 January 2014</p> <p>January 2014</p>	<p>Service Manager, CYP</p> <p><b>Joint Commissioning Leads for Lewisham, Lambeth Southwark, and Croydon</b></p> <p>Jacky Weise Service Manager AWLD</p> <p>Tom Bird Joint Commissioning Manager LD</p> <p>Tom Bird Joint Commissioning Manager LD</p> <p>Keri Landau Joint Commissioning Manager LD</p>
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	<p>Quality and Choice' (DCMQC) being piloted in Lambeth. And in line with national tools such as the Care Fund Calculator (CFC) and other Lewisham Resource Allocations Systems (RAS) as may be developed to ensure cost effective support packages are available for people with complex needs, including behaviour which challenges.</p> <p>Work with the Safer Lewisham Partnership to review options for closer working with probation and police services to better support this population (e.g. on discharge from hospital, in custody suites etc)</p>	<p>March 2014</p>	<p>Fiona Kirkman Prevention and Inclusion Manager</p>
<p>Review funding arrangements for people whose behaviour challenges, and in particular people in hospital placements, ensuring that local action plans to reflect pathways of support required to develop local options which meet individuals' needs</p>	<p>Pathways for agreeing funding responsibilities are already established through the Section 75 Agreement.</p> <p>Table top review of all clients currently placed out of borough to establish who was placed out of borough because of behaviour which challenges. Clear decision about whether return to borough is an option. Plus review of clients whose behaviour challenges in borough and statement about how/ why they are successfully</p>	<p>Completed</p> <p>January 2014</p>	<p>Dee Carlin Head of Joint Commissioning</p> <p>Learning Disability Joint Management Team</p>

	<p>maintained here.</p> <p>Review of young people with LD 16 plus whose behaviour challenges and at risk of going out of borough. Pathway mapping and statement about services to be commissioned to meet needs.</p> <p>Development of a Challenging Behaviour 'register' based on the above. The utility of this register, given resources required to maintain it, will be considered as part of service planning in the longer term.</p>	March 2014	<p>Keri Landau Joint Commissioning Manager LD</p> <p>Helen Alsworth Operational Manager AWLD</p> <p>Liz Bryan SEND Project Manager</p> <p>Heather Hughes Joint Commissioner LD</p>
All patients requiring an assessment for autism have access to a diagnostic service. Those people newly diagnosed with autism receive individual support response and where appropriate, support services which respond to their individual needs.	Lewisham already has a pathway for autism diagnosis with SLaM, and a service support system (Burgess Autistic Trust) in place. See also the Autism SAF.	Completed	<b>Dee Carlin</b> <b>Head of Joint Commissioning</b>
Review current community learning disability provision	In the main, current service options continue to reflect the response to the 1980s hospital closure programme. The Transition population in particular is changing in terms of complex health needs (physical and also severe challenging behaviour) ,	1 April 2014	Public Health  Learning Disability JMT

	<p>and the population of the borough is changing in terms of ethnicity. These changes need to be captured through the JSNA (see above). Additionally, the potential impact of Personalisation over the next decade needs to be mapped. The current, provision then needs to be mapped against this and service changes/ redevelopments to be added to the commissioning plan.</p>		
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# Agenda Item 12

HEALTH AND WELLBEING BOARD			
<b>Report Title</b>	Lewisham Warm Homes Healthy People project 2012/13 evaluation		
<b>Contributors</b>	Martin O'Brien, Sustainable Resources Group Manager	Item No.	13
<b>Class</b>	Part 1	Date: 19 September 2013	

## 1. Purpose

- 1.1 This report summarises the evaluation of the 2012/13 Lewisham Warm Homes Healthy People project.

## 2. Recommendation/s

- 2.1 Members of the Health and Wellbeing Board are recommended to note the contents of the report and invited to comment on future plans for work to respond to fuel poverty and excess winter deaths, set out in section 6 below.

## 3. Policy Context

- 3.1 The contents of this report are consistent with the Council's policy framework and in particular the corporate priorities '*Active, healthy citizens*'; '*Caring for adults and older people*'; '*Inspiring efficiency, effectiveness and equity*'. The report also supports the achievements of the Sustainable Community Strategy policy objective '*Healthy, active and enjoyable – where people can actively participate in maintaining and improving their health and well-being.*' Lewisham's Annual Public Health Report identified fuel poverty as an important social determinant of health.
- 3.2 In November 2012 Lewisham Council signed up the End Fuel Poverty Coalition's Local Authority Fuel Poverty Commitment<sup>1</sup>, pledging to:
  - Ensure we understand the extent of fuel poverty in our area, its impact on health, housing and quality of life, and to take action to address it
  - Ensure that Lewisham's Joint Strategic Needs Assessment informs strategies to tackle fuel poverty
  - Work with partners such as Health and Wellbeing Boards and advice services to develop effective referral systems to reduce fuel poverty and cold-related ill health

<sup>1</sup> <http://councilmeetings.lewisham.gov.uk/documents/s18666/Climate%20Local%20-%20Carbon%20Reduction%20and%20Climate%20change%20Strategy.pdf>

- Develop a strategic approach to improving energy efficiency in all housing and fulfil its potential to create jobs and prosperity in our local communities
  - Work with energy companies and related organisations to help make sure the Green Deal, Energy Company Obligation (ECO) and other energy efficiency programmes are delivered effectively in the borough
  - Administer the benefits we are responsible for efficiently and fairly, and help make sure eligible households receive the benefits to which they are entitled
  - Explore ways of reducing fuel poverty that involve the whole community, including community groups and town and parish councils
- 3.3 The Marmot Review into health inequalities in England was published in February 2010<sup>2</sup> and included a comprehensive overview of the evidence linking fuel poverty-related factors to poor physical and mental health, as well as the effect of interventions to mitigate them.
- 3.4 The Hills Fuel Poverty Review was published in March 2012<sup>3</sup> and produced a series of recommendations on how fuel poverty should be understood, measured and the effectiveness of policy approaches to reducing it.
- 3.5 The Warm Homes and Energy Conservation Act 2000 (WHECA)<sup>4</sup> and the Energy Act (2010)<sup>5</sup> define fuel poverty as: *“a person is to be regarded as living “in fuel poverty” if [s]he is a member of a household living on a lower income in a home which cannot be kept warm at reasonable cost.”* Following the Hills Review, DECC has consulted on redefining the way fuel poverty is measured, including taking account of housing costs.
- 3.6 The Department of Health (DH) annual Cold Weather Plan for England<sup>6</sup> sets out advice for individuals, communities and agencies on how to prepare for and respond to severe cold weather.
- 3.7 Wider DH measures alongside the Cold Weather Plan includes the flu vaccination programme, advice for the public on staying healthy in cold weather and two rounds of £20m funding under the Warm Homes Healthy People fund in 2011/12 and 2012/13. The aim of the Warm Homes Healthy People fund is to support local authorities in winter to reduce the levels of deaths and morbidity in their area due to vulnerable people living in cold housing in partnership with their local community and voluntary sector and statutory organisations.

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<sup>2</sup> <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report>

<sup>3</sup> <https://www.gov.uk/government/news/independent-review-on-fuel-poverty-final-report-published>

<sup>4</sup> <http://www.legislation.gov.uk/ukpga/2000/31/section/2>

<sup>5</sup> <http://www.legislation.gov.uk/ukpga/2010/27/contents>

<sup>6</sup> <http://www.dh.gov.uk/health/2012/10/cwp-2012/>

3.8 Lewisham's Annual Public Health Report describes the health impacts on cold housing including respiratory symptoms in children, mental health, circulatory and respiratory disease and excess winter deaths and cites a number of sources of evidence describing the affect living in cold housing has on illness and mental health.

#### 4. Summary of the 2012/13 Warm Homes Healthy People project

4.1 Lewisham's Warm Homes Healthy People (WHHP) project was created as a result of the Department of Health's WHHP Fund 2012/13 and drew on previous work in the borough and good practice elsewhere. The project was led by the Council's Sustainable Resources Group and was delivered in partnership with a range of public, private and community sector organisations.

4.2 The project provided help to residents vulnerable to the effects of living in cold housing, and sought to develop longer-term resilience to fuel poverty across the borough. To do this the project worked across four inter-related strands:

- *People*: a tailored package of support for residents identified as potentially at risk from the cold, including practical advice on keeping warm, income maximisation, a *winter warm* pack, warming foods, advice on switching to lower energy prices and access to volunteer and befriending services.
- *Homes*: funding and installation of insulation; heating upgrades and repairs; draught proofing and emergency heating.
- *Communities*: funding and support for community-led events raising awareness; and delivery of large parts of the programme by local voluntary and community sector organisations.
- *Joining-up local services*: a multi-agency approach to referrals and delivery that included training for local frontline staff across social services, health and housing teams as well as for community and voluntary organisations.

4.3 The project ran from November 2012 to March 2013 and received £105,628 from the Department of Health's WHHP fund 12/13.

4.4 The headline achievements of the 12/13 project were

- A total of 408 referrals received from 34 different organisations working with residents likely to be vulnerable to fuel poverty and cold weather
- A 'joined up' offer linking to 13 different support services
- 100% of residents receiving services from the project rated the experience as 'Excellent' or 'Very good'<sup>7</sup>
- 319 vulnerable households received a home energy visit and *winter warm* pack

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<sup>7</sup> Results from a telephone sample of 30 residents receiving the WHHP project

- 246 vulnerable households were added to the Priority Services Register providing additional safeguards on utilities contracts (such as priority reconnection during a power cut)
- 160 vulnerable households received benefits and welfare advice with an estimated £97,000 a year additional income from benefits<sup>8</sup>
- 49 vulnerable households received a fire safety check and smoke alarm
- 21 *help at home* visits from Age UK
- 19 vulnerable households received heating improvements and/or insulation, bringing in £24,000 external funding
- 13 people were registered for the local Age UK befriending scheme
- 600 people attended 14 events run by our community partners
- 2,500 residents received an information sheet on keeping warm
- Training for 160 front line professionals on fuel poverty and health awareness
- Winter resilience mapping of community organisations offering support to vulnerable residents

## 5. Key findings identified in the evaluation

- 5.1 The stop-start nature of one-off grant funding is a challenge, and it was frustrating to have to discourage referrals towards the end of March, when it was still cold, to prevent unbudgeted commitments in the next financial year.
- 5.2 A multi-agency approach was central to the way the project worked. Although time consuming to establish and maintain, the benefits included:
- Reduced administration through using the professional judgement of partners as the test of who received services rather than qualifying criteria and form filling
  - Increased awareness and capacity in staff delivering activity related to fuel poverty leading to a more joined up approach to the needs of vulnerable residents
  - Faster and extended reach into key target groups, particularly the elderly and residents with long-term health problems
- 5.3 Using small charities and community organisations as service providers has helped build capacity, knowledge and awareness across the local voluntary and community sector. There are however risks where delivery is reliant on a single individual.
- 5.4 There were a lower number of referrals from health professionals than expected, which may be partly due to ongoing changes across the local health sector. It was difficult to establish lines of communication with staff in the local NHS Trust.

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<sup>8</sup> Pre-welfare form calculation of benefits

- 5.5 Home visits were the most popular aspect of the project with recipients and the *winter warm* pack proved to be the most popular element of the home visit. Blankets were identified most frequently as the most valued element of the pack.
- 5.6 Age UK found it difficult to find an adequate supply of suitable volunteers for the befriending service, and there were more referrals than volunteers. There does appear to be an unmet need for this service, or similar, locally.
- 5.7 The energy switching element of the home visit only provided advice and many people needed far greater support to actually switch to a better tariff than could have been offered in the visit.

## **6. Next steps**

- 6.1 A bid for £75,000 has been put forward for Lewisham Public Health Funding in 2013/14, which if successful will continue to enable the service to be maintained. The project will run on similar lines as previous years, but with a greater emphasis on fuel switching and development of the befriending element.
- 6.2 There would however be a clear benefit in providing funding for more than one year to allow a dedicated resource to support and develop the partnerships required to deliver a high quality service protecting the most vulnerable residents from the cold.

## **7. Financial implications**

- 7.1 There are no financial implications arising as a direct result of this report. Any specific projects delivered and any costs arising in relation to work on fuel poverty and excess winter deaths will need to be agreed on a separate basis following corporate procedures and delegations.

## **8. Legal implications**

- 8.1 There are no legal implications arising as a direct result of this report.
- 8.2 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 the area.

## **9. Crime and Disorder Implications**

- 9.1 There are no crime and disorder implications arising as a result of this report.



## **10. Equalities Implications**

10.1 The Warm Homes Healthy People project is targeted at residents vulnerable to the cold. This includes low income households, the elderly and people with long-term health problems. It is therefore considered that the impact of the project on equalities is positive. Delivery of the project includes local third sector organisations which is also expected to have a positive impact.

## **11. Environmental Implications**

11.1 Improvements to the energy efficiency of homes through the project may be expected to have wider environmental benefits for example in reducing carbon emissions and improving air quality. Where energy efficiency improvements result in improved levels of heating then this impact may be neutral.

## **Background Documents**

Lewisham Warm Homes Healthy People End Project Report 2012/13 (enclosed)

Report to the Shadow Health and Wellbeing Board 6 February 2013 "Fuel poverty and Excess Winter Deaths in Lewisham"  
<http://www.lewishamstrategicpartnership.org.uk/docs/060113%20SHWB%20Fuel%20Poverty%20and%20Excess%20Winter%20Deaths%20for%20Jane%20Miller.doc>

If there are any queries on this report please contact **Martin O'Brien, Sustainable Resources Group Manager, Lewisham Council; 020 8314 6605; martin.o'brien@lewisham.gov.uk**

## **Lewisham Warm Homes Healthy People**

End Project Report 2012/13

Lewisham Council  
Sustainable Resources Group  
May 2013



## 1) Introduction

- 1.1 Lewisham's Warm Homes Healthy People (WHHP) project was created as a result of the Department of Health's WHHP Fund 2012/13 and drew on previous work in the borough and good practice elsewhere. The project was led by the Council's Sustainable Resources Group and delivered in partnership with a range of public, private and community sector organisations.
- 1.2 The project provided help to residents vulnerable to the effects of living in cold housing, and sought to develop longer-term resilience to fuel poverty across the borough. To do this the project worked across four inter-related strands:
- **People**: a tailored package of support for residents identified as potentially at risk from the cold, including practical advice on keeping warm, income maximisation, a *winter warm* pack, warming foods, advice on switching to lower energy prices and access to volunteer and befriending services.
  - **Homes**: funding and installation of insulation; heating upgrades and repairs; draught proofing and emergency heating.
  - **Communities**: funding and support for community-led events raising awareness; and delivery of large parts of the programme by local voluntary and community sector organisations.
  - **Joining-up local services**: a multi-agency approach to referrals and delivery that included training for local frontline staff across social services, health and housing teams as well as for community and voluntary organisations.
- 1.3 The project ran from November 2012 to March 2013.
- 1.4 This report presents a summary of the project, its outcomes and lessons learned. A more detailed description of the methodology, deliverables, satisfaction survey and participating organisations is available on request.

## 2) Headline achievements

- A total of **408 referrals** received from 34 different organisations working with residents likely to be vulnerable to fuel poverty and cold weather
- A 'joined up' offer linking to **13 different support services**
- **100%** of residents receiving services from the project rated the experience as 'Excellent' or 'Very good'<sup>1</sup>
- 319 vulnerable households received a **home energy visit and winter warm pack**
- 246 vulnerable households were added to the **Priority Services Register** providing additional safeguards on utilities contracts (such as priority reconnection during a power cut)
- 160 vulnerable households received benefits and welfare advice with an estimated **£97,000** a year additional income from benefits<sup>2</sup>

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<sup>1</sup> Results from a telephone sample of 30 residents receiving the WHHP project

- 49 vulnerable households received a **fire safety check and smoke alarm**
- 21 households received a **help at home visit** from Age UK
- 19 vulnerable households received heating improvements and/or insulation, bringing in **£24,000 external funding**
- 13 people were registered for the local Age UK **befriending** scheme
- **600** people attended 14 events run by our community partners
- **2,500** residents received an information sheet on keeping warm
- Training for **160 front line professionals** on fuel poverty and health awareness
- **Winter resilience mapping** of community organisations offering support to vulnerable residents

### 3) Funding

- 3.1 Lewisham Council received £105,628 under the 2012/13 Department of Health's WHHP Fund. An underspend of £42,637 from the 2011/12 WHHP allocation was used to create a budget of £148,265 for the 12/13.
- 3.2 Lewisham Council officer time was not funded through the WHHP grant and the project had a dedicated officer project managing delivery through from September to March. Other funding accessed as part of the project included Carbon Emissions Reduction Target (CERT) funding for insulation works and DECC Local Authority Fund grant to pay for heating repairs and upgrades.

Activity	Funding 000's
Home visits	23,000
Winter warm packs	18,000
Measures installed in home visits	11,000
Income maximisation advice	20,000
Help at home services	1,000
Befriending project staff	8,000
Thermotext cold alarms	15,000
Access costs/clearances for insulation works	1,000
'Change Agent' graduate placement	15,000
Database	2,000
Training for frontline workers	4,000
Other	3,000
Contingency	27,000
<b>TOTAL WHHP GRANT FUNDING</b>	<b>148,000</b>
CERT funded loft and cavity wall insulation work	5,000
DECC LA grant funded heating repairs and upgrades	19,000
<b>TOTAL ALL EXPENDITURE</b>	<b>172,000</b>

Table 1: Lewisham WHHP Expenditure 2012/13

<sup>2</sup> Pre-welfare form calculation of benefits

#### 4) Summary of the Lewisham WHHP offer

4.1 Residents were referred into the project through a variety of local public sector and community and voluntary sector partners. Each resident was then contacted by phone and matched to the different elements of the service. This included:

- A home energy visit.
- Income maximisation service.
- *Help at home* and befriending services for elderly residents.
- Insulation and heating services.
- Utility companies priority services register offering additional safeguards for vulnerable people.
- The Lewisham Handyperson scheme.
- Fire safety checks.

4.2 In addition, residents were given advice about other relevant services and organisations including: Disability Facilities Grant, Lewisham Disability Coalition, Taxicard, meals on wheels, health checks and eye tests.

4.3 Home energy visits lasted on average 90 minutes and included:

- A *winter warm* pack including slippers, blanket, thermal flask, microwavable hot water bottle, gloves, hand warmer and room thermometer.
- Practical advice on heating controls, energy efficiency, supplier switching.
- Installation of draught proofing, energy monitor, cold alarm, hot water tank jackets, chimney balloons and emergency heating.

4.4 Alongside these direct services to residents the project also funded:

- 14 community events on fuel poverty and keeping warm in winter, attended by over 600 people.
- Fuel poverty training for 160 public sector and third sector staff delivering services to vulnerable residents.
- A 6-month graduate placement to undertake mapping of winter resilience activity and develop proposals for future action. A detailed report that identifies current support services in extreme cold weather and presents recommendations for future action has been produced as part of this work.

#### 5) Partners

5.1 The project was set up and run by the Sustainable Resources Group within Lewisham Council but delivered in partnership with a wide range of organisations from across the public, private and community sectors.

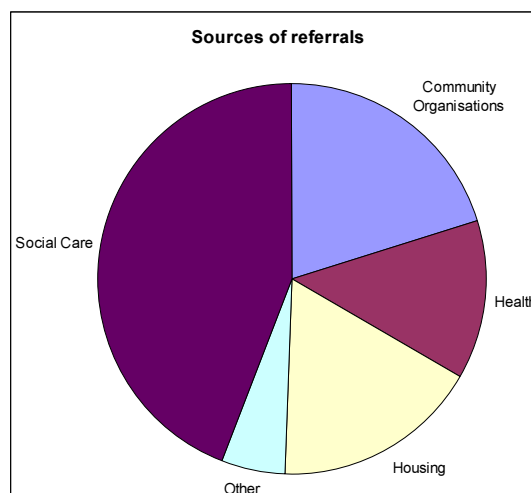
5.2 Our principle partners involved in the project include:

Age UK Lewisham and Southwark	End Loneliness Campaign and befriending service as well as ' <i>Help at Home</i> ' service sending volunteers to isolated and housebound residents to support them during periods of extreme cold weather.
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CAG Consultants	Training sessions for frontline workers in public, community and voluntary organisations.
Groundwork London	Delivery of home energy visits providing advice, draught proofing, cold alarms, <i>winter warm</i> pack, and emergency heating (where required).
Lewisham Advice Providers Consortium (LAPC)	Income maximisation services; Co-ordination of community outreach events.  LAPC includes Lewisham CAB; Carers Lewisham; 170 Community Advice; Evelyn 190; Lewisham Refugee Migrant Network; Lewisham Multi Lingual Advice; Age UK Lewisham; Lewisham Disability Coalition.
Lewisham Council services	Emergency Planning; Linkline; Handyperson; Private Sector Housing Grants; Social Services
Lewisham Healthcare NHS Trust	Stop smoking service, health checks, flu vaccination, local falls clinic
Lewisham Homes	Referring clients and staff training.
Lewisham Multi Lingual Advice Service (LMLAS)	Advice and support to residents for whom English is not their first language to help them get cheaper energy through switching.
London Fire Brigade	Fire safety checks and smoke alarms.
Osborne Energy	Free loft and cavity wall insulation and heating repairs / boiler replacements.
Phoenix Community Housing	Referring clients and staff training.
Public Health Lewisham	Project development and evaluation.
Thames Water	Adding qualifying residents to the register of vulnerable customers offering safeguards for utilities contracts (such as priority reconnection if cut off for any reason).
UK Power Networks	Adding qualifying residents to the register of vulnerable customers offering safeguards for utilities contracts (such as priority reconnection during a power cut).

Table 2: Lewisham WHHP partners

- 45% of referrals into the project came from social care professionals;
- 13% from the health sector;
- 20% from local community organisations; and
- 17% from housing providers.



A break down of the figures by individual organisation is given at the end of the report.

## 6) Lessons learned

### Grant funding

- 6.1 The flexibility of the DoH WHHP funding and the absence of conditions and restrictions on the grant has been highly beneficial. It created the freedom to decide how best to use the funding locally, and minimised time spent on administration which has undoubtedly led to a better project.
- 6.2 The stop-start nature of one-off grant funding created challenges in relation to the referral process. It takes time to communicate your offer and to generate referrals and to then get the balance right between fully using the grant without over-committing. It was frustrating to discourage referrals towards the end of March when it was still cold to prevent unbudgeted commitments in the next financial year.

### Preparation

- 6.3 Early planning in the summer meant the project was ready to go from an early stage and when the WHHP Fund was announced in September we could submit a funding bid in partnership with locally-based community organisations.
- 6.4 Another advantage of early preparation meant there was time to set up systems and literature for the beginning of the project, so that once funding was confirmed we were able to receive referrals right away.
- 6.5 The use of a bespoke project database made a big difference to administering the project. It enabled the project team to store a large amount of client information securely and in an organised fashion, and it facilitated a relatively complex onward referral system. Trying to do something similar with a standard excel spreadsheet would have taken a lot more officer time.

### Partnerships

- 6.6 A multi-agency approach was central to the methodology of the project. Although time consuming to establish and maintain, the benefits included:
  - Reduced administration and easier access to the project through eliminating requirements for qualifying criteria using instead the professional judgement of partners as the test of who received services
  - Increased awareness and capacity in staff delivering activity related to fuel poverty leading to a more joined up approach to the needs of vulnerable residents
  - Faster and extended reach into key target groups, particularly the elderly and residents with long-term health problems
- 6.7 Using small charities and community organisations as service providers has helped build capacity, knowledge and awareness across the local voluntary and

community sector. There are however risks where delivery is reliant on a single individual.

#### Generating and managing referrals

- 6.8 The rate of referrals into the scheme was inconsistent. High numbers were observed during periods of colder weather and following events and training courses with front line staff. This inconsistency could be managed more effectively by establishing a year round service, with ongoing marketing and promotion of the project.
- 6.9 There were a lower number of referrals from health professionals than expected, which may be partly due to ongoing changes across the local health sector. It was difficult to establish lines of communication with staff in the local NHS Trust, for example NHS staff experienced problems accessing the referral form on the Council website, as, despite numerous attempts to fix the problem, Lewisham website links did not work on NHS computers. Health staff were also less likely to spend time at a desk receiving emails which meant that engaging health professionals at the level required for this project was challenging.
- 6.10 Telephone assessments carried out before the home visit were very time consuming, some calls lasting over ½ hour. The aim of the telephone assessment was to inform the client that they had been referred to WHHP and assess the services they needed. In future, it may be better to tailor the referral form so that the referrer specifies exactly which services their client needs and/or build this into the home visit.

#### Communications and marketing

- 6.11 Not having qualifying criteria was a significant benefit in terms of minimising administrative time and encouraging referrals. However, as eligibility relied on referrals we did not publicise the programme directly to residents. This may have meant some people who would have benefited did not access the service.
- 6.12 Emails and circulars are good at generating interest, but often the message fails to infiltrate down to the target audience – which in this case was front line staff in partner organisations. Face to face interaction was more effective at generating referrals than emails were.

#### Service delivery

- 6.13 Home visits were the most popular aspect of the project with recipients and the *winter warm* pack proved to be the most popular element of the home visit. Blankets were identified most frequently as the most valued element of the pack.
- 6.14 Despite consent being required for a referral there was a higher than expected drop out rate. This was mainly due to difficulties contacting clients (language



barrier, hearing problems, client in hospital etc) but in some cases clients did not want to accept help or did not trust a free service was really free. This is why 408 referrals translated into 319 home visits (a drop off rate of 22%).

- 6.15 There was lower than expected uptake of the Age UK *help at home* support. Most of the older WHHP clients who lived alone were offered free help at home, but the majority declined. Many were worried about letting a stranger into their home.
- 6.16 Age UK found it difficult to find an adequate supply of suitable volunteers for the befriending service, and there were more referrals than volunteers. There does appear to be an unmet need for this service, or similar, locally.
- 6.17 Residents were less interested in taking up the offer of a cold alarm than expected. The alarm, which sends an automated message to a predefined set of numbers was seen by some as being a possible burden on others.
- 6.18 The energy switching element of the home visit only provided advice and many people needed far greater support to actually switch to a better tariff than could have been offered in the visit. The project attempted to start a dedicated switching service for residents whose first language was not english although this could not be started in the time available. It is recommended that future projects of this type direct more resource to this area.

## **7) Next steps**

- 7.1 Lewisham's WHHP project achieved its targets in 2012/13 and made a positive difference to the lives of those directly benefiting. Measuring the extent to which this achieved health outcomes was outside the scope of the project, but there are a wealth of studies and literature that make the connection between action on fuel poverty, improved health and benefits for health services<sup>3</sup>.
- 7.2 Lewisham is seeking to put in place an holistic approach to services to vulnerable adults bringing together delivery of frontline services on adult social care and public health. The multi-agency approach adopted within Lewisham's WHHP project fits well with this and we will look to integrate future delivery as part of this coordinated service delivery.
- 7.3 Based on the lessons learned during the 12/13 WHHP project we recommend maintaining the project's focus on '*People; Homes; Communities; and Joined-up Services*' through the following activity in 13/14:

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<sup>3</sup> See for example citations in a February 2013 report to Lewisham's Health and Wellbeing Board on 'Fuel Poverty and Excess Winter Deaths'  
<http://www.lewishamstrategicpartnership.org.uk/docs/060113%20SHWB%20Fuel%20Poverty%20and%20Excess%20Winter%20Deaths%20for%20Jane%20Miller.doc>

- A home energy advice service with a focus on fuel switching and heating controls
- A quick-responding temporary emergency heating offer
- Ongoing training for front line staff in health, social care, housing and other relevant services
- Befriending services and development of wider community resilience

7.4 It is also recommended that the project seek to extend the reach of those benefiting and in particular

- Target low income families
- Reach more people with a wider set of long-term health problems
- Connect to financial inclusion work within social housing and benefit services

7.5 **Critical to establishing this offer is finding a way to resource it on a more stable basis that can be achieved through one-off grant funding. This is an urgent priority if we are going to be able to design and commence an offer from September 2013.**

7.6 Securing ongoing funding will allow a baseline of activity to be created that can be used to secure wider investment for example from the new ECO energy company obligation to fund insulation and heating improvements.

7.7 It will also allow any future one-off grants - such as the DoH WHHP, if this is repeated - to extend the coverage and reach of the programme.

7.8 A similar scale project running from Sept 13 to March 5 addressing the issues above and benefitting 400-500 residents each year would cost around £150,000 a year.

Resource	Cost
Project management and coordination	£50,000
Home visits and advice services (energy, income, grants and debt)	£80,000
Emergency heating	£5,000
Befriending and winter resilience	£9,000
Events and training	£6,000
<b>Total</b>	<b>£150,000</b>

Table 3: Estimated costs of future activity

7.9 This represents a cost of approximately £300-£370 per resident benefiting, each of whom would typically receive:

- Immediate help to stay warm and reduce the risk of ill-health associated with living in cold housing
- Increased home energy efficiency through draught proofing, insulation and heating improvements
- A wider support network and resilience for individuals particularly those who may be isolated

## 8) Breakdown of referrals by organisation

Category	By Organisation	Referrals	Total
Community Organisations	Age UK	14	82
	Lewisham Refugee & Migrant Network (LRMN)	14	
	Family Budget Project	12	
	Carers Lewisham	10	
	Lewisham Advice Providers Consortium (LAPC)	16	
	Deptford Action Group for the Elderly (DAGE)	4	
	Groundwork	7	
	Lewisham CAB	1	
	170 Community Project	1	
	British Red Cross	1	
	Action for Refugees in Lewisham	1	
	Lewisham Targeted Family Support	1	
Health	Community Nursing	31	53
	SLAM NHS Trust	15	
	GP	7	
Housing	Hexagon Housing Association	18	70
	Thames Reach	4	
	L&Q	5	
	Lewisham Homes	4	
	One Housing Group	3	
	Phoenix Community Housing	5	
	LBL Private Sector Housing	30	
	Viridian Housing	1	
Other	Sustainable Resources Group	9	21
	Lewisham Probation	1	
	London Fire Brigade	1	
	LINC	2	
	Self	8	
Social Care	Cassel Centre	3	179
	Equinox Care	1	
	LBL Sheltered Housing	96	
	LBL Adult Social Care	77	
	Care Watch	1	
	London Care PLC	1	

## 9) Lewisham Warm Homes Healthy People Case studies

Mrs. A, 54, had an accident last year which left her with chronic pain and subsequently became unemployed. She is living on her own and identifies herself as disabled. She was referred to WHHP by her social worker because she was finding it difficult to pay for her energy bills and felt unable to manage her home. Mrs A had a home energy advice visit from our partner Groundwork who installed a cold alarm, draught-proofing and gave her a *keep warm* pack. They also showed her how to use her central heating controls, and set the timer based on her daily needs. She had a home visit from a local advice agency who carried out a full income maximisation assessment, which identified that she qualified for Attendance Allowance, and helped her with the application. She was also referred for befriending services from Age UK who are in the process of matching her up with a volunteer who will check in on her from time to time. She also received Age UK help at home visits to help with domestic tasks.

B & C are a young couple with a 3 month old baby who are struggling financially, and in arrears with their phone and other utility bills. At the time of the referral (December) their heating was not working. They were provided with a temporary electric heater to tide them over until the landlord fixed the heating. They also had a full benefit check but were advised that they are receiving all the benefits they are entitled to. Despite this they were struggling to meet all their commitments (debt repayments) and felt they couldn't afford to turn on their heating when it was fixed. The financial adviser supported them with negotiating affordable repayments on the arrears for their telephone bill and helped them appeal against PPI payments on their sofa. This assistance led to a reduction in their outgoings giving them greater confidence that they could afford to heat their home.

Mr. E, 70, suffers from chronic respiratory problems and is on a concentrated oxygen supply at home. He was referred by his community matron in early January and he has since been added to the gas, water & electricity suppliers' Priority Services Register so that his electricity supply will not be cut off, or if it is cut in an emergency, the utility companies will arrange an emergency supply for him. He was referred to the Lewisham Handyman service as he wanted help moving furniture in his house. He received a home energy visit and *keep warm* pack. We also recommended he get a free home eye check as he hadn't had his eyes tested in over a year.

Mr and Mrs F both have health problems. Mr F has dementia, diabetes and heart disease. Mrs F has arthritis and dementia. They are looked after by their daughter who reported suffering health problems herself. An adviser from the Lewisham Advice Providers Consortium identified various benefits they could apply for, and they helped them complete a Community Care Grant application (CCG), a Taxi Card application and an Attendance Allowance application. The CCG application was successful and they were awarded nearly £1,000. They were also given advice about caring options and were signposted to other agencies for help.

## 10) Feedback and testimonials

### The following is a selection of feedback from clients benefiting from the project

"I couldn't fault it. It was brilliant. It is comforting and good to know that there are people out there to provide this help. The energy advisor was very useful and a lovely young man. I have been following all the advice so I hope the next bill is lower." - **Client A, comments on the home energy visit**

"Shows somebody cares what happens to you" - **Client B, received a home energy visit, Age UK services, fire safety check and a welfare benefit check**

"Very helpful service and have been able to get £130.00 off my electric bill." - **Client C, who received a home energy visit**

"Great service was unsure benefit checks exist. Also wonderful to know that I could get a cheaper tariff from the same supplier." - **Client D, who received a home energy visit and a benefit check**

"Warm homes discount is great, so unfortunate I only knew it existed from the Green Doctor service. Better late than never. Very good advice. Have no other questions feel you have covered all of them. The electric monitor is a very great product, I did not know kettle used so much energy!" - **Client E, received a home energy visit**

"Pleased with service, hopefully the house will be warmer after having cavity walls insulated." - **Client F, received a home energy visit from Groundwork and insulation from Osborne Energy**

### The following is a selection of feedback from partners involved in the project

"This was a fantastic service and very helpful, partly because it was so broad in the criteria and also because it was such a unique referral pathway. I really hope it can be run again next winter." – **GP, Lee Health Centre, Nightingale Surgery**

"I hope you will be able to provide this service again. It was very useful for our tenants with private landlords." – **Environmental Health Assistant, Lewisham Council**

'I found referring to Warm Homes very easy and any queries I had were always answered efficiently over the telephone if need be. I was initially surprised how quickly clients were contacted and were provided with advise/equipment that had a direct impact on their well being.' – **Community Occupational Therapist, Prevention and Response team, Lewisham Council**

"WHHP has enabled us to get the End Loneliness Campaign off the ground, and make a real difference to older people's lives." – **End Loneliness Coordinator, Age UK Lewisham & Southwark**

"She [Client X] has a variety of issues and often feels like she is trying to do everything herself and could not be more thankful for the support *Warm Homes Healthy People* gave to her. This program along with a couple of other support centres has made her feel like a weight has been lifted from her shoulders." - **Improving Access to Psychological Therapies (IAPT) Employment Worker, South London and Maudsley NHS Foundation Trust**

# Agenda Item 13

HEALTH AND WELLBEING BOARD			
<b>Report Title</b>	Health and Wellbeing Board Work Programme		
<b>Contributors</b>	Service Manager – Strategy and Policy, Directorate for Community Services	Item No.	12
<b>Class</b>	Part 1	Date: 19 September 2013	

## 1. Purpose

1.1 This report presents the Health and Wellbeing Board with a draft work programme (included as Appendix 1) for discussion and approval.

## 2. Recommendations

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

- note the current draft of the work programme and consider whether amends or additions are necessary;
- approve the work programme;
- agree that the work programme will be considered as a standing item at each meeting of the Health and Wellbeing Board.

## 3. Policy context

3.1 The activity of the Health and Wellbeing Board is focussed on delivering the strategic vision for Lewisham as established in Shaping our future – Lewisham’s Sustainable Community Strategy and in Lewisham’s Health and Wellbeing Strategy.

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

## 4. Work programme

4.1 The work programme will be a key document for the Health and Wellbeing Board. It will allow the Board to schedule activity, reports and presentations across the year. It will also provide members of the public and wider stakeholders with a clear picture of the Board's planned activity.

4.2 The draft work programme (see Appendix 1), includes some of the key items which the Board will need to consider over the course of 2013/14. This includes the Board's statutory functions in regard to the Joint Strategic Needs Assessment, the Pharmaceutical Needs Assessment and the Health and Wellbeing Strategy.

4.3 It is proposed that the work programme is reviewed as a standing item at each meeting of the Board. This will allow members of the Board to add, amend or reschedule items as necessary.

4.4 In adding items to the work programme, the Board should specify the information and analysis required in the report, so that report authors are clear as to what is required. The Health and Wellbeing Board Agenda Planning Group may also propose items for inclusion on the work programme, and will seek approval for their inclusion from the Board.

4.5 Upon agreement of the work programme, the Health and Wellbeing Agenda Planning group will commission the necessary reports and activities.

## **5. Financial implications**

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

## **6. Legal implications**

6.1 The Board's statutory functions are broadly set out in paragraph 4.2.

6.2 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.

6.3 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.

6.4 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.

6.5 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/>

6.6 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

6.7 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/](#)

6.8 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. Equalities implications**

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

### **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.

### **Background documents**

None

If there are any queries on this report please contact Edward Knowles, Service Manager – Strategy, Community Services, London Borough of Lewisham on 0208 314 9579 or by e-mail at [edward.knowles@lewisham.gov.uk](mailto:edward.knowles@lewisham.gov.uk)

# Health and Wellbeing Board – Work Programme

last updated @ 9.09.13 (10:00)

Meeting date		Agenda Planning		Report Deadline			Agenda Publication		Minutes drafted by	
19 November 2013		TBC		30 October 2013			11 November 2013		27 November 2013	
Agenda item	Report Title	Deferred?	Key decision or information	Part 1 or Part 2	Lead Organisation(s)	Author(s) / Presenter (indicate A or P)		Previous report pathway & date	Next report pathway & date	
1	Draft CCG Commissioning Strategy	From July meeting		Part 1	CCG	Martin Wilkinson		HCSC		
2	Public Health Budget	From September (agreed at July meeting)		Part 1	LBL	Danny Ruta				
3	Autism Self Assessment Framework				LBL	Corinne Moccarme				
4	Housing Strategy and Older People's Housing				LBL	Martin Cheeseman / Joan Hutton / Carmel Langstaff (?)				

5	Briefing note on the National Health Service Commissioning Board (payments to local authorities) Directions 2013 (re spending review))	From September meeting		Part 1	CCG / LBL	Tony Read / Robert Mellor		
6	Report on arrangements for the performance management of the Health and Wellbeing Delivery Plan					Alfred Banya/Mary Farinha/DannyRuta TBC		
7	Integration Programme Outline Framework			Part 1	LBL	Ruth Hutt		
8	Sexual Health			Part 1	LBL	Ruth Hutt		

<b>Meeting date</b>	<b>Agenda Planning</b>		<b>Report Deadline</b>		<b>Agenda Publication</b>		<b>Minutes drafted by</b>	
January 2014 (Date TBC)	TBC		TBC		TBC		TBC	
<b>Agenda item</b>	<b>Report Title</b>	<b>Deferred?</b>	<b>Key decision or information</b>	<b>Part 1 or Part 2</b>	<b>Lead Organisation(s)</b>	<b>Author(s) / Presenter</b> <small>(indicate A or P)</small>	<b>Previous report pathway &amp; date</b>	<b>Next report pathway &amp; date</b>
1	Reducing alcohol harm: update on progress			Part 1	LBL	Jane Miller		
2	Overview of achievement on 3 public health priorities (smoking, alcohol and obesity)			Part 1	LBL	Danny Ruta		
3	Learning Disabilities – Self			Part 1	LBL	Heather Hughes		

	Assessment Form							
<b>Agenda item</b>	<b>Report Title</b>	<b>Deferred?</b>	<b>Key decision or information</b>	<b>Part 1 or Part 2</b>	<b>Lead Organisation(s)</b>	<b>Author(s) / Presenter</b>  <i>(indicate A or P)</i>	<b>Previous report pathway &amp; date</b>	<b>Next report pathway &amp; date</b>
4	Annual Public Health Report			Part 1	CCG / LBL	Tony Read / Conrad Hall		
5	Healthwatch update			Part 1	Voluntary Sector	Tony Nickson		
6	Integrated Health & Social Care information hub			Part 1	LBL	Ruth Hutt		