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HEALTH AND WELLBEING BOARD

Date: TUESDAY, 19 JULY 2016 at 2.00 pm

Parkside Community Centre
Rooms 1-3
1 Copperwood Place (off Parkside Avenue)
SE10 8FY

Enquiries to: Stewart Snellgrove
Telephone: 020 8314 9308 (direct line)

MEMBERS

Magna Aidoo	Healthwatch Bromley & Lewisham	
Councillor Chris Best	Community Services, London Borough of Lewisham	L
Aileen Buckton	Directorate for Community Services, London Borough of Lewisham	
Mayor Sir Steve Bullock	London Borough of Lewisham	L
Elizabeth Butler	Lewisham & Greenwich Healthcare NHS Trust	
Gwen Kennedy	NHS Engalnd	
Tony Nickson	Voluntary Action Lewisham	
Dr Simon Parton	Lewisham Local Medical Committee	
Peter Ramrayka	Voluntary and Community Sector	
Marc Rowland	Lewisham Clinical Commissioning Group	
Dr Danny Ruta	Public Health, London Borough of Lewisham	
Brendan Sarsfield	Family Mosaic	
Sara Williams	Directorate for Children & Young People, London Borough of Lewisham	

Members are summoned to attend this meeting

Barry Quirk
Chief Executive
Lewisham Town Hall
Catford
London SE6 4RU
Date: Monday, 11 July 2016

INVESTOR IN PEOPLE

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

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MINUTES OF THE HEALTH AND WELLBEING BOARD

Tuesday, 29 March 2016 at 3pm

ATTENDANCE
PRESENT: Mayor Sir Steve Bullock, Chair, Dr Marc Rowland, Chair (Chair of Lewisham Clinical Commissioning Group and Vice-Chair of the Health and Wellbeing Board), Tony Nickson (Director, Voluntary Action Lewisham), Peter Ramrayka (Voluntary and Community Sector representative), Brendan Sarsfield (Family Mosaic), Cllr Chris Best (Cabinet Member for Health, Wellbeing and Older People), Aileen Buckton (Executive Director for Community Services, LBL) Sara Williams (Executive Director for Children & Young People, LBL), Elizabeth Butler (Chair of Lewisham & Greenwich Healthcare NHS Trust),

IN ATTENDANCE: Jane Miller (Consultant in Public Health), Carmel Langstaff (Service Manager, Interagency Development and Integration, LBL), Andy Thomas (Clerk to the Board, LBL), Robert Mellors (Group Finance Manager, LBL)

APOLOGIES: Dr Danny Ruta (Director of Public Health, LBL), Dr Simon Parton (Chair of Lewisham Local Medical Committee), Magna Aidoo (Healthwatch Bromley and Lewisham)

Welcome and Introductions

The Chair welcomed everyone to the meeting and invited Board members to introduce themselves

1. Minutes of the last meeting and matters arising

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

1.2 There were no matters arising.

2. Declarations of Interest

There were no declarations of interest.

3 Adult Integrated Care Programme and the Better Care Fund

3.1 Robert Mellors presented a report highlighting the priority areas for action within the 16/17 Adult Integrated Care Programme. The Board noted that a more detailed programme plan was being developed and will be monitored by the adult integrated care programme board. The report also highlighted the high level expenditure plans for the Better Care Fund for 16/17. Robert explained that the deadline for final submission of the Better Care Fund plan is 25 April. As there is no formal meeting of the Board before that date, Robert requested that the Board agree to receive a copy of the plan electronically for comment and that final sign off of the plan be delegated to the Chair and Vice Chair of the Health and Wellbeing Board.

Liz Butler noted that the report states that a first submission of the Better

3.2 Care Fund submission would take place by 21 March and asked if a copy of this was available. Aileen Buckton agreed to circulate the information to the board.

3.3 Peter Ramrayka asked what is meant when the report refers to 'home wards'? Aileen Buckton replied that this is where people are supported to be cared for in more appropriate settings, in their own homes for example. Aileen explained that the idea is to break down the barriers between hospital care and caring for people in the community in order to ensure that care takes place wherever is most appropriate. This might involve such support as provision of equipment or night time visiting.

3.4 The Board approved the priority areas for the Adult Integrated Care Programme 2016/17. Members agreed that final sign off of the BCF plan be delegated to the Chair and Vice Chair on behalf of the Health and Wellbeing Board but requested that a copy of the submission be circulated for comment.

4. Neighbourhood Care Networks

4.1 Carmel Langstaff presented a report which provided an update on the development of Lewisham's neighbourhood care networks. She invited the Board to comment on connections that need further developing or gaps that need addressing within neighbourhoods to better meet people's needs and to identify any specific action that could be taken to further develop the networks within Lewisham.

4.2 Brendan Sarsfield asked whether any links had been made with housing. Carmel said that links had been made but that ideas on how this could be strengthened would be welcomed. Brendan said that one way to do this would be to share the report with the Housing Association Group facilitated by Genevieve Macklin

4.3 Liz Butler commented that GPs feature heavily in the case studies and given the current pressures on GPs wondered how this would work going forward. Marc Rowland responded to say that it is true that GPs are under a lot of pressure but are very supportive of NCNs. He was keen to ensure that other partners are fully involved including housing, pharmacists, Children's Centres etc. as this would increase the effectiveness of the model. He commented that this is a very positive development.

4.4 Chris Best said that it was a very helpful update and she was keen to ensure that all services were included in the programme such as 'Be Active' and 'Healthy Walks' as well as voluntary sector opportunities. In order to do this, information needed to be made available digitally so that it is was easily accessible. Carmel confirmed that work is being done to develop the on line information offer.

4.5 Chris Best commented that it was important to make sure people were well networked, particularly older people at risk of becoming socially isolated. Jane Miller agreed and said that there were some good models that we could learn from such as the North Lewisham Partnership and the Well Bellingham initiative.

5. Devolution Pilot Update

5.1 Aileen Buckton presented a report updating the board on the health and social care devolution pilot. Aileen explained that the pilot supports the current integration programme and seeks to accelerate change and remove barriers. There are three elements to the pilot:

A. Workforce**:** developing new workforce models and enhanced roles to support new models of care.
B. Estates: using buildings more flexibly and developing local agreements around the shared use.
C. Funding: aligning budgets to support transformation.

5.2 Aileen reported that the timetable is currently being agreed but that it is likely that the outline business case will need to be submitted by the end of July. She proposed that as the Health and Wellbeing Board is scheduled before the end of July 2016, the outline business case be circulated to board members in advance of the deadline for submission for comment.

5.3 Marc Rowland said that he thought that it was important to be clear that what is being proposed is not devolution as it is in Manchester but simply extends the work of the integration programme.

5.4 Liz Butler said that it is important that use of technology is also considered as part of the pilot, particularly mobile working. Aileen agreed that this was the case and said that mobile working is one of the issues being explored.

6. Health and Wellbeing Board Work Programme

6.1 Andy Thomas presented the report and highlighted the fact that this is the first work programme report that has come to the Board since the change in the pattern of meetings. Given the lower frequency of meetings, he invited the Board to give some consideration to programming of reports to ensure that any necessary deadlines would be met. He also invited the Board to put forward agenda items for future.

6.2 The following potential agenda items were put forward:

- Lewisham pilot on obesity
- Better Care Fund – report on what has been achieved
- Winter / system resilience
- Milestones for the Our Healthier SE London programme

7 Any Other Business

7.1 The Chair reminded the meeting that a Health and Wellbeing Strategy Refresh 2015-18 had been presented to the Board at its September meeting and that after discussion it had been agreed that some minor amendments should be made. The Chair asked the Board to formally approve the Health and Wellbeing Strategy Refresh 2015-18. The Board approved the Strategy.

The meeting ended at 16:00 hrs.

Agenda Item 2

Health and Wellbeing Board			
Title	Declarations of interest		
Contributor	Chief Executive – London Borough of Lewisham		Item 2
Class	Part 1 (open)	19 July 2016	

Declaration of interests

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

1 Personal interests

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

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

2 Disclosable pecuniary interests are defined by regulation as:-

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

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

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

(d) Beneficial interests in land in the borough.

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

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

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

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

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

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

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

(3) Other registerable interests

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

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

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

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

(4) Non registerable interests

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

(5) Declaration and Impact of interest on members' participation

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

(b) Where a member has a registerable interest which falls short of a disclosable pecuniary interest they must still declare the nature of the interest to the meeting at the earliest opportunity and in any event before the matter is considered, but they may stay in the room, participate in consideration of the matter and vote on it unless paragraph (c) below applies.

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

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

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

(6) Sensitive information

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

(7) Exempt categories

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

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

Health and Wellbeing Board		
Title	Comments of the Healthier Communities Select Committee on the HealthWatch report, *The Polish Community and Access to Health and Wellbeing Services in Lewisham*.	
Contributor	Healthier Communities Select Committee	Item 3
Class	Part 1 (open)	19 July 2016

1. Context

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

2. Summary

2.1 This report informs the Health and Wellbeing Board of the comments and views of the Healthier Communities Select Committee, arising from discussions held on the HealthWatch report on *The Polish Community and Access to Health and Wellbeing Services in Lewisham*, considered at its meeting on 18 May 2016.

2. Recommendation

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

3. Healthier Communities Select Committee views

3.1 At its meeting on 18th May 2016 the Healthier Communities Select Committee received a report from Bromley and Lewisham Healthwatch tilted "The Polish Community and Access to Health and Wellbeing Services in Lewisham" (attached as Appendix 1).

3.2 The Committee took oral evidence from the CEO of Bromley and Lewisham Healthwatch. After questioning the witness and subsequent discussion, the Committee resolved to refer the report to the Health and Wellbeing Board in the following terms:

- The Committee noted that Healthwatch had first-hand conversations with a number of members of Polish Communities and accepts that the qualitative evidence in the report accurately reflected the content of these conversations. However, the Committee had reservations that concerns elicited from these might be presented as representative of all members of Polish Communities.

- The Committee noted that a proportion of the comments were similar to those which might be expected from other communities, including other minority communities. However, the Committee was disturbed to read reported comments

from those interviewed such as “Polish doctors have better qualifications” and “the NHS is a disaster”. The Committee considers that there is an opportunity for the Health and Wellbeing Board to commission more robust research into the beliefs behind these comments.

- The Committee was concerned to read of a reported lack of trust of the NHS of some members of Polish communities, with reports that some chose to return to Poland or attend private clinics for diagnosis, treatment and medication. The Committee was concerned that some members of Polish communities may fail to appreciate how UK health services are organised and operated compared to those in Poland. The Committee considers there are opportunities for greater engagement.

- The Committee was also concerned that there was no evidence about the status of the private clinics operating in the UK reported to be used by members of Polish communities: that is, whether they were providing services which might require registration with, for example, the CQC. The Committee recommends that the Health and Wellbeing Board commissions research into the reasons why members of Polish communities attend private clinics and the nature of and services provided at these clinics.

4. Financial implications

4.1 There are no financial implications arising out of this report per se; but there are financial implications arising from carrying out the action proposed by the Committee.

5. Legal implications

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

6. Further implications

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

Background papers

Healthier Communities Select Committee Agenda (18 May 2016)

If you have any queries about this report, please contact John Bardens, Scrutiny Manager (ext. 49976) or Kevin Flaherty, Business and Committee Manager (ext. 49327)

The Polish Community and Access to Health and Wellbeing Services in Lewisham

April 2016

Healthwatch Bromley and Lewisham, Community House, South Street, Bromley, BR1 1RH, 0208 315 1916

Contents

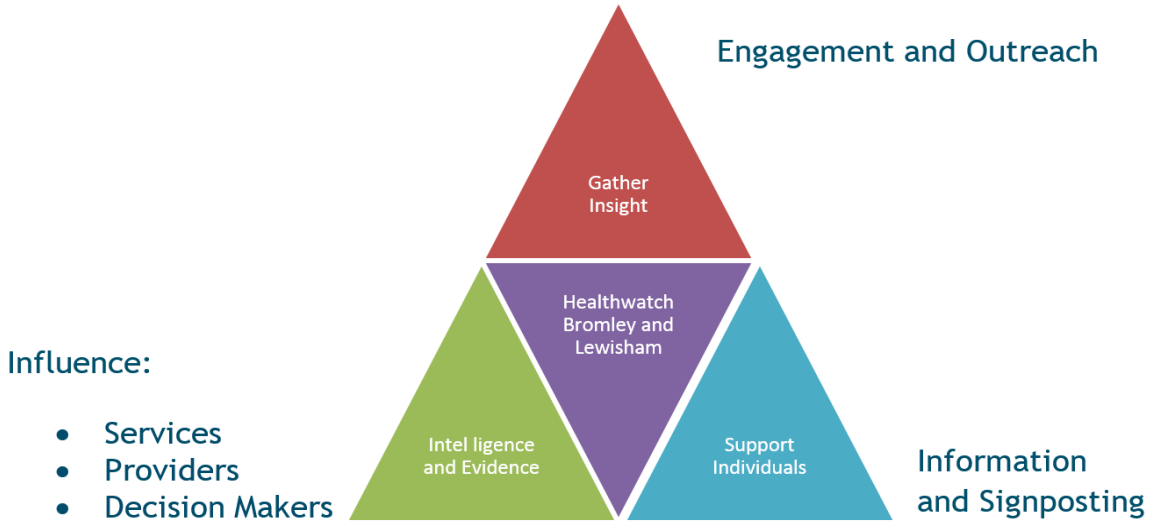
1. About Healthwatch Bromley and Lewisham

Healthwatch Bromley and Lewisham ((HWBL) is one of 152 local Healthwatch organisations that were established throughout England in 2013, under the provisions of the Health and Social Care Act 2012. The dual role of local Healthwatch is to champion the rights of users of health and social care services and to hold the system to account for how well it engages with the public.

The remit of Healthwatch Bromley and Lewisham as an independent health and social care organisation is to be the voice of local people and ensure that health and social care services are safe, effective and designed to meet the needs of patients, social care users and carers.

Healthwatch Bromley and Lewisham (HWBL) gives children, young people and adults in Lewisham a stronger voice to influence and challenge how health and social care services are purchased, provided and reviewed within the borough.

Our approach is to encourage broad public involvement and to inform, influence and help shape future commissioning and provision.



- We gather insight through our engagement, outreach and participation activities.
- We listen to views and experiences of local health and social care services and help people share their views and concerns about health & social care
- We use what we have heard in our Influencing role –
  - telling service providers and commissioners and those who monitor services what the public have told us;

- asking providers and commissioners questions and make suggestions so that services are fair for everyone;
- using our Enter and View powers to visit some services to see and report on how they are run;
- sitting on both Bromley and Lewisham Health and Wellbeing Board and on other decision-making or influencing groups, ensuring that the views and experiences of patients and other service users are taken into account;
- recommending investigation or special review of services via Healthwatch England or directly to the Care Quality Commission (CQC).

- We support individuals by providing information and signposting about services so they can make informed choices. We also signpost people to the local independent complaints advocacy service if they need more support.

2. Acknowledgements

Healthwatch Bromley and Lewisham would like to thank the Polish Cultural Centre for providing a platform to engage with its members.

We would like to encourage people who speak up on behalf of seldom heard groups to consider this report in their work and to consider joining Healthwatch Bromley and Lewisham to amplify this voice.

3. The Polish community of Lewisham

Since Poland and seven other central and Eastern European countries (collectively known as the A8) joined the EU in May 2004 around 66 per cent of all A8 citizens migrating to the UK have been Polish citizens. Between the year ending December 2003 and the year ending December 2010 the Polish-born population of the UK increased from 75,000 to 532,000 making it one of the three largest non-UK born population groups in all countries and most regions of the UK.[1]

London has 123,000 Polish-born residents (24 per cent of the UK total) which makes it the second largest ethnic minority group after Indian.[2]

Lewisham has a population of about 286,000 people and is the 15th most ethnically diverse local authority in England with two out of every five residents from a black and minority ethnic background. [3]

[1] http://www.ons.gov.uk/ons/rel/migration1/migration-statistics-quarterly-report/august-2011/polish-people-in-the-uk.html
[2] http://www.theguardian.com/news/datablog/2011/may/26/foreign-born-uk-population

[3] Lewisham's Joint Strategic Needs Assessment 2016 (http://www.lewishamjsna.org.uk/)

According to the 2011 Census there are 27,826 people from White other ethnic minority groups living in Lewisham.[4] Polish was the second most spoken language in Lewisham after English and accounts for 1.6% of the population followed by French 1.5%. This suggests that Polish migrants are the largest group of people who don't speak English as their first language.[5]

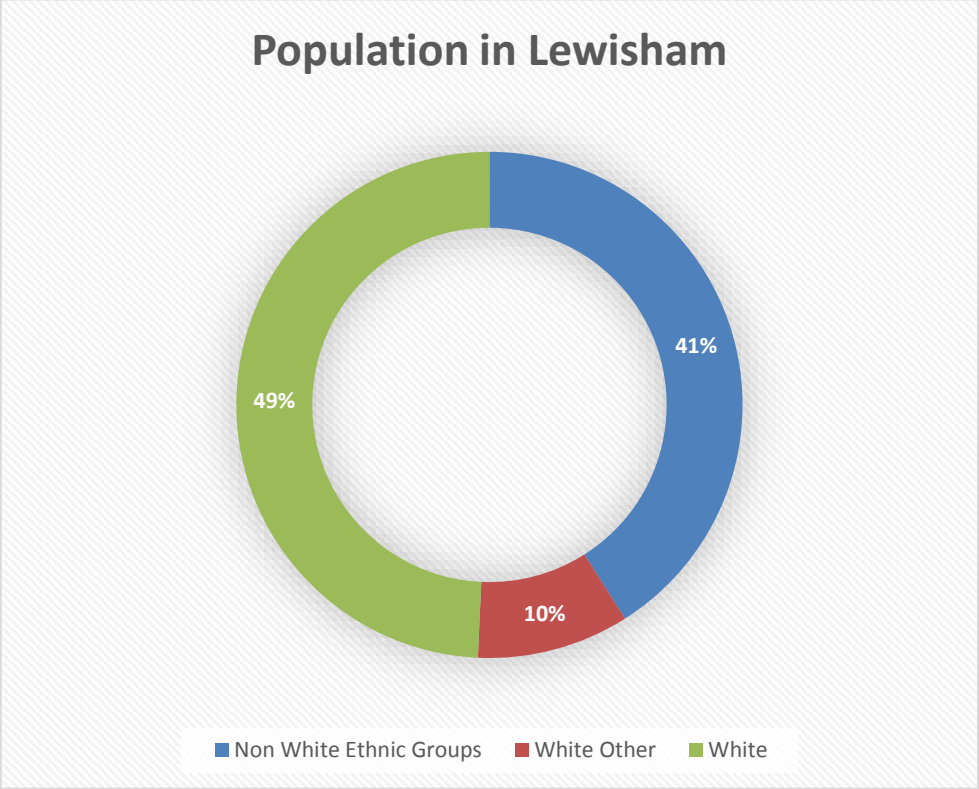


Figure 1 [6]

4. Purpose of the engagement

National evidence suggests that public bodies and services need to do more to take protected characteristics within communities into account when developing services. The Department of Health in 2012 published an NHS Patient Experience Framework developed by the NHS National Quality Board. It provides evidence based guidance on a number of issues known to affect the patient experience.[7] These include the need for respect for cultural issues, the need for information, communication and education as well as for emotional support.

[4] https://lewisham.gov.uk/inmyarea/Documents/2011CensusSecondReleaseDec2012.pdf
[5] http://localstats.co.uk/census-demographics/england/london/lewisham
[6] Lewisham JSNA, 2016
[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215159/dh_132788.pdf

People from BME communities report numerous issues with access to health services. Barriers include dissatisfaction with mainstream services which they perceive as lacking in understanding and consideration. This situation can result in poorer health compared to other groups, with unnecessary visits to Accident and Emergency, higher rates of hospital admission, and the likelihood of more complex, intrusive interventions.[8]

Through this report, Healthwatch Bromley and Lewisham draws attention to the experiences of access to health and social care services faced by members of the Tamil community living in Lewisham. The report presents themes that emerged through Healthwatch engagement and highlights the key issues that are important for this community. Recommendations are provided, where possible, to support decision making and commissioning of services which will improve access for this community.

The report will be submitted to commissioners at NHS Lewisham Clinical Commissioning Group and Lewisham Council to the Lewisham Health and Wellbeing Board, Lewisham Healthier Communities Select Committee, Healthwatch England and local providers of services. The report will be made public on Healthwatch Bromley and Lewisham websites.

5. Healthcare in Poland - Background

In Poland there is a national Healthcare system called Narodowy Fundusz Zdrowia offering free medical care, however according to research around 65% of Polish people also access private care. [9]

The care accessed privately is primarily dental, genealogical and medical tests services. Patients often use the two systems to supplement each other. The main reason behind it is to speed up the process of diagnosis and access to treatment. For example, a patient might use free healthcare for an initial visit and diagnosis, but pay for medial test and go back to the free healthcare system for diagnosis and ongoing medical treatment. [10]

It is possible that Polish migrants are used to the above system and therefore try to replicate similar behaviour patterns in respect of their health care in the UK.

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[8] Good Access in Practice, BME Health Forum 2010
[9] http://www.nfz.gov.pl/
[10] http://www.bankier.pl/wiadomosc/Przyszlosc-prywatnej-sluzby-zdrowia-i-opieki-medycznej-w-Polsce-2264989.html

6. Methodology

Healthwatch Bromley and Lewisham gathered information about access to services for Polish people living in Lewisham by attending an open day at the Lewisham Polish Centre in October 2015. We gathered the information from 18 people by conducting one to one interviews and distributing a '*story gathering*' form with an option to send feedback in a pre-paid envelope.

The Healthwatch Bromley and Lewisham researcher speaks Polish and was able to translate responses from the one to one interviews and the story gathering forms.

Participants were asked to share experiences that had taken place in the last 12-24 months.

HWBL gathered equality and diversity data alongside the prevalence of long term conditions amongst the participants. This can be found in Appendix 2.

7. Findings: The Themes

Lack of trust

When speaking to participants the reoccurring theme was lack of trust towards health care professionals. It is a theme that underlines several other themes identified in this report.

Lack of trust can be formed as a result of one or a combination of factors such as a bad personal experience and or cultural differences. For example, there is a difference in the structure of the Polish health care system in comparison to the NHS. In Poland some specialist care is accessed directly such as genealogical or dermatological.[11]

In addition, according to one of the local Polish magazines, Polish people preferred to go to 'their own' doctors. And a receptionist from one of Polish Health Care clinics stated that 'often Polish doctors have better qualifications than British ones'.[12]

A couple of participants expressed lack of trust in the skill and knowledge of NHS pharmacists saying: 'Pharmacists here don't know much themselves; they have not been to university to get a degree'. This again is a difference as most Polish pharmacies' customer facing roles are often staffed with qualified staff whereas pharmacies in England might have a pharmacist working in the background.[13]

Referrals and GP services – negative comments

Many of the participants complained about GPs not referring them for tests or to a specialist which delays or in their eyes disables diagnosis and treatment. In many participants' eyes GPs do not seek to *'get to the bottom of the problem'* and fail to treat patients. Some patients feel that the treatment offered by their GPs is insufficient and ineffective. One participant told Healthwatch that she had a spine operation in the past. She still experiences problems with her back and for the past three years she has been asking her GP for a referral for an MRI scan. She has not received it and was only able to access physiotherapy which didn't help her problem. Another participant told Healthwatch *'I haven't got a good experience with GPs. They don't want to send for tests and don't give referrals. It is difficult*

[11] http://www.prawapacjenta.eu/index.php?pId=840
[12] https://goniec.com/wiadomosci/spoleczenstwo/12377-nhs-vs-nfz-czyli-gdzie-jest-gorzej
[13] https://forum-farmaceutyczne.org/topic/414-czy-analityk-medyczny-moze-pracowac-w-aptece/

to have tests and diagnosis for serious illnesses such as cancer. We were waiting for a long time for someone to react (to pay attention and diagnose cancer) so we took matters in our own hands and found a doctor who did something about our concerns'. A female participant said: *'My Husband fainted and had a seizure but he didn't get a referral for an MRI scan or any other tests'.* Another female participant said that after a number of *'pleas'* with her GP she got referred for a test to diagnose the condition she suspected she had for a long time. Until then the doctor was only prescribing some drops and ibuprofen to treat the symptoms, but did not look for the root of the problem. The tests confirmed her self-diagnosis and she was finally offered a treatment to manage the condition instead of just 'dampening' the symptoms. Although she got the referral and a subsequent diagnosis, she said she had to *'fight for it'* and the final decision to send her for a test was a result of her determination and perseverance. Another young mother was unhappy with the lack of a referral to see a specialist: *'I went to see a GP in relation to my long term skin condition. I got a referral for blood tests and afterwards I should have been referred to a dermatologist or to another specialist.'* A middle aged carer of her mum expressed her anger in relation to the lack of referrals to specialists: *'It is very hard for an elderly person to receive a referral despite requesting one, even if this person is not well. My mum has a lot of long term conditions and health issues such as heart problems, high blood pressure, arthritis and varicose veins. I'm very unhappy with the service.'*

Many patients who complained expressed feeling left on their own with their conditions and felt that professionals did not care. This is a worrying fact as many people with long term conditions may live undiagnosed and as a result their health may worsen over time resulting in needing more care later on. In addition, patients can be emotionally, mentally and physically harmed as a result of delayed diagnosis or lack of it. This can have a ripple effect on their families as many participants were parents of children below 16 years old.

Use of private Polish Clinics

As a result of the negative experience of treatment and/or access to NHS care many participants told Healthwatch they access private health care. One patient said '*my son has allergies (food and pollen) but only gets a cream (from his GP) so I went to Poland and got £100 worth of treatment and medicines. Now I contact my doctor via skype to get more medicine'.* Another female patient accessed private healthcare for support in tests and diagnosis, however she couldn't afford

an ongoing treatment privately and went back to the NHS. Another female participant complained: *'I don't use GPs as I can never book an appointment even if I try. So I need to somehow look after myself and take matters in my own hands to get help. I try to help myself or go to the Polish clinic.'* A young Polish female suffering long term conditions said: *I tried to see my GP about a month ago. I had symptoms of "woman's" nature. It was hard to get an appointment so I went to a private Polish clinic. The NHS is a disaster.'*

A middle aged man told the Healthwatch that he uses the NHS only for minor issues with his child. As a result of problems in accessing referrals to see a specialist and obtain the right treatment and long waiting times he is accessing private healthcare. Another young woman told Healthwatch that if she wasn't happy with the received treatment she would go to one of the Polish health centres.

Paracetamol

Many participants were referred to doctors who advised patients to use paracetamol instead of treating the condition. A middle aged female participant said: *'Doctors here cannot give anything but paracetamol.'* Another participant praised her doctor for her professionalism saying *'she doesn't just prescribe paracetamol'* which indicates that this is an established theme within the community that many members identify with. It is even used as a 'measuring tool' to assess the professionalism of a GP. It reflects the dissatisfaction with NHS services and a lack of trust in the care provided by GPs. It also confirms the members of the community are worried that they are not accessing an adequate treatment and care.

Staff attitudes

Some participants complained about staff attitudes. A female participant with multiple long term conditions who needed access to the healthcare system frequently told Healthwatch that she wasn't happy with the way her GP treats *her 'He is only looking at a computer. He treats me like a number.'* The same GP then asked her embarrassing questions relating to habits she never had which suggests he was looking at a wrong file or there were errors in her medical records. Another participant said her GP refused a requested treatment and told her to go to Poland to get help. She later filed a complaint, however the matter was unresolved as the GP no longer worked there.

NHS staff skills - Varied service 'depending on who you see'

Many participants told Healthwatch they have a mixed experience using NHS services and it often *'depends on who you see'*. These comments related to staff in primary and secondary care. A middle aged mum told Healthwatch: *'some GPs are good and some are very bad. I had to change GP as he did not treat me seriously. He didn't explain his diagnosis or opinion and didn't give me reassurance. The new GP is very thorough and caring.'* Another participant told Healthwatch she underwent an operation at Lewisham Hospital and commented that some nurses were brilliant and provided excellent care where as others *'didn't have a clue what they're doing and how to do things they needed to do. To the point that I had to give them instructions myself.'* The participants recognised that there is an inconsistency in the level of skills amongst the NHS staff and it is worrying that some may access excellent care where others may simply not depending on the individual they saw. The comments suggest that there is an inconsistency in the skills of the staff. This reflects badly on NHS services overall and has a negative impact on patients' satisfaction.

Interpreting

Many members of the community had a good level of English and didn't express the need for translation services. However, about a half did not speak English confidently enough to communicate with health professionals and needed support. Most people in this group use family and friends to translate with a few saying they need a translation in relation to more serious medical issues. However, some participants with multiple health conditions, that don't speak English well, said that they experienced significant barriers in accessing health care as a result.

'I know from my own experience and from the experience of my 60 years old mum that it's very hard to access a translator. Even if you ask for the service. Every time my mum needs to book a visit or needs a GP visit someone needs to go with her.'

'My English is not the best. I try to communicate however when I struggle to speak (use correct words) health professionals ignore me. No one ever suggested to use a translator although I know I'm eligible to one. When I ask, they refuse and blame lack of time etc.' Another participant complained about cancelled appointments as the result of interpreters not turning up. During her visit at one of the local hospitals she was told she can only access an interpreter once.

Healthwatch discovered that people who cannot communicate well in English feel ignored and as a result cannot access appropriate care. The research also suggests that patients are not offered translation or when they request the service they are refused.

In addition, the use of family and friends poses problems for patients' confidentiality and translation quality which may have impact on treatment outcomes.

Happy with the NHS services

Healthwatch was pleased to hear that participants shared a number of positive experiences and many said they are generally happy with the NHS. The services people were happy about were: maternity wards, midwives, free prescriptions for children, walk in centres and eye and vision care at Kings College Hospital.

GPs – positive comments

A number of participants praised their GPs for having a caring attitude and giving quick referrals. One participant described why she was happy with her GP: *'My current doctor is very caring; this ensures that I'm involved in the treatment. She explains the treatment plans, refers me for tests appropriately and timely. She explains medicine and discussed with me the treatment time. She doesn't clock watch. She gives me enough time when I need it. I don't mind waiting for the appointment as I know that when I need more time she gives it to me and that's the price to pay.'* Another participant said she was happy with the timely and responsive care in relation to her Varicose Veins problem.

Management of long term conditions - positive comments

A few people praised the NHS for good care in managing long term conditions especially Diabetes. Another middle age patient with Diabetes said she is happy with how NHS services support her in her condition. She praised the fact that all

her necessary tests are done in timely, regular manner and are all arranged to fit in a day. Another female patient told Healthwatch she was happy with her GP and other services monitor her condition and prompt her to attend a visit.

7. Conclusion

Healthwatch found that the main themes were lack of referrals for tests and referrals to see specialists and a lack of trust towards healthcare professionals. Healthwatch found that a number of participants had to *'fight'* to access tests and as a result to receive a diagnosis. Participants also felt there is inconsistency in the services as a result of varied skillset amongst the staff. As a result of the above mentioned themes participants were often using local Polish private clinics. Despite uncovering many negative themes, Healthwatch was pleased to hear that many participants were generally happy with the NHS with caring GPs who refer appropriately and a management of long term conditions.

8. Recommendations

As a result of our findings through our engagement with Polish community members in Lewisham, Healthwatch Bromley and Lewisham sets out the following recommendations to improve access to services for the Polish community.

COMMISSIONERS AND PROVIDERS:

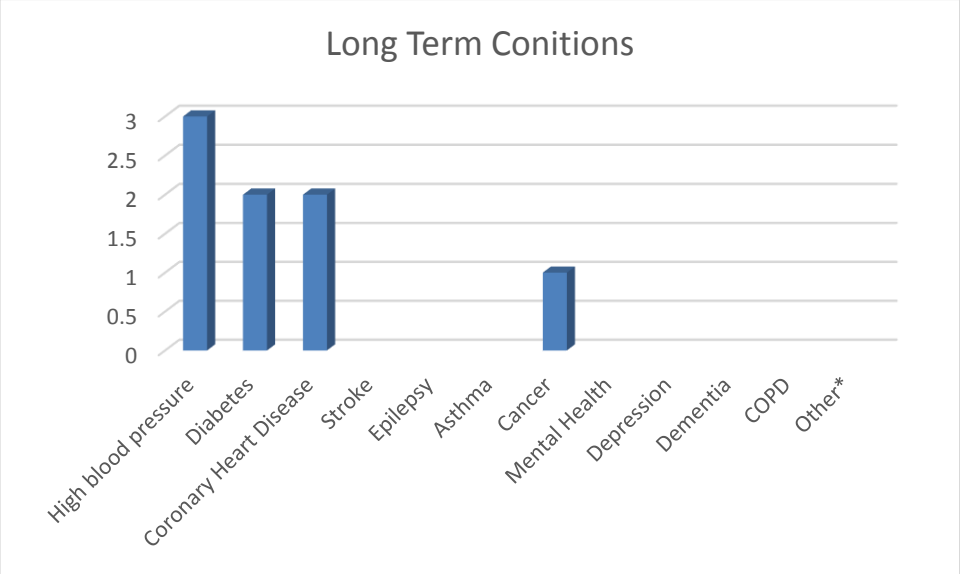
- Provide appropriate training to staff to enable improved communication, customer services and cultural awareness.
- Provide information about services available locally, how to access them, what to expect with focus on vulnerable groups and migrants that are new to the system and do not speak English as their first language. The information could be in a form of a booklet or as information sessions delivered through local groups.
- Ensure patients understand the treatment plan and treatment options available to them such as medical test or escalation to the specialists.
- Improve access to interpreting services both in primary and secondary care settings.
- Clarify interpreting eligibility criteria.
- Staff to engage with patients and provide reassurance around treatment plans, diagnosis, and NHS service availability.
- Promote and share good practice of services that are performing well to inspire good practice amongst the staff.

9. Appendices

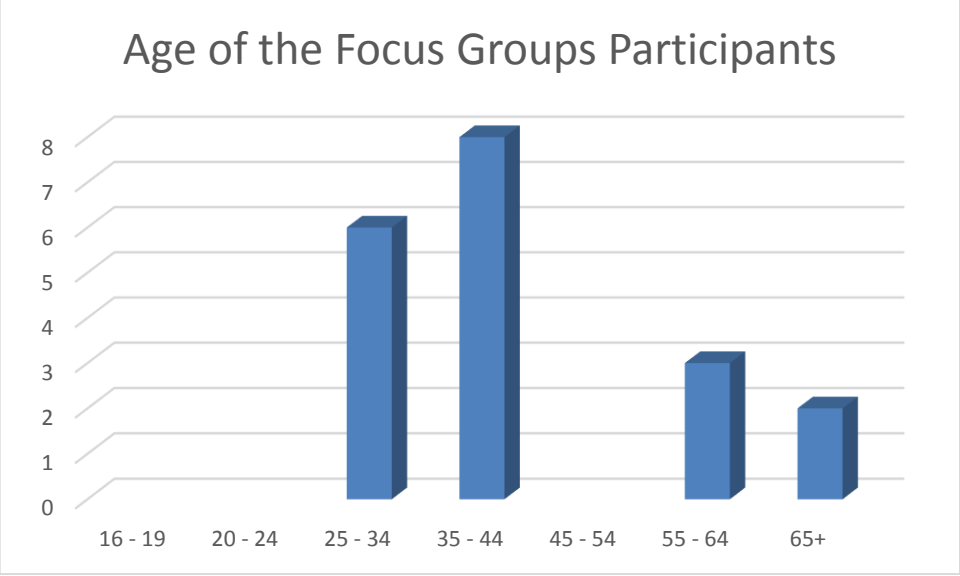
Appendix 1 - Equality and Diversity Data and Long Term Conditions

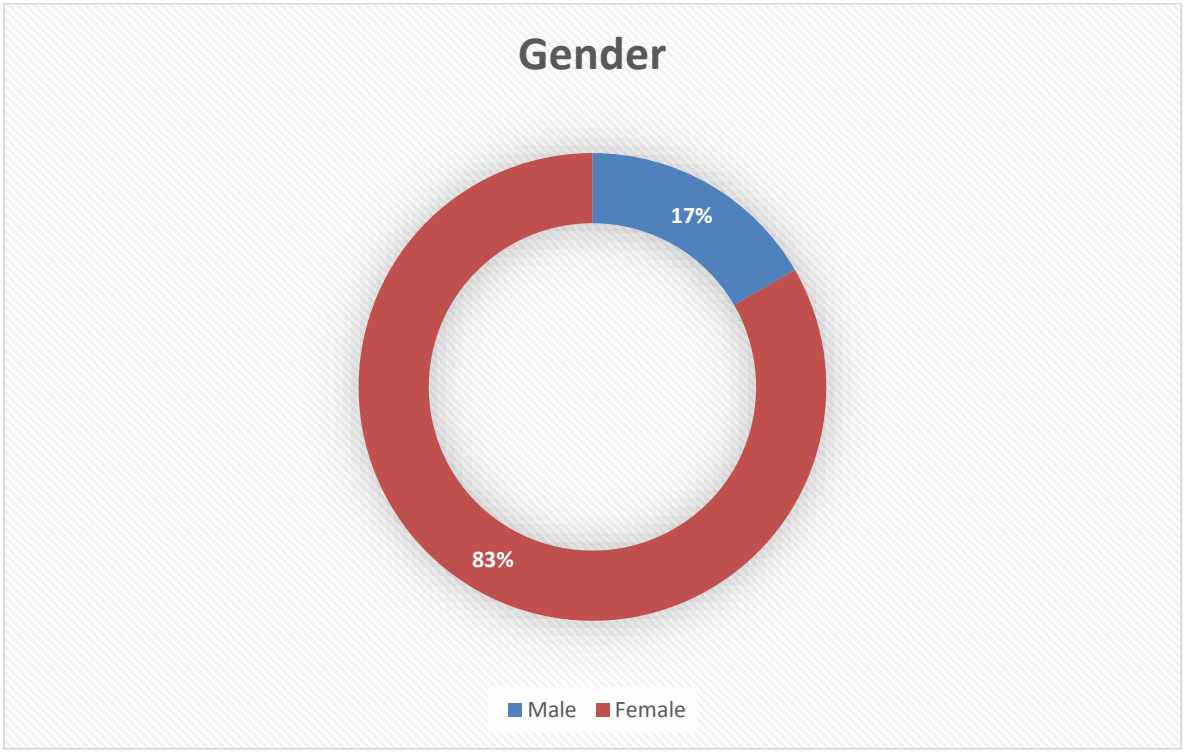
Healthwatch engaged with people from the Polish Community in Lewisham by face to face interviews with 18 people at the Lewisham Polish Cultural Centre.

Two of the respondents said they were carers and 13 were parents or guardians of a child/children under 16 years of age.



*Other consisted of: Dermatological Problem, Underperforming Thyroid x 2, Headaches, Low Blood Pressure, Arthritis, Varicose Veins x 2 and Spine Problems x 2

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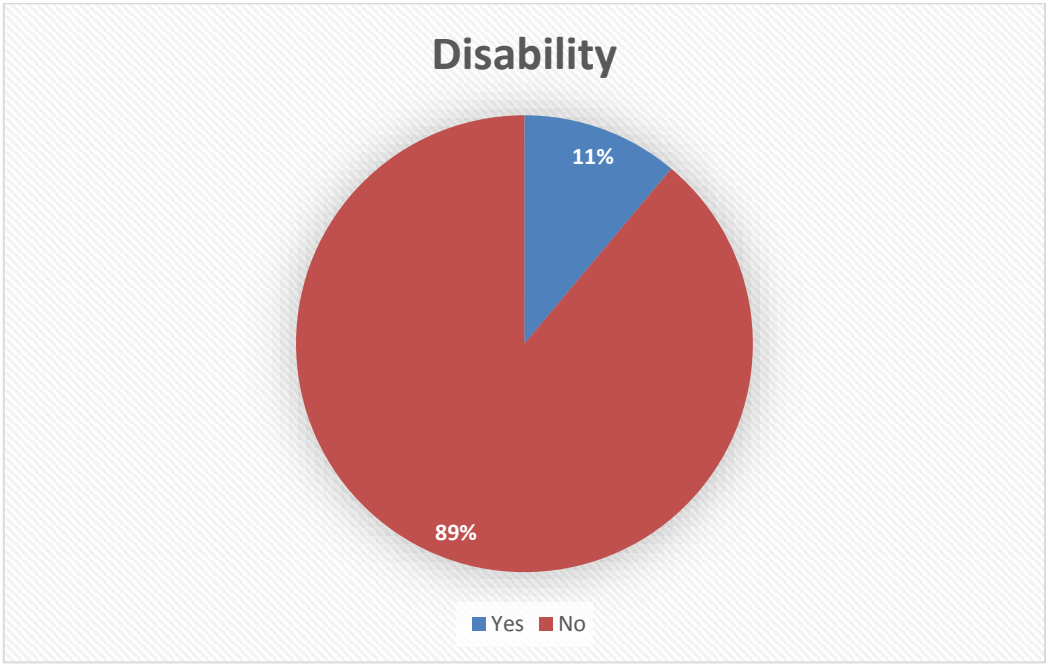
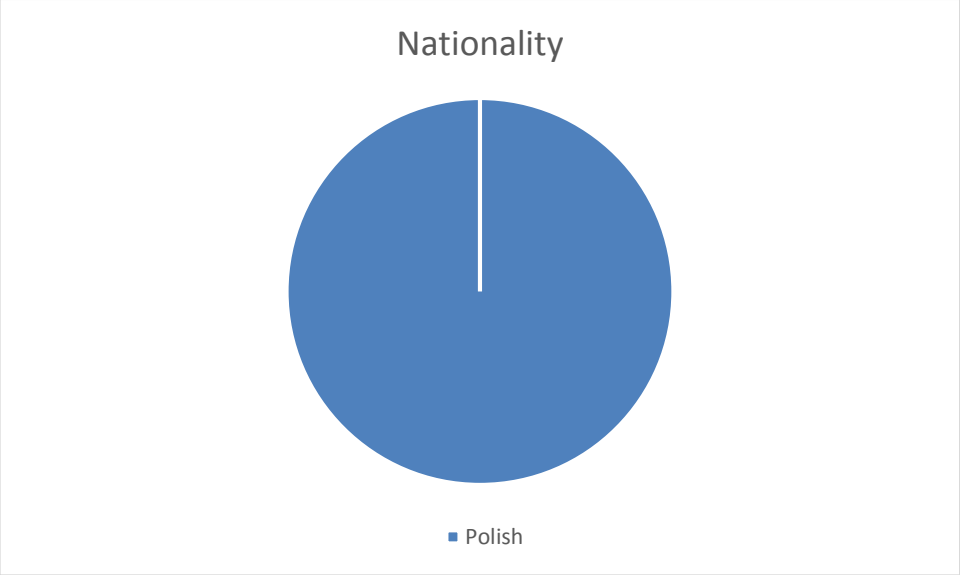
17%
83%
Male
Female


Disability
11%
89%
Yes
No



Appendix 2 - Healthwatch Bromley's core functions

They are:

- Gathering the views and experiences of service users, carers, and the wider community
- Making people's views known
- Involving locals in the commissioning process for health and social care services, and process for their continual scrutiny
- Referring providers or services of concern to Healthwatch England, or the CQC, to investigate
- Providing information to the public about which services are available to access and signposting people to them
- Collecting views and experiences and communicating them to Healthwatch England
- Work with the Health and Wellbeing board in Bromley on the Joint Strategic Needs Assessment and Joint Health and Wellbeing strategy (which will influence the commissioning process).

The Polish Community and Access to Health and Wellbeing Services in Lewisham

Any enquiries regarding this publication should be sent to us at admin@healthwatchbromley.co.uk

You can download this publication from www.healthwatchlewisham.co.uk

HEALTH AND WELLBEING BOARD		
Title	Devolution Pilot and One Public Estate Update	
Contributors	Executive Director for Community Services and Chief Officer, Lewisham Clinical Commissioning Group	Item 5
Class	Part 1	19 July 2016

1. Purpose

1.1 This report provides members of the Health and Wellbeing Board with a progress update on Lewisham's Devolution Pilot and the One Public Estate initiative (OPE).

2. Recommendations

2.1 The report outlines work undertaken in relation to Lewisham's devolution pilot and the relationship between the pilot and the One Public Estate initiative. Given the timing of the Health and Wellbeing Board meeting and the interdependencies between the devolution pilot and OPE, it has not been possible to submit a detailed business case. It is recommended that officers circulate the final business case to members outside the meeting and delegate approval to the Chair and Vice Chair.

3. Strategic Context

3.1 The Care Act places a legal duty on local authorities and organisations in the NHS to work collaboratively to improve health outcomes. Since 2010, Lewisham Council and the Clinical Commissioning Group have been working with our provider partners to develop integrated services for the population of Lewisham to improve health and care outcomes and reduce inequalities. The CCG has developed a Local Estates Strategy which will be considered by the Governing Body in September 2016.

3.2 Lewisham Health and Care Partners recognise that Lewisham's health and care system needs to change. The current system is not sustainable and we are not achieving the health and care outcomes we should. There are significant health inequalities in Lewisham; too many people live with ill health, high quality care is not consistently available and demand for care is increasing, both in numbers and complexity.

3.3 Lewisham is developing an integrated whole system model which fully integrates physical and mental health and social care delivered to the whole population. Health and care partners are focused on the redesign and reshaping of services to transform the way in which residents are encouraged and enabled to maintain and improve their own health and wellbeing, transforming the way in which local health

and care services are delivered within the borough, and transforming the way in which people access and are connected to the assets that are available within their own communities and neighbourhoods. The key strands of activity are focussed on prevention and early intervention, community based care delivered through Neighbourhood Care Networks and enhanced care and support. The devolution pilot will focus on the supporting enablers, specifically estates and workforce development that underpin the transformation of the whole system.

3.4 Lewisham Council became a signatory on Tuesday 15 December to a cross-London agreement, involving health organisations and local councils, that aims to transform services and improve health and wellbeing outcomes in London through new ways of working together and with the public. Parties to the agreement agreed that a small but essential part of this transformation is the devolution of functions, powers and resources from government and national bodies where that can assist, enable or accelerate improvements.

3.5 Lewisham is one of five devolution pilots being developed in London that aim to test the impact of devolving resources, decision-making and powers on accelerating transformation locally.

4. Developing the Business Case

4.1 A business case is being developed for each pilot, identifying the specific powers and resources for which devolution is sought. This is an iterative process and Lewisham's business case will initially focus on the use of estates to support the delivery of the whole system model of care. It will also include new approaches to workforce development.

4.2 Since submitting the expression of interest to be a devolution pilot, Lewisham has applied to the Cabinet Office and LGA's 'One Public Estate' (OPE) initiative. Notification was received in mid-June that Lewisham has been awarded £50,000 to develop the second stage bid to the OPE initiative. If the second stage bid is successful, Lewisham will secure up to £500,000 to support the delivery of the programme.

4.3 OPE is a pioneering initiative delivered in partnership by the Cabinet Office Government Property Unit and the Local Government Association. It provides practical and technical support and funding to councils to deliver ambitious property-focused programmes in collaboration with central government and other public sector partners. The programme has four core objectives:

- Creating economic growth
- More integrated, customer-focused services
- Generating capital receipts
- Reducing running costs

4.4 Lewisham's OPE submission outlined three interdependent schemes:

- Regeneration – activity focussed on shared use of area specific sites that can deliver new homes, employment and fit for purpose assets.

- Collaboration – activity to enable the expansion of community based care services, new models of care at home and primary care development.
- Strategic Estate Planning – activity to maximise the use of existing facilities and co-location of services.

4.5 The detail of the devolution pilot business case in relation to the issues regarding estates will be identified through the OPE process. However, there are two key areas where devolution could provide more local accountability and enable the health and care partnership to better meet the needs of Lewisham residents:

(a) Retention of capital receipts to enable reinvestment in local healthcare assets: at the minute, some capital receipts (including those from sale of NHS Property Services assets, plus non-FT trusts) cannot be retained by the local health economy for reinvestment – this investment is critical both for delivering a sustainable health economy (hence addressing any deficit that may exist) and for delivering best health outcomes to local people.

(b) Regularisation of leases: the regularisation process that all the health estate providers are required to deliver on works in direct opposition to the development of flexible, fully utilised space, as it ties tenants into what are generally inefficient space utilisation. Estate providers therefore need to be able to work with tenants where appropriate to change leased, inflexible space into licensed, flexible space which a range of providers might be able to use across the entire week, including evenings and weekends.

4.6 The delivery of a strategic estates programme will enable new approaches to workforce development. The devolution asks relating to workforce development will also be informed by a detailed examination of the Buurtzorg approach. Officers from across the health and care partnership visited the Netherlands at the end of June to explore the potential of the Buurtzorg model. Having completed the visit, the detail in relation to this area will now be developed. A number of key areas have been identified that devolution could support:

(a) Devolved powers may enable greater flexibility in relation to the development of new roles to work across the health and care system.
(b) The STP highlights opportunities in relation to the consolidation of back office functions. Devolution may provide the flexibilities required to work across organisations.

5. Next Steps

5.1 The initial timetable required each pilot to submit the business case to the London Health Board by June 2016. It was planned that a draft business case would be presented to the Health and Wellbeing Board in July 2016 before being considered by the Healthier Communities

Select Committee, Mayor and Cabinet and the respective governing bodies of the health and care partnership. However, the timetable has since been revised in recognition of the need to align the business case with the Sustainability and Transformation Plan. The deadline for the initial devolution business case is now the 29th July 2016.

5.2 The London Health Board recognises that the development of the business case is an iterative process. The London Health Board has also acknowledged the interdependency between Lewisham's devolution bid and the OPE process. The deadline for submission to the second stage of the OPE initiative is also 29th July 2016.

6. Financial Implications

6.1 £50,000 was awarded to Lewisham Council to develop the second stage OPE submission. If the second stage submission is successful Lewisham will secure up to £500,000 to develop the business case. The financial implications will be considered as part of the development of the business case.

7. Legal implications

7.1 There are no specific legal implications from the work to develop the devolution pilot at this time. The legal implications will be considered as part of the development of the business case and the OPE submission.

8. Crime and Disorder Implications

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

9. Equalities Implications

9.1 There are no specific equalities implications arising from this report.

10. Environmental Implications

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

11. Conclusion

11.1 This paper has provided an overview of activity to develop the devolution pilot business case and the One Public Estate submission.

If there are any queries on this report please contact:
Carmel Langstaff, Service Manager - Interagency Development and Integration: carmel.langstaff@lewisham.gov.uk / 020 8314 9579.

HEALTH AND WELLBEING BOARD				
Report Title	South East London Sustainability and Transformation Plan & Our Healthier South East London Update			
Contributors	Our Healthier South East London Programme Team		Item No.	6
Class	Part 1	Date: 19 July 2016		
Strategic Context	The report provides an update on strategic planning processes for South East London and planned pre-consultation engagement activity for changes to elective orthopaedic services			
Pathway				

1. Purpose

This report provides members of the Health and Wellbeing Board with an update on the NHS South East London Sustainability and Transformation Plan. The report is for information.

The report also provides an update and assurance on planned pre-consultation engagement activity elective orthopaedic services.

2. Recommendation/s

Members of the Health and Wellbeing Board are recommended to:

- Note the progress of these programmes of work.

3. Background Sustainability and Transformation Plan

Planning guidance was published on 22 December 2015 which set out the requirement for the NHS to produce five year Sustainability and Transformation Plans (STP). These are place based, whole system plans driving the Five Year Forward View.

The STP:

- It takes a whole system approach to health and social care planning.
- It requires systems to work together to produce a sustainable plan that both meets quality and performance standards and ensures financial sustainability.

- Requires commissioner and provider plans to align activity and finance and achieve the national standards on quality and performance.
- The STP is the single application and approval process for transformation funding for 2017/18 and thereafter.

A milestone submission was made in April setting out the geographical scope of the STP, “the footprint”, and the governance arrangements. This submission is required by 30 June but planning and assurance process will continue thereafter.

Our starting point for the STP has been the CCG-led Our Healthier South East London strategy, but the STP has developed this work considerably further both in terms of collective governance and scope of plans across both commissioners and providers in our system. Under national guidance we have established a leadership team (the quartet) of four individuals from across each part of our system and refreshed our joint governance arrangements, notably the Strategic Planning Group. The quartet are:

Amanda Pritchard, CEO Guys and St Thomas NHSFT (overall SRO)
Andrew Bland, CO Southwark CCG
Andrew Parson, Chair Bromley CCG
Barry Quirk, CEO Lewisham Council

The STP covers a number of areas not originally within OHSEL such as specialist commissioning (and NHSE specialist commissioning are partners to the plan), mental health and learning disabilities (Transforming Care Partnerships).

In addition an important provider productivity strand has developed which seeks to identify significant savings from collective working.

4. Current stage of the STP process

The attached summary (Appendix 1) of the draft of the STP is the latest iteration of the document. To reach this point the document has been developed through a number of stages. Including:

- Initial draft developed using content provided by OHSEL Delivery Groups and organisations in SEL
- Direction and feedback from SROs and Delivery groups
- Feedback from NHSE on an initial draft including the reflection of national guidance
- Review by the Strategic Planning Group on 19 May
- Updated to reflect additional guidance from NHSE issued on 19 May
- Subsequent feedback on this document from NHSE and the STP Quartet – particularly Amanda Pritchard and Andrew Bland

Summary of additional guidance

Additional guidance was issued by NHSE on 19 May which:

- Gave a greater emphasis than previous guidance to a 'golden thread' of finance and the need to be clear on how each of the priorities contributes to the financial position
- Reiterated the need for a coherent strategy that reflects the 5YFV ambition
- Reiterated the need to focus on a 3-5 critical decisions required to shift the dial to close the three gaps
- Indicated that the submission will form the 'basis of a conversation' about the choices to be made and will be a work in progress
- Indicated that the plans will not need formal approval from boards or consultation
- Limits the submission to a maximum of 30 pages (with appendices including governance, workforce, estates and the local digital roadmap)

5. Collective decision making on our priorities

It is important to note that will be collectively held to account for the commitments in the STP. As we move into the delivery of the programme we will be required to make decisions that benefit the system as a whole – either financially or for quality – which may impact differentially on individual providers or organisations.

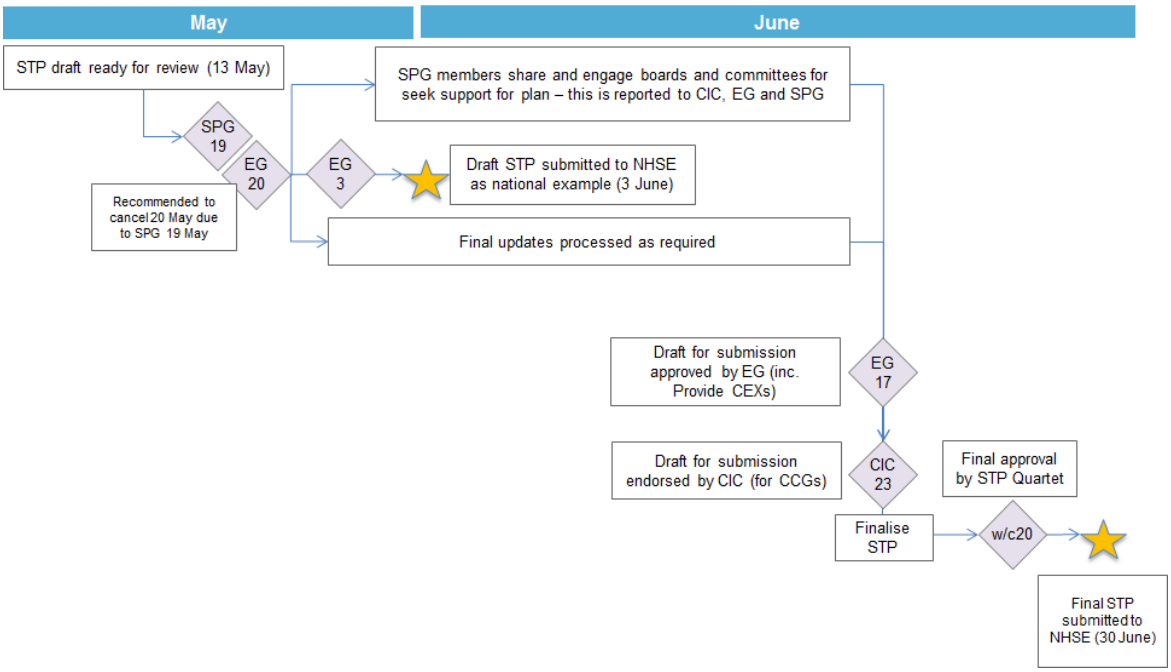
At SPG on 19 May it was agreed that a piece of work will be undertaken, to outline process for dealing with these decisions through the delivery of the STP.

6. STP approval process

Throughout this process it is recommended that organisations submit endorsements and comments from their meetings to the OHSEL inbox (SELStrategy@nhs.net). Comments will be collated and shared with the STP Executive, and Quartet.

The approval process for signing off the plan for final submission is outlined below:

7.



7. Elective Orthopaedic Services

The strategy for south east London is clinically-led and developed, with over 300 clinicians, nurses, allied health professionals, social care staff, commissioners and others developing ideas through the six Clinical Leadership Groups (CLGs). Patient and public voices feed directly into the CLGs and support the work streams.

It is considered, following a series of meetings and events with the public, patient representatives and key stakeholders, that the Planned Care work stream is likely to develop proposals that will require public consultation.

Clinicians and managers from south east London's existing orthopaedic teams have formed a working group alongside patient representatives to develop a strategy to improve orthopaedic planned care and are currently exploring the benefits and feasibility of a consolidated elective orthopaedic service.

Specifications setting out the clinical requirements and standards for a proposed new model have been developed. A number of public and stakeholder workshops, events and other engagement activity are, therefore, being proposed to involve local people, key stakeholders and partners in the decision-making and planning of the new model and evaluation criteria.

In March The Committee in Common (CiC) agreed the outputs recommended by the orthopaedic working group and that work should be continued to develop options through the submission of further proposals, evaluation process and pre-consultation business case. Options have yet to be agreed.

The CCG has a number of statutory requirements: Health and Social Care Act 2012 and Equalities Act 2010 which collectively set out the CCG's duty to undertake inclusive engagement activities that facilitate public and patient participation in decisions about their care and treatment and with due regard to the protected characteristics.

In addition NHS England, in 'Planning and delivering service changes for patients' published in December 2013, outlined good practice for commissioners on the development of proposals for major service changes and reconfigurations. This guidance builds upon the 'Four Tests', as set out in the 2014/15 mandate from the Government to NHS England, that proposed service changes should be able to demonstrate evidence of these tests as follows:

1. Strong public and patient engagement;
2. Consistency with current and prospective need for patient choice;
3. A clear clinical evidence base; and
4. Support for proposals from clinical commissioners

Within the guidance a 'pre-consultation' period is also required once proposals ready for full consultation have been developed. The purpose of the pre-consultation is to plan and prepare for fuller broader consultation, if required, by using initial informal discussions with local stakeholders to better tailor and conduct more comprehensive engagement activities.

It is hoped that taking this best practice approach will ensure engagement will reach those communities most affected, key clinical stakeholders and partners, maintain a continual dialogue with local people and ensure transparency and openness from design through to implementation.

It is currently not expected that the pre-consultation phase for any proposed changes to elective orthopaedic services would begin before mid September 2016.

Background Documents

Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 can be found at www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

Further information on the Our Healthier South East London programme can be found at www.ourhealthiersel.nhs.uk

If there are any queries on this report please contact Charles Malcolm-Smith, Deputy Director (Strategy & OD), Lewisham CCG, e-mail charles.malcolm-smith@nhs.net

Our Healthier South East London
Improving health and care together

NHS

South East London: Sustainability and Transformation Plan

Briefing Paper

v1.0

Introduction and context

- Health and care systems were asked to come together to create their own ambitious local blueprint for implementing the 5YFV, covering Oct 2016 to Mar 2021.
- The STP is the “umbrella” plan for south east London
- Although CCGs were developing a transformation strategy previously, the STP process has broadened this and has taken it much further by bringing organisations together to establish a place-based leadership and decision-making structure
- To date, we have established:
  - A single responsible officer supported by a quartet leadership and a strategic planning board to provide direction and oversight
  - Collaborative oversight and decision-making bodies at various levels
  - A single reporting structure bringing transparency across the system
  - A ‘single version of the truth’ setting out our challenges, including our financial challenge
- This document provides an overview of our STP

Our commitments

Over the next five years we will:

- Support people to be in control of their health and have a greater say in their own care
- Help people to live independently and know what to do when things go wrong
- Help communities to support each other
- Make sure primary care services are consistently excellent and have an increased focus on prevention
- Reduce variation in outcomes and address inequalities by raising the standards in our health services
- Develop joined up care so that people receive the support they need when they need it
- Deliver services that meet the same high quality standards whenever and wherever care is provided
- Spend our money wisely, to deliver better outcomes and avoid waste

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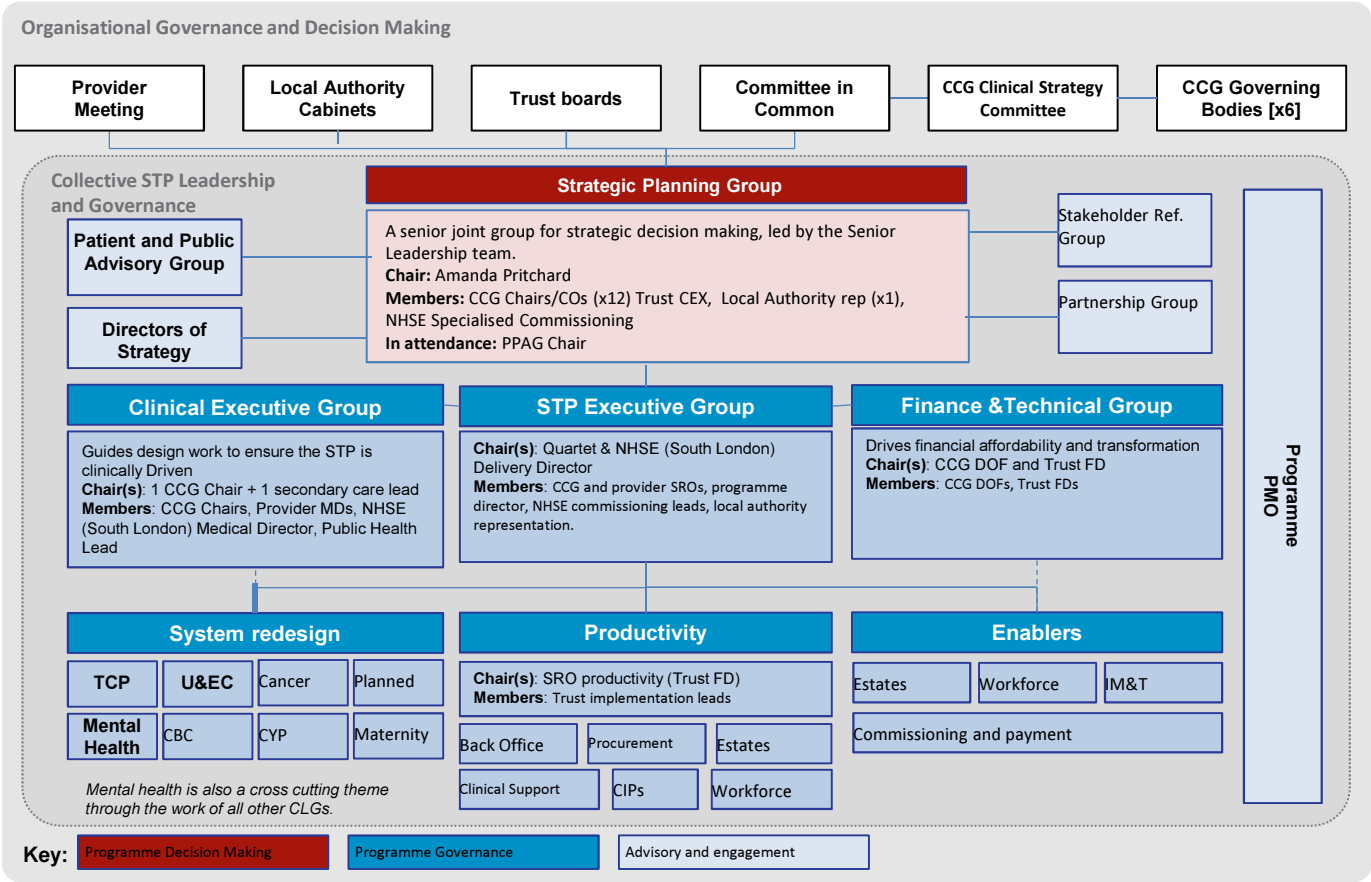
STP Governance

STP SRO and Leadership

- **SRO**: Amanda Pritchard, GSTT
- **CCG**: Andrew Bland, Southwark CCG
- **Council**: Barry Quirk, London Borough Lambeth
- **Clinical Lead**: Andrew Parsons, Bromley CCG



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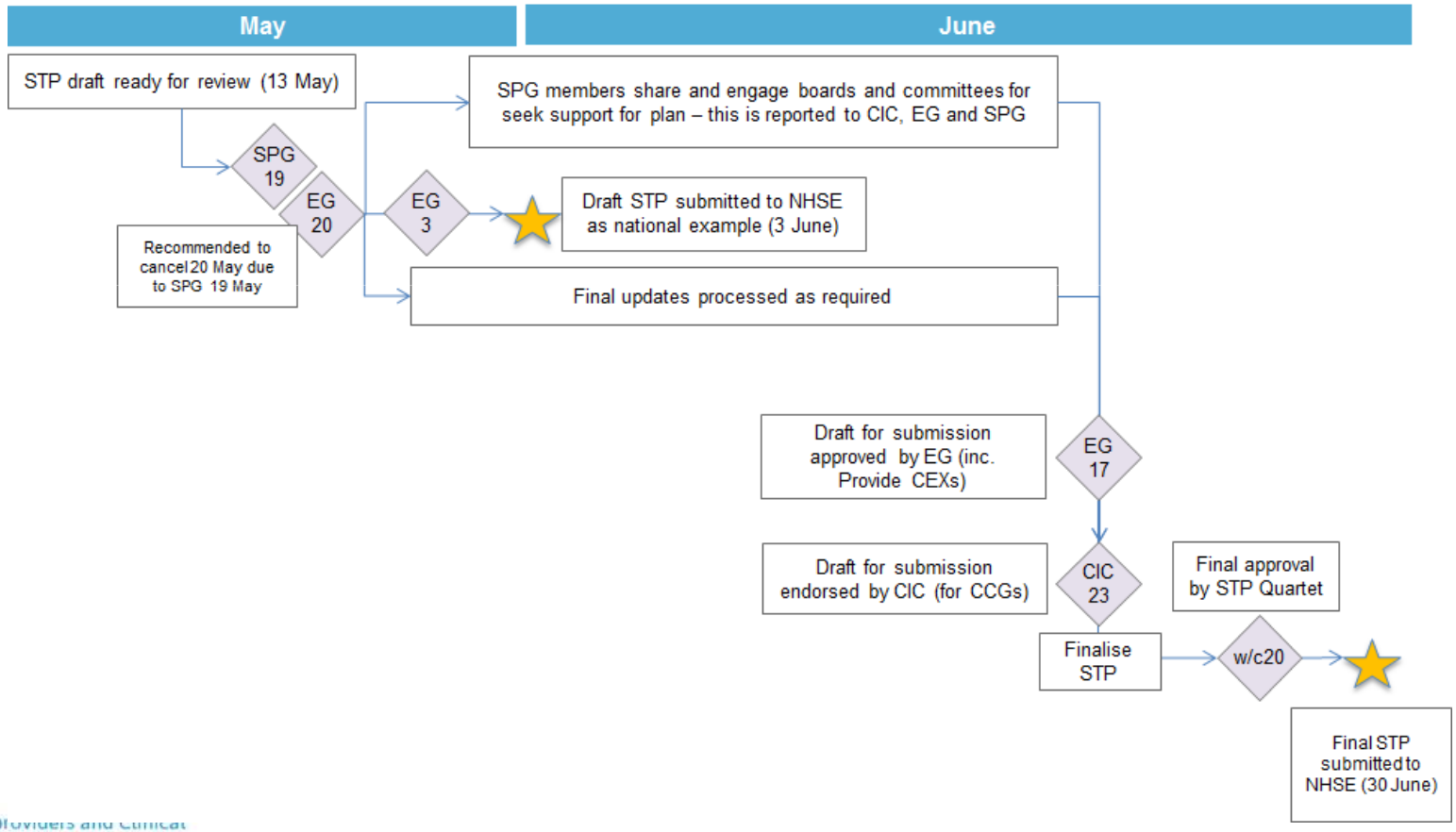
STP: Sign off process for June submission

The STP will be submitted on 30 June in advance of national discussions in July. NHSE have said that there is no need for formal board or governing body approval at this time.



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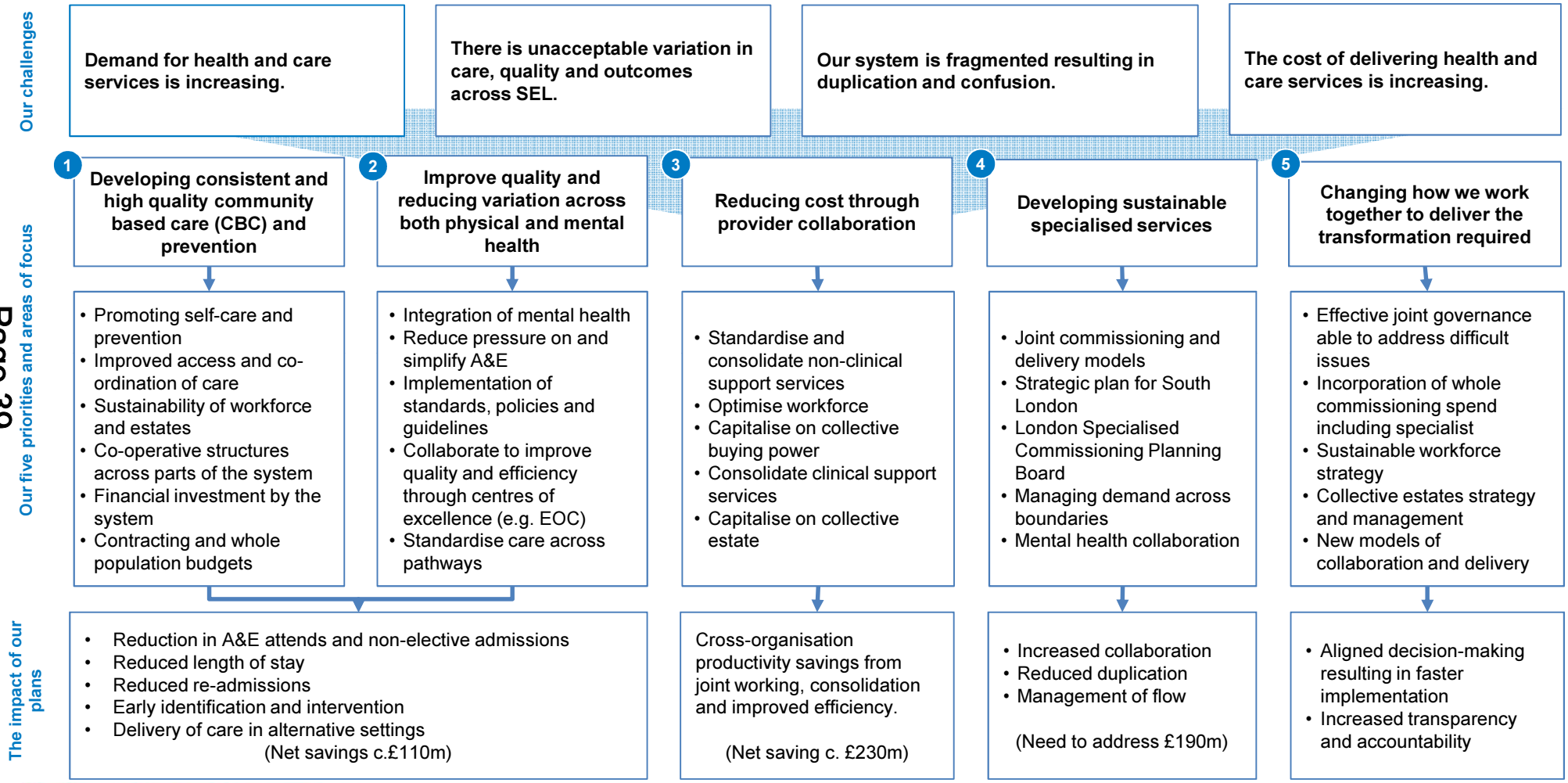
STP: Plan on a page



A partnership of NHS providers and Clinical Commissioning Groups serving the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, with NHS England

Our Healthier South East London
Improving health and care together

NHS

STP: Summary of our priorities

1. **Developing consistent and high quality community based care (CBC) and prevention**

Investment in CBC is essential to transform our system and move towards lower cost, higher value care delivery. Over the next five years we will continue to support the development of LCNs to establish coherent, multi-disciplinary networks that work at scale to improve access as well as manage the health of their populations. This will include fully operational federations and networks; adopting population based budgets and risk-based contracts; and fully integrating IM&T across organisations and pathways. Fully operational LCNs will deliver our new model of care - adopting population based budgets and risk based contracts, supported by sustainable at scale delivery of primary care and enabled by fit for purpose estate and integrated IM&T across their organisations and the pathways the deliver

2. **Improve quality and reducing variation across both physical and mental health**

We have identified a range of initiatives across our system to improve consistency and standards by working collaboratively. Our main areas of focus are:

- reducing pressure on A&E by providing high-quality alternatives (through CBC), simplifying access and developing a truly integrated offer;
- collaborating to improve value within planned care pathways, including the development of centres of excellence. We are starting with orthopaedics before expanding to other specialties;
- integrating mental health across health and care services adopting the mind/body approach

3. **Reducing cost through provider collaboration**

Our acute and mental health providers have identified opportunities for reducing the costs of delivering care in 5 priority areas; clinical and non-clinical support services, workforce, procurement and estates. Our immediate step is developing businesses cases for each opportunity and delivering quick wins payroll, workforce and non-clinical sourcing. Over the next 5 years we will continue to look for opportunities in other areas.

4. **Developing sustainable specialised services**

We wish to develop world class and sustainable specialised services that meets the needs of patients both locally and across England. Specialised services are a significant part of SEL health economy and provide services at a local, regional and national level – a third of patients come from outside of SEL. The size of this service has an impact on the sustainability of our system both in terms of financial sustainability and the quality of other services. Specialised services offer great potential for pathway reconfiguration and service consolidation to support quality improvement and better value for money. We are supporting NHSE to establish a London-wide board.

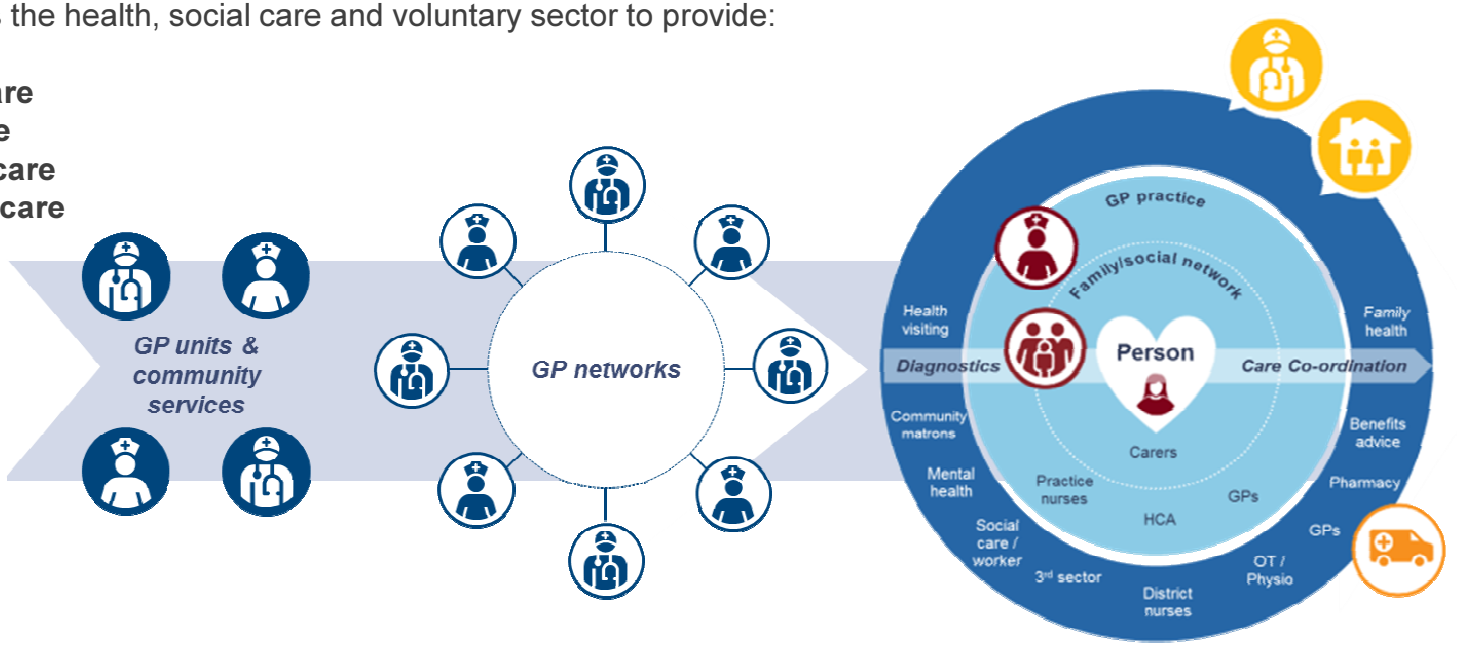
5. **Changing how we work together to deliver the transformation required**

To deliver this plan we must establish the right governance, secure appropriate resources and address system incentives. This transformation will mean having to think differently and more radically. Crucially our structures must allow us to make difficult decisions and investment in transformation for the benefit of the system rather than our own organisations. Our immediate priority is developing the appropriate infrastructure to deliver our plan, agreeing roles and functions across the system. We are learning from our acute care collaboration vanguard between Guy's and St Thomas' and Dartford and Gravesham.

1. Investment in CBC is essential to transform our system and move towards lower cost, higher value care delivery

Primary and community care (defined in its broadest sense) will be provided at scale by Local Care Networks and drawing on others from across the health, social care and voluntary sector to provide:

- **Accessible care**
- **Proactive care**
- **Coordinated care**
- **Continuity of care**



Enablers supporting the transformation

The Local Care Networks are the super enabler for integration of services

IM&T, Commissioning Framework, Workforce, Estates, Leadership

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2. We have identified a range of initiatives across our system to improve consistency and standards by working collaboratively

Clinical Leadership Group	High level summary of the model of care	Estimated savings
Community based care	• Delivery of local care networks	£48m
Urgent and emergency care	• Improving access in Primary Care, in hours and out of hours, to unscheduled care. • Specialist advice and referral. • An enhanced single “front door” to the Emergency Department.	£71m
Planned care	• Standardisation of planned care pathways. • Enhanced diagnostics. • Elective care centres.	£41m
Children and young people’s care	• Children’s integrated community teams. • Short stay paediatric assessment units.	£13m
Maternity	• Early assessment by the most appropriate midwife team. • Access to assessment clinics. • Culture of birthing units.	£6m
Cancer	• Primary prevention including early detection. • Provider collaboration in treatment of cancer. • Enhanced end of life care.	£10m
	Net savings after 40% reinvestment **£113m**	**Gross Total £189m**

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Integrating mental health is a key area of focus across our priorities

Community based care	• Integrated mental and physical health in CBC by aligning services, developing multi-professional working, supporting people with housing and meaningful occupation including employment and increase training of teams within LCNs • Building mental health into our approach for capitated budgets and risk sharing • Incorporating mental health into our population health management approach • Increase early access in primary care • Tackling wider determinants of health in children and their families • Improved services for people with dementia
Improving quality and reducing variation across both physical and mental health	• Embed an integrated mind/body approach to support both the physical and mental health of patients and service users • Deliver quality improvement methodologies across the provider landscape • Improving timely access to specialist mental health support in the community • Increase diagnosis rates for people with mental health conditions • Develop access to crisis care for children and adults • Explore how we can achieve the four hour target for mental health • Ensure sufficient and appropriate capacity is available to meet future demand
Improving productivity through provider collaboration	In addition to our collaborative productivity work we are: • Establishing a pan-London procurement approach and legal support across south London • A joint approach across providers in south London to managing the budget for forensic provision and potentially specialist mental health services for children • Collaborative approaches to estates planning to support new models of care and more integrated working
Optimising specialised services	• Establish a joint approach to taking on the specialised commissioning budget • Collaborative work will be further developed between the three south London mental health trusts to develop a joint approach to taking on the specialised commissioning budget for forensic support
Standardised care across pathways	• Ensure a standardised approach to Making Every Contact Count • Encourage open and positive discussion about mental health and wellbeing across settings. • Promote excellence in relation to mental health across all services and conditions • Increase early identification and early intervention for mental health needs

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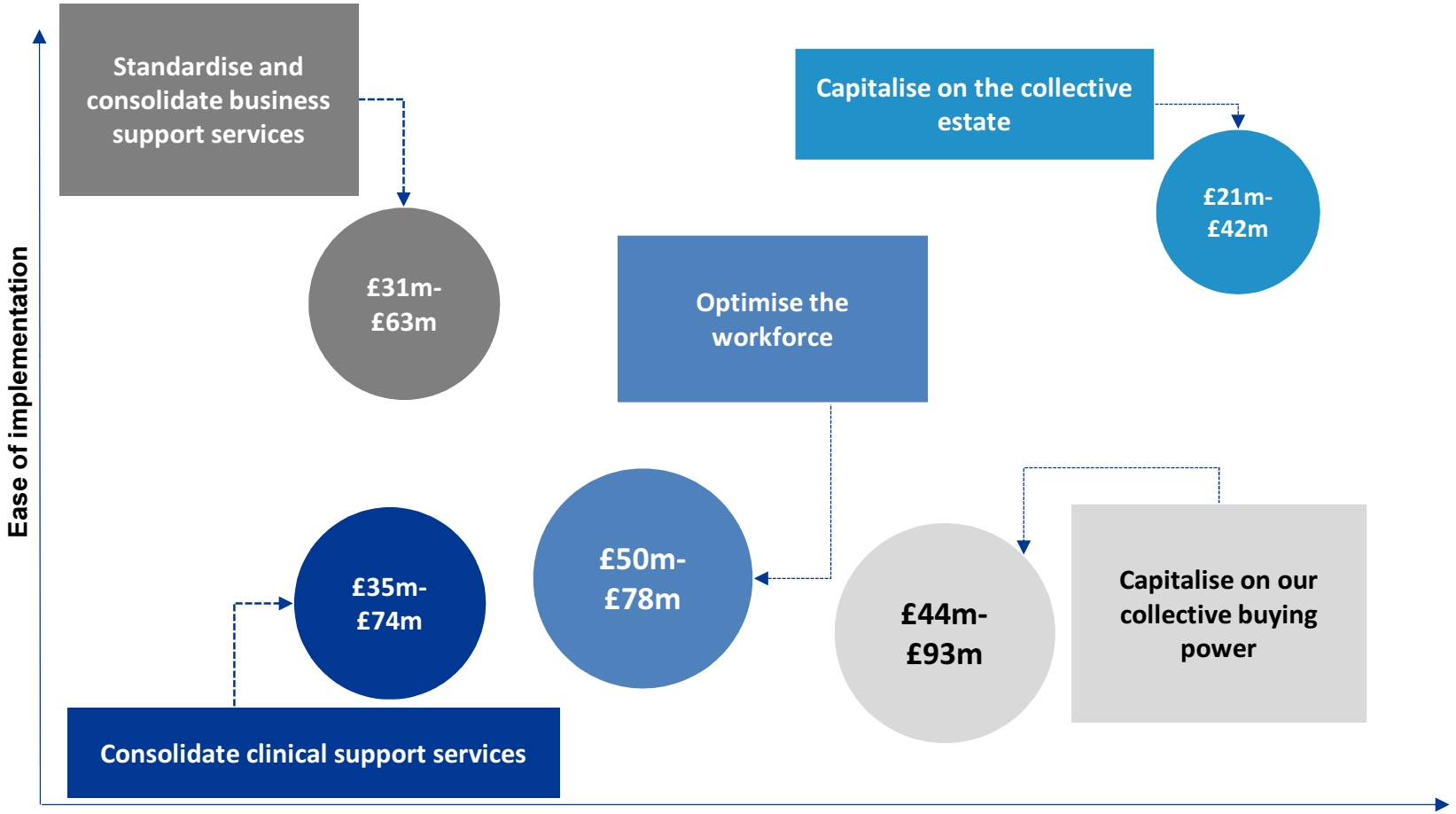
3. Our acute and mental health providers have identified opportunities for reducing the costs of delivering care in 5 priority areas



A partnership of NHS providers and Clinical Commissioning Groups serving the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, with NHS England

4. We wish to develop world class and sustainable specialised services that meets the needs of patients both locally and across England

We have been working collaboratively with NHSE to develop the specialised content for the STP. We now have a greater understanding of the challenge, the future programme of work and the need to work with colleagues in South London to ensure sustainable and high-quality services.

Involvement to date in developing the STP	• An indicative high-level estimate (in a 'do-nothing' scenario) on the projected specialised commissioning funding gap for the April STP submissions (based on a top-down approach). Updated modelling outputs will be ready for inclusion in the June • A portfolio of transformation projects, as part of the Healthy London Partnership, is being developed to improve quality, consistency and efficiencies in specialised services. Initial London projects are focusing on: neuro-rehabilitation; CAMHS Tier 4; HIV services and paediatric and neonatal transport
Development of a London-wide programme board	• Given the scale and challenge of specialised commissioning there needs to be a specific London-wide focus on specialised services • A new regional Specialised Commissioning Planning Board is being set up to include all five STP 'system leaders', representatives of specialised providers and national and neighbouring regional specialised commissioners to set strategic direction and priorities
Sustainable services across South London	• There are potential opportunities for reviewing current service provision across South London and discussions have started between NHSE, and SEL & SWL STP leads

5. To deliver this plan we must establish the right governance, secure appropriate resources and address system incentives

- **Balancing system benefit and impact on individual organisations** to make decisions that are in the best interest of patients and sustainability of the system
- **Aligning transformation funding to the objectives of the STP** by building processes to ensure that investment across the system supports our collective vision
- **Investing in shared planning and delivery** to ensure that a collaborative approach runs throughout the programme with the appropriate resources
- **Align system incentives** that drive population health and value and shared risk.
- **Have an ongoing dialogue with our stakeholders** through existing and new communication channels
- **A system-wide delivery plan and agreed measures** to monitor the implementation of the STP
- **Working collaboratively across London** with existing partners including HLP
- **Adopting new models of collaboration and delivery** by collaborating and learning lessons from local and national vanguards

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HEALTH AND WELLBEING BOARD				
Report Title	Overview of the System Resilience Plan 2016/17 and Overview of the Approach to Enhanced Care & Support Services			
Contributors	Martin Wilkinson		Item No.	7
Class	Part 1	Date:		
Strategic Context	System resilience planning is a national expectation for NHS organisations and senior leaders from across Bexley, Greenwich and Lewisham (BGL) health and care economy to bring together system wide resilience, planning & oversight for the health and care services serving the population of BGL. For Lewisham, the System Resilience Plan links to relevant workstreams of the Adult Integration Programme. Parties in the System Resilience Group are the 3 local CCGs, Lewisham and Greenwich NHS Trust, Oxleas Foundation NHS Trust (as Bexley and Greenwichs' community provider) and 3 Local Authorities supported by a range of other providers and organisations including primary care and mental health providers.			
Pathway	N/A			

1. Purpose

1.1 This report provides members of the Health and Wellbeing Board with an overview of the System Resilience Plan 2016/17.

2. Background

2.1 Our approach for system resilience planning 2016/17 draws together the lessons learned from planning last year, and the recommendations from 'One Version of the Truth' (OVT, a diagnostic of what is happening along the urgent and emergency care pathway based on available data and insights). The plan encompasses a range of initiatives assessed for their potential impact upon the 4 hour standard, flow across the pathway including use of the Emergency Departments, admission to hospital and supported discharges including reported delayed transfers of care (DTOC).

Building on lessons learned from 2015/16 there are two strands to the approach for system resilience this year:

a. A transformational agenda which will deliver sustainable change by addressing underlying system issues as evidenced in the 'One Version of the Truth' (OVT) review

b. An escalation agenda which sets out our system-wide approach to planning for known escalation events such as Christmas and Easter, and with contingency for the unseen events (e.g. junior doctor's industrial action, inclement weather).

The OVT system review of February 2016 established a whole-system vision for the future development of urgent and emergency care services for 2016/17 and beyond.

3. Our Guiding Principles

3.1 All parties to this plan share the objectives of facilitating high-quality care for all and improving service-user outcomes now and in the future. We have agreed to work together for the benefit of patients, service users and the public. We recognise that the NHS and Local Authorities need to be able to deal with the challenges ahead, such as an ageing population, a rise in the number of people with long term conditions and greater public expectations.

3.2 With resources considerably constrained this year, the emphasis of the plan is to increase the efficiency of the system to respond to winter and beyond, and to prioritise investment in those schemes with a robust evidence base, capable of reducing key risk across the system. This year's plan is inherently connected to the QIPP (Quality, Innovation, Productivty and Prevention programme) and ensures that patients are seen in the most appropriate setting; whether this is in the community or hospital environment. Priority will be given to low cost, high impact schemes capable of reducing demand for Emergency Departments, appropriate hospital admissions and reducing long stay patients: defined as patients staying in hospital over 9 days.

4. Overview of winter 2015/16 and lessons learned

4.1 For the first 3 quarters of 2015/16, performance against the 4 hour standard remained on an improved trajectory at approximately 2.5% above 2014/15 (UHL 2.26%/QEH – 3%). To the extent that October 2015 performance at LGT was noted by NHS England as demonstrating the greatest level of improvement in comparison to all Trusts across London. The period heralded the implementation of 'Winter Countdown' which brough momentum to the implementation of plans ahead of winter. Similarly planning for the Christmas and New Year (Operation Aladdin) successfully delivered performance well above the forecast trajectory. This tells us that joint planning across agencies for known escaltation events does have a positive impact on stabilising performance and this should continue to be a significant feature of system resilience planning. Unfortunately outside of escalation events, performance did deteriorate which clearly demonstarates the fragility of the system and need for transformational change aimed at the underlying root cuases.

4.2 The system resilience plan for 2015/16 was framed around 5 separate plans which included: LGT Emergency Care Pathway Redesign Plan, a joint BGL CCG plan which included investment across 5 health and social care schemes and 3 CCG specific plans all with differing priorities and emphasis. Although the evaluation does demonstrate some successful pilots that can be built upon (e.g. the Lewisham Winter Assessment and Treatment Service (LWAT)), the overall result was fragmentation of impact and a lack of commissioning leverage because the plans were developed outside of the annual contracting process.

5. System Resilience Priorities for 2016/17 and beyond

5.1 With regard to service transformation, there are four priority areas:

- **Improving discharge**
    - To radically redesign the complex discharge process in a way that prioritises duty of care to patients via the Care Act, and delivers clinical efficiency thus reducing acute length of stay.
    - To bring simple discharges earlier in the day through increased operational rigour and implementation of ward and time specific discharge targets
- **Delivering improvements to the emergency care pathway**
    - To provide a timely multi-disciplinary assessment response to patients who present in the emergency department (ED), and promptly redirect those who can return home with support to a community hospital facility
    - To deliver the revised medical model including the ambulatory care (medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention and rehabilitation services)
- **Handover Schemes**
    - To implement handover schemes against a revised service specification to ensure that patients receive the appropriate treatment in the right place at the right time
- **Increasing community capability**
    - To either prevent unnecessary admission or support hospital discharge home rather than to an institutional setting

5.2 Improving the whole-system response to escalation and contingency planning is highly dependent on delivering sustainable change. Our

experience over the last year indicates that while interagency planning for known escalation events does result in performance improvement, this is not maintainable long term. This means that until the system starts to realise the benefits of improving the discharge process and emergency care pathway, escalation bed capacity (acute and non-acute) is likely to be required to cope with seasonal escalation in demand.

With this in mind there are two aims for 2016/17:

- **Joint planning through the year**
    - To collaborate on joint plans ahead of known seasonal fluctuations in demand. This should take the form of an annual calendar and continue with built in mechanisms for future learning and improvement
- **Escalation Capacity**
    - To determine the quantum of escalation capacity (community beds, Hospital at Home and social care bridging for packages of care etc.) required in 2016/17

5.3 The BGL system resilience plan is a dynamic programme of initiatives and actions, which has been divided into two site-specific plans to better reflect local issues with the health and social care systems aligned to Queen Elizabeth Hospital and University Hospital Lewisham. The plans have been adapted as necessary to ensure collective efforts are successful in improving the quality and responsiveness of urgent and emergency care including the achievement of the 4 hour standard and DToC indicators.

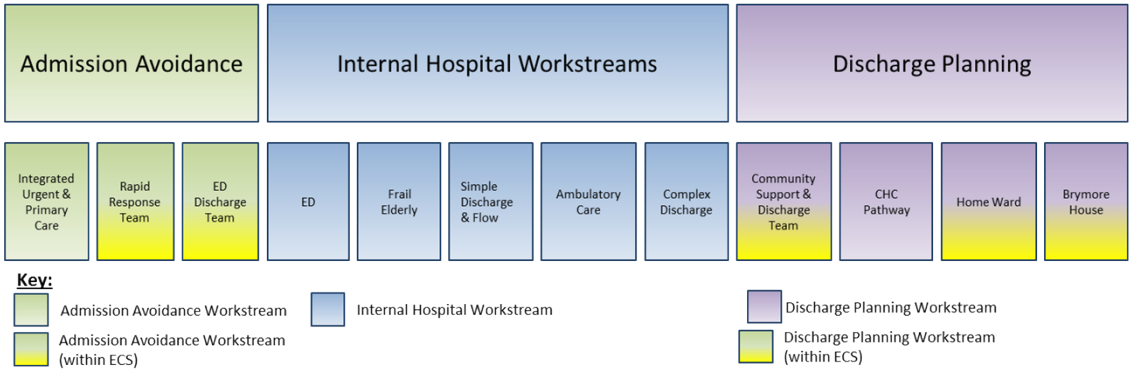
6. Enhanced Care and Support (ECS)

6.1 The ECS is one of the key priorities of the Adult Integrated Care Programme Board. It is integral to the redesign and transformation of the community services commissioned by the CCG and provided by Lewisham & Greenwich Trust.

The ECS workstreams are:

- Rapid Response
- Home Ward
- Community Discharge Support Team
- Emergency Department Team
- Brymore House

The ECS programme spans across the Admissions Avoidance and Discharge Planning aspects of the non-elective pathway.



7. Lewisham Initiatives and Actions

7.1 Integrated Urgent & Primary Care – a new integrated service that takes into account local priorities, existing urgent and primary care resources delivering a local vision of national requirements that will provide the right access to urgent and primary care services. This will look at how primary care working at scale can offer extended hours and appropriate connections made between primary care, 111 and UCC/ED.

7.2 Rapid Response Team – Remodelling of the existing service in collaboration with London Borough of Lewisham and Lewisham & Greenwich NHS Trust to become a 7 day week (8am – 6pm) crisis focused medical team; providing rapid assessments by triage for patients to reduce the risk of an attendance at A&E or an emergency admission. This service would have a 7 day rapid response social care component.

7.3 Emergency Discharge Team – A remodelling of the existing service to provide; 7 day week (8am – 8pm) service that will identify patients aged 60+ coming into A&E with ambulatory care sensitive conditions and link them to other appropriate services

7.4 Home Ward – A new service designed in collaboration with London Borough of Lewisham and Lewisham & Greenwich NHS Trust to provide 7 day week (8am to 8pm) early 'step up' care for patients in the community who require medical assistance before becoming ill and requiring to attend hospital which will prevent avoidable admissions and 'step down' care for patients ready for discharge but who require on-going medical interventions

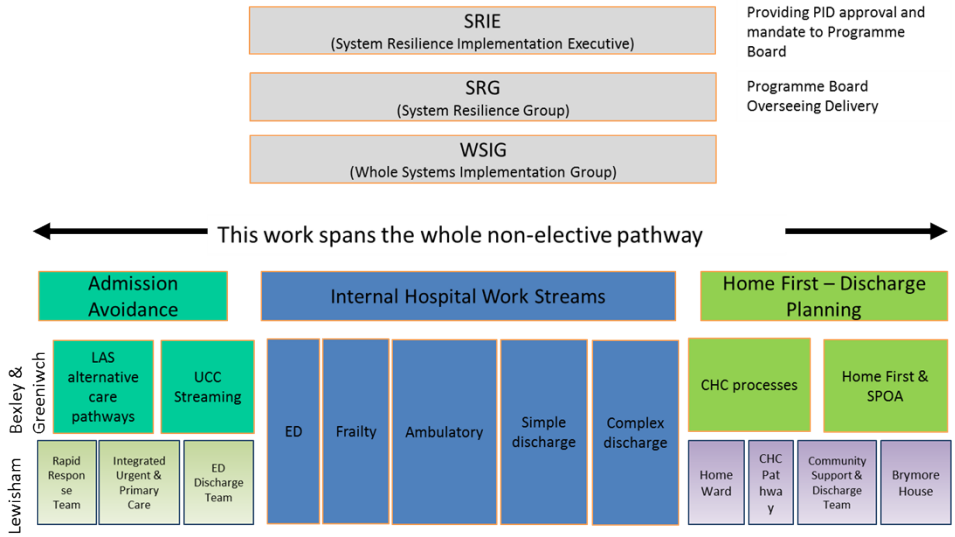
7.5 Continuing Health Care Pathway – A new Lewisham Continuing Healthcare Team being established with responsibility for all assessments, reviews and case management duties for fully funded Continuing Health Care patients to deliver consistent outcomes for patients and ensure that the process is efficient, timely and effective.

7.6 Community Discharge Support Team – A remodelling of the existing service to provide 7 day week (9am – 5pm) service that will target people who have a deterioration in function and or require medical support following discharge from the hospital.

7.7 Brymore House – A remodelling of the existing services to provide 7 day week rehabilitation bed based service providing 10 Home Ward Beds and 15 rehabilitation beds for a period of up to six weeks

8. Governance and Performance Management

8.1 The senior responsible officer (SRO) for BGL systems resilience is Martin Wilkinson Chief Officer for Lewisham CCG. A programme management function to support delivery of the plan is derived from Bexley, Greenwich & Lewisham CCG's and Lewisham and Greenwich NHS Trust. The SRDE is the programme board, with operational delivery of the workstreams assigned to specific task and finish groups and the WSIG.



Background Documents

- Transformation Nous (February 2016): UHL Emergency Care Diagnostic / QEH Emergency Care Diagnostic / Emergency Care Diagnostic – Supported Discharge Section

If there are any queries on this report please contact Martin Wilkinson, Chief Officer for Lewisham CCG, on 020 7206 3200, *or by email at:* martinwilkinson@nhs.net

HEALTH AND WELLBEING BOARD			
Title:	Lewisham Whole System Approach to Obesity		
Contributors:	Dr Danny Ruta, Director of Public Health	Item:	8
Class:	Part 1 (Open)	19th July 2016	

1. Purpose

1.1 The purpose of this report is to seek the members of the Health and Wellbeing Board support and engagement in Lewisham's Whole System Approach to tackling obesity and to delivery of a Lewisham Whole System Obesity Action Plan.

2. Recommendations

2.1 Members of the Health and Wellbeing Board are asked to endorse and give support to the proposed draft action plan.

3. Background

3.1 Lewisham has a high prevalence of children and adults with excess weight: over a third of 10-11 year olds, a quarter of 4-5 year olds and nearly two third of adults being overweight or obese. Less than half of the adult population meet the '5-a-day' recommendation for fruit and vegetables. Over a quarter of adults are classed as inactive - doing less than 30 minutes of moderate intensity physical activity per week.

3.2 WHO first sounded the alarm on the global obesity epidemic in the 1990s, and it has only very recently shown signs of leveling off, but not decreasing. The world's scientific community has concluded that the obesity epidemic is a 'normal response of normal individuals to an abnormal environment'. Whilst there is no single silver bullet solution, and encouraging individuals to live healthier lifestyles should form part of the solution, most experts now agree that only a whole system approach offers a real chance of turning the tide on the epidemic. A whole system approach to obesity not only promotes behaviour change directly, for example through weight management programmes, but it brings about healthy eating and increased physical activity indirectly by creating a less obesogenic environment in which people live. This involves and engages stakeholders across society and includes schools, the NHS, food retailers, food manufacturers and suppliers, town planning, transport, sport and leisure, the voluntary sector, and many other sectors.

3.3 **National Whole System Obesity Pilot** - In 2016 Lewisham Council was awarded National Pilot status for a whole system approach to tackling obesity; one of only four local authorities in the country and the only London Borough. This three year pilot does not bring with it any direct funding, but a team of obesity and physical activity experts from Leeds Beckett University have been commissioned to support and advise the pilot sites on the design and implementation of a whole system

approach to reducing population levels of adult and child obesity. It is intended that not only will the research team bring learning and evidence of best practice to the pilot local authorities, but that the lessons learnt will be shared nationally.

3.4 Pan London Childhood Obesity Sector Led Improvement - In late 2015 / early 2016, Lewisham led a Sector Led Improvement (SLI) Programme on childhood obesity involving all London Boroughs. As part of the SLI each borough completed a self-assessment and engaged in a peer challenge event with 4-5 other boroughs. The interim results have been published, and the recommendations, together with the learning from the self-assessment and the peer challenge, has allowed Lewisham to develop a draft Whole System Obesity Action Plan for the next 2-3 years.

4. Policy Context

4.1 The Foresight report on Tackling Obesities (2007) identified that obesity is the result of a very large number of determinants with many of the drivers beyond the scope of individuals to influence. The consensus opinion is that there needs to be a whole system approach, with co-ordinated policies and actions across individual, environmental and societal levels to prevent and tackle obesity and that the leadership role of local authorities in developing a workable whole systems approach is crucial.

4.2 The government is expected to publish its national obesity strategy towards the end of June or in early July. The Prime Minister intends to launch the strategy and has said he wants the publication to be 'a game-changing moment'.

4.3 The Chief Medical Officer's report (2011) recommends:

- adults aged 19-64 years undertake 150 minutes of moderate intensity physical activity (MPA) per week in bouts of 10 minutes or more, or 75 minutes of vigorous intensity physical activity (VPA) per week or an equivalent combination of the two and should minimise the amount of time spent sedentary.
- children aged 5-15 years should engage in at least 60 minutes and up to several hours physical activity per day
- children aged 2 -4 years should engage in at least 180 minutes activity spread throughout the day

4.4 Building muscle strength and skills is also a key component of physical activity, this could be through active play in children and resistance-type activity in adults.

4.5 Public Health England in 2014 published a framework to embed physical activity into daily life, Everybody Active, Everyday Day: an evidence based approach to physical activity. It concluded that to get people active everyday would only happen if all sectors work together to make physical activity easy, affordable and the 'normal' choice for communities.

4.6 The Scientific Advisory Committee on Nutrition (SACN) in July 2015 published its new recommendations on carbohydrates and health and the recommended amount of free sugar has been halved (average intake of free sugars should not exceed 5% of total dietary energy intake). This applies to all age groups from 2 years upwards. It identified particularly high consumption of sugar and sugar sweetened drinks amongst school age children and recommended that the consumption of sugar sweetened drinks should be minimized in children and adults.

4.7 In October 2015 Public Health England published 'Sugar Reduction: the evidence for action'. The report concluded that no single action will be effect give in reducing sugar intakes, and that the problem could not be solved by approaches that rely on individuals changing their behaviour in response to health education and marketing. The environmental drivers are just too big. Their analysis of the evidence suggests that a successful programme could include the following levers:

1. Reduce and rebalance the number and type of price promotions in all retail outlets including supermarkets and convenience stores and the out of home sector (including restaurants, cafes and takeaways);

2. Significantly reduce opportunities to market and advertise high sugar food and drink products to children and adults across all media including digital platforms and through sponsorship;

3. The setting of a clear definition for high sugar foods to aid with actions 1 and 2 above. Currently the only regulatory framework for doing this is via the Ofcom nutrient profiling model, which would benefit from being reviewed and strengthened;

4. Introduction of a broad, structured and transparently monitored programme of gradual sugar reduction in everyday food and drink products, combined with reductions in portion size;

5. Introduction of a price increase of a minimum of 10-20% on high sugar products through the use of a tax or levy such as on full sugar soft drinks, based on the emerging evidence of the impact of such measures in other countries;

6. Adopt, implement and monitor the government buying standards for food and catering services (GBSF) across the public sector, including national and local government and the NHS to the ensure provision and sale of healthier food and drinks in hospitals, leisure centres etc;

7. Ensure that accredited training in diet and health is routinely delivered to all of those who have opportunities to influence food choices in the catering, fitness and leisure sectors and others within local authorities;

8. Continue to raise awareness of concerns around sugar levels in the diet to the public as well as health professionals, employers, the food industry etc., encourage action to reduce intakes and provide practical steps to help people lower their own and their families sugar intake.

4.8 The chancellor announced the introduction of a sugar sweetened drinks tax in 2018. The levy, which will start in April 2018, will put up the price of drinks such as Red Bull, Capri Sun, Sprite and several versions of cola. The Treasury has not decided exactly how much extra they will force producers to charge for heavily sweetened drinks, but health campaigners want it to be 20%. Companies that produce or import soft drinks with significant added sugar will have to pay one level of the tax for drinks containing at least 5g of sugar per 100ml and a higher rate for those with more than 8g per 100ml. It is understood that the Treasury is currently exploring the possibility of piloting the tax early in London.

5. Lewisham's Whole System Obesity Action Plan

5.1 Following the award to Lewisham Council of national pilot status for a whole system approach to obesity, a whole system obesity project board was established which included: senior officer representation from the council directorates of Community Services, Children's Services and Customer Services; the cabinet member for Children & Young People; and Lewisham CCG.

5.2 Members of the National team, which included academics from Leeds Beckett University and representatives from PHE, visited Lewisham in early 2016 and met with the Mayor and with the Lewisham whole system obesity project board. This was followed up by a two day workshop at Leeds Beckett University in March involving all four local authority pilot sites.

5.3 Following the two day workshop the Lewisham project board met twice more and developed a draft whole system obesity action plan.

5.4 The overarching aims of Lewisham's draft whole system obesity action plan are:

1) **to promote an environment that supports healthy weight and wellbeing as the norm, making it easier for our residents to choose healthier diets and active lifestyles;**

2) **Supporting our communities and families to become healthier and more resilient, which will include addressing the wider determinants of health.**

5.5 At a strategic level, we will achieve these aims by engaging the wider Lewisham Partnership to ensure a better co-ordinated approach around the wider determinants of obesity, by forming a **Lewisham Obesity Alliance**. The alliance will continue to build on progress in delivering actions across four priority areas:

Children and Young People
Increased Public Awareness and engagement
Health and Public Services
Environment

5.6 Initially however, the Alliance will focus on **three cross cutting actions** to create healthy environments: **Sugar Smart Lewisham; the Lewisham Daily Mile; and Use of Lewisham's Parks**.

5.7 **Sugar Smart Lewisham**

Lewisham, together with Greenwich will become the first 'SUGAR SMART' boroughs in London, and will launch Jamie Oliver & Sustain's national Sugar Smart Campaign in September 2016. SUGAR SMART is an ambitious campaign helping towns, cities, counties and boroughs across the UK to raise awareness and reduce consumption of sugar across all age groups. The campaign aims to promote healthy alternatives and remove or reduce unhealthy food and drink. As a Sugar Smart borough, we will seek commitments from institutions and businesses across different sectors to develop their own sugar smart policies, to make good food and drink more affordable, accessible and better marketed than high sugar food and

drink. The principles of the campaign are aligned to the levers identified by Public Health England to reduce sugar consumption (outlined in section 4.4)

5.8 **The Lewisham Daily Mile**

All Lewisham primary schools will be encouraged to allow all children in the school to run outdoors for 12 minutes each day, as part of the Daily Mile initiative. Originally created by a primary head teacher in Stirling, this simple, 'no cost' initiative has swept the UK. Two Lewisham schools have already started running the daily mile, and several more are planning to start in September. An initial Scottish evaluation has demonstrated impressive outcomes in terms of reduced prevalence of childhood obesity and improved levels of cardio respiratory fitness. Anecdotal evidence suggests improvements in attendance, behaviour and educational attainment.

5.9 **Use of Lewisham's Parks**

Lewisham council aims to build on its track record of success in increasing the use of its parks to improve physical and mental health and wellbeing (for example through it 'Nature's Gym' initiative - https://natureconservationlewisham.co.uk/how-to/natures-gym-2/). The council plans to explore the use of social media and web based technology developed locally to make it easier for people to meet in parks and open spaces to play, exercise and run (www.sportstarta.com).

5.10 A number of other new innovations have been identified in the action plan, for example: increasing participation in physical activity through dance, working with Trinity Laban; and increasing recreational physical activity through football and basketball, working with primary schools, London Thunder Basketball Club and Millwall FC Community Trust.

5.11 **Appendix one** describes Lewisham's Whole System Obesity action Plan in more detail.

6. Financial implications

6.1 In order to fulfill its statutory responsibilities for delivering the prescribed public health functions (sexual health, NHS health checks, Public Health advice to the CCG, Health Visiting and the National Child Measurement Programme) as resources are being reduced through council savings and cuts in Public Health Grant, the council will have to look at reducing investment in preventative lifestyle services, and achieve public health outcomes through more upstream whole system approaches that change the environment and address the wider determinants of ill health. The proposed whole system obesity action plan aims to achieve such a shift in approach to public health. None of the actions described in this report are funded from the Public Health budget.

7. Legal implications

7.1 There are no legal implications

8. Crime and disorder implications

8.1 There are no crime and disorder implications

9. Equalities implications

9.1 The prevalence of obesity amongst the 20% most disadvantaged is twice that of the 20% least disadvantaged in the UK. Childhood obesity rates also tend to be higher amongst some black and asian communities. Unless they are highly targeted, preventive lifestyle obesity interventions are more likely to be taken up by those communities with the highest prevalence. The actions proposed in Lewisham's whole system approach, for example the Sugar Smart Lewisham campaign, are targeted at the obesogenic environment (e.g. Junk food and confectionary at checkouts in shops and supermarkets) and they are likely to have the biggest impact on those most in need, thereby reducing inequalities.

10. Environmental implications

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

If there are any queries on this report please contact Danny Ruta, Director of Public Health, 020 8314 9094 danny.ruta@lewisham.gov.uk.

Draft Obesity Action Plan 2016

APPENDIX 1

Whole System Approach to Obesity

Areas of focus

Reduce the impact of the obesogenic environment
Increase proportion of residents with a healthy weight

Overarching aims of the Plan

- Lewisham has a high prevalence of children and adults with excess weight: over a third of 10-11 year olds, a quarter of 4-5 year olds and nearly two third of adults being overweight or obese.
- Less than half of the adult population meet the '5-a-day' recommendation for fruit and vegetables.
- Over a quarter of adults are classed as inactive - doing less than 30 minutes of moderate intensity physical activity per week

Overarching aims of plan

- Promote an environment that supports healthy weight and wellbeing as the norm, making it easier for our residents to choose healthier diets and active lifestyles
- Supporting our communities and families to become healthier and more resilient, which will include addressing the wider determinants of health

Work over four priority areas:

- Children and Young People
- Increased Public Awareness and engagement
- Health and Public Services
- Environment

How We Are Going to do this

- **Engage wider Lewisham partnership to ensure a better co-ordinated approach around the wider determinants of obesity by forming a new Lewisham Obesity Alliance.**
- **Continue to build on progress across twelve themes under four priority areas.**
- **Initial focus high on three cross cutting actions to create healthier environments**

1. **Food - Become a Sugar Smart Borough**
2. **Physical activity - Implement the Daily Mile in primary schools**
3. **Communities – improve access and appeal of parks for recreation**

How will we measure success

Performance measure	Current performance	Comparator performance	Target 2017/18	Desired Direction of travel	Who is monitoring this?
Number of pledges to Sugar Smart				↑	Promoting Healthy Weight Group
Excess Weight in Children - Reception Year (%)	23.7%	21.9%		↓	Promoting Healthy Weight Group
Excess Weight in Children - Year 6 (%)	38.9%	33.2%		↓	Promoting Healthy Weight Group
Excess Weight in Adults (%)	60.7%	64.6%		↓	Promoting Healthy Weight Group

Obesity Action Plan 2016

Children & Young People

Areas of focus

- **Breastfeeding**
- **Introducing Solid Food**
- **Schools**

Why is this important

Overweight and obesity, lack of physical activity and poor nutrition present a major challenge to the current and future health and wellbeing of children and young people in Lewisham.

Breastfeeding: There is strong evidence that babies who are breastfed are at reduced risk of becoming overweight as well as providing a range of other health benefits to babies and mothers.
Introducing Solid Food: There is evidence that babies that are weaned appropriately are at reduced risk of becoming overweight.
Schools: The school environment is hugely influential on children's behaviour, both through the influence of the curriculum, and the culture of the school. Schools also provide a range of valuable opportunities for engaging families and the wider community. There is a growing evidence base on the effectiveness of school-based intervention to promote health, diet and physical activity.

What are we going to do locally

- **Implementing and maintaining UNICEF Baby Friendly standards**
- **Increase number of breastfeeding friendly premises**
- **Embedding health in EYFS framework for settings**
- **Implementing a Healthy Early Years award in early years settings**
- **Improve uptake of school meals**
- **Schools participate in the Daily Mile**
- **Increase recreational physical activity through football and basketball, working with primary schools**
- **Schools sign up to Healthy Schools London**

How will we measure success

Performance measure	Current performance	Comparator performance	Target 2017/18	Desired Direction of travel	Who is monitoring this?
Breastfeeding Initiation	86.5%			↑	0-5 Steering Group
Breastfeeding Prevalence 6-8 weeks (%)	79.7%	45.2%	77%	↑	0-5 Steering Group
Take up of school meals - Primary	56.8%	N/A	68%	↑	Promoting Healthy Weight Group
Take up of school meals - Secondary	28.0%	N/A	44%	↑	Promoting Healthy Weight Group
Number of pupils taking part in the Daily Mile		-		↑	
Number of Schools signed up To Healthy Schools				↑	

Obesity Action Plan 2016

Increased Public Awareness and engagement

Areas of focus

- **Journeys on foot or bike**
- **Supporting active people**
- **Knowledge**

Why is this important

We want our communities to be healthy and active, confident and able to make healthy choices and to understand how this can improve their health and wellbeing.

Journeys on foot or bike: There is clear evidence of the health benefits of walking and cycling. Enabling more people to walk and cycle as part of their daily routine or for leisure is important in raising activity levels.

Supporting active people: Planned activity such as sport and exercise provide important opportunities for people to be physically active, it is beneficial to increase the range of options such as dance so that we engage with a wider community. However many of our residents are inactive, it is important therefore to support all individuals to build a greater level of activity into their everyday routine, including active travel

Knowledge: Healthy choices are partly enabled by individuals' knowledge, by their motivation to be healthy, and a feeling that their choices can make a difference to their health.

What are we going to do

- **Increase awareness by promoting Change 4 Life and One You campaign**
- **Promote the physical activity guidelines for all ages**
- **Provide cycle training for children and adults**
- **Increase participation in physical activity through dance, working with Trinity Laban School of Dance**
- **Train community physical activity and healthy eating volunteer champions**
- **Utilise sugar smart campaign to raise awareness through surveys and local conversations**
- **Gain better understanding on raising the issue of weight, healthy eating and being more active and with our diverse communities**

How will we measure success

Performance measure	Current performance	Comparator performance	Target 2017/18	Desired Direction of travel	Who is monitoring this?
Adults (16+) who are physically active (%)	57.1%	57.0%		↑	
Adults (16+) who are physically inactive (%)	27.5%	27.7%		↓	
Number taking up Cycle Loan scheme				↑	
Change for Life Sugar Swap Sign Ups	1225	-		↑	

Obesity Action Plan 2016

Health and Public Services

Areas of focus

- **Health Services**
- **Engagement and Commitment**
- **Workplaces**

Why is this important

Health services: Health services are a vital contact point residents, and a trusted source of support and information. Health services have a clear role in helping people manage their wider health, including through the provision of treatment services for individuals who are already overweight.

Engagement and Commitment: Obesity can only be tackled through a whole systems approach this means increase engagement and commitment to tackle child obesity among partners in all sectors, ensuring they share ownership of the issue and are fully committed to delivering change.

Workplaces: Employers and workplaces can be influential in shaping the knowledge, behaviour and lifestyle of individuals, and in turn that of their families and children. There is increasing evidence of the health benefits that can be provided by employers, and the business benefits to employers of supporting workplace health.

What are we going to do

- **Maternal obesity programme**
- **Specific workforce training and MECC training to frontline staff**
- **Provide improved feedback and support to families as part of the NCMP**
- **Increase number of residents taking up NHS Health Checks**
- **Implement Diabetes prevention programme**
- **Increase number of employers and workplaces signed up to healthy workplace charter**
- **Gain wide stakeholder representation of the obesity alliance**

How will we measure success

Performance measure	Current performance	Comparator performance	Target 2017/18	Desired Direction of travel	Who is monitoring this?
% women who are obese or overweight at their maternity booking appointment	43.5%	N/A	40%	↓	Promoting Healthy Weight group
Number of staff attending specific and MECC training				↑	
Number signed up to workplace health				↑	
Number of stakeholders signed up to obesity alliance		-		↑	

Obesity Action Plan 2016

Environment

Areas of focus

- **Access to healthy foods**
- **Physical environment**
- **Public and Community settings**

Why is this important

Access to healthy foods: The availability and price of foods and drink is a major factor in influencing the diet of residents. It is far more difficult to eat a healthy diet if healthy foods are relatively expensive or unavailable in local food outlets.

Physical environment: The street and outdoor environment is a strong influence on both activity levels and diet. Proximity and ease of access can influence whether residents use open and green spaces for activity. Our choice of travel mode can be influenced by how convenient it is to walk, cycle, use public transport or private cars; and whether we feel it is safe and enjoyable to do so (e.g. because of anxieties about traffic, personal safety). These factors may also influence where and how families shop for food, and the availability of healthy foods within communities.

Public and Community setups: A wide range of services delivered by, or in partnership with, Local Authorities offer opportunities to engage and influence children and their families. These include early years, youth, and a range of community settings.

What are we going to do

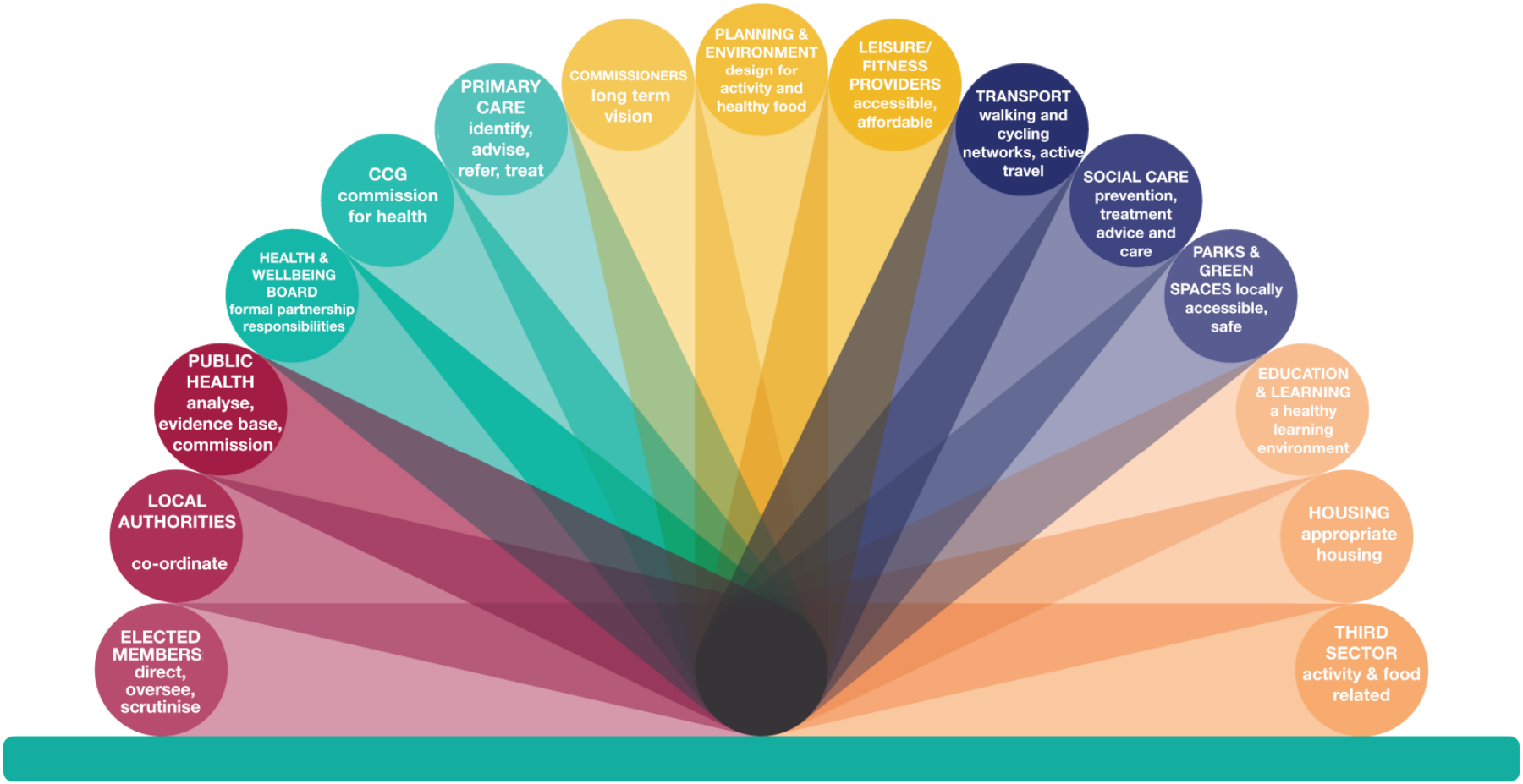
- **Become a sugar smart borough**
- **Implement the Healthier Catering Commitments in local food businesses**
- **Make it easier for people to meet in parks and open spaces to play, exercise and run**
- **Improve walkability and bikeability of the outdoor environment**
- **Increase local food growing opportunities**
- **Health Impact Assessments embedded in the planning process**
- **Coordinated approach to monitor access to food banks**

How will we measure success

Performance measure	Current performance	Comparator performance	Target 2017/18	Desired Direction of travel	Who is monitoring this?
Use of Outdoor Space for exercise health reasons (%)	13.2%	17.9%		↑	
Parks Indicator					
Sugar Smart Indicator		-		↑	
Planning applications for fast food outlets refused	2	-		↑	

Public Health England

Partnership: the key to success



HEALTH AND WELLBEING BOARD			
Report Title	**Health and Wellbeing Board Performance Dashboard Exceptions Report**		
Contributors	Director of Public Health	Item No.	9
Class	Part 1	Date:	19 July 2016
Strategic Context	Please see body of report		

1. Purpose

This report provides members of the Health and Wellbeing Board with an update on performance against its agreed priorities within the Health & Wellbeing Strategy and the performance indicators for the Better Care Fund.

2. Recommendations

Members of the Health and Wellbeing Board are recommended to note performance as measured by health and care indicators set out in the attached dashboard at Annex A.

3. Strategic Context

3.1 The Health and Social Care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. The activity of the Health and Wellbeing Board is focused on delivering the strategic vision for Lewisham as established in Shaping our Future – Lewisham's Sustainable Community Strategy, and in Lewisham's Health and Wellbeing Strategy.

3.2 The work of the Board directly contributes to the priority outcome in Shaping our Future that communities in Lewisham should be Healthy, Active and Enjoyable – where people can actively participate in maintaining and improving their health and wellbeing.

3.3 The Health and Social Care Act 2012 placed a duty on local authorities and their partner clinical commissioning groups to prepare and publish joint health and wellbeing strategies to meet needs identified in their joint strategic needs assessments (JSNAs). Lewisham's Health and Wellbeing Strategy was published in 2013.

3.4 The Health and Social Care Act also required health and wellbeing boards to encourage persons who arrange for the provision of any health or social services in the area to work in an integrated manner, for the purpose of advancing the health and wellbeing of the area.

4. Background

4.1 In response to the request from members of the Board, the Director of Public Health has worked alongside colleagues within Adult Social Care, Children's Services and the Clinical Commissioning Group (CCG) to produce a dashboard of indicators which would assist members in monitoring health and wellbeing improvements across Lewisham and the effectiveness of the integrated adult care programme.

4.2 The dashboard also includes a number of indicators (including those on low birth weight, immunisation and excess weight) that are also included in the 'Be Healthy' priority of the Children and Young People's Partnership Plan.

4.3 Since the board last saw the dashboard it has been streamlined to focus attention on key areas as well as introducing the performance metrics of the Better Care Fund.

5. Health and Wellbeing Board Performance Dashboard Update

5.1 The dashboard is based on metrics drawn from the Quality and Outcomes (Primary Care), Public Health, NHS and Better Care Fund Frameworks. These metrics have been selected to assist members in their assessment of the impact and success of the plans and activities in relation to the Health and Wellbeing Strategy.

5.2 Updated indicators that show a worsening position since the previous period of data availability (marked with a red arrow in the dashboard in Annex A) are highlighted below, together with a commentary on actions being taken to improve the position.

5.3 Overarching Indicators of Health & Wellbeing

No overarching indicators have deteriorated since the last dashboard was produced.

5.5 Priority Objective 1: Achieving a Healthy Weight

A new indicator has been added to the dashboard on Maternal Obesity. Maternal obesity (defined as obesity during pregnancy) increases health risks for both the mother and child during and after pregnancy and is a risk factor for childhood obesity. Statistics on the prevalence of maternal obesity are not collected routinely in the UK, hence this data is taken from information received from Lewisham and Greenwich Trust for women booked at Lewisham University Hospital. Therefore it should be noted that the data does not only refer to Lewisham residents. The proportion of women with excess weight in 2015-16 was 45.8%, which was higher than for 2014-15 (42.0%). However this latest data is still below figures seen between 2010 and 2012.

Actions to address maternal obesity include ensuring that all obstetricians and midwives at the Trust have been trained in how to raise the issue of healthy weight with pregnant women and in ensuring that all women with a possible problem are referred appropriately. Additionally the Lewisham Public Health Team have worked with Lewisham CCG and Lewisham Hospital to design an improved care pathway for overweight and obese women who choose to have their babies at the hospital. This has also been the subject of a CQUIN in 2015-16.

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

The latest data for cervical cancer screening coverage has decreased to 71.7% in 2015, down from 73.7% in 2014. This level is significantly lower than the England average, but above the London figure. More smear tests were conducted in 2015 than in 2014, however due to the increasing population the percent uptake has decreased. A change in the service specification for Sexual Health Services, whereby they no longer offer routine smear tests is also likely to have impacted this indicator. This change was made due to the pressures on public health budgets and the fact that the financing of cervical screening is through the GP contract.

5.7 Priority Objective 3: Improving Immunisation Uptake

Figures for immunisation uptake are now provided as an average for the last four quarters to make the figures less susceptible to quarter by quarter fluctuation. However there was a substantial increase in MMR2 uptake in the last quarter of 2015/16. This relates to extensive work undertaken by the Lewisham Immunisation Coordinator who identified a problem with vaccination data recording by GP practices. Over a period of several months many Lewisham GP practices were using the wrong READ codes to record MMR2 vaccination after migrating to EMIS web. The Immunisation Coordinator has now corrected this problem. In addition, a GP registrar has been carrying out work with individual GP practices to ensure that children are invited for MMR1 and 2 vaccinations at the appropriate age.

However HPV vaccine uptake has declined notably from the previous period 73.4% in 2014/15 from 82.9% in 2013/14. This is also below the London average (an England average is currently not available). Public Health and School Nursing are developing an action plan to address the recent fall in HPV coverage. This decline appears to relate to increasing numbers of parents withholding consent for their daughters to be vaccinated, as well as changes to the dosage schedule and delivery in schools.

5.8 Priority Objective 4: Reducing Alcohol Harm

The rate of alcohol related admissions has increased since the previous reporting period, from 614 per 100,000 in 2013/14 to 644 per 100,000 in 2014/15. Alcohol Brief Intervention Training has been taking place throughout the year and has been well attended, this is likely to have a positive impact on reducing future admissions.

5.9 Priority Objective 5: Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking

There is no deterioration of indicators with new data under this priority objective.

5.10 Priority Objective 6: Improving mental health and wellbeing

Prevalence of Serious Mental Illness has increased fractionally from 1.28% in 2014/15, compared to 1.27% in 2013/14. The rate remains higher than the England average but the increase is not statistically significant. Prevalence of Depression in Adults has risen from 5.90% in 2013/14 to 6.40% in 2014/15. This increase is statistically significant. Public Health will now raise this issue with Lewisham GPs to better understand and develop actions.

5.11 Priority Objective 7: Improving sexual health

No newly updated indicators show a decline in performance.

5.12 Better Care Fund Performance Metrics

The indicator regarding Patient Experience which looks at the proportion of people feeling supported to manage their long term conditions has declined on the previous year, from 59.1% in 2014/15 down to 56.0% in 2015/16. There are a number of schemes funded by the Better Care Fund with the objective of increasing such support including the Co-ordinated Care Service, neighbourhood community teams, community connections and dementia services. Continued evaluation of these schemes is necessary to ensure that an increase proportion of patients feel supported.

6. Financial implications

There are no specific financial implications arising from this report, however the board may wish to consider how resources are utilised in regards to poorly performing indicators.

7. Legal implications

As part of their statutory functions, members of the Board 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 well-being 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.

8. Crime and Disorder Implications

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

9. Equalities Implications

There are no specific equalities implications arising from this report or its recommendations, but the dashboard highlights those areas where health inequalities exist in Lewisham and can be monitored.

10. Environmental Implications

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

11. Summary and Conclusion

The increased uptake of the second dose of Measles Mumps and Rubella vaccine at five years being accurately reflected in performance has been a key break through. The Director of Public Health has written to GP Surgeries, Health Visitors and School Nurses to acknowledge this success.

Although there are a number of indicators that show a decline in performance, issues have been identified and actions are being taken forward.

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

If there are any queries on this report please contact Dr Danny Ruta, Director of Public Health, Community Services Directorate, Lewisham Council, on 020 8314 8637 or by email danny.ruta@lewisham.gov.uk

Annex B: Definitions and Data sources

1a/1b. Life Expectancy at Birth (Male/Female)	
Definition	The average number of years a person would expect to live based on contemporary mortality rates. For a particular area and time period, it is an estimate of the average number of years a newborn baby would survive if he or she experienced the age-specific mortality rates for that area and time period throughout his or her life. Figures are calculated from deaths from all causes and mid-year population estimates, based on data aggregated over a three year period. Figures reflect mortality among those living in an area in each time period, rather than what will be experienced throughout life among those born in the area. The figures are not therefore the number of years a baby born in the area could actually expect to live, both because the mortality rates of the area are likely to change in the future and because many of those born in the area will live elsewhere for at least some part of their lives.
Numerator	Number of deaths registered in the respective calendar years
Denominator	ONS mid-year population estimates for the respective calendar years
Data source	PHOF 0.1ii http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/6/par/E12000007/are/E09000023

2. Under 75 Mortality Rates from CVD	
Definition	Mortality from all circulatory diseases (ICD-10 I00-I99 equivalent to ICD-9 390-459).
Numerator	Deaths from all circulatory diseases, classified by underlying cause of death (ICD-10 I00-I99, ICD-9 390-459 adjusted), registered in the respective calendar year(s).
Denominator	2011 Census based mid-year pop estimates
Data source	NHSIC - P00400 Data https://www.indicators.ic.nhs.uk/download/NCHOD/Data/06A_076DRT0074_12_V1_D.csv Specification https://www.indicators.ic.nhs.uk/download/NCHOD/Specification/Spec_06A_076DRT0074_V1.pdf

3. Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (DSR)	
Definition	Directly age and sex standardised potential years of life lost to conditions amenable to healthcare in the respective calendar year per 100,000 CCG population.
Numerator	Death registrations in the calendar year for all England deaths based on GP of registration from the Primary Care Mortality Database (PCMD).
Denominator	Unconstrained GP registered population counts by single year of age and sex from the HSCIC (Exeter) Systems; supplied annually on 1 January for the forthcoming calendar year.
Data source	NHOF 1a (NHSIC P01559 – CCGOI 1.1) Data https://www.indicators.ic.nhs.uk/download/Clinical%20Commissioning%20Group%20Indicators/Data/CCG_1.1_I00767_D_V5.xls Specification https://www.indicators.ic.nhs.uk/download/Clinical%20Commissioning%20Group%20Indicators/Specification/CCG_1.1_I00767_S_V4.pdf

4. Low birth weight of all babies	
Definition	Percentage of live and stillbirths weighing less than 2,500 grams
Numerator	Number of new born babies weighing less than 2500gms
Denominator	Number of all births
Data source	CHIMAT Child health Profiles for Lewisham http://www.chimat.org.uk/resource/view.aspx?RID=101746&REGION=101634 Original source is from ONS

5. Number of practitioners attending Brief Intervention Training	
Definition	The number of practitioners who have attended Brief Intervention Training)
Numerator	N/A
Denominator	N/A
Data source	Lewisham Public Health

Priority Objective 1: Achieving a Healthy Weight

6. Excess weight in Adults	
Definition	Percentage of adults classified as overweight or obese
Numerator	Number of adults with a BMI classified as overweight (including obese), calculated from the adjusted height and weight variables. Data are from APS6 quarters 2-4 and APS7 quarter 1 (mid-Jan 2012 to mid-Jan 2013). Adults are defined as overweight (including obese) if their body mass index (BMI) is greater than or equal to 25kg/m2
Denominator	Number of adults with valid height and weight recorded. Data are from APS6 quarters 2-4 and APS7 quarter 1 (mid-Jan 2012 to mid-Jan 2013).
Data source	PHOF 2.12 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source: Active People Survey (APS), England

7a/7b. Excess weight in Children - Reception Year/ Year 6 Children	
Definition	Proportion of children aged 4-5 classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.
Numerator	Number of children in Reception (aged 4-5 years) or Year 6 (aged 10-11) and classified as overweight or obese in the academic year. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex
Denominator	Number of children in Reception (aged 4-5 years) or Year 6 (aged 10-11) measured in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England
Data source	PHOF 2.06 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source: HSCIC National Childhood Measurement Programme (NCMP)

8. Maternal Obesity	
Definition	Maternal obesity is defined as obesity during pregnancy. Obesity is defined as BMI which is 30 or higher. increases health risks for both the mother and child during and after pregnancy and is a risk factor for childhood obesity. Statistics on the prevalence of maternal obesity are not collected routinely in the UK, hence this data is taken from information received from Lewisham and Greenwich Trust for women booked at Lewisham University Hospital. Therefore it should be noted that the data does not only refer to Lewisham residents.
Numerator	Number of women whose BMI was 30 or higher at booking appointment.
Denominator	Number of women attending booking appointment.
Data source	University Hospital Lewisham Data

9. Breastfeeding Prevalence 6-8 weeks	
Definition	This is the percentage of infants that are totally or partially breastfed at age 6-8 weeks. Totally breastfed is defined as infants who are exclusively receiving breast milk at 6-8 weeks of age - that is, they are not receiving formula milk, any other liquids or food. Partially breastfed is defined as infants who are currently receiving breast milk at 6-8 weeks of age and who are also receiving formula milk or any other liquids or food. Not at all breastfed is defined as infants who are not currently receiving any breast milk at 6-8 weeks of age.
Numerator	Number of infants at the 6-8 week check who are totally or partially breastfeeding.
Denominator	Number of infants due for 6-8 week checks.

Data source	PHOF 2.02ii http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source: Department of Health Integrated Performance Monitoring Return

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

10a. Cancer screening coverage - breast cancer	
Definition	The percentage of women in the resident population eligible for breast screening who were screened adequately within the previous three years on 31 March
Numerator	Number of women aged 53–70 resident in the area (determined by postcode of residence) with a screening test result recorded in the previous three years
Denominator	Number of women aged 53–70 resident in the area (determined by postcode of residence) who are eligible for breast screening at a given point in time.
Data source	PHOF 2.20i http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source: Health and Social Care Information Centre (Open Exeter)

10b. Cancer screening coverage - cervical cancer	
Definition	The percentage of women in the resident population eligible for cervical screening who were screened adequately within the previous 3.5 years or 5.5 years, according to age (3.5 years for women aged 25-49 and 5.5 years for women aged 50-64) on 31 March
Numerator	The number of women aged 25-49 resident in the area (determined by postcode of residence) with an adequate screening test in the previous 3.5 years plus the number of women aged 50-64 resident in the area with an adequate screening test in the previous 5.5 years
Denominator	Number of women aged 25–64 resident in the area (determined by postcode of residence) who are eligible for cervical screening at a given point in time.
Data source	PHOF 2.20ii http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source: Health and Social Care Information Centre (Open Exeter)

10c. Cancer screening coverage - bowel cancer	
Definition	The number of persons registered to the practice aged 60-69 invited for screening in the previous 12 months who were screened adequately following an initial response within 6 months of invitation.
Rate of Proportion	Screening uptake %: the number of persons aged 60-69 invited for screening in the previous 12 months who were screened adequately following an initial response within 6 months of invitation divided by the total number of persons aged 60-69 invited for screening in the previous 12 months.
Data source	Cancer Commissioning Toolkit GP Profiles Data https://www.cancertoolkit.co.uk/Profiles/PracticePublic/Filters Specification https://www.cancertoolkit.co.uk/Profiles/PracticePublic/Documents NB: Data in the performance indicator portal is local data from London Bowel Screening hub obtained via Open Exeter.

11. Early diagnosis of cancer	
Definition	New cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed (specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas, and invasive melanomas of skin). This indicator is labelled as experimental because of the variation in data quality: the indicator values primarily represent variation in completeness of staging information.
Numerator	Cases of cancer diagnosed at stage 1 or 2, for the specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas, and invasive melanomas of skin

Denominator	All new cases of cancer diagnosed at any stage or unknown stage, for the specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas, and invasive melanomas of skin
Data source	PHOF 2.19 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source: National cancer registry

12. Conversion of Two Week Wait Referrals to Cancer Diagnosis	
Definition	The number of Two Week Wait (GP urgent) referrals where cancer is suspected for patients registered at the practice in question
Rate or proportion	The proportion of Two Week Wait Referrals which result in a confirmed cancer diagnosis.
Data source	CCG source - to be confirmed

13. Under 75 Mortality from all cancers	
Definition	Age-standardised rate of mortality from all cancers in persons less than 75 years of age per 100,000 population
Rate or proportion	Rate
Numerator	Number of deaths from all cancers
Denominator	Population-years (aggregated populations for the three years) for people of all ages, aggregated into quinary age bands up to 74).
Data source	Public Health England http://www.phoutcomes.info/public-health-outcomes-framework#page/6/gid/1000044/pat/6/par/E12000007/ati/102/are/E09000023/iid/40501/age/163/sex/4

Priority Objective 3: Improving Immunisation Uptake

14. Uptake of the second dose of Measles Mumps and Rubella Vaccine (MMR2) at five years of age	
Definition	All children for whom the CCG is responsible who received two doses of MMR on or after their 1st birthday and at any time up to their 5th birthday as a percentage of all children whose 5th birthday falls within the time period. Estimates for local authorities are based on CCGs, which include all people registered with practices accountable to the CCG.
Numerator	Total number of children who received two doses of MMR on or after their 1st birthday and at any time up to their 5th birthday.
Denominator	All children in the responsible population whose 5th birthday falls within the time period. The CCG is responsible for all children registered with a GP whose practice forms part of the CCG, regardless of residency, plus any children not registered with a GP who are resident within the CCG's statutory geographical boundary.
Data source	PHOF 3.03 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by PHE. Available from HSCIC.

15. Uptake of Human Papilloma Virus (HPV) vaccine in girls in Year 8 in Lewisham Schools	
Definition	The percentage of girls aged 12 to 13 years for whom the CCG is responsible who have received all doses of the HPV vaccine. Estimates for local authorities are based on CCGs, which include all people registered with practices accountable to the CCG.
Numerator	Number of Year 8 schoolgirls (aged 12 to 13 years) who have received all three doses of the HPV vaccine.
Denominator	Number of Year 8 schoolgirls (aged 12-13). The CCG is responsible for all

	children registered with a GP whose practice forms part of the CCG, regardless of residency, plus any children not registered with a GP who are resident within the CCG's statutory geographical boundary.
Data source	PHOF 3.03xii http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 NB: Data in the performance indicator portal is local data from GP systems obtained via EMIS Web. Original source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by PHE. Available from HSCIC.

16. Uptake of Influenza vaccine in those over 65 years of age	
Definition	Flu vaccine uptake (%) in adults aged 65 and over, who received the flu vaccination between 1st September and 31st January each financial year.
Numerator	Number of adults aged 65 years and over vaccinated between 1st September and 31st January of the financial year.
Denominator	Adults aged 65 years and over. The CCG is responsible for all adults registered with a GP whose practice forms part of the CCG, regardless of residency.
Data source	PHOF 3.03 xiv http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original source: PHE https://www.gov.uk/government/organisations/public-health-england/series/vaccine-uptake

Priority Objective 4: Reducing Alcohol Harm

17. Alcohol Specific Hospital Admission	
Definition	The number of hospital admissions due to alcohol-specific conditions, directly age standardised rate per 100,000 population.
Numerator	The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause. See LAPE user guide for further details - http://www.lape.org.uk/downloads/Lape_guidance_and_methods.pdf
Denominator	ONS mid year population estimates
Data source	PHOF 6.01 http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#gid/1938132833/pat/6/ati/102/page/6/par/E12000007/are/E09000002/iid/91384/age/1/sex/4

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

18. Smoking Prevalence (18+)	
Definition	Prevalence of smoking among adults aged 18+
Numerator	The number of persons aged 18+ who are self-reported smokers in the Integrated Household Survey. The number of respondents has been weighted in order to improve representativeness of the sample. The weights take into account survey design and non-response.
Denominator	The number of persons aged 18+ who are self-reported smokers in the Integrated Household Survey. The number of respondents has been weighted in order to improve representativeness of the sample. The weights take into account survey design and non-response.
Data source	PHOF 2.14 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source: ONS Integrated Household Survey

19. 4 week smoking quitters	
Definition	This indicator relates to clients receiving support through the NHS Stop Smoking Services. A client is counted as a self-reported 4-week quitter if they have been assessed 4 weeks after the designated quit date and declares that he/she has not smoked even a single puff on a cigarette in the past two weeks. The indicator is a count of treatment episodes rather than people, so an individual who undergoes two treatment episodes and has quit at four weeks in both cases are counted twice.

Numerator	Number of self-reported 4-week smoking quitters.
Denominator	Population aged 16 or over.
Data source	Data – Local NHS Stop Smoking Service database. Specification https://nascis.hscic.gov.uk/download.ashx?src=MetaDataPdf&file=JSNA_Metadata_NI+123.pdf

20. Smoking at time of delivery	
Definition	Number of women who currently smoke at time of delivery per 100 maternities. Data includes all women resident within the CCG's boundary, and no data are available to break down the CCG denominators for different areas within the CCG.
Numerator	Number of women known to smoke at time of delivery.
Denominator	Number of maternities.
Data source	PHOF 2.03 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 NB: Latest available quarter data from NHS Stop smoking service database.

Priority Objective 6: Improving mental health and wellbeing

21. Prevalence of Serious Mental Illness	
Definition	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on practice disease registers.
Numerator	Patients with schizophrenia, bipolar affective disorder and other psychoses
Denominator	CCG responsible population
Data source	National GP Practice Profiles http://fingertips.phe.org.uk/profile/general-practice/data#mod,3,pyr,2013,pat,19,par,E38000098,are,-,sid1,2000003,ind1,-,sid2,-,ind2,- Original Source: HSCIC QOF http://www.hscic.gov.uk/catalogue/PUB12262

22. Prevalence of Depression	
Definition	The percentage of patients aged 18 and over with depression, as recorded on practice disease registers.
Numerator	Patients aged 18 and over with depression, as recorded on practice disease registers.
Denominator	CCG responsible population
Data source	Original Source: HSCIC QOF http://www.hscic.gov.uk/catalogue/PUB12262

23. Improving Access to Physiological Therapies (IAPT) referrals entering treatment (%)	
Definition	The proportion of patients who have been referred to IAPT that have actually entered treatment
Numerator	The number of accepted referrals
Denominator	The total number of referrals
Data source	Lewisham and Greenwich Trust

24. Proportion of those accessing IAPT who moved to recovery (%)	
Definition	The proportion of IAPT patients who successfully moved to recovery
Numerator	The number of IAPT [patients who have moved to recovery
Denominator	The total number of IAPT patients
Data source	Lewisham and Greenwich Trust

Priority Objective 7: Improving sexual health

25. Rate of chlamydia diagnoses per 100,000 young people aged 15 to 24	
Definition	Crude rate of chlamydia diagnoses per 100,000 young adults aged 15-24 based on their area of residence
Numerator	The number of people aged 15-24 diagnosed with chlamydia
Denominator	Resident population aged 15-24
Data source	PHOF 3.02i http://www.phoutcomes.info/public-health-outcomes-

	framework#gid/1000043/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source http://www.chlamydiascreening.nhs.uk/ps/data.asp

26. People presenting with HIV at a late stage of infection (%)	
Definition	Number of adults (aged 15 years or more) newly diagnosed with HIV infection with CD4 counts available withing 91 days and indicating a count of less than 350 cells per mm^3 as a percentage of number of adults (aged 15 years or more) newly diagnosed with HIV infection with CD4 counts available within 91 days.
Numerator	Number of adults (aged 15 years or more) newly diagnosed with HIV infection with CD4 counts available within 91 days and indicating a count of less than 350 cells per mm^3
Denominator	Number of adults (aged 15 years or more) newly diagnosed with HIV infection with CD4 counts available within 91 days.
Data source	PHOF 3.04 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023

27. Legal Abortion rate for all ages	
Definition	Legal Abortions: Age Standardised Rate per 1000 resident women aged 15-44
Numerator	Number of all Legal Abortions
Denominator	Number of resident women aged 15-44
Data source	ONS via DH. Detailed data obtained through Local commissioners. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307650/Abortion_statistics__England_and_Wales.pdf

28. Teenage conceptions	
Definition	Conceptions in women aged under 18 per 1,000 females aged 15-17
Numerator	Number of pregnancies that occur to women aged under 18, that result in either one or more live or still births or a legal abortion under the Abortion Act 1967.
Denominator	Number of women aged 15-17 living in the area.
Data source	Public health outcomes framework 2.04 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original source: ONS

Better Care Fund Indicators

29. Percentage of older people (65+) still at home 91 days after discharge from hospital into rehabilitation/reablement services	
Definition	This measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – a key outcome for people receiving reablement. It captures the joint work of social services and health staff and services commissioned by joint teams, as well as adult social care reablement.
Numerator	Number of older people (aged 65 and over) discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. This should only include the outcome for those cases referred to in the denominator.
Denominator	Number of older people (aged 65 and over) discharged from acute or community hospitals from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with the clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting).
Data source	Better are Fund Metric

30. Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	
Definition	This is a two part-measure reflecting the number of admissions of younger adults (part 1) and older people (part 2) to residential and nursing care homes relative to the population size of each group. The measure compares council records with ONS population estimates.
Numerator	Number of council-supported permanent admissions of older adults to residential and nursing care, excluding transfers between residential and nursing care (aged 18-64 – part 1 and aged 65 and over - part 2)
Denominator	Size of older adult population in area (aged 65 and over)
Data source	Better Care Fund Metric

31. Delayed Transfers of Care (Days Delayed per 100,000 population 18+)	
Definition	This measures the impact of hospital services and community based care in facilitating timely and appropriate transfer from hospital. However the measure looks at the total number of days of delay, rather than the number of patients that were delayed.
Numerator	Number of delays
Denominator	18+ Population
Data source	Better Care Fund Metric

32. Total Non-Elective Admissions	
Definition	Composite measure of: • unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages); • unplanned hospitalisation for asthma, diabetes and epilepsy in children; • emergency admissions for acute conditions that should not usually require hospital admission (all ages); and • emergency admissions for children with lower respiratory tract infection.
Numerator	Total avoidable emergency admissions for primary diagnoses covering those in all four metrics above, by local authority of residence (NB. This is not the same as adding admissions from the separate metrics as the four separate metrics overlap to some degree and this will therefore lead to 'double counting')
Denominator	Mid-year ONS population estimates
Data source	Better Care Fund Metric

33. Patient Experience (Proportion of people feeling supported to manage their long term conditions) %	
Definition	Proportion of people feeling supported to manage their long term conditions
Numerator	Number of survey respondents who answered positively that they do feel supported to manage their long term conditions
Denominator	Total survey respondents
Data source	Better Care Fund Metrics

Health and Wellbeing Board Performance Dashboard - July 2016

	Updated indictors are bolded	Frequency	Latest Period of Availability	Previous Available Period (Lewisham)	Latest Available Period (Lewisham)	Lon	Eng	England Benchmark	Direction from Previous Period	Data Source
Overarching Indicators										
1a	**Life Expectancy at Birth (Male)(yrs)**	**Annual**	**2012-14**	**78.7**	**79.0**	**80.3**	**79.5**	**sig low**	↑	ONS
1b	**Life Expectancy at Birth (Female)(yrs)**	**Annual**	**2012-14**	**83.0**	**83.4**	**84.2**	**83.2**	**similar**	↑	ONS
2	**Under 75 from CVD mortality (DSR)**	**Annual**	**2012-14**	**87.0**	**84.9**	**78.7**	**75.7**	**sig high**	↓	NHSIC - P00400/ PHOF 4.04i
3	Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (DSR)	Annual	2014	-	2212.6	-	2064.5	sig high	-	NHSOF 1A - ONS (CCG 1.1 DSR)- P01559
4	**Low Birth Weight of all babies (%)**	**Annual**	**2014**	**7.8**	**7.8**	**7.7**	**7.4**	**sig high**	→	P00455/CHIMAT Profle 2014
5	**Number of Practitioners attending Brief Intervention Training**	**Annual**	**2015-16**	-	110	-	-	-	-	Local Data
Priority Objective 1: Achieving a Healthy Weight										
6	**Excess weight in Adults (%)**	**Annual**	**2012-14**	**61.2**	**60.7**	**58.4**	**64.6**	**similar**	↓	PHOF 2.12
7a	**Excess weight in Children - Reception Year (%)**	**Annual**	**2014-15**	**24.6**	**23.7**	**22.2**	**21.9**	**sig high**	↓	PHOF 2.06
7b	**Excess Weight in Children - Year 6 (%)**	**Annual**	**2014-15**	**39.3**	**38.9**	**37.2**	**33.2**	**sig high**	↓	PH NCMP Profiles
8	**Maternal Excess Weight (%)**	**Annual**	**2015-16**	**42.0**	**45.8**	-	-	-	↑	LGT Data
9	**Breastfeeding Prevalence 6-8 weeks (%)**	**Annual**	**Q4 14/15-Q3 15/16**	**73.3**	**75.9**	-	**42.8**	**sig higher**	↑	NHS ENGLAND
Priority Objective 2: Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years										
10a	**Cancer screening coverage - breast cancer (%)**	**Annual**	**2015**	**65.0**	**65.7**	**68.3**	**75.4**	**sig lower**	↑	PHOF 2.20i
10b	**Cancer screening coverage - cervical cancer(%)**	**Annual**	**2015**	**73.7**	**71.7**	**68.4**	**73.5**	**sig lower**	↓	PHOF 2.20ii
10c	**Cancer screening coverage - bowel cancer (%)**	**Annual**	**2015**	**-**	**63.5**	**-**	**57.1**	sig higher	-	PHOF 2.20iii
11	**Early diagnosis of cancer (%)**	**Annual**	**2014**	**45.6**	**47.3**	**48.2**	**50.7**	-	↑	PHOF 2.19 – experimental statistics
12	**Conversion of Two Week Wait Referrals to Cancer Diagnosis**	**Annual**	**Awaiting confirmation of how data will be calculated**							
13	**Under 75 mortality from all cancers (DSR)**	**Annual**	**2012-14**	**159.2**	**146.1**	**132.6**	**141.5**	**similar**	↓	NHSIC - P00381/ PHOF 4.05i
Priority Objective 3: Improving Immunisation Uptake										
14	**Uptake of the second dose of Measles Mumps and Rubella Vaccine (MMR2) at five years of age (%)**	**Annual**	**2015-16**	**71.5**	**71.5**	**79.5**	**88.0**	-	→	Local Immunisation cover data
15	**HPV Vaccine Update (All Doses) %**	**Annual**	**2014-15**	**82.9**	**73.4**	**79.2**	**-**	-	↓	PHOF 3.03xii
16	Uptake of Influenza vaccine in persons 65+ years of age	Annual	2014-15	70.2	71.4	69.2	72.7	**similar**	↑	PHOF 3.03xiv
Priority Objective 4: Reducing Alcohol Harm										
17	**Alcohol related admissions (ASR per 100,000 pop)**	**Annual**	**2014-15**	**614**	**644**	**526**	**641**	**similar**	↑	PHOF 2.18
Priority Objective 5 : Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking										
18	**Smoking Prevalence(%) in persons 18+ years**	**Annual**	**2014**	**20.6**	**20.6**	**17.0**	**18.0**	**similar**	→	PHOF 2.14
19	4 week smoking quitters (crude rate per 100,000)	Annual	2014-15	751	680	531	522	-	↓	Smoking Quitters
20	**Smoking status at time of delivery (%)**	**Annual**	**2015-16**	**4.9**	**4.5**	**4.9**	**10.6**		↓	HSCIC
Priority Objective 6: Improving mental health and wellbeing										
21	**Prevalence of Serious Mental Illness (%)**	**Annual**	**2014-15**	**1.27**	**1.28**	**1.07**	**0.88**	**sig high**	↑	QOF
22	**Prevalence of Depression 18+ (%)**	**Annual**	**2014-15**	**5.90**	**6.40**	**5.33**	**7.30**	**sig lower**	↑	QOF
23	**Improving Access to Physiological Therapies (IAPT) referrals entering treatment (%)**	**Annual**	**2014-15**	-	**6.9**	-	-	-	-	IAPT Annual Report
24	**Proportion of those accessing IAPT who moved to recovery (%)**	**Annual**	**2014-15**	-	**35**	**-**	**-**	**-**	**-**	IAPT Annual Report
Priority Objective 7: Improving sexual health										
25	Rate of chlamydia diagnoses per 100,000 young people aged 15 to 24 (crude rate)	Annual	2014	3661	3504	2178	2012	**sig high**	↓	PHOF 3.02i/3.02ii (NCSP & CTAD)
26	**People presenting with HIV at a late stage of infection (%)**	**Annual**	**2012-14**	**45.2**	**40.7**	**36.6**	**42.2**	**similar**	↓	PHOF 3.04
27	Legal Abortion rate for all ages (crude rate per 1000 women)	Annual	2014	26.6	25.0	21.8	16.5	**sig high**	↓	ONS Abortion Stats
28	**Teenage conceptions (Rate per 1,000 15-17 Yr olds)**	**Annual**	**2014**	**33.1**	**31.3**	**21.5**	**22.8**	**sig high**	↓	PHE Sexual Health Profile
Better Care Fund Metrics										
29	**Proportion of Older People (65+) who were still at home 91 days after discharge from hospital (%)**	**Annual**	**2015/16**	**87.9**	**88.0**	**-**	**-**	**-**	↑	Better Care Fund
30	**Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population**	**Annual**	**2015/16**	**566.2**	**559.9**	-	-	**-**	↓	Better Care Fund
31	**Delayed Transfers of Care (Days Delayed per 100,000 population 18+)**	**Annual**	**2015/16**	**-**	**568.3**	**-**	**-**	**-**	-	Better Care Fund
32	**Total Non Elective Admissions**	**Annual**	**2015/16**	**-**	**25,229**	**-**	**-**	**-**	-	Better Care Fund
33	**Patient Experience (Proportion of people feeling supported to manage their long term conditions) %**	**Annual**	**2015/16**	**59.1**	**56.0**	**-**	**-**	**-**	↓	Better Care Fund

Key

sig high -signficantly higher than England; sig low - significantly lower than England
similar - statistically similar to England
DSR - Directly Standardised Rates
ASR - Age Standardised Rates
ISR - Indirectly standardised Rates
Lew - Lewisham; Lon - London; Eng - England

Statistically Better than England
Statistically Similar to England
Statistically Worse than England
Blank where no statistical comparison could be made
Where performance is notably lower but other areas data is not statistically robust to compare

Arrows Indicate up or down performance of current year /qtr from previous yr/qtr

Links to Source with their abbreviations

http://www.phoutcomes.info/	Public Health Outcomes Framework (PHOF)
http://www.phoutcomes.info/profile/sexualhealth	Public Health England Sexual Health Profiles
https://www.indicators.ic.nhs.uk/webview/	NHS Indicator Portal (NHSIC) by Health and Social Care Information Centre (HSCIC)
http://www.hscic.gov.uk/qof	Quality and Outcomes Framework (QOF) by HSCIC
http://ascof.hscic.gov.uk/	Adult and Social Care Outcomes Framework (ASCOF)
http://www.productivity.nhs.uk/	NHS Better Care Better Value Indicators
https://www.nhscomparators.nhs.uk/NHSComparators/HomePage.aspx	NHS Comparators by HSCIC

HEALTH AND WELLBEING BOARD				
Report Title	Health and Wellbeing Board Work Programme			
Contributors	Service Manager, Strategy and Policy (Community Services, London Borough of Lewisham).		Item No.	10
Class	Part 1	Date:	19 July 2016	

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.

1.2 The report also seeks strategic direction from the Board on how the work programme is managed within the new schedule of meetings agreed in November 2015.

2. Recommendations

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

- Approve the draft work programme
- Propose additional items to be included in the work programme

3. Strategic Context

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

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

3.3 There are a number of core duties defined in the Health and Social Care Act 2012 which underpin the work of Health and Wellbeing Boards. These include:

- To encourage the integration of health and social care commissioning and provision;
- To undertake a Joint Strategic Needs Assessment (JSNA) to identify the health and wellbeing priorities of the local population;
- To develop a joint Health and Wellbeing Strategy outlining how the board intends to achieve improvements to local health outcomes.

4. Background

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

4.2 The HWB has previously agreed that the work programme would include regular progress updates on the Health and Wellbeing Strategy and a progress update in relation to the Adult Integrated Care Programme as a standing item.

4.3 The HWB is also required to consider the Joint Strategic Needs Assessment. It has been proposed that the Health and Wellbeing Strategy Implementation Group takes responsibility for reviewing and assessing recommendations from completed JSNA topics and proposing priorities to the Health and Wellbeing Board.

4.3 The HWB has agreed to consider and approve the work programme at every meeting. In adding items to the work programme, the Board has agreed to specify the information and analysis required in the report, so that report authors are clear as to what is required.

4.4 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.

5. Work programme

5.1 The draft work programme (see Appendix 1), includes those items which the Board has agreed to consider over the course of next year.

5.2 The standing item on the Adult Integrated Care Programme has been amended to a report on the whole system of care as recommended in Item 3 of the agenda.

5.3 The following items have been added to the work programme since the last HWB meeting:

- Public Health Annual Report (November 2016 and November 2017)
- Healthwatch Annual Report (November 2016 and November 2017)
- Local Account (November 2016 and November 2017)
- JSNA update (July 2017)

5.5 Members agreed that a report on the Better Care Fund Plan would be considered in March 2017. This will form part of the report on the whole system of care. As agreed by the Board, quarterly Better Care Fund returns will be circulated to members with authority for sign off delegated to the Chair and Vice Chair.

5.6 It was proposed that a regular update on the Health and Wellbeing Strategy be provided to the Board. Updates will be scheduled at the agenda planning meeting.

5.7 The Board is required to consider the Pharmaceutical Needs Assessment. This will be undertaken every two years. This will be added to the work programme when a date for the next PNA has been agreed.

5.8 Board members are requested to consider additional items to be included in the work programme.

6. Financial implications

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

7. Legal implications

7.1 The Equality Act 2010 (the Act) introduced a new public sector equality duty (the equality duty or the duty). It covers the following nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

7.2 In summary, the Council must, in the exercise of its functions, have due regard to the need to:

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

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

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

http://www.equalityhumanrights.com/legal-and-policy/equalityact/equality-act-codes-of-practice-and-technical-guidance/

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

1. The essential guide to the public sector equality duty
2. Meeting the equality duty in policy and decision-making
3. Engagement and the equality duty
4. Equality objectives and the equality duty
5. Equality information and the equality duty

7.6 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/

7.7 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. 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.

If there are any queries on this report please contact Carmel Langstaff, Service Manager: Interagency Development and Integration, London Borough of Lewisham on: 020 8314 9579 or by e-mail at carmel.langstaff@lewisham.gov.uk

Appendix A

Health and Wellbeing Board – Work Programme

15 November 2016				
Agenda item	**Report Title**	**Deferred**	**Information / Agreement**	**Lead Organisation(s)**
1	**Whole System Model of Care**		Agreement	LBL/CCG
2	**Joint Commissioning Intentions**		Agreement	LBL
3	**Annual Public Health Report**		Discussion	LBL
4	**The Mental Health Awareness Strategy**	Deferred from July 16	Agreement	LBL/CCG
5	**Health and Wellbeing Board Work Programme**		Agreement	LBL
6	**Healthwatch Annual Report**		Information	Healthwatch
7	**Local Account**		Information	LBL

March 2017				
Agenda item	**Report Title**	**Deferred**	**Information / Agreement**	**Lead Organisation(s)**
1	**Whole System Model of Care (to include the Better Care Fund Plan)**		Agreement	LBL/CCG
2	**Performance Dashboard Update – Exceptions Reporting**		Agreement	LBL
3	**Health and Wellbeing Board Work Programme**		Agreement	LBL

July 2017				
Agenda item	**Report Title**	**Deferred**	**Information / Agreement**	**Lead Organisation(s)**
1	**Whole System Model of Care**		Agreement	LBL/CCG
2	**JSNA Update**		Agreement	LBL
3	**Health and Wellbeing Board Work Programme**		Agreement	LBL

November 17				
Agenda item	**Report Title**	**Deferred**	**Information / Agreement**	**Lead Organisation(s)**
1	**Adult Integrated Care Programme**		TBC	LBL/CCG
2	**Joint Commissioning Intentions**		Agreement	LBL
3	**Annual Public Health Report**		Agreement	LBL
4	**Performance Dashboard Update – Exceptions Reporting**		Agreement	LBL
5	**Health and Wellbeing Board Work Programme**		Agreement	LBL
6	**Healthwatch Annual Report**		Information	Healthwatch
7	**Local Account**		Information	LBL

HEALTH AND WELLBEING BOARD				
Report Title	Key Messages from the Joint Strategic Needs Assessment			
Contributors	Director of Public Health, London Borough of Lewisham		Item No.	11a
Class	Part 1	Date: 19.07.16		
Strategic Context	Provides an overview of the health of the population of Lewisham and key challenges to inform the Health and Wellbeing Board and the Strategy			

1. Purpose

1.1 Provides an overview of the health of the population of Lewisham and key challenges to inform the Health and Wellbeing Board and the Strategy. Additionally the report describes the process for engaging stakeholders and the wider community in the selection and production of needs assessment topics for the JSNA.

2. Recommendation/s

Members of the Health and Wellbeing Board are recommended to:

2.1 Consider the key messages and direct as required any further analysis;

3. Policy Context

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

3.2 Lewisham's Joint Strategic Needs Assessment provides access to a profile of Lewisham's population, including demographic, social and environmental information. It also provides access to in-depth needs assessments which address specific gaps in knowledge or identify issues associated with particular populations/services. These in-depth assessments vary in scope from a focus on a condition, geographical area, or a segment of the population, to a combination of these. Needs assessments in Lewisham are carried out to an agreed standard as outlined in the joint Community Services/Public Health guide. The overall aim of each needs assessment is to translate robust qualitative and quantitative data analysis into key messages for commissioners, service providers and partners.

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

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

4. Background

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

5. Population Profile and Health Challenges

5.1 Population

5.1.1 The Lewisham population is projected to continue to grow by a further 20,000 residents over the next five years. Growth is predicted across almost all age brackets, with the exception of residents aged 20-29, where a small decrease is projected. For this period the largest increases are likely to be seen in the brackets, 10-14, 40-44 and 55-59, which will all increase by 3,000 or more residents. By 2026 the population is projected to be 341,000, growth of almost 40,000 residents from the 2016 figure.

5.1.2 The birth rate in Lewisham continues to be above the London average, however the actual number of births per year has dropped slightly since a peak in 2012.

5.1.3 Lewisham is the 14th most ethnically diverse local authority in England and Wales. Black and Ethnic Minority (BAME) groups make up 49.3% of the population, the two largest groups are Black African (12%) and Black Caribbean (11%). In the school population 78% of pupils are from BAME, with over 170 languages spoken. The ethnic profile of the older population, which has been predominately White will change.

5.2 Overarching Data and Health Inequalities

5.2.1 There have been improvements in the health of Lewisham residents. However Lewisham experiences significantly worse health outcomes than London and England. The 2014 Standardised Mortality Ratio (SMR) for All Cause Mortality in Lewisham was 102 compared to London (SMR 91) and England (SMR 99). This was a slight increase for Lewisham compared to 2013.

5.2.2 Health outcomes are variable across Lewisham. Data on life expectancy by ward from 2010-2014 shows that on average Males in Crofton Park ward can expect to live for five years longer than Males in New Cross, 81.1 years compared to 75.1 respectively. For Females the

gap is even bigger between both Perry Vale and Crofton Park wards (86.5 years) and New Cross (78.0 years).

5.2.3 The premature mortality rate for Lewisham is significantly higher than that of London. There are higher rates of overall and specific causes of mortality in the more deprived areas of the borough. Rates of Premature All Persons, All Cause Mortality are significantly higher in Lewisham Central, Bellingham and New Cross wards compared to the Lewisham average. Cancer, Circulatory disease and Respiratory disease are the main contributors to the gap in life expectancy between Lewisham and England for both men and women. However the most recent released of the Indices of Multiple Deprivation indicated that relative to other areas in England, Lewisham is now less deprived than in 2011.

5.2.4 In addition to deprivation impacting on inequalities in health outcomes, other populations such as those with mental health problems, homeless people, asylum seekers and Black and minority ethic groups experience health inequalities. For example 70% of people with mental health problems smoke, please see 5.7 below for further information. Additionally for inequalities seen in Sexual Health see 5.9.

5.2.5 The rate of low birthweight in Lewisham has declined significantly over the past eight years. Despite this the Lewisham rate of low birthweight is still significantly greater than the country as a whole (7.8% compared to 7.4%) but we are now in line with London at 7.7%. Maternal smoking is the single biggest contributor to low birthweight. Also, a significant proportion of low birthweight babies are pre-term. Extreme prematurity is the single most important cause of mortality in childhood in Lewisham.

5.2.6 The highest risk of low birth weight is in babies born to mothers of Black African and Black Caribbean ethnicity, to mothers of any Asian ethnic group, and to mothers from deprived areas.

5.3 Priority Objective 1: Achieving a Healthy Weight

5.3.1 Obesity rates in children are high compared to England although similar to rates in London. Maternal obesity, i.e. obesity in pregnancy is also high.

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

5.4.1 Cancer is now the main cause of death (28.3%), followed by circulatory disease (28.1%), respiratory disease (13.8%) and dementia (9%). Screening for both breast and cervical cancer are significantly lower than England, however bowel cancer screening is significantly higher.

5.5 Priority Objective 3: Improving Immunisation Uptake

5.5.1 Significant work around childhood immunisations has taken place with particular focus on Measles, Mumps and Rubella at five years of age. This has resulted in a dramatic improvement in performance of this indicator in quarter 4 of 2015-16. Other childhood immunisations have also seen uptake improve.

5.6 Priority Objective 4: Reducing Alcohol Harm

5.6.1 There is a high rate of alcohol harm in Lewisham and Alcohol related hospital admissions are increasing. Reducing levels of obesity, alcohol intake and inactivity would also contribute to improving health outcomes.

5.7 Priority Objective 5: Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking

5.7.1 More people smoke in Lewisham than the national average, reducing the number of people who smoke would make a major impact on the key causes of premature death.

5.8 Priority Objective 6: Improving Mental Health and Wellbeing

5.8.1 Prevalence of mental illness is high in Lewisham both for Common Mental Illnesses and Severe Mental Illness. Poor mental health is more prevalent in disadvantaged communities in Lewisham. Demand for services is high.

5.8.2 Mental ill health is more prevalent in certain Black and Minority Ethnic groups, those who identify as Lesbian, Gay or Bisexual, those who are divorced/widowed/separated and those living in deprived areas.

5.8.3 Dementia - with the increasing age of the population the number of dementia cases will rise; prevalence increases particularly in the population older than 65. Lewisham's prevalence is currently lower than England's but is rising

5.9 Priority Objective 7: Improving Sexual Health

5.9.1 Lewisham has very high rates of abortion, teenage pregnancy and sexually transmitted infections. HIV rates are high and over half of all cases are diagnosed 'late'. Certain groups are disproportionately affected by sexual ill-health. For example, HIV has had a greater impact on several groups such as men who have sex with men and those from Black African communities.

5.10 Long-Term Conditions

5.10.1 There will be increasing numbers of people who have long-term conditions and this will further increase with the ageing population,

particularly the likelihood of having more than two conditions. Currently 28.9% of residents have a long term condition and 11.2% have two long term conditions.

5.10.2 Lewisham's Black and Minority Ethnic communities are also at greater risk from health conditions such as diabetes, hypertension and stroke. Identifying those with disease early and treating them optimally will be essential to managing this increasing demand.

5.10.3 Lewisham residents with Long term conditions are less likely to be in employment than the overall population (65.7% compared to 74.5%). more prevalent amongst the poorest in society. However the Lewisham figure is above the England rate of 60.9%.

5.11 Children

5.11.1 The main health risks for children are premature delivery, high levels of obesity, and high levels of toxic stress defined as exposure to strong, frequent, and/or prolonged adversity, such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship. The level of child poverty in Lewisham (26.0%) is significantly worse than the England average (18.6%). The rate of family homelessness is also worse than the England average.

5.12 Young People

5.12.1 The main health risks for young people are mental health issues, often as a consequence of exposure to toxic stress during early development, and sexual ill-health. High levels of obesity, and use of tobacco alcohol and cannabis also adversely affect young people's health in Lewisham.

5.13 **Adults**

5.13.1 Health risks for adults are the increasing numbers of people diagnosed with long term conditions and their management, in particular, Diabetes, COPD, CVD and hypertension.

5.13.2 Level of mental health needs for both common and severe mental illness are significantly higher for adults in Lewisham compared to London and England. None of the cancer screening programmes meet the national targets. The prevalence of risk factors such as obesity and overweight affect 61% of the adult population. Around 1 in 5 adults smoke, rising to 1 in 4 for routine and manual workers and there is a high rate of alcohol harm in Lewisham.

5.14 Older People

5.14.1 The prevalence of having a long term condition increases with age and over fifty percent of those aged 75+ will have two or more long term conditions.

5.14.2 The prevalence of dementia increases markedly with age, at about 1% of 65 to 69 year olds and almost one in four people aged over 90. In 2012/13 it was estimated that under half of all people with dementia are undiagnosed in Lewisham.

5.14.3 The rate of emergency hospital admissions for accidental falls is significantly higher in Lewisham than the England average, at 3,367 per 100,000 in 2012/13.

6. Financial implications

6.1 There are no specific financial implications. The Public Health team will have to allocate the appropriate human resources to manage and coordinate the JSNA process. Relevant commissioners will also be required to allocate appropriate human resources to the relevant JSNA Topic Expert Group.

7. Legal implications

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

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

8. Crime and Disorder Implications

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

9. Equalities Implications

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

10. Environmental Implications

10.1 There are no Environmental Implications from this report.

11. Conclusion

11.1 Lewisham continues to face notable health challenges, despite deprivation falling relative to other areas. With recently upwardly revised figures on population growth predicted these issues need to continue to be addressed through the Health and Wellbeing Board and its Strategy to ensure that improvements are continued and that areas of poor performance are addressed.

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

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