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Healthier Communities Select Committee Agenda

Tuesday, 18 October 2016
7.00 pm,
Civic Suite
Catford
SE6 4RU

For more information contact: John Bardens (02083149976)

Part 1

Healthier Communities Select Committee Members

Members of the committee, listed below, are summoned to attend the meeting to be held on Tuesday, 18 October 2016.

Barry Quirk, Chief Executive
Thursday, 6 October 2016

Councillor John Muldoon (Chair) Councillor Stella Jeffrey (Vice-Chair) Councillor Paul Bell Councillor Colin Elliott Councillor Jamie Milne Councillor Jacq Paschoud Councillor Joan Reid Councillor Alan Till Councillor Susan Wise Councillor Alan Hall (ex-Officio) Councillor Gareth Siddorn (ex-Officio)	

MINUTES OF THE HEALTHIER COMMUNITIES SELECT COMMITTEE

Tuesday 13 September 2016, 7pm

Present: Councillors John Muldoon (Chair), Stella Jeffrey (Vice Chair), Colin Elliot, Jacq Paschoud, Joan Reid, Alan Till and Susan Wise

Apologies: Councillors Paul Bell

Also Present: Aileen Buckton (Executive Director of Community Services), Tim Higginson (Chief Executive, Lewisham and Greenwich NHS Trust), Caroline Hirst (Joint Commissioner, Children and Young People's Services), Ruth Hutt (Consultant in Public Health, Lewisham Council), Sarah Perman (Consultant in Public Health), Joan Hutton (Head of Assessment and Care Management), Carmel Langstaff (Service Manager – Interagency Development and Integration), James Lee (Service Group Manager, Prevention, Inclusion and Public Health, Lewisham Council), Tony Read (Chief Financial Officer, Lewisham CCG), Warwick Tomsett (Head of Targeted Services and Joint Commissioning for Children and Young People, Lewisham Council), Geeta Subramaniam (Head of Crime Reduction and Supporting People, Lewisham Council), Danny Ruta (Director of Public Health, Lewisham Council), and John Bardens (Scrutiny Manager).

1. Minutes of the meeting held on 28 June 2016

Resolved: the minutes of the last meeting were agreed as a true record.

2. Declarations of interest

The following non-prejudicial interests were declared:

- Councillor John Muldoon is a governor of the South London and Maudsley NHS Foundation Trust.
- Councillor Jacq Paschoud has a family member in receipt of a package of adult social care.
- Councillor Susan Wise is a member of the King's College Hospital NHS Foundation Trust and the South London and Maudsley NHS Foundation Trust.

3. Health and Wellbeing Board response to Committee's referral on Healthwatch report

Resolved: the Committee noted the response

4. Health and adult social care integration - evidence session

Aileen Buckton (Executive Director of Community Services), Tim Higginson (Chief Executive, Lewisham and Greenwich NHS Trust), Tony Read (Chief Financial Officer, Lewisham CCG) introduced the report. The following key points were noted:

- The Council started integrating staff working in the community in 2011 – including district nurses, occupational therapists and physiotherapists. Virtual Neighbourhood Community Teams of social care staff and District Nurses working with primary care have now been established.
- Residents had said that they found it difficult and confusing to organise their care. GPs had also said that they were sometimes unsure about where to refer people to for additional care and support.
- GPs had said that many people they were seeing, particularly those who were lonely and isolated, could be better helped by other organisations in the community. The Community Connections programme has since been set up – matching people like this with appropriate organisations in the community.
- The Council and the CCG brought together health and social care commissioning some time ago and are now looking at joint commissioning across the whole system.
- A new virtual patient record, Connect Care, has been developed so that Patient records have also been integrated so that different health and care professionals can share information and work together.
- Integration work is also focused on reducing avoidable admissions to hospital and delays with discharge. It has also led to more efficient management and better co-ordination of services.
- The Government has now asked local authorities to have a plan in place by April 2017 for how they will fully integrate adult social care and community-based staff by 2020. Over the last year, Lewisham Health and Care Partners have reviewed the governance arrangements and established an Executive Board that will consider new models for health and adult social care integration.
- The Board will also be looking at estates and IT and the possibility of co-locating neighbourhood teams; and how the roles and responsibilities of the workforce can encourage closer and more person-centred care.
- A key part of this work includes closer integration with mental health services.

Aileen Buckton (Executive Director of Community Services) and partners answered questions from the Committee. The following key points were noted:

- A whole communications strategy about the wider transformation of services will come out alongside the SE London Sustainability and Transformation Plan (STP). It will be brought to the Committee before it goes out. The integration of health and adult social care is only a small part of this.
- The STP draws heavily on the Our Healthier South East London (OHSEL) programme, which has had significant public engagement. The STP submission itself hasn't been published yet because it hasn't been finalised. But people can

find a huge amount of information about it on the OHSEL website (http://www.ourhealthiersel.nhs.uk/about-us/).

- Delays in discharging people from hospital are sometimes down to the hospital not doing its side of things, not doing all of the assessments for example. But it is increasingly down to problems finding the right placements for people with very complex needs.
- Providing better support for people in their homes will help with discharge delays as well as reducing unnecessary admissions.
- Health partners are also now much more aware of who those people with complex needs are and why they are not being discharged in good time. They also know that a significant number of re-admissions are down to people not having the right support at home and in the community.
- In Lewisham, it's rare that a delayed discharge is down to a social care package not being ready. It's normally down to the need to find specialist placements or when someone has chosen to go to another borough. Staff are starting to plan patient discharges at the time of admission.
- Local health partners are held jointly accountable for the hospital's four-hour A&E target, and this target also relates to delayed transfers of care. The data is scrutinised by a board of local health partners every fortnight.
- Health and care partners are looking to expand admission avoidance services. The enhanced care and support workstream is looking, for example, at "home wards", so that people can receive treatment within their own home rather than within a hospital.
- The capacity of Lewisham's rapid response team is being extended to a 7 day, 8am to 8pm service to increase access, particularly over the weekend.
- The Council and SLAM are working together to improve access to health services for people with mental health needs. This includes looking at whether assessments can be done somewhere else rather than A&E.
- Services in the community are being extended – the social work offer is very close to being 7 days a week. There will be extended access to GPs 7 days a week, 8am to 8pm.
- Under the proposed model, an individual's key worker will think more holistically about what's needed and co-ordinate care around the person's needs as a whole. It doesn't mean there will be only one person – others will be brought in as and when they were needed.
- Pharmacies, although not part of multi-disciplinary teams – as they don't go into people homes the same way – are very much part of whole wider community network.

The Committee made a number of comments. The following key points were noted:

- The Committee noted that major service transformation is best achieved by taking people with you. People must be told about the changes that are coming and much thought must be given to how this is done.
- The Committee noted that in developing new models of care, public involvement and co-production is needed right from beginning. There's a lot of suspicion and fear around the STP process because of the perceived secrecy.
- The Committee also noted that it is important to look at people's personal support networks as well as community and social services. Lots of vulnerable people – those with mental health needs, substance abuse issues as well as older people – are still ending up in A&E when it's not best for them.

Resolved: the Committee noted the report.

5. Lewisham Future Programme

A18 – widening the scope of charging for social care services

Joan Hutton (Head of Assessment and Care Management) introduced the report. The following key points were noted:

- £200,000 of the proposed savings will be achieved by, among other things, removing the subsidy and increasing charges for day care meals; charging arrangement fees for those who fund their own social care; increasing charges for the Linkline/community alarm service; and changing the non-residential charging policy to reflect Government guidance.
- A further £300,000 will be saved by improving the way payments are collected. This includes making service users aware of care charges, and sending out invoices at an earlier point in the process.

Joan Hutton (Head of Assessment and Care Management) answered questions from the Committee. The following key points were noted:

- The exact amount that each individual charging proposal will save will be identified by analysis of each element and confirmed once the proposal has been agreed.
- Previous IT systems have prevented the Council from being able to collect payment in better way Officers are confident that the new IT system will help improve things.
- People are less likely to try to avoid paying care fees if it the costs are made clear to them early on in the process.
- The social care arrangement service will continue to be provided by the Council when charges come in for those who fund their own care.
- Proposed charges will market tested and put out to consultation for three months.

The Committee made a number of comments. The following key points were noted:

- The Committee noted that some people can well afford to pay for their social care. And that with some social care debts running into the tens of thousands of pounds, this affects the care the Council is able to provide to those who genuinely can't afford to pay.
- The Committee noted that some of the proposed charges seemed quite high and expressed concern that they may lead to fewer people using these services, simply creating pressures in other parts of the system – the Linkline alarm service for example.

Resolved: the Committee agreed to refer its views on this proposal to the Public Accounts Select Committee:

The Committee expressed concern about the possibility of vulnerable people choosing not to use services like this as a result of increased charges – the Linkline alarm services in particular. The Committee recommended, should this proposal be accepted, that the Mayor and Cabinet make sure that any decrease in use by vulnerable people is closely monitored.

A19 – reduction in the staffing costs for assessment and care management

Joan Hutton (Head of Assessment and Care Management) introduced the report. The following key points were noted:

- The proposed saving of £500,000 will primarily come from deleting 12 to 15 FTE posts from across the assessment and care management teams.
- Savings will also come from improving staff IT, introducing mobile working, and improving access to information, advice and signposting for service users.

Joan Hutton (Head of Assessment and Care Management) answered questions from the Committee. The following key points were noted:

- The proposals are not just about cutting staff – they're also about better managing and reducing demand at the front end. This includes using multi-agency staff to make sure that every contact counts and people get the right assessments.
- Savings will also come from a more proportionate approach to assessments. This involves making sure that people are signposted to other services in the community at the right time – reducing the demand for Council services.
- The Live Well App will also help save money by providing professionals with access to range of advice and information about services – helping them to navigate residents around the system.

Resolved: the Committee agreed to refer its views on this proposal to the Public Accounts Select Committee:

The Committee expressed concern about possible increases in delays for assessments, and decreases in the quality of assessments, as a result of deleting 10% of posts in the assessment and care management teams. The Committee recommended, should this proposal be accepted, that the Mayor and Cabinet make sure any negative consequences are closely monitored.

A20 – reduction in Day Care

- The proposed saving of £300,000 will come from not renewing the existing block contract for 50 day care places across two sites. Demand has been falling and people will instead be funded on an individual basis by personal budgets and direct payments.

Joan Hutton (Head of Assessment and Care Management) answered questions from the Committee. The following key points were noted:

- The current direct payment amount is £50 per day.

Resolved: the Committee noted the proposal

A21 a) and b) – reduction in mental health spend

Joan Hutton (Head of Assessment and Care Management) introduced the report. The following key points were noted:

- Of the proposed saving, £300,000 will come from better managing demand for accommodation-based care. A further £200,000 will come from making sure that people subject to s117 of the Mental Health Act are reviewed and discharged when appropriate – meaning that they may need to contribute to the cost of their care.

Joan Hutton (Head of Assessment and Care Management) answered questions from the Committee. The following key points were noted:

- Focusing on prevention is more cost-effective and will help absorb the savings.
- Officers agreed to provide more detail about the proposals, including the numbers of people affected, to Committee members by the next day.

The Committee made a number of comments. The following key points were noted:

- The Committee expressed concern about the ability for sector to absorb the when mental health services are already seriously underfunded.

Resolved: the Committee noted the proposal, subject to further detail being provided the next day.

L10 – Adult Learning Lewisham subsidy

Aileen Buckton (Executive Director of Community Services) introduced the report. The following key points were noted:

- The proposed saving of £40,000 will come from removing the Council's subsidy for Adult Learning Lewisham. There will be no impact on the service.

Resolved: the Committee noted the proposal

Q7 a) and b) – review of Child and Adolescent Mental Health Services (CAMHS)

Warwick Tomsett (Head of Targeted Services and Joint Commissioning for Children and Young People) introduced the report. The following key points were noted:

- Child and Adolescent Mental Health Services (CAMHS) are one part of a broader range of support for the emotional and mental health needs of children and young people in Lewisham.
- The proposal will involve reducing the Council's financial contribution and using more funding from the pupil premium grant.

Resolved: the Committee noted the proposal

6. Public health savings

Danny Ruta (Director of Public Health, Lewisham Council) and colleagues introduced the report. The following key points were noted:

- The Council has to save £4.7m after the Government announced further cuts to public health funding. The Council have tried to protect public health services as much as possible and believe that the impact of residents could have been greater without this. But there is still a £300,000 shortfall and officers will have to come back with further proposals in the future.
- The current proposed savings come from preventative health services; health visiting and school nursing; and sexual health services.

Danny Ruta (Director of Public Health, Lewisham Council) and colleagues answered questions from the Committee. The following key points were noted:

Preventative health services

- Given the level of cuts, closer integration between services and making sure every contact counts will become increasingly important in the future.
- Officers pointed out that Stop Smoking services are a cost-effective intervention and said that the health service will have to pay sooner or later for more preventative services.

- Lewisham's Staying Healthy pilot, for example, is about looking at the whole environment that people live in and tackling those parts that make people fat.
- Officers also pointed out that Lewisham has been given highest level of 'Baby Friendly' award and that the borough is also on the right path to increasing breastfeeding.

The Committee made a number of comments. The following key points were noted:

- The Committee expressed particular concern about cuts to Stop Smoking Services. The Committee also accepted, however, that if we don't cut these services we will have to cut services for the most vulnerable.
- The Committee noted that it is disappointing to see cuts to public health when much of the drive towards further integration is about prevention too

Resolved: the Committee voted against making a referral to Mayor and Cabinet and noted the proposal.

School nursing and health visiting

Warwick Tomsett (Head of Targeted Services and Joint Commissioning for Children and Young People) and colleagues introduced the report. The following key points were noted:

- Officers received lots of positive feedback about these services during the consultation – and a mixed reaction to the proposed changes.
- People were broadly supportive of changes to school nursing. People were also supportive of more integration between health visitors and children's centres. But there was some concern about the possibility of families with high needs being lost by making changes to the universal health checks to include more group-based activity.
- The Council's equalities analysis assessment found that the proposed changes do not discriminate. But these are not finalised proposals. There will be more engagement, including with providers.

Warwick Tomsett (Head of Targeted Services and Joint Commissioning for Children and Young People) and colleagues answered questions from the Committee. The following key points were noted:

- Representatives from the Save Lewisham Hospital Campaign expressed particular concern about the damage to children's health. They said the cuts to CAMHS, health visiting and school nursing were very risky and concerning. They stressed how dangerous it is to make cuts so early in a child's life. They said that evidence shows children need support early on – especially under the age of five.

- Representatives from the Save Lewisham Hospital Campaign said they were worried about the extra pressure on GPs and the drop-off in people using the help that's there if it's more difficult to access. They also said they were worried about the possibility of services being provided by private companies in the future. They asked the Committee to reject the cuts.
- Officers noted that there is currently some overlap and duplication in services and that the proposals maintain a universal service. Support will be maintained for the most vulnerable. Officers are working with providers and stakeholders to ensure that the needs of vulnerable parents will continue to be identified and the report outlines how the risks will be mitigated.
- A member of the public, a health visitor, said it is very hard for many people to speak out in a group. Another health visitor added that the Council should avoid cutting health visitor team leaders as they proved essential support.

The Committee made a number of comments. The following key points were noted:

- The Committee noted the potential risks of making cuts at early points in children's lives, when they are so vulnerable.
- The Committee also expressed concern about the increased risk that the most vulnerable people won't be recognised and supported.

Resolved: the Committee noted the proposal

Sexual health services

- The proposed savings will be achieved primarily through a new way of charging for sexual health activity (a new integrated sexual health tariff) and moving uncomplicated contraception and STI testing online and into pharmacies.
- Consultation found high level of support for proposals, in particular online testing. Many people said they'd experienced long waits at sexual health clinics.
- Consultation also found a high level of support for young people's sexual health services. Officers will be looking to develop a teenage wellbeing service – focused on sex and relationships education as well as STI prevention.

Ruth Hutt (Consultant in Public Health, Lewisham Council) and colleagues answered questions from the Committee. The following key points were noted:

- Officers noted that some people from high-risk groups may still choose to visit specialist clinics out of borough. Officers said that this was right for some people but that they still didn't want others to feel forced out of borough.
- Officers said that the best way to deal with high rates of re-infection among 15-24-year-olds is to get partners tested – breaking the chain of infection – and encourage condom use.

Resolved: the Committee noted the proposal

7. Devolution pilot business case

Aileen Buckton (Executive Director of Community Services) introduced the report. The following key points were noted:

- The Council is asking for more powers in how it manages its estates and workforce. Officers are asking for the freedom to set up hubs of community-based care and to create more flexible health and social care roles (as used in the Buurtzorg model from the Netherlands).

Aileen Buckton (Executive Director of Community Services) and partners answered questions from the Committee. The following key points were noted:

- The next steps for the pilot will be developing more detail about each area and working with the London-wide team to see what might be done without formal devolution of powers. Officers will come back to the Committee in the future with more details about workforce changes,

The Committee made a number of comments. The following key points were noted:

- The Committee noted the importance of retaining the freehold of any estates.

Resolved: the Committee noted the report.

8. Select Committee work programme

John Bardens (Scrutiny Manager) introduced the report.

Resolved: the Committee agreed the work programme

9. Referrals

The Committee agreed to refer it's views on savings proposals A18, widening the scope of charging for social care services, and A19, reduction in the staffing costs for assessment and care management, to the Public Accounts Select Committee.

The meeting ended at 10.15pm

Chair:

Date:

Healthier Communities Select Committee			
Title	Declaration of interests		
Contributor	Chief Executive		Item 2
Class	Part 1 (open)	18 October 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;

(b) and either

(i) the total nominal value of the securities exceeds £25,000 or 1/100 of the total issued share capital of that body; or
(ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person* has a beneficial interest exceeds 1/100 of the total issued share capital of that class.

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

3. Other registerable interests

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

(a) Membership or position of control or management in a body to which you were appointed or nominated by the Council
(b) Any body exercising functions of a public nature or directed to charitable purposes, or whose principal purposes include the influence of public opinion or policy, including any political party
(c) Any person from whom you have received a gift or hospitality with an estimated value of at least £25

4. Non registerable interests

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

5. Declaration and Impact of interest on members' participation

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

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

consideration of the matter and vote on it unless paragraph (c) below applies.

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

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

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

6. Sensitive information

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

7. Exempt categories

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

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

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Healthier Communities Select Committee		
Title	Health and adult social care integration – second evidence session	
Contributor	Scrutiny Manager	Item 3
Class	Part 1 (open)	18 October 2016

1. Overview

As part of the second evidence session of the in-depth review of health and adult social care integration, the Committee will be hearing from four witnesses:

- Fiona Russell, Senior Adviser, Local Government Association, Care and Health Improvement Programme
- Clive Grimshaw, Strategic Lead for Health & Adult Social Care, London Councils
- Susan Underhill, Deputy CEO, Age UK Lewisham and Southwark (lead provider of Community Connections in Lewisham)
- James Archer, Public World (will be giving an introduction to the Buurtzorg model)

The Committee has also received written evidence (included in this report) from the following organisations:

- Lewisham Local Medical Committee
- Carers Lewisham

These relevant reports are also included as appendices for further reading:

- Parliamentary Office of Science and Technology, *Integrating health and social care*, August 2016
- Kings Fund, *Social care for older people: Home truths*, September 2016

2. Written evidence

2.1 Lewisham Local Medical Committee

Lewisham LMC is grateful to you for your request for an LMC view on the integrated paper. The LMC is sorry for the delay in responding and thanks you for your patience.

In principle, the LMC supports the vision of integrated care across health and social care to provide a more seamless approach to improving lives. The LMC can see that through this, with appropriate resourcing and planning, health outcomes could be improved and unplanned care attendances could be reduced.

The key is in the planning and ensuring a sustainable process and the LMC wishes to highlight some key areas relevant to the primary care role.

1. Development and integration into practices of the neighbourhood care networks and timetabled meetings between the teams - NCNs and GPs

This could be real or virtual using the I Boards. The keys for success here are that the right people are at the table (enablers) and there is protected time for GPs to attend. The process will not work if the meetings are slipped between clinics - the practices will need to be released from patient care services with practice cover provided to ensure continuity of care for the patients

2. Clear simple pathways for communication between partners within the team

One suggestion is that for an integrated form for services users such as Occupational therapy, physio, social care , children's services, third sector etc. to be developed. These would need to simple and easy to complete similar to the integrated referral form used for diabetes. If 3 different forms are required for one patient to meet their needs then it won't happen. Also when patients are referred directly this should be a simple one step process.

Currently if GPs refer to occupational health we often receive a request for more information about the patient such as ability to self care etc - this non clinical information could be captured in the form or reviewed by the receiving service.

A similar process happens with child social care - so a phone call to duty then requires Child Assessment Form (CAF) and this can often be followed by further requests using section 17 enquiries - often the same information is sent 3 times - whilst it is essential that the right information is shared duplication and more of reports is a disabler and could discourage referrals

The LMC appreciates that this works both ways so in essence a more streamlined and efficient method of sharing information would benefit all.

3 Working with our partners

Primary care is an essential spoke in the integration wheel but we face unprecedented demand and limited resources and staffing - as does the Local Authority

So that we can better work together and develop better understandings the LMC would suggest that those leaders charged with developing the integration share work experiences - maybe a ‘walk in my shoes’ scheme between social care and health care.

If we better understand the limitations and barriers of those involved we can better overcome them

4 For integration to be a success there needs to be closer working between the acute services and primary care

This will involve the acute providers seeing primary care as an equal partner where appropriate work is shared and there are clear expectations of each providers rules and responsibilities. If primary care is overwhelmed with inappropriate work demand it will not be able to deliver on the work required for integration. Again once we better understand how each provider works, what they can do and what they can't then outcomes will be improved.

Essentially all providers need to understand the role they have in wrapping care around the patient and take equal responsibility for delivering their part in the care package

5 Sustainability and Transformation Plan (STP)

The LMC noted that STP plans were referenced in relation to integration. However this was presented as a resourced and well-funded programme that might help develop integration. The LMC is not sure that this truly reflects the STP - which in essence is about developing a sustainable health care model through efficiency savings. As indicated there is little new money available and integration is more about reallocating budgets. There does need that be a clear risk assessment about the impact of this 'movement' of resources and the potential impact on currently resources services. In other words where is the money coming from and what is left behind

Finally but probably most importantly if we are to truly integrate and make a success of it there needs to be clear public engagement and ownership. Changes in design need to be patient focused and ensure we are truly meeting our populations needs and thus not exposing patients to risk. The plans need to ensure that it tackles and tries to reduce health inequalities.

The LMC hopes you find the above comments helpful.

2.2 Carers Lewisham

Initial thoughts on integration of health & social care

It is obviously difficult to offer any meaningful comment or critique without seeing concrete proposals so the following represents our initial thoughts based upon discussion we had at board level.

From a practical, carer-perspective:

1. Carers would broadly welcome the integration of health and social care if it resulted in a simplified, streamlined service for them. It would be counterproductive however - for their ability to remain an unpaid carer - if this integration led to the services, which they need to support the medical needs of the cared for person to, becoming subject to means-testing.

2. One key change that would benefit carers would be that they would not have to repeat their story and situation at each consultation and that their situation would be considered as a whole and not in part. For example the situation of the family is not always considered when multiple appointments are made for the cared for person

which can be disruptive and stressful for the carer. It puts pressure on both their time and resources and perhaps could be streamlined in some cases.

3. But this would require an integrated approach to their personal details and their input in the data that is collected and shared, not only between agencies but between the medical professionals and the carer, not just the cared for person. This has a practical implication for an agency such as Carers Lewisham, which uses a distinct CRM database and does not have access to Connect Care or other statutory databases. Any integration would therefore need to allow for the costs of integrating ICT systems, processes and databases particularly amongst voluntary sector partners.

4. There would need to be considerable investment in time and training for staff to consider the whole situation when deciding on interventions (eg, hospital admission or discharge) including the identification of the carer and, once identified, consultation with the carer. A lead organisation responsible for identifying the carer in each situation, particularly young carers, and for sharing that information with all the agencies involved will therefore need to be identified. This is especially important when carrying out risk assessments. Carers need to be at the heart of the solution not an after-thought.

5. Within that consultation and involvement there would need to be an agreed weight given to the input that the carer gives. For example if a risk assessment is taking place around a hospital discharge and the carer says they cannot cope with the person being discharged immediately then there needs to be weight given to that statement, whilst recognising it may also be a nuanced response. The carer might mean “I cannot cope at the moment because I am feeling unwell, but I will be OK in a week or two”. Or it might be their way of saying “I don’t feel I can cope given their level of disability following their hospital admission, but I am not sure / or don’t want them to feel rejected by me”. We would suggest that carers’ needs should be assessed at this point as a matter of course.

6. There would need to be an integration of complaints processes so that the carer, or cared for person, could make one complaint which although it may involve a number of providers would result in one investigation within a set timescale and with a single set of possible outcomes.

7. If integration is going to lead to an increased role and/or reliance upon carers, there must be an increase in funding and opportunities for both general and emergency respite. It is a fundamental fact that carers need respite if their own health and wellbeing is not to suffer. To fail to realise and acknowledge this, is simply storing up problems for the future.

From a professional-perspective:

1. We agree with the premise that greater co-ordination of health and social care would be a good thing. Health outcomes are at least as dependent on LA work as on the NHS. So, aligning objectives and reducing duplication must be good.

2. However we note that all the mechanisms and policy encouragement to integrate was provided in the Government paper, ‘Partnership in Action: new opportunities for

joint working between health and social services; a Department of Health discussion document,' in 1998. This provided for lead commissioning; better coordinated provision of services; pooled budgets; integrated teams; transfer of funds between sectors; joint finance of services; joint education, training and development; and the development of shared information systems. In other words we have been here before, especially, but not solely, with mental health services. There is therefore perhaps a danger of policy fatigue amongst practitioners and professionals coupled with the danger of policy confusion amongst client groups and the public in general. Indeed, for many of our clients, these policy initiatives do simply conjure up fear and confusion.

3. One of the difficulties with the Scrutiny paper, which admittedly is proposing a review, is that none of the strategies discussed is given any relative weight, so it is unclear what direction the Council is proposing to go in. Terms such as collaboration lack any clear definition and have been used synonymously with concepts such as co-operation, co-ordination, participation and integration.

4. A further difficulty is that integration is not defined. Does this mean: Working more closely? Sharing teams? Different teams working in the same place? Sharing budgets? Merging budgets and commissioning? We note that there is already close working in Lewisham with the Better Care Fund enabling Joint Commissioning by the LBL and CCG. Relationships are - to the outsider - generally good and productive.

5. There is a natural worry that, because these changes are happening under "austerity", quality standards may slip and not be mandated. Furthermore, local authority budgetary pressures may very well make integrated health services more liable to cuts. As we are seeing now, local authorities are so cash-strapped that they are cutting services, including those that used to be in the NHS, such as health visitors and school nurses.

6. We worry that this new push for integration is driven not by client needs but by the Treasury where the focus is on reducing NHS spend and efficiency savings. In SE London, for instance, the STP has to bridge a £1.015bn gap in NHS funding over 5 years to 2020/21. And a £242m gap in social care funding to 2020. Whither the client here?

7. If services are moved into local authorities will this open them up to back-door privatisation through tendering, etc? The service redesigns will be procured by the rules for tendering which remain in place. Indeed, there appears to be a new putsch to privatisation: "NHS Improvement is to explore new partnerships between the health service and the private sector, including the potential for further outsourcing of clinical services and the use of "independent sector management models"." http://www.hsj.co.uk/topics/service-design/nhs-improvement-to-explore-new-private-sector-partnerships/7009575.article

8. It is not clear if it is intended to have virtual joint teams with common IT systems but separate locations; to co-locate staff but leave them within their own employing organisations, or to have them employed within one integrated Health and Social

Care organisation? Within any joint system it is crucial that the social care element is not lost as has happened to some LA mental health teams which have been located within health systems and lost their social care focus, or lacked support from their social care line managers, or even in some many cases been managed by health staff with little reference to local authority staffing systems. In systems where teams have been integrated, but not been placed under a common employer, all sorts of difficulties have arisen over performance and disciplinary issues where those involved are from different organisations. Similarly the professional needs of staff have sometimes been neglected by managers and training departments unfamiliar with the requirements of other professions. In systems where staff are co-located and integrated, but remained employed by different organisations, it is crucial that staff have effective support from their employing organisation. The overarching legal contracts that have been set up in such situations have always been open to question, which would not occur if all staff were employed within one organisation. Such a situation which pertains in Ireland, would mean that staff within social care who invariably are present in smaller numbers, need an effective voice within a health organisation to represent their professional needs and requirements.

9. The integrated care pioneers mentioned in the document clearly consist of co-located staff, who are only integrated in the sense of their function. It is unclear if they have integrated management or whether the social care staff have their own managers, and vice versa.

10. We would like to make clear at this point that we have significantly reorganised our services along a neighbourhood delivery model to facilitate co-location and integration and wish to discuss this further at a practical level with the Council/CCG

11. We think the concerns about the medicalisation of social care are very real, and it would be essential to have social care representation throughout the management structure of any integrated service, whatever form that service took.

Generally, Carers Lewisham would like to reiterate that we very much want to work in partnership with the Council and CCG to ensure the best possible outcome for our client group and are broadly in favour of integration (but the devil, as always, is in the detail). We are therefore more than happy to participate further and to appear before the committee itself if that would help.

3. Recommendations

The Committee is asked to note this information.

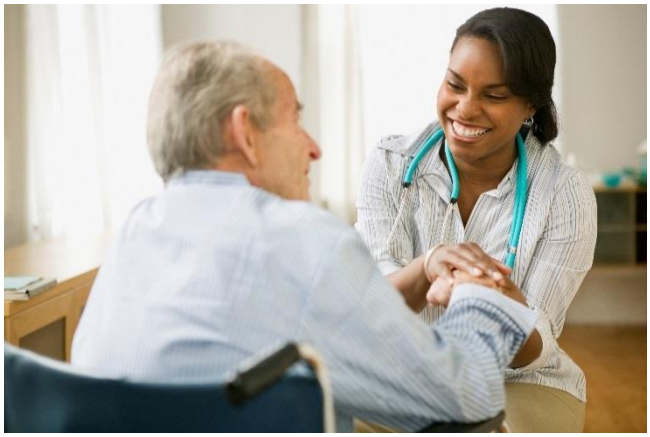
If you have any questions, please contact John Bardens (Scrutiny Manager) on 02083149976.

HOUSES OF PARLIAMENT
PARLIAMENTARY OFFICE OF SCIENCE & TECHNOLOGY

POSTNOTE

Number 532 August 2016

Integrating health and social care



An ageing population and the increasing prevalence of long-term conditions are putting pressure on health and social care services. The four UK nations have committed to better integration between health and social care as one solution to these challenges. This briefing outlines what integration is, examines policies to enable it and gives examples of integration in England. It also looks at the evidence on the challenges of achieving integration and assessing the effectiveness of approaches.

Overview

- Integration aims to put the needs of people at the centre of how services are organised and delivered. Models of integration vary.
- Co-ordinating resources or pooling budgets between health and social care services can enable joint working. The four nations of the UK have introduced different financial arrangements to support integration.
- Data sharing, as well as different incentives and employment terms between sectors, pose challenges for integration.
- Assessing the effectiveness of integration schemes is difficult. Evaluation tends to focus on whether integration has relieved pressure on services, such as reducing emergency hospital admissions, which data suggest is not routinely achieved. However, integration may improve user outcomes and experiences, but data to assess these are not consistently collected.

Background

Health and social care services are facing two major population challenges. First, the UK has an ageing population. In 2010 there were three million people aged over 80; by 2020 this figure is expected to double.[1] Second, life expectancy has risen over the past 50 years. However, self-reported healthy life expectancy has not risen at the same rate and increasing numbers of people have multiple long-term conditions, such as diabetes or dementia.[2,3] In 2008 there were 1.9 million people with three or more long-term conditions; this is likely to rise to 2.9 million by 2018.[4]

The effect of this population shift on health and social care services is significant; over-75s use more than 60% of bed days in acute hospitals and 70% of the health and social care budget is spent on chronic conditions.[3,5] Increasing demand is one of the key factors causing funding gaps, estimated at £30 billion in the NHS and £4.3 billion in social care by 2020 in England alone.[6,7] Older people are likely to require both health and social care to meet their needs.[8] Better integration between health and social care has been put forward as a way to reduce costs, relieve pressure on services and improve user outcomes and experiences.[9,10]

Defining integration

Integration is a broad term and definitions vary. Recent policies across the UK that have encouraged greater integration between health and social care have tended to define it as care that is person-centred and coordinated across care settings. Integration can be within different healthcare settings (e.g. primary and secondary) or between health and social care services.[11] This POSTnote focuses on integration across health and social care. It also briefly covers broader models of integration, which seek to extend integrated care to include improving population health.

For care to be integrated, organisations and professionals must bring together all of the different elements of care that a person needs. Approaches to achieve this form a spectrum, from loose networks to full structural integration.[12] For example, health and social care staff working in separate locations may share electronic patient data. Alternatively, health and social care professionals may be physically integrated in a single location to improve multidisciplinary working. Integration schemes can seek to integrate care for a whole local population, or for specific sub-populations, such as older people or those with a

particular condition. Many schemes also include partnerships with voluntary and third sector organisations.[13]

Policies to enable integration in the UK

Integrated care policy in the UK has a long history. From case management in the 1980s, through inter-agency working in the 1990s, to integrated care pathways in the 2000s, successive governments have tried to bridge the divide between health and social care.[14] Across the four UK nations, health and social care systems are funded and operate differently; however, all have free healthcare at the point of access and all have committed to better integrated care. Coordinating resources or pooling budgets between health and social care is seen as an enabler for joint working.[15] However, integrating separately funded systems is challenging, especially in situations where healthcare is funded through taxation and social care is means-tested.[16] Recent policies across the home nations have established varying financial arrangements to support integration.

Wales

Health and social care services are separate in Wales. NHS Wales is responsible for healthcare, and Local Authorities (LAs) for means-tested social care. The 2014 Social Services and Wellbeing Act requires LAs, Health Boards and NHS Trusts in Wales to work together to look after the health and wellbeing of their local areas. In 2013, Wales established the Intermediate Care Fund. This fund (totalling £60 million in 2016/17) is used to support people to maintain their independence and remain in their own home, to avoid delays in discharge from hospital. It may be used by LAs, health and housing organisations and the voluntary sector.[17]

Scotland

Until recently, health and social care services were separate in Scotland. NHS Scotland is responsible for healthcare, and LAs for social care. Although most social care is means-tested, personal care costs for people aged over 65 years are not, following the recommendation of the 1999 Royal Commission on long-term care for the elderly (Sutherland report).[18,19] The 2014 Public Bodies (Joint Working) Act requires Health Boards and LAs in Scotland to enter into joint financial arrangements, either by one delegating functions and resources to the other, or both delegating to an integrated joint board. The Act also specifies expected health and social care outcomes for which Health Boards and LAs are jointly responsible. The Act came into force in April 2016 and 31 local partnerships have been established.

Northern Ireland

Since 1973 Northern Ireland (NI) has had one organisation responsible for healthcare and means-tested social care.[20] However, health and social care have continued to operate separately. A Government-commissioned review in 2011 suggested that the system was unsustainable and recommended a shift towards community care.[21] The report led to the formation of 17 Integrated Care Partnerships across NI, joining together GPs, social care, voluntary bodies and other services.[20] These built on pilots conducted in 2010.[22]

Box 1. The Better Care Fund in England

In 2013 the Government announced the Better Care Fund (BCF), a £3.8 billion pooled fund for Clinical Commissioning Groups (CCGs) and Local Authorities (LAs) to commission jointly health and social care services starting in 2015/16. The fund is not new money. It is £3.46 billion ring-fenced from NHS England's budget topped up with the Disabled Facilities Grant (DFG) and the Social Care Capital Grant (previously both paid directly to LAs). The BCF is allocated to local areas based on a formula derived from the CCG allocation formula, the social care formula and the DFG distribution formula. LAs, CCGs and Health and Wellbeing Boards agreed on plans for spending their BCF allocation in April 2015. Around half of local areas contributed additional funding, adding another £1.5 billion to the fund.[23] In 2016/17 the BCF increased to £3.9 billion, and from 2017/18 the Government will make an extra £1.5 billion available for the scheme.[24,25]

England

Health and social care services are separate in England. NHS England is responsible for healthcare, and LAs for means-tested social care. The 2014 King's Fund-established commission on the future of health and social care (Barker report), recommended that health and social care funding in England should be brought together in a single ring-fenced budget.[26] Policies in England have focused on encouraging local areas to coordinate resources. For example, in 2013 the Better Care Fund (originally known as the Integration Transformation Fund) was introduced to encourage financial integration between health and social care services (see Box 1).

NHS England's 2014 Five Year Forward View launched new models for different types of integration tailored to local needs (see below).[6] The 2015 Spending Review made a commitment to integrating health and social care further. It stipulated that every part of the country must have an integration plan by 2017, to be implemented by 2020, noting that the approaches taken by local areas will differ. Devolution to local government is likely to provide new approaches to integration between health and social care. For example, Greater Manchester Combined Authority (GMCA) was granted full control of its £6 billion health and social care budget in April 2016.[27] Although in early stages, GMCA has committed to a wider population health approach (see Box 2 for examples).[27]

Examples of integration in England

From 2009, the Department of Health (DH) and NHS England used three schemes to support local areas across England in developing plans for integration within healthcare settings and, in some cases, across health and social care. These schemes are outlined below, because they represent the largest dataset available on integration between health and social care in the UK. However, the broad approaches described have been used more widely across the UK.

Integrated Care Pilots

In 2009, DH launched a two-year integration pilot programme focusing on primary care. 16 local areas tested various integration schemes. Five schemes included efforts to integrate social care with GPs. For example, in Cockermouth, GPs, dentists, diagnostic teams and voluntary and community sector services co-located to

Box 2. Population health system approaches
The term 'population health systems' describes approaches that seek to improve the health of local populations, including tackling the wider determinants of health.[28] This requires coordination between organisations that provide not only health and social care services but also services such as housing support, education programmes and employment advice. It also requires coordination between different governance levels, from central government to local communities. These systems are emerging in a number of countries, including New Zealand and the US. A long-established system is Kaiser Permanente (KP) in the US. KP is a 'health maintenance' organisation, with over 10 million people on its register across nine regions.[28] KP integrates primary and secondary healthcare, focusing on prevention of illness as well as treatment, and uses risk stratification (analysing population data to identify possible future ill health) to tailor lifestyle interventions. Integration of social care services is currently limited to 'integrator' roles, where KP staff support members to connect with community-based social services, and more recently, institutional partnerships, such as KP medical care in assisted living facilities.[29]

Accountable Care Organisations (ACOs)
An ACO is a type of population health system. It is a network of independent health and social care providers sharing financial and medical responsibility for people on their register. Developed in the US in 2006, ACOs receive payments from the federal government for meeting cost efficiency and quality of care standards. Evaluations of ACOs in the US suggest that they are successful at delivering high quality care. However, financial results are mixed, with some reporting savings and others losses.[30] The model has been criticised for failing to integrate long-term care providers.[31] NHS England's Five Year Forward View states that some local areas will operate through similar arrangements to ACOs, for example Northumberland.[7]

provide care for older people. They also used virtual wards, where high risk patients were treated and monitored at home rather than in hospitals (see POSTnote 456).[32,33]

Integrated Care Pioneers

In 2013, 14 local areas (pioneers) were chosen through competition as exemplars of integrated approaches. 11 more sites were added in 2015.[34] The pioneers' approaches varied. For example, Greenwich Coordinated Care took a person-centred approach where people with high service use were assigned a care navigator to help individuals express their needs in specific 'I' statements (e.g. 'I would like to stop smoking' or 'I would like help with the damp in my home').[35] The care navigator then organised a multidisciplinary team meeting (including GPs, housing services and mental health workers) to develop an action plan to meet the 'I' statements.[36] Other pioneers worked with voluntary organisations to improve care provision, such as NHS Kernow's Living Well programme to improve care for older people in partnership with Age UK.[34] DH has commissioned a long-term independent evaluation of the Pioneers, which will run up to 2020.[37]

New Care Models

NHS England announced the 'New Care Models' in 2014.[7] Five models are being trialled across 50 local areas (vanguards); three of which include integration between health and social care.

- **Enhanced Health in Care Homes** is focusing on integrating services for older people in residential care.
- **Integrated Primary and Acute Care Systems** are trialling ways to join up GPs, hospitals, community services and mental health services. Some will operate like Accountable Care Organisations, a type of population health system (see Box 2).
- **Multispecialty Community Providers (MCPs)**, also a type of population health system, are testing ways to move specialist care out of hospitals and into the community. MCPs provide primary care as well as community-based health and care services.

Within each of these models, the approaches taken by the vanguards differ. For example, Calderdale MCP and Birmingham & Sandwell MCP have the same care model, but use different interventions. Calderdale MCP is co-locating a variety of community-based services (including GPs, social care and mental healthcare) in one place. Birmingham & Sandwell MCP is developing a health and social care system accessed through GPs, who assigns users a care coordinator who manages their care plan and access to services as outpatients.[38]

The challenges to integration

Research on integration schemes in the UK suggests that there are three key challenges, outlined below.

Data sharing

Health and social care providers regularly collect personal and confidential information about people in their care. This is regulated under the Data Protection Act 1998 and various other legislation (see Box 6 in POSTnote 474). Data sharing is vital for high quality integrated care. For example, social care workers assisting with medication management need access to NHS data on prescribed drugs. Sharing data also prevents duplication of effort, where providers unnecessarily take the same user information (e.g. allergies).[39]

Sharing data requires providers to ensure that it is used appropriately and legally. Integration schemes have reported problems with contradictory guidance around information governance from different government and NHS bodies.[16,34] Evaluation of the integrated care pilots in 2012 suggested that there is a culture of risk aversion, where some services are reluctant to share data because of continued uncertainties around lawful practice.[32] Data sharing between sectors can also be difficult as it requires information to be collected and coded following agreed practices before being stored on interoperable IT systems.[32] Steps have been taken to improve data sharing. In 2014, the Government appointed a National Data Guardian to build trust in the use of data across health and social care, including encouraging clinicians and care workers to share information to enable joined-up care.[40] The 2015 Health and Social Care (Safety and Quality) Act also introduced a legal duty for health and social care bodies in England and Wales to share information when it can facilitate care.

Incentives and targets

Health and social care providers have different audit systems and payment models, which can result in conflicting interests and a lack of incentives for building services

around users rather than organisations.[41] For example, tariff systems, where hospitals are paid for treating certain conditions, do not have a financial incentive for preventive care that reduces the need for hospital admission.[39] The UK nations have tried to reconcile these differences. In England, the BCF implemented financial risk sharing between providers.[25] In Scotland, the 2014 Scottish Public Bodies (Joint Working) Act legislates for shared accountability between providers.

Workforce practices

Integration schemes have reported 'hard' and 'soft' issues relating to integrating different professional groups.[42] 'Hard' issues include different employment terms (e.g. contracts and pension schemes), which can make transferring and sharing staff across sectors challenging. 'Soft' issues include different organisational cultures and attitudes towards collaboration and professional status. For example, social care professionals have reported that their skills are underutilised by healthcare staff, while healthcare workers report perceiving social care staff as unwilling to adapt to new practice.[43,44] High rates of staff turnover in the social care sector has also been reported as a challenge.[43] A rapid evidence assessment in 2013 for the Skills for Care charity found that training to meet new requirements and develop new skills and competencies was effective in helping to overcome some of these issues.[45] Quality and style of leadership have also been found to be important for delivering change and maintaining an integrated approach.[45]

Assessing effectiveness

Integration is sometimes suggested as a way to reduce costs.[9,10] However, there is little robust evidence that this is commonly achieved, with available reviews even reporting higher costs associated with some integration approaches.[16,46,47] Research suggests that this may be, in part, because integration can result in the identification of previously unmet need.[48,49] The dominant rationale for integrated health and social care is twofold:

- **Improving efficiency and value for money**.[50] This includes making more effective use of existing infrastructure to curtail rising costs. These outcomes are typically reported using organisational and infrastructure measures (see Box 3).
- **Improving users' experience, health and wellbeing**.[50] User outcomes are assessed by some schemes but are not consistently required and there are currently no nationally agreed measures (see Box 3).[25] The British Medical Association and the British Association of Social Workers consider that improved outcomes and experiences for users should be the primary objective.[51,52]

Evaluating schemes

Of the measures outlined in Box 3, reductions in non-elective admissions (NEAs) and delayed transfers of care (DToCs), both primarily NHS measures, are widely used to assess whether schemes have been effective.[24,25] Evidence from the integrated care pilots and other schemes suggests that a significant reduction in NEAs or DToCs is unlikely in the short-term.[32,53] Current evaluations of the BCF have also not shown sustained reductions in NEAs or DToCs.[54] This may be because there are long-term upwards trends in NEAs and DToCs for a number of reasons, and reversing these will take time.[55,56] Research also suggests that integration schemes may not reduce NEAs and DToCs if social care is underfunded.[57] Furthermore, assessing schemes via measuring DToCs and NEAs does not capture whether they have improved user outcomes and experiences. Research suggests that a combination of organisational and person-centred measures will provide a more accurate picture of effectiveness.[32] In addition, integration may have wider benefits in reducing health inequalities;[58] however, this is rarely measured despite the availability of indicators (e.g. Marmot Indicators).[59]

Integrating health and social care is complex and evaluation can be difficult because of policy and budget changes, which can make it challenging to attribute results to a specific intervention.[48] Experts generally agree that long-term evaluation is necessary because the effects of integration may take a long time to become apparent.[60,61] Intermediate markers of progress may be beneficial to assess whether schemes are making progress. The lack of an agreed set of measures for assessing integration schemes across the UK makes comparison between schemes very difficult.[62]

Box 3. Measures of effectiveness

Organisational and infrastructure measures

Two widely reported measures are:

- **Non-elective admissions (NEAs)**: The number of people who are admitted into hospital as an emergency. NEAs cost the NHS £12.5 billion annually and have risen by 47% in England over 15 years.[63]
- **Delayed transfers of care (DToCs)**: The number of patients ready to move from hospital care into social care but are unable to do so because of infrastructure delays between services (see CLB 7415).

Person-centred measures

Measures reported by some schemes, which could be used more widely are described below. Some schemes, such as those funded through the BCF, are required to report user experience, but there is no requirement to report health or wellbeing measures.[25]

- **User experience**: There are national measures used by the NHS to capture patient experience (e.g. the GP patient survey), which could be used or adapted to assess user's experience of integrated health and social care services. However, currently most schemes are using locally-developed measures.[24,25]
- **Health measures**: Relevant measures vary with the aims of the integration scheme, but can include survival rates and specific clinical measures, such as lung capacity for people with respiratory disease. Some studies also measure functional outcomes, such as the ability to perform daily activities.[64]
- **Wellbeing measures**: Improved wellbeing is an aim of multiple integration interventions but outcomes are rarely reported, even though various measures are available (see POSTnote 421).[6]

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The King's Fund nuffield trust

Social care for older people

Home truths

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Key messages

- The social care system in its current form is struggling to meet the needs of older people. Six consecutive years of cuts to local authority budgets have seen 26 per cent fewer people get help. No one has a full picture of what has happened to older people who are no longer entitled to publicly funded care: the human and financial costs to them and those who care for them are mounting.
- Our assessment of national data and in-depth interviews in four unnamed local authority areas found that the past six years have also brought huge pressures on the social care market. Central government grant reductions to local authorities have been passed on to care providers in the form of reduced fees, or below inflation increases. Combined with shortages of nurses and care workers, higher regulatory standards and the introduction of the National Living Wage, this has put many social care providers under unprecedented pressure.
- Many social care providers are surviving by relying increasingly on people who can fund their own care, but those dependent on local authority contracts are in difficulty. Home care services face particularly acute workforce shortages and are now in a critical condition everywhere, threatening to undermine policies to support people at home. The possibility of large-scale provider failures is no longer of question of 'if' but 'when' and such a failure would jeopardise continuity of the care on which older people depend.
- Local authorities have sought to protect the most vulnerable older people with the highest needs, while at the same time encouraging others to be independent, drawing on the resources of their families and communities, and to reduce dependence on support from the state. For many people the experience of needing to find and pay for care comes as an unpleasant surprise for which, in general, they are unprepared. Unpaid carers will also be expected to do even more.

- Access to care depends increasingly on what people can afford – and where they live – rather than on what they need. This favours the relatively well off and well informed at the expense of the poorest people, who are reliant on an increasingly threadbare local authority safety net – especially if they live in areas where local authorities have been least able to sustain spending levels – and who are at a higher risk of declining quality and provider failure.
- The situation for older people has been compounded by pressures elsewhere in the NHS. Cuts to social care should not be viewed in isolation from overstretched general practice and community nursing and the uneven distribution of intermediate care beds; these are all factors identified by our interviewees. Under-investment in primary and community NHS services threatens to undermine the policy objective of keeping people independent and out of residential care.
- The most visible manifestation of pressures on health and social care budgets is the rapid growth in delayed discharges from hospital. While this is undoubtedly driven by funding pressures on both services and exacerbated by workforce shortages in social care, local authorities, NHS providers and commissioners must work more effectively together to address a problem that imposes a significant cost on the NHS and is taking an unacceptable toll on older people, their carers and families.
- The funding outlook for the next five years looks bleak. The measures announced by the government will not meet a widening gap between needs and resources set to reach at least £2.8 billion by 2019. Public spending on adult social care is set to fall to less than 1 per cent of GDP. The potential for most local authorities to achieve more within existing resources is very limited and they will struggle to meet basic statutory duties.

- Based on the national and local evidence we have considered in this report, there are three major strategic challenges facing policy-makers in shaping how the adult social care system could develop over the next five years.
  - **Achieving more with less** This could include continuing to work within the grain of existing policies such as personalisation, better commissioning and integrated care. But these efforts will not in themselves be sufficient to meet immediate funding needs. As the NHS England Chief Executive, Simon Stevens, has said, there is a strong argument that any extra funding should go to social care. As a minimum, the forthcoming Autumn Statement must recognise the scale of the immediate funding pressures facing the sector by bringing forward the additional Better Care Fund money planned from 2018/19, accelerating progress towards establishing a single pooled budget for health and social care in all areas by 2020 and developing a workforce strategy.
  - **A different offer** If the government is unwilling to provide adequate public funding to support the current system, it must be honest with the public about what they can expect from publicly funded services. This would mean establishing a fresh and more explicit policy framework, which makes it clear that primary responsibility for funding care sits with individuals and families, creating incentives for people to plan ahead for their care needs and revisiting some of the new duties and rights created by the Care Act 2014 so that expectations are aligned more realistically with what the government is prepared to fund and local authorities can afford. This will be an unpalatable future but it is one that is already upon us.
  - **Long-term reform** Because reliance on additional private funding will not be sufficient or equitable, a longer-term strategy is needed. England remains one of the few major advanced countries that has not reformed the way it funds long-term care in response to the needs of an ageing population. The Barker Commission – which called for a new settlement for health and social care – is the latest of a number of independent commissions and reviews to set out how this could be achieved. A frank and open debate is needed on how to fund health and social care on a sustainable basis into the future, recognising that a long-term strategy will exceed the lifetime of a single parliament. A mechanism is needed to secure cross-party consensus on some shared principles of reform.

1 Background and context

The adult social care system offers help, care and support to people with a wide range of needs arising from disability, illness or other life situations. It helps people to live as independently as possible, protects people from harm in vulnerable situations, balances risks with rights and offers essential help at times of crisis. Support is offered in people's own homes, residential and nursing homes or other community settings. Unlike NHS care, most of these services involve an assessment of the individual's 'eligible' needs and financial resources (means-testing). This report focuses on services for older people.

Local authorities have important statutory duties, but more than 90 per cent of actual support is provided by a diverse range of more than 19,000 independent organisations, ranging from big corporate chains to small family-run businesses, charities and social enterprises (Skills for Care 2016b). The withdrawal of local authorities and the NHS from the direct provision of long-term care has been a major strategic shift in adult social care policy over the past 30 years. The quality and sufficiency of these services are key indicators of a good society (Association of Directors of Adult Social Services 2015).

The success story of longer lifespans means there are many more people with care and support needs arising from a mixture of physical health and mental health conditions including dementia and frailty in old age. But the system is in trouble. Even before austerity gripped public spending in 2010, the state was able to meet only a proportion of older people's care needs; the remainder had to use their own resources, financial and family, to support themselves. Although 1.5 million people are employed in social care, another 6 million offer unpaid care as friends and family members. The gap between need and funding has grown wider since 2010. Over the past five years, local authority spending on the essential care and support needed by older and disabled people has fallen by 11 per cent in real terms and the number of people getting state-funded help has plummeted by at least 25 per cent. More people are paying for their own care, but the complexities of the system can be difficult for people to understand (Independent Age 2016; Health and Social Care Information Centre 2015d).

Older people generally have health as well as care needs. By the age of 65, most people will have at least one long-term condition and by the age of 75 most will have at least two (Oliver *et al* 2014). Older people account for 62 per cent of all hospital bed days and 52 per cent of admissions that involve hospital stays of more than seven days (National Audit Office 2016). The NHS, too, is under pressure even though its funding has been protected compared with funding for local authorities. Hospitals have struggled to meet the needs of the older age group in a timely way, in both emergency departments and inpatient admissions, and caring for older people in their communities has been hampered by shortages of non-acute beds, community nurses and overstretched general practices. Too often health and social care services are not joined up (Care Quality Commission 2016a). Most professionals and commentators believe that the cuts to social care services have contributed to the pressures on health services.

Low levels of pay, training and skills of care staff – 37 per cent have no recognised qualification – and increasing difficulties in recruitment raise worries about the quality of care, at a time when the acuity of people's needs in all care settings is rising. The former Chancellor's announcement in the 2015 Spending Review and Autumn Statement of a new National Living Wage has been welcomed but will add at least £2 billion to workforce costs by 2020. This has triggered fresh concerns about the financial viability of many care providers after several years in which fees from local authorities have been frozen. Already some of the largest providers of home care have withdrawn from the market (LaingBuisson 2016).

It is therefore not surprising that the National Audit Office has warned that 'national and local government do not know whether the care and health systems can continue to absorb these cumulative pressures, and how long they can carry on doing so' (National Audit Office 2014a).

The need for a better understanding of the current pressures facing care services and the implications for their future sustainability has never been greater. Yet evidence about the relationship between changes in public spending on social care, the quality and quantity of services and the impact on the health and wellbeing of people who use them is extremely limited. More older people are falling outside the social care system, either because their financial means are too high for publicly funded help or their care needs are not high enough, yet knowledge about what happens to them is limited (Baxter and Glendinning 2014; Institute of Public Care 2012).

2 The purpose of this report

The overall focus of this project is to better understand the impact of changes in local authority spending on social care for older people, through an analysis of national data and evidence and a snapshot of four local areas, taking account of the important relationship between the NHS and social care services in meeting the needs of older people.

This report concentrates on services for older people, defined here as people aged 65 years and over, noting that although pressures arising from other kinds of need, such as disabled people of working age, are considerable, they raise different policy and funding issues.

The project had four lines of inquiry that guided our conversations with local areas.

- How local authorities are dealing with current pressures, the implications for their financial sustainability and their ability to meet their statutory requirements.
- The implications for the social care market, including recruitment and retention issues, the impact of the new National Living Wage and the risks of provider failure.
- The impact on the NHS, with a particular focus on primary care, community nursing and acute services. How have changes in the availability of these services affected care needs and the ability of local authorities to meet them?
- The implications for older people's experience of social care and the quality of care they receive.

Figure 1 Our lines of inquiry

Methodology and approach

National data analysis

We conducted a comprehensive analysis of national trends in adult social care expenditure and activity for older people since 2009/10, and examined related NHS data and trends in independent sector care provision to form a view across the whole system of health and social care.

Case studies

Alongside this national data, we used a case study approach to describe what is happening at a local level. We conducted semi-structured interviews and focus groups in four local authority areas that varied in terms of size and type of council.

The authorities were in the North West, the West Midlands, the South East and London. We asked participants about changes to the funding of social care for older people in their area over the last five years; the impact this has had on social care providers, service users and other services; strategies that commissioners and providers are using to mitigate current pressures; and what they feel this means for the future of adult social care.

Participants included key representatives from local authorities (n=17); clinical commissioning groups (CCGs) (n=5); NHS providers (n=6); independent sector social care providers (n=25); voluntary organisations (n=8); and Healthwatch and other local groups representing people who use services (n=4).

Sites were selected to represent variations in local authority type; geographical area; rurality; and the deprivation and ethnic mix of the local population. The anonymity of sites is protected.

User interviews

Alongside this work we were commissioned by the Richmond Group of Charities to interview seven older people about their personal experiences of using social care services and/or about their experience as a carer of someone who uses these services. We draw on some of these stories in this report to illustrate the human dimension of our research findings. A full account of these interviews will be published by the Richmond Group (Hall and Holder 2016).

The structure of this report

In each section we provide a brief overview of the national data, followed by an analysis of themes from our interviews, which aimed to explore the experiences, perceptions and predictions from those involved in the care and health system for older people. The research findings are divided into five sections.

- The views of **local authorities** about the scale and nature of the savings made so far, the principles that have guided their decisions and their perceptions about the future (Section 3).

- The views of **social care providers**, including residential, home care and related voluntary sector players about the impact of local authority budget pressures (Section 4).
- The views of interviewees from all sectors about the impact on **older people, their families and carers** (Section 5).
- The view from **the NHS**, including commissioners and those within hospitals, on the experience of managing rising pressures from older patients, and the part played by local authorities (Section 6).
- An account of the various national and local **strategies to improve care and support for older people** and to mitigate the budget pressures (Section 7).

Finally, we consider the implications of our findings for the future of social care and assess the major strategic challenges facing policy-makers in shaping how the system could develop over the next five years.

3 Local authorities: managing austerity

The national picture: what do we know?

Local authorities' spending on social care for older adults

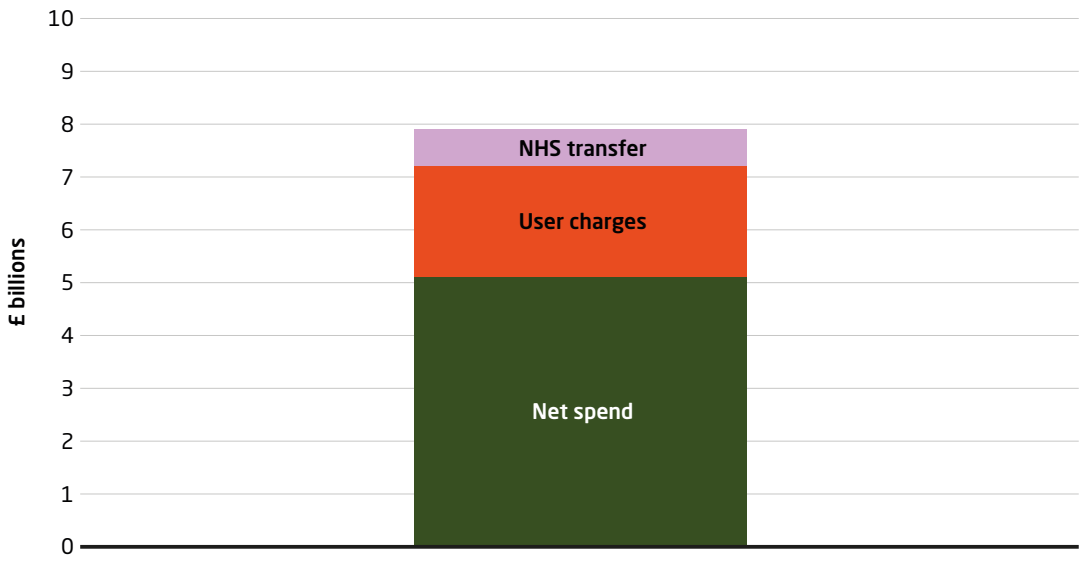
Central government has reduced its funding to local government by 37 per cent in real terms between 2010/11 and 2015/16 (National Audit Office 2014b).

In 2014/15, local authorities spent £7.23 billion on social care for older people, £5.12 billion after user charges and other income is taken into account (*see* Figure 2). This accounts for 42 per cent of all council spending on adult social care (traditionally this has been closer to 52 per cent but has fallen because of definitional changes), the rest being spent on support for people aged 18–65 years. Since 2010, NHS money has been transferred to local authorities to support social care, currently through the Better Care Fund.

Although outside the local authority system, the government also spends a further £4.7 billion on attendance allowance, a cash benefit administered by the Department for Work and Pensions payable directly to older people with care needs. Knowledge of who receives this benefit and how it used is relatively limited. The government is proposing to consult on whether this spending should be transferred to local authorities.

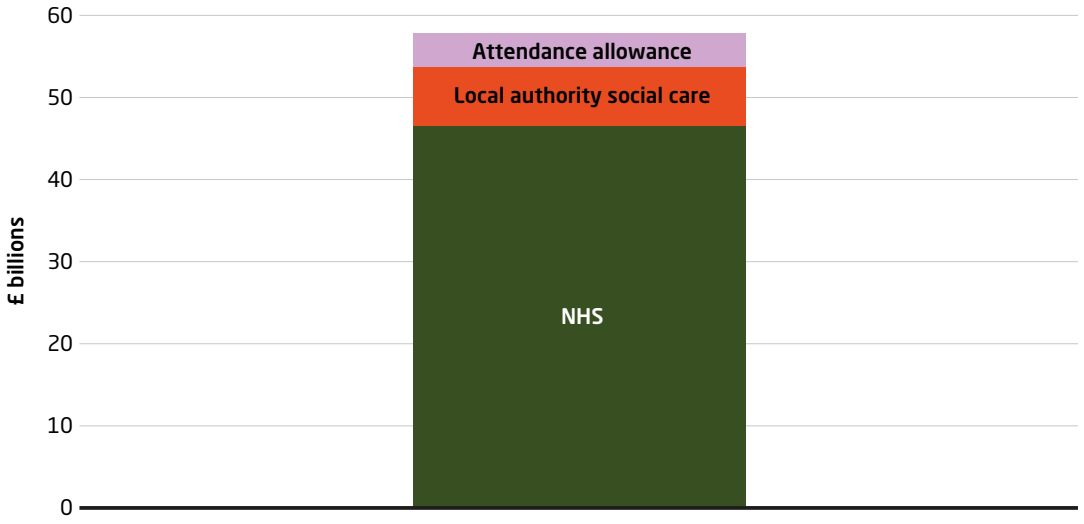
To put this into perspective, the NHS budget in 2014/15 was £116.4 billion, and figures prepared by the Nuffield Trust for the *Guardian* (Robineau 2016) suggest that two-fifths was spent on older people. Given that total public expenditure of all kinds is £755 billion, the level of spending by local authorities on the care of older people seems a relatively modest sum (*see* Figure 3).

Figure 2 Local authority spending on social care for older people, 2014/15



Source: Health and Social Care Information Centre 2015e

Figure 3 All health- and care-related spending on older people, 2014/15

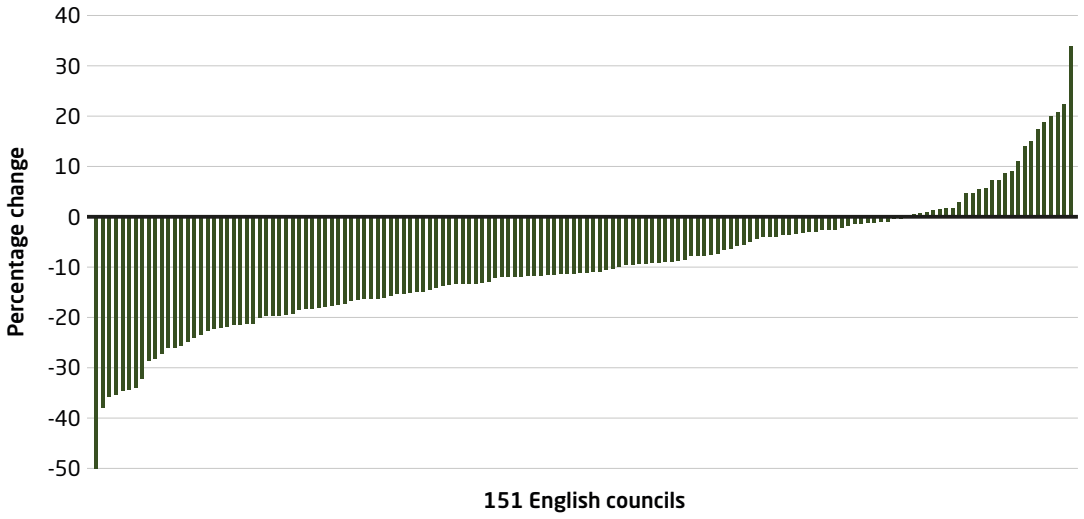


Source: Department for Work and Pensions 2016; Robineau 2016; Health and Social Care Information Centre 2015e

Against this relatively modest baseline, gross spending by local authorities on social care for older people has fallen by 9 per cent in real terms between 2009/10 and 2014/15. Without income from charges and money transferred from the NHS, it would have been 25 per cent. The NHS transfer, including the Better Care Fund, has made a real difference but has not fully compensated for cuts in local authority budgets. Of the £5 billion Better Care Fund, in 2015/16 just a third (£1.67 billion) was being used to protect social care services (Association of Directors of Adult Social Services 2016).

The national picture, on average, is one of reductions, especially taking into account increases in the older population over this period. Eighty-one per cent of local authorities cut their spending in real terms on social care for older people over the past five years. In more than half of local authorities the reduction was at least 10 per cent. However, the picture is not uniform – 18 per cent maintained or increased spending (*see* Figure 4).

Figure 4 Percentage change in gross total expenditure on older people's social care (per 100k population aged 65+) between 2009/10 and 2014/15, by local authority

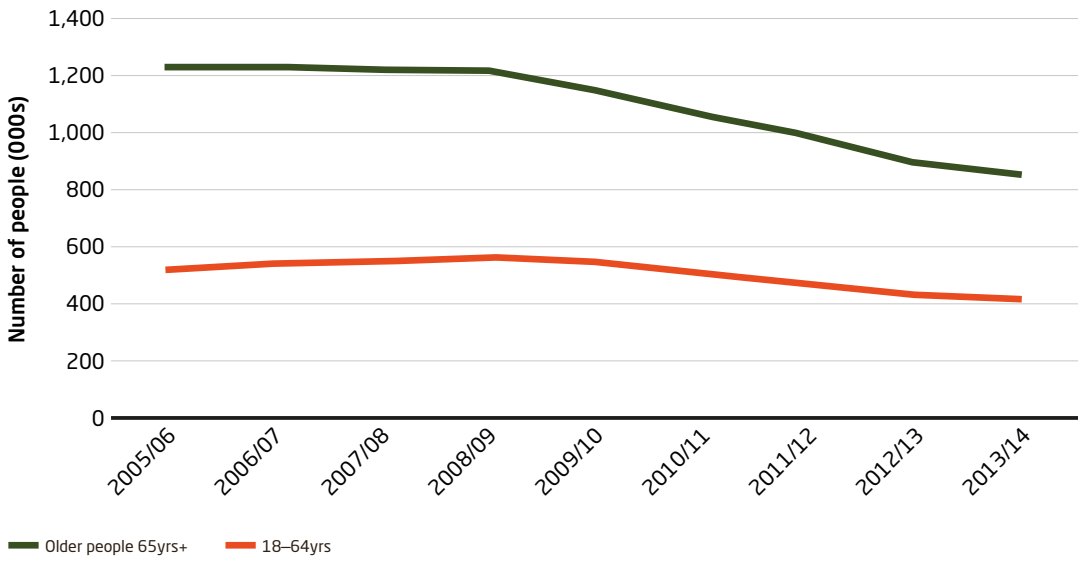


Source: Health and Social Care Information Centre 2015e

Reductions in numbers of people receiving publicly funded social care

There has been a big reduction in the numbers of older people receiving local authority-funded social care – from more than 1.1 million in 2009 to 853,615 in 2013/14 – a fall of 26 per cent (*see* Figure 5). It is likely that the trend will have continued in 2014/15 and beyond but changes to data collection unfortunately mean that there is no a longer a comparable figure. The fall has been especially steep since 2010, but this forms part of a longer-term trend that began in 2009. The number of people aged between 18 and 64 years getting help has also fallen, but not by as much.

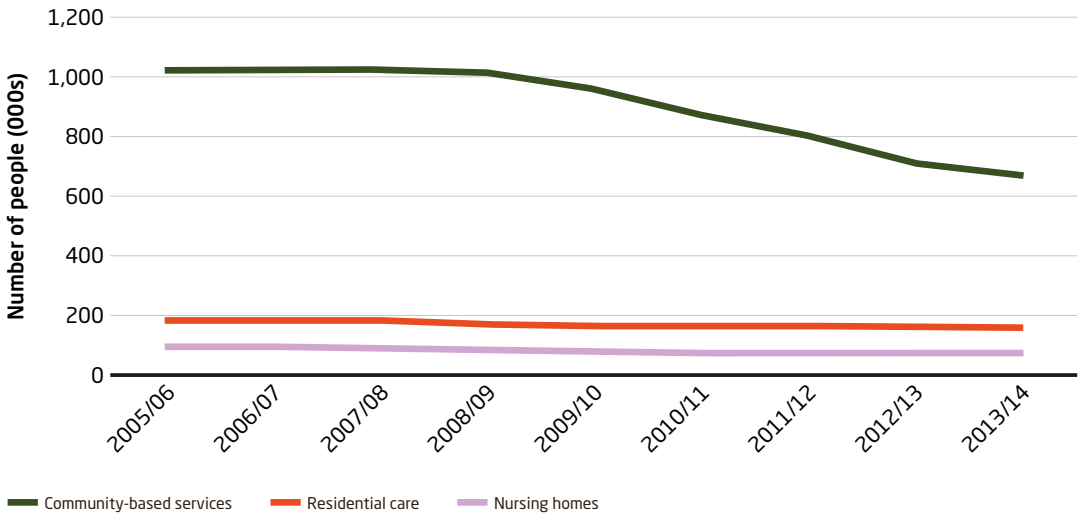
Figure 5 People receiving local authority-funded social care, 2005/06 to 2013/14



Source: Health and Social Care Information Centre 2014

Despite the policy objective of supporting people to live at home, the steepest reduction has been in the number of people receiving local authority-funded community-based services – down 30 per cent since 2009 compared with just 4 per cent fewer for residential care and 6 per cent for nursing home care (*see* Figure 6).

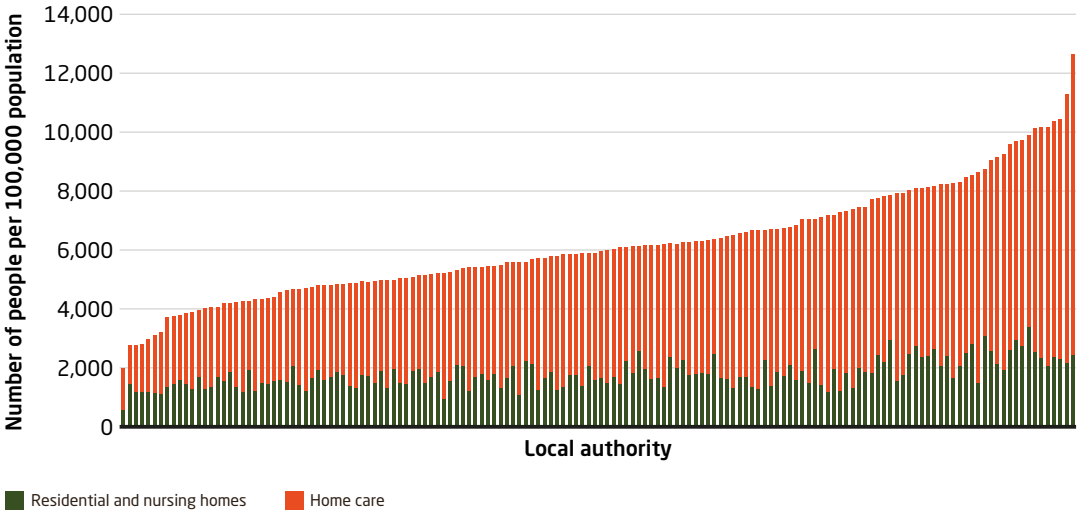
Figure 6 Older people receiving community-based, residential or nursing home care, 2005/06 to 2013/14



Source: Health and Social Care Information Centre 2014

These national trends conceal wide variations in provision between different parts of the country and between individual councils. There is more than a six-fold variation between councils in their rates of people supported in care homes, and an eight-fold variation in their provision of home care (*see* Figure 7). The north-east and north-west tend to provide higher levels of both residential and community care (albeit with variations within those two regions). London stands out as having a low rate of residential provision, but high rates of home care. These differences arise from a variety of factors including historical patterns of provision, local property markets, levels of income, wealth and deprivation, the population age profile and different commissioning practices.

Figure 7 Rate of older people aged 65 and over receiving publicly funded care by local authority, at year end 2013/14



Source: Health and Social Care Information Centre 2014

The local picture: what we learned from our case studies

The scale of budget reductions

Interviewees in all local authority sites reported having had to generate millions of pounds of savings over the past five years and facing even more challenging savings targets until 2018. Even when an authority was achieving an overall net growth in spending on adult social care, the process over recent years was described as 'taking money out' because of the growth in demand over the same period. Interviewees described how savings in adult social care were made in the context of big savings across local government services as a whole. Because adult social care accounts for the largest proportion of local government spending, 'protecting' social care from cuts has not been a viable option for all local authorities:

> *We knew we had a council that had such huge cost savings to make across the years, you couldn't protect social care because of the width of its services from that scenario.*
>
> (Local authority)

A theme common across all sites was the difficulty of this process, including painful conversations with elected council members and other departments. Interviewees from other organisational stakeholders in the area, even where budget cuts had directly affected their own viability, often expressed empathy with the unenviable position that the local authority found itself in:

> *It's horrible… [A] lot of the directors started off as social workers, they didn't go in there to cut services or make a service work… but they've been put in this very difficult position.*
> (Social care provider)

Where have the savings come from?

The approach taken to secure the millions of pounds' worth of savings in our case study sites is consistent with current knowledge in this area (**Association of Directors of Adult Social Services 2016**). Across the four case studies, interviewees from the local authorities reported having used a range of strategies, including:

- reductions in the number of people in residential placements
- reductions in domiciliary care placements
- reductions in the number of assessments carried out
- reductions in local authority staff
- reductions/no increases in payments to local authority funding to providers (homes and domiciliary care)
- reductions in grants to voluntary sector providers
- decommissioning local authority owned homes
- reductions in step-down beds
- reductions in additional services (for example, meals on wheels).

Although each of the local authorities we spoke to had challenges that were unique to them (for example, in relation to the labour market or the distribution of social care providers), a powerful theme common for nearly all of them was that there

was no easy route to further savings, as the obvious opportunities for savings had already been made.

> *We've pulled out anything that is, what we would almost say now is the nice stuff, the wrap-around stuff… we haven't got many places to go, is the answer.*
> (Local authority)

One local authority interviewee described how this financial year's savings target of just under £15 million could not be met without breaching the council's legal duties under the Care Act 2014 to assess and meet eligible needs. They had attempted to think innovatively – for example, charging users for telecare equipment already in use in their home, but had decided that the risk of people turning down the equipment and being more likely to have to turn to the NHS outweighed any savings they might have made. It would have been 'a silly thing to do'.

Another local authority felt that it hadn't 'quite reached the end of the road yet' but that things were extremely tough. In this case, the council's comparison of its own spending against that of others – suggesting that it was still a 'high spender' – had convinced the council that further savings must theoretically be possible. By contrast, an interviewee from another council felt that he had been pressured by the council leadership to reduce spending based on comparative performance. He felt that the figures underlying this comparison were 'misleading' because other councils had higher numbers of self-funders, making it possible for providers to survive on lower fees through cross-subsidy (whereby self-funding residents are charged more than the local authority rate).

The narrative from the local authorities was not all about reductions in spending. There were also examples of increasing investment where it could reinforce broader goals of reducing long-term admissions to care homes; for example, increasing investment in adaptations and re-ablement services to enable more people to be cared for at home.

What has been the approach guiding the savings?

A guiding principle common to all the case study sites – in addition to bringing spending in line with that of other comparable authorities – was a redefinition of the purpose of publicly funded social care for older people. Although different names were attached to this – a 'new vision', an 'asset-based approach' or 'promoting

independence' – interviewees described a set of ideas that involved thinking of publicly funded social care in a different way. This was framed slightly differently in different places, depending on the history of each local authority. For example, interviewees at one local authority felt that theirs had previously been an overly generous authority, which they described as having a 'gift-giving culture'. They said that in the past they had delivered too many services to people and undermined their independence:

> *… but what it did do was stop people going out, it stopped people socialising, stopped people's interaction with others, stopped people exercising. It was very patronising and wasn't very good.*
> (Local authority)

This authority looked to the example of a neighbouring council as something to follow: it provided a much more intensive information and signposting function, and diverted people to community groups and other non-statutory resources. They felt that people should be seen as citizens rather than potential service users, and should be willing to use whatever is available in their neighbourhood, however small, even 'one woman on a street' doing meals for some neighbours:

> *This is not about local authority interventions. This is about us shaping what happens with our communities.*
> (Local authority)

A similar approach was described in another case study site as 'asking questions back to people', rather than automatically deciding which services they could provide for them:

> *We ask individuals first of all what they can do for themselves, and then we turn to the family and say 'What can they do', then to the local community and say 'What can you do', then only after that do we think about what the council should do.*
> (Local authority)

The core idea of this approach – of facilitating a person's autonomy, preferably in their own home – also frames the provision of formal services when people do eventually need them. Our third case study site spoke about the challenges this brought, particularly in changing mind-sets in both the public and NHS clinicians, away from thinking about

care homes as a default option when older people reach a crossroads such as after an admission to hospital, to thinking about how that person can go home:

> *… we probably do find ourselves in greater debate, at times, with families about their views about whether their elderly relative can go home with support or not.*
> (Local authority)

The fourth case study site also described a similar shift in approach, which had successfully 'damped down demand' for long-term, bed-based care. This involved retargeting resources to services such as incontinence services, to address the more immediate triggers that often lead people into long-term care:

> *So we just said, 'Well we're not going to fund lunch clubs any more, we're not going to fund transport that trundles people round to get to lunch clubs, if you want to do it, the voluntary sector, that's up to you, but we're not funding it.'*
> (Local authority)

There was also agreement that the scale of the cuts that lie ahead would be even more challenging, even where councils planned to take advantage of the opportunity to raise Council Tax (the precept) granted in the 2016 Budget.

> *So much has come out of the rest of the council, it is going to come out of children and adult services, it is, because there's nowhere else for this to come from.*
> (Local authority)

> *Next year looks completely horrible.*
> (Local authority)

While local authorities described themselves as so far having been able to protect the most vulnerable service users, one area outlined that continued reductions in the adult social care budgets would start to reach 'diminishing returns', particularly if investment in prevention failed, leading more people at risk of needing long-term care.

There was also an awareness that some of the strategies that had been used until now, for example reducing fees to providers, could no longer be used, as it risked putting too many providers out of business or damaging quality. One local authority

had called a halt to further fee reductions for home care providers, and signalled that they would also meet the National Living Wage:

> *There was a commitment made to reduce the cost of home care to about £10.50 or something, wasn't it? So whatever we were paying was down to £10.50. Looked at it again, I said this is just ridiculous, you can't keep slicing the money. So what I said was we need sustainable services going into the future because they're our responsibility. Our issue is controlling demand, not salami slicing services.*
> (Local authority)

Concern about the impact of the National Living Wage on home care providers was also expressed in another of our case studies: even if the council could increase its fees to offset the National Living Wage, it might not be enough to reverse the recruitment problem facing home care:

> *Well, the home care has been proving very difficult and it is largely an issue of workforce and recruitment. It started off particularly in some of the rural areas… And then it spread a bit. So retail is our major competitor… Looking at some analysis of how retailers are responding to the National Living Wage, what we're able to do won't solve that problem.*
> (Local authority)

Prevention

Across all our case study sites, interviewees spoke about a 'gradual erosion' of preventive services as a result of the difficult process local authorities had undertaken to reduce budgets (Healthwatch). One interviewee felt that 'not enough' had been going into prevention, while an interviewee from another local authority said that investment was going to be reduced in this financial year (2016/17). Prevention was described by one interviewee as the 'poor relation' of health and care services, often not prioritised because the benefits may not be visible in the short term (Healthwatch). There was recognition that it was important to focus on the root causes of increases in demand and to support people so that they do not need to access services. However, as summarised by one interviewee, this is an example of an unintended consequence arising from operating in this financial environment without 'headroom': '[you] deal with one thing and, as you sort out that issue, something else pops up' (CCG).

4 The impact on social care providers

The national picture: what do we know?

Fee levels

Most local authorities have sought to manage financial pressures by freezing or even reducing annual fees to providers with whom they contract. Estimates suggest that average council fee rates have fallen by 6.2 per cent since 2011. However, this has begun to change. In 2015/16, the average increase for care homes for older people was 1.9 per cent, higher than previous years but still below a 'standstill' requirement of 2.5 per cent (Laing 2015).

This year has seen a sharp increase – 82 per cent of councils increased provider fees. Some 18 per cent increased fees by between 1 per cent and 1.9 per cent, and 46 per cent of councils increased fees by more than 3 per cent in 2016/17. Fees in home care in particular have risen quickly, with 5 per cent increases in a third of councils (Association of Directors of Adult Social Services 2016).

National Living Wage

Pressures are likely to intensify following the announcement in the 2015 Budget of a new National Living Wage of £7.20 per hour from 2016, rising to £9.15 per hour by 2020. Although any measures to raise wage levels in a notoriously poorly paid sector are to be welcomed, this will add substantially to the financial pressures faced by providers. It is estimated this will add £300 million to local authority costs in 2016/17, rising to £800 million by 2020 (Local Government Association *et al* 2015). But the increase in total payroll costs of frontline staff is much higher – £2.3 billion by 2020, on top of £1.7 billion of costs already implied by above-inflation increases in the National Minimum Wage (Gardiner 2015). This has been seen as a new threat to the financial viability of providers (Care England 2016).

Workforce

Providers have also been struggling to recruit and retain staff. The care sector as a whole has a vacancy rate of 4.8 per cent (compared with a vacancy rate of 2.6 per cent across the economy). This rises significantly for qualified nurses, where the vacancy rate is 9 per cent; slightly more than a third of nurses (34 per cent) were estimated to have left their role within the past 12 months (Skills for Care 2016a). One estimate suggests that the sector could face a shortfall of more than 1 million care workers by 2037 (Independent Age 2015).

Given the sector's ongoing diffculty with recruitment and retention, migrant workers play a large role in the social care workforce. Around 266,000 care workers were born outside the UK, one in five of the total. This figure rises to three in five in London. Among this population of foreign-born workers, 28 per cent were born within the European Union (Independent Age 2015). The outcome of the UK's referendum vote to leave the EU has increased concerns about the sustainability of the care workforce.

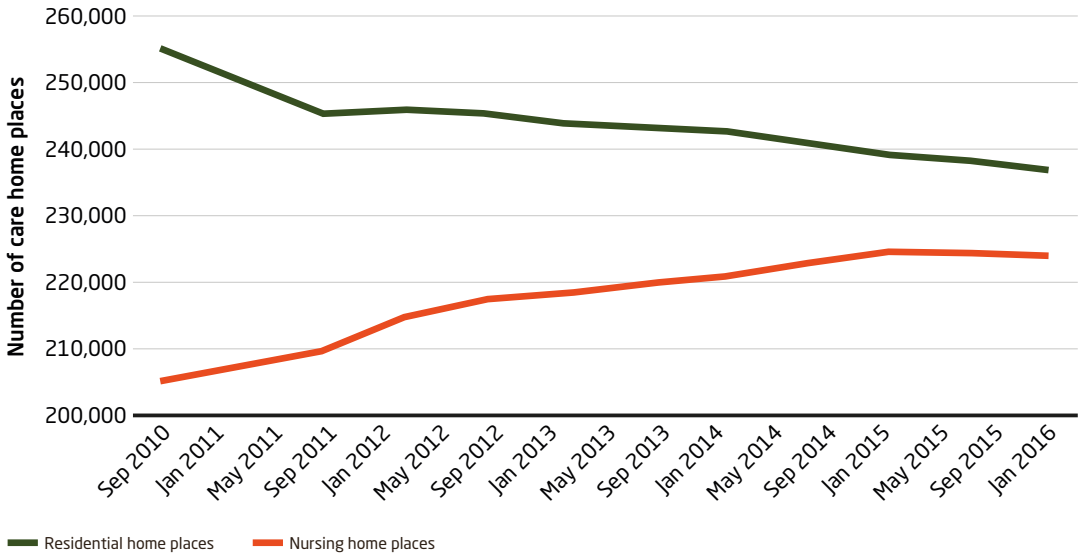
Market developments

There has been a steady reduction in the number of residential care homes since 2010 and the number of places has fallen by 7 per cent (Care Quality Commission, unpublished). But the number of nursing homes increased over the same period and there were 9 per cent more places (*see* Figure 8). There are wide regional variations in these changes, with the loss of residential care home beds ranging from -18 per cent in London to -2 per cent in the East of England. Nursing home places have increased by as much as 16 per cent in the East of England but just 3 per cent in Yorkshire and the Humber.

Signs of provider distress are increasing. Seventy-seven local authorities reported that at least one care home provider has ceased trading in their area in the past six months (Association of Directors of Adult Social Services 2016). Recent analysis of care home company accounts for the BBC suggests that 28 per cent of care homes are at risk of financial failure (BBC Radio 4 2016). Homes of lower quality and where there is more competition between providers are at higher risk of closure (Allan and Forder 2015). The spectre of large-scale provider failure was raised by the collapse in 2011 of Southern Cross, the largest independent care home operator in the country,

which threatened the care of 17,000 people in some 750 homes (National Audit Office 2011). Some of the key factors behind this crisis – high levels of debt, separation of property ownership from care provision, under-occupancy and reliance on squeezed local authority fee levels – are still present in parts of the market (Burns *et al* 2016; Institute of Public Care 2014).

Figure 8 Number of care home places, 2010 to 2016



Source: Care Quality Commission registration data (unpublished)

Many providers have responded to the financial pressures by concentrating on people who pay for their own care ('self-funders'). Some 53 per cent of residential and nursing care funding now comes from private individuals, if 'top-ups' from relatives are included (though in part this increase arises from more older people having property and savings that place them above the £23,250 threshold for local authority financal support). The gap between local authority and private fee rates has widened over the past five years – one estimate is that average self-funded rates have risen by 40 per cent over this period (Laing 2015). There is now clear evidence that in many places self-funders are cross-subsiding local authority residents who receive generally the same care and accommodation at a much lower price (County Councils Network and LaingBuisson 2015).

These developments are leading to the polarisation of the market, with some providers in generally less affluent areas with low levels of self-funding very reliant on inadequate local authority fee levels. In contrast, in affluent areas with higher levels of self-funders the market is relatively bouyant. This is being reinforced by new scheme developments concentrating on the private market rather than local authority-funded residents (Laing 2015).

Financial pressures on providers of care in people's own homes (also known as domiciliary care) are also intense, with clear signs that a tipping point has been reached in a fragmented market. The minimum sustainable price for home care is estimated at £16.70 per hour, with one survey showing that last year just 14 per cent of local authorities paid the minimum price (United Kingdom Home Care Association 2015a, b). Two of the largest national home care providers have already left the publicly funded market and two others have posted operating losses in the past year (LaingBuisson 2016). In the past 16 months, home care providers have handed back contracts in 59 local authority areas, and in another 48 areas at least one home care provider has ceased trading (Association of Directors of Adult Social Services 2016).

The local picture: what we learned from our case studies

Although the landscape of social care providers looks different in different areas, our interviewees from residential, domiciliary and third sector care providers described how a combination of fee pressures and rising costs was creating a 'perfect storm', with implications for workforce, the shape of the provider market and the quality of care for older people.

Fee levels

The local authorities we interviewed were candid about how they had used fee reductions to providers as a key strategy to make the savings needed each year:

> *We made savings on hammering down provider prices, so we didn't pass on any inflation for five years. If I look back over five years, holding price, provider prices down, was quite a strong part of our overall savings.*
> (Local authority)

Sometimes these reductions were made as part of retendering contracts at lower fee rates. In one local authority, this had reduced the number of providers in the market, in this case home care, when the providers found they were unable to continue offering services on such low prices:

> *We did a tender about five years ago, we took considerable costs out of the market, again… We'd wanted eight providers across the borough, but we lost two, in quite quick succession, because the business model that they'd built their tenders on wasn't sustainable. So, and we're still unpicking from that, really, we're down to four providers.*
> (Local authority)

There was a common theme from interviews with both providers and local authorities that this process of reducing fees had reached its limits; in some cases, local authorities were starting to increase the amount paid:

> *I think it's clear that we can't strip any more costs out of the care providers.*
> (Local authority)

But in the view of many of the providers we spoke to, even small increases were not now going to be enough to offset rising costs:

> *All the fees that are being announced now for, I'll get my years right, 16/17, we've had as low as 0.2 per cent and the highest one we've had so far is 4 per cent. So is that going to cover the costs? No, there's real-world cuts happening, and unfortunately, where we stand, and I'm not saying as a provider, it's as an industry, it's a question of last man standing.*
> (Social care provider)

Care home providers expressed frustration with local authorities when it came to estimating the true costs of providing care. In one case study site, providers reported that the local authority had based its costs on the assumption that homes had 100 per cent occupancy, which they felt was unrealistic. In another, there was frustration that the council had spent money on external consultants to estimate costs, when in reality they knew what the real costs were:

> *I mean, how many times do I have to submit those cost of care calculations? We know what the cost of care is. If all these councils and the amount of millions they have spent, on trying to calculate fees, to fit their model, you know. They're just opinion shopping. I mean, we know that the cost of care is probably over £600 [a week]. If they can't afford that, let's recognise it and say, going forward, you know, this is what we expect.*
>
> (Social care provider)

There was equal frustration from our interviews with providers of home care, where prices had also been driven down. In one case study area, this had had a direct impact on their ability to retain staff, particularly because a neighbouring council was prepared to pay a higher hourly rate:

> *So the situation now across the board really with the exception of [council X] is reaching the untenable stage because it is now proving to be almost impossible to find the staff who are willing to work for the low pay which is made available by the councils.*
>
> (Home care provider)

In some areas, a trend towards increased transparency was emerging between commissioners and providers as financial pressures intensified. Two social care providers in one area spoke about how they had spent time with the local authority explaining their costs in detail as a way of justifying their fees. One of these providers explained that it was important to try to show that the organisation was not trying to make a profit in the way that others perceived private providers to do. Conversely, two providers in one area said that the transparency and 'frankness' shown by the local authority had worked in its favour and facilitated positive working relationships (social care provider).

The National Living Wage

All providers also mentioned the impact of the National Living Wage. Across the board, it was welcomed, but was also met with scepticism about its reach and worry about its affordability. One social care provider outlined that the costs for their organisation were going to be higher than originally modelled because they

were planning to apply the wage increase to all ages, to make it 'fair'. The cost of maintaining pay differentials was also stated as another resulting cost.

For home care providers, this worry was particularly amplified, given that a bigger proportion of their costs are made up by wages. One local authority commissioner described the potential worry for an already stretched home care market in his area:

> *I think in home care, it's not just National Minimum Wage, it's the rulings on paying travel time or sleep or pensions, there's all sorts of stuff, isn't there, that are combined together. I mean, they weren't making big margins anyway, the providers, I did quite a lot of work on it, so our worry is that we'll see; already we've had local providers who have sold up and said 'It's not worth doing any longer'.*
> (Local authority)

Despite these challenges, the National Living Wage was seen as a positive step in trying to improve the perception of care work as a rewarding career and was supported, in principle, by many of the interviewees. However, one interviewee pointed out, it did not solve the provider market's competition for staff with the retail sector.

Workforce

A theme common across our interviews in residential, nursing care and care in the home was the increasing difficulty in recruiting and retaining both care staff and nurses. Interviewees described intense competition with the retail and service industries as well as the NHS:

> *It's an incredibly difficult job, difficult profession, which doesn't pay very well, where you're being asked to do more and more on less ratios that will become less appealing.*
> (Social care provider)

Two providers discussed their reliance on migrant workers, but emphasised that they needed to be mindful of the needs of these workers if they wanted to retain them:

> *Bring in folk from Eastern Europe, but be clear about their ability to speak English and invest management time and resources into doing the cultural transition for those folk: it's a pretty, literally, foreign workplace for them.*
> (Social care provider)

A number of interviewees described real difficulty in recruiting and retaining nurses both in the context of the declining numbers of nurses, competition with the NHS and the lack of clear career paths in social care. Where competition from the NHS is strong, care homes are finding themselves having to pay more, under pressure from potential staff aware of the alternatives:

> *Two years ago, I was probably paying nurses £13–£14, now I'm paying up to £20… I now get nurses who say 'I'll only work for £17' and I think 'Who is interviewing who here?'.*
> (Social care provider)

In two of our fieldwork sites, interviewees suggested that in order to survive some providers were employing people on a 'cash-in-hand' basis; they hinted that many may be working without proper documentation and/or being paid less than the minimum wage. One provider was frank:

> *I expect there are quite a few who pay cash in hand and below the minimum wage… I get people knocking on my door looking for a job cash in hand.*
> (Social care provider)

This would be consistent with evidence of a wider problem of non-compliance with the National Minimum Wage in the social care sector (HM Revenue and Customs 2013).

Older people with more complex needs

Similarly, all sites reported an intensification of need in their client group, across the voluntary sector, domiciliary, residential and nursing care. For providers of nursing and residential homes, this was often seen as a result of the success of the policy agenda of keeping people at home longer. Although interviewees were split about the merits of this approach (some thought older people with care needs were often

staying in their own home too long), they all agreed that the average complexity of need had intensified:

> *We've seen an increase in dependency levels… There has been a huge government push for people to be cared for as long as they can in their own homes and this is the consequence of the success of that policy.*
> (Social care provider)

Another interviewee suggested that care workers were often being asked to carry out clinical tasks, or tasks which may have traditionally been carried out by a community nurse. Examples include stoma care or dressings. Care home providers also illustrated this intensification, describing a pressure from local authorities to accept inappropriate placements, putting people with dementia into residential care:

> *You end up having to move them because they're wrongly placed. The council are saying, 'Put them in a residential bed until they can't cope, then we'll move them'.*
> (Social care provider)

The same care home provider explained how far the situation had to deteriorate before additional payment was forthcoming to meet the older person's needs:

> *In order for you to get the dementia payment, the person has to be beating somebody up, or violent towards the staff, they have to be wrecking the home.*
> (Social care provider)

For providers of home care, the combination of low fees from local authorities, workforce shortages and the greater needs of older people was described as extremely challenging, putting enormous pressure on the remaining workforce. An example was given by a home care provider of what happens when meeting the complex needs of a person (needing two carers and described as 'particularly difficult' by the provider) exceed the time being paid for by the council for a morning visit:

> *We've not been able to do it for less than an hour and a half and because the council are yet to approve the extra time, the carer is now refusing to go back and we're literally almost out of carers, our supervisor had to go at 7am this morning*

because we couldn't find a carer to go to do the other half of the 'double up'. So the complex needs is certainly something which is very apparent.
(Social care provider)

Quality

The challenge of maintaining quality under these pressures was a strong thread running through all the interviews with providers, local authorities and the NHS. The CQC's role as regulator of quality was seen as powerful: examples were given of care homes that had closed as a result of not being able to meeting the minimum standards of care – 'the expectations of the standards, quite rightly, is going up' (NHS provider).

Many social care providers felt ambivalent about the role of the CQC and, unsurprisingly, there were negative views about the style and content of the inspections. The social care providers we interviewed recognised that the funding pressures were having an impact on quality. In one site, social care providers were sceptical that high-quality care could be provided on the fees that the local authority was prepared to pay:

I just don't understand how you can provide CQC compliant care for £400 and… I don't know how they do it and I suppose I don't want to know how they cover it up that they don't do it and unless you've got a really hot CQC inspector in there asking the right questions and looking in the right ways…
(Social care provider)

Interviewees mentioned that savings could be made by not investing in new furniture, or requiring staff to buy their own gloves and aprons. Concerns were mentioned by several participants about the quality of training being offered by social care providers and about the ratio of staff to residents. Inappropriate referrals could also have an impact on the balance of staff to older people in care homes.

What happens is CCGs, local authorities and the hospitals are under pressure and when everyone is pushed out of hospital you are under pressure to fill the beds. What happens then is you get a frail resident next to a dementia nursing patient and it upsets the whole balance of care.
(Social care provider)

Overall, where providers were under financial pressure, the view was that quality was going to be harder to maintain:

> *I think ultimately quality has to suffer. There is no maliciousness to it, most people working in care do it to the best of their ability. I think people came into it for the right reasons. But we're at the back of the bus queue when it comes to recruitment. If all the good young staff are going to Sainsbury's where you get £8.50 an hour, what is left for us when we pay the minimum wage and have to operate on a casual basis doing really difficult work?*
>
> (Social care provider)

Market developments

An interesting aspect of our interviews was the impact of fee reductions on providers' business strategy. Although participants did not agree on how exactly providers should respond to the operating environment, many providers discussed a change in their business models and described a shift (where possible) to offering more services to self-funders and the NHS (acute trusts and CCGs) as well as local authorities.

Care homes described making renewed offers to CCGs and acute trusts to assist with admission and delayed transfer of care pressures. They often saw themselves as offering a less intense environment than an acute inpatient ward, which could replace a shrinking NHS intermediate care offer, essentially acting as additional NHS capacity for older people. This contribution was typical:

> *If you've got someone going into hospital, it has a great impact on the hospital; it's easily managed within a care home because you've got the right person in there to support you. But then, what you need to do is up-skill all the rest of your staff and it's something that we're starting to look at: the business of starting around having a more senior carer role that then picks up – I suppose you could say – the bottom end of that nursing role.*
>
> (Social care provider)

Another way in which both care homes and home care agencies discussed changing their business model was shifting towards one that relies on self-funders. One of our local authority interviewees, in an area with more prosperity and more self-funders,

described the impact this was having: the income from self-funders was being used to subsidise local authority-funded users, leading some providers to abandon local authority-funded people altogether:

> *… unquestionably, there's cross-subsidisation in those homes that will do business with us. They afford our rates by what they charge self-funders. But, increasingly there are homes that, actually, don't need to, don't want to do business, again, particularly in the more affluent parts of the county.*
> (Local authority)

What this meant for the older people who were supported by the local authority in the wealthier areas was less choice, and the prospect of being placed in homes at some distance across the county, which was large. Choice could also be reduced by the decision of social care providers to close down their businesses altogether. The combination of higher standards being driven by the CQC and the challenges of finding staff had led to care home providers deciding to quit in parts of the same local authority area, leaving the local NHS hospital with a reduced number of homes to discharge people into:

> *And a number of care home owners have said, 'I can't recruit. It's getting harder and harder to maintain registration at the levels that I would want to in a safe and financially viable way. So, do you know what? I'll sell my massive, big, Victorian house overlooking the sea and turn it into flats and make an absolute killing.' It's not a difficult decision for someone to make and that's what they've done.*
> (NHS provider)

Another local authority in an area with plenty of self-funders described how nursing care providers were now in a strong negotiating position because they had alternatives to local authority funding. This had resulted in the local authority having to pay more for nursing home places. The interviewee understood why providers were shifting to a model built on self-funding but realised that this option was not available to providers elsewhere:

> *In our bit of [city] there's a very buoyant, self-paid market, so providers are on a strategy of just saying: 'We can just shift more and more towards self-pay and just get rid of these miserable local authorities who don't pay us enough.'*
> (Local authority)

A large care provider in the same area described how it was working to diversify its income streams, including investing in specialist rehabilitation care, as well as self-funders. This provider recognised that the instability in the provider market would eventually shift the balance of power, through a process of survival of the fittest, as providers both small and large dropped out:

> *I think what will happen is you will see a huge amount of 'ma and pa' type facilities going out, you'll see a number of corporates falling over, and actually the only thing that will change the dynamic will be less places available, and at that point those that have got through the difficult times will have leverage and actually say, 'We're not having £600 a week, it's now £800'.*
> (Social care provider)

This social care provider had calculated that it would be impossible to survive without at least 25 to 33 per cent of fees coming from self-funders to cross-subsidise the business as a whole. This level of cross-subsidy brought with it some ethical dilemmas, in the view of the provider in question, who felt uneasy raising self-funder fees at well above the rate of inflation:

> *We try and justify it, that unfortunately it's government legislation; however, on the softer side, you get a paper, WiFi and some flowers every now and then, ultimately it's the same service. I think what's becoming increasingly difficult is in many instances I'm the one stood up at the front in residents and relatives meetings and people are asking me to justify and people are saying, 'Can I have a breakdown of my fees?'. It's an unanswerable question, what do we say?*
> (Social care provider)

What was clear from our case study sites was that the decision to focus on self-funders was driven by the affluence (or lack of it) at a local level, and these sorts of strategies were very unevenly distributed.

In one of the case study sites with much lower levels of personal wealth, the problems for the provider sector were more apparent. The home care market was described by the local authority as having 'fallen over':

> *The number of providers in the market has reduced, except for some of the bigger ones. And the bigger ones are, some of them, are considering whether to stay in the market, [these are] some of the messages we're getting.*
> (Local authority)

For residential and nursing care in our case study areas with more dependence on local authority fees and fewer self-funders, social care providers described the situation as heading for a crisis, with five or six homes in the area having already closed:

> *And I think it's quite a tragedy, really, that we all know that's going to happen, it feels like we're heading to that brick wall. And it almost feels like there needs to be a wall to collapse, in order to get some government action.*
> (Social care provider)

A provider in a local authority-dominated market confirmed this view:

> *Most of our residents are publicly funded, there aren't many top-ups. So you know, you can't expect all the bells and whistles. We have to operate very economically here. That is the reality.*
> (Social care provider)

In this case study site, also heavily dependent on local authority-funded business, survival often hinged on whether the care home was willing to charge a 'top-up' above the local authority rate:

> *So those homes have really struggled, especially if they've been homes that have never requested or been able to get a third party top-up as well, they're really struggling and those have been the homes who have got into trouble really if I'm honest.*
> (Social care provider)

An NHS provider described how providers would try to maximise top-ups when a patient was ready to be discharged. In two of our sites, the local authority admitted it was aware that because it seeks out the lowest price, it means providers not only rely on cross-subsidisation to stay profitable, but maximise the amount they can make from top-up fees, often in an arbitrary way.

One home care operator, however, suggested that providing for (or deliberately reorienting towards) only private payers could be counterproductive, and would result in no access to local authority markets and problems when people 'run out of money'.

Reflecting the national data, all areas described the emergence of a 'two-tier' system as a result of the change in business strategy: one for those who can afford to pay for their own care, and one for those who rely on local authority-arranged care.

As a result of a reduction in public sector funding, interviewees felt that the social care provider market was likely to undergo a number of changes over the next five years. One interviewee predicted a 'large-scale collapse' of the market, particularly affecting small providers in old stock that are unable to make the investments needed to sustain their buildings (care home provider), and that, without an increase in local authority rates, providers would be without an 'adequate incentive' to continue their businesses. As a care home provider in a different area put it:

> *If all I could take was local authority we'd be bankrupt, yeah, we wouldn't survive.*
> (Social care provider)

Another interviewee agreed that the number of small providers would be reduced, alongside the possible failure of a number of large corporate providers. The suggestion was that there are some large providers, with 'deep pockets', taking a longer-term view about investing in this market (that is, waiting and strengthening their market share) that are therefore subsidising their activity in the social care market with other parts of their business (social care provider).

Voluntary and community sector

Interviewees from the voluntary and community sector also spoke about the pressures created by local authority cuts. At the same time, they recognised that their services were more in demand than ever, and that their role in any 'asset-based' vision of care was a crucial one.

In some areas, voluntary sector organisations had come together to work collaboratively, often in response to local authorities wanting to streamline and simplify their contracts. Several participants discussed how voluntary and

community sector organisations were coming together across local authorities to consolidate services, and look for grant funding at a national level. Others talked of diversifying income and fundraising streams, looking harder at national grants and charging. A few also talked about reorienting towards the NHS, which was perceived as having deeper pockets, offering preventive services and rapid response discharge assistance.

There was no doubt that the recent years have been painful, however. A common theme from the voluntary and community sector interviews was the determination to continue services even when contracts with the local authority had been curtailed:

> *We fund our own information and advice services now, having not successfully gained a tender. We fund it through our trading programme, through our own resources, and a couple of small grants, and we just find the demand is growing and growing. Because of the complexity of the system, and older people, and their families and their carers, the complication of being able to access the services which they have an entitlement to.*
>
> (Voluntary and community sector provider)

Where the voluntary sector delivered services to older people directly, reductions in local authority grants were particularly difficult to manage, especially if the voluntary and community sector provider did not want to introduce payments. In one case study, a provider described the experience of negotiating with its cash-strapped local authority:

> *We spent a long time putting a case forward to say we couldn't, because we're delivering services, we literally pay staff to go out and deliver services so what do you want anyone to do, if I deliver less hours I've got to keep the same number of staff on, I can't just sack the staff or pay them a lower salary, so I can't give them less, so I'm just delivering less hours which means our unit costs are going up… So they listened to that, came back and said, 'We don't care'.*
>
> (Voluntary and community sector provider)

Voluntary sector organisations were also looking to the NHS for funding, but in two case study areas voluntary and community sector providers observed that NHS funding could be even more short term, often funding pilots with no commitment

to continue funding. A number of interviewees felt that the public sector tended to assume that volunteers were cost free: 'They aren't free… they need training, support and supervision' (voluntary and community sector provider).

Descriptions of providers' relationships with CCGs echoed this sentiment. In one area, a voluntary and community sector provider described the CCG as 'faceless', stating that its approach is similar 'whether you're buying bins or lightbulbs, or people's services. It's really worrying'. Another provider commented on the difficulties of working across multiple CCGs, each with varying priorities; in a different area, a voluntary and community sector provider described the CCG as being indecisive even in the face of contracts that were near their end and, therefore, involved possible staff redundancies. However, one voluntary and community sector organisation explained that the local CCG was more open than the local authority to exploring new models of care and other provider innovation, because the latter had severe internal capacity issues.

There were a number of examples of how voluntary sector organisations worked hard to maximise their income, from renting out office space in buildings that they owned to more familiar charitable activities such as raffles and generating income from their shops. One common theme was the need to charge users for services that might once have been free, for example a small charge for cutting toenails, which was set significantly below what it would cost for an older person to buy it privately.

Other organisations had bitten the bullet and introduced charging for their core services. One example was a day centre that had lost its funding:

> *Our strategy is about selling services and people paying for them themselves on a full cost recovery basis. With effect from the 1st of April the people coming in downstairs pay £20 for half a day, £40 for a full day for day care.*
> (Voluntary and community sector provider)

But despite this perception of relative resilience in the sector, a few interviewees discussed the loss of a number of smaller organisations that had struggled to recruit good trustees or to adapt to a more flexible way of working which might ask service users to contribute more by way of volunteering and charging for services.

Governance has been a vital part of our ability to adapt in this environment. Without it and without flexible trustees and leadership, we may have been in a much more difficult situation.

(Voluntary and community sector provider)

Voluntary and community sector organisations were felt to be facing threats to their sustainability similar to those experienced by commercial providers:

A lot of good charities have been lost and will continue to be lost. And once you lose those, they never come back.

(Voluntary and community sector provider)

5 The impact on older people, their families and carers

The national picture: what do we know?

Access to care and unmet need

As we have seen, the most striking feature of social care for older people is the dramatic reduction of at least 26 per cent in the numbers of people receiving publicly funded services over the past five years. Some of this reduction may reflect positive developments that have reduced the need for care and other approaches based on promoting independence and alternative community support (Bolton 2016a). But the fact that there is an increasing number of older people with multiple health conditions and more acute levels of need suggests that more older people should be getting social care, not fewer. It should be noted also that access to care had been tightened considerably over the past decade, so that by 2010 90 per cent of local authorities were limiting help only to those with 'substantial' or 'critical' needs (Fernandez *et al* 2013).

Although defining, let alone measuring, the extent of unmet need is fraught with difficulty, by 2011 there was already strong evidence of significant levels of unmet need among older people (Vlachantoni *et al* 2011). A more recent assessment of official statistics and the English Longitudinal Study of Ageing for Age UK indicates that unmet need has grown. More than a million people who have difficulties with the basic activities of daily living, such as getting out of bed, washing and dressing, now receive no formal or informal help at all. That is an increase of 100,000 in one year alone (Marmot *et al* 2015).

The Care Act 2014 introduced a new requirement on local authorities to consider how they can identify unmet needs (Department of Health 2016b). Monitoring

arrangements are in place in 34 per cent of local authorities and in development in a further 31 per cent (Association of Directors of Adult Social Services 2016). As yet we do not have a clear and comprehensive national picture of what happens to people who are not eligible for publicly funded social care – those who are 'lost to the system' (Henwood and Hudson 2008).

Even if older people have needs that are high enough to be eligible for publicly funded care, they may have to pay for some or all of it themselves if they have resources that exceed £23,250. Some 41 per cent of care home funding is met by individuals from their own private resources and a further 12 per cent from 'third parties', usually relatives who top up the fees paid by local authorities in order to secure higher standards of accommodation (Laing 2015). The extent to which people pay for care in their own homes is much less understood but one estimate suggests it amounts to around £1 billion of private expenditure (LaingBuisson 2016). Some will be using their own resources to pay for care without necessarily getting good advice or information (Institute of Public Care 2012). A further source of confusion and inequity for older people is the continuing division between health care free at the point of use and means-tested social care, exemplified by the continuing health care assessment process. Older people are not well served by our complex and fragmented health and social care system that is difficult to understand and navigate (Commission on the Future of Health and Social Care in England 2014; Independent Age 2016).

Quality and experience of care

For those older people who get publicly funded social care, 90 per cent are satisfied with the care and support they receive, slightly higher than working-age people at 86 per cent. Only 4 per cent were dissatisfied (Health and Social Care Information Centre 2015d). Changes to the methodology of the national social care user survey means it is no longer possible to compare current satisfaction levels with those of previous years. But considering the 2014/15 survey took place in the fourth consecutive year of real-term cuts in local authority social care budgets, it is interesting that satisfaction levels have stood up so well, emphasising that the survey does not capture the experience of people who fall outside the publicly funded system. This contrasts with rising levels of complaints to the ombudsman about adult social care – up by 18 per cent since 2013; 55 per cent of claims were upheld. In 2014/15,

complaints about home care rose by 29 per cent (Local Government Ombudsman 2016). That a high proportion of these – 67 per cent – were upheld by the ombudsman is consistent with the concerns about the state of home care that have emerged from our research. The upward trend in complaints suggests that councils are finding it harder to meet people's needs and expectations

Another window into quality is the outcomes of inspections by the regulator. Changes in inspection regimes and standards make it hard to assess changes over the past five years, with a new approach introduced from 2014. Based on inspection up to May 2015, care in 1 per cent of locations was judged to be outstanding, in 59 per cent it was good, 33 per cent required improvement and 7 per cent were judged to be inadequate (Care Quality Commission 2015). By 4 April 2016, this had changed to 1 per cent, 67 per cent, 29 per cent and 3 per cent respectively (Care Quality Commission 2016b). In part, this reflects the prioritisation by the CQC of higher-risk locations for inspection; the overall picture is likely to improve further as more lower-risk locations are inspected.

There are differences between services, with nursing homes less likely to offer good care. Smaller homes of all kinds provide better care than larger ones. Just under half (46 per cent) of nursing homes inspected up to 31 May 2015 were rated good or outstanding and 10 per cent were rated inadequate. Home care, residential homes and community social care (which includes Shared Lives schemes) were rated as being good or outstanding (68 per cent, 65 per cent and 68 per cent respectively).

This does not suggest that there has been a collapse in the quality of care as a result of spending reductions but, as discussed earlier, our case studies indicate that providers are finding it harder to maintain standards. The CQC has warned that the impact of budget pressures and expectations created by the Care Act 2014 is likely to have significant implications for the ability of providers to improve or maintain their quality of care while trying to maintain financial viability (Care Quality Commission 2015).

The role of carers

The social care system is heavily reliant on unpaid informal carers, usually family members, whose numbers exceed the paid social care workforce by around two to one. There has been an increase in the number of unpaid carers, who have risen from 16.6 per cent of the population in 2011, peaking at 18.9 per cent in 2013, before falling slightly to 17.6 per cent by 2014. In 2014, 30.6 per cent of people providing care did so for 20 or more hours a week. Many older people are carers themselves (Mortimer and Green 2016).

The Care Act 2014 offers important new rights for carers, including taking into consideration the carer's health and wellbeing; their family relationships and the need to balance their home life with their education or work; their entitlement to support from their local authority, if eligible; and provision of advice and information to prevent their needs from getting worse. A year on, the potential benefits of the legislation appear to be outweighed by pressures in social care and changes in the benefits system. A recent assessment by the Carers Trust (2016) concluded that the Care Act had made 'little or no difference' to many carers.

In another survey of more than 6,000 carers, one in three carers (34 per cent) reported a change in the amount of care and support services they or the person they care for receive. Of these, more than half (59 per cent) saw a reduction in care and support services due to cost or availability; this includes 13 per cent who said a service was closed with no replacement offered (Carers UK 2016).

The annual national survey of more than 131,000 adult carers reveals much lower levels of satisfaction than expressed by older people who receive social care – 74 per cent of carers were satisfied with the support and services they received (3 per cent lower than the year before), compared with 90 per cent among older people. Some 38 per cent of carers reported that they spend 100 hours or more a week looking after or helping the person they care for, up from 36 per cent in 2012/13 (Health and Social Care Information Centre 2015d). Demographic projections suggest that the availability of intensive unpaid care to older people by their children is unlikely to keep pace with demand in future years (Pickard 2015).

The local picture: what we learned from our case studies

One of the main questions behind this research project was whether the reductions in services to older adults have had a negative impact on older people and their carers. This includes: people who might have received services of any sort when funding was more generous and who are now directed elsewhere, and those who still receive services but who might have fewer hours or experience a lower quality of service as fees have been reduced to providers. This section contains the views of the NHS, local authority officials, the voluntary and community sector and Healthwatch on what is happening to users. We present the experiences of users themselves in the boxes.

The local authority perspective

All the local authority staff we interviewed emphasised how savings had been designed with the aim of not harming service users and carers. All conceptualised their role as targeting scarce resources to support people with the highest and most complex needs, and all were confident that the savings they had implemented had not led directly to unmet need or harm among older people. The local authority officers backed up their views with reference to an array of sources, including hard data (from public health or user surveys) or soft data from the voluntary sector, Healthwatch, centres for independent living, elected council members and consultation exercises led by local government. One local authority felt that its close working arrangements with GPs, community nurses and locality social workers meant that it would know if someone had slipped through the net:

> *… because they just tell each other who they are worried about and get on with it, and I don't think, you know, they work so closely with GPs, I think that if there was somebody there who needed, we'd know.*
> (Local authority)

Another local authority put it more precisely: there was 'not an unmet, eligible need'. However, the same interviewees thought that some people who had had their care packages reduced were not happy. They cited an example brought to them by one of

their elected members who had been knocking on doors, and who had reported to them an example of a reduced care package that meant the user had had to pay for her own cleaner:

> *… they would interpret that as a decrease in quality, wouldn't they… I think we would say it's not an unmet eligible need. Of course, everyone's got needs, but we don't have the money to meet all needs, we just meet eligible needs in a very, very targeted way.*
> (Local authority)

A common theme across all the local authority interviews was that people with lower-level needs were not simply being turned away from services, but redirected towards other sources of support, such as voluntary organisations in the community. But it was striking that there were no obvious sources of information about what was happening to those no longer eligible for statutory services: 'We just don't have the resources to do follow-up studies on everyone that we signposted away'. Local authorities were relying instead on soft data from the voluntary sector and Healthwatch.

For those still eligible to receive social care from local authorities, the view from local authority interviewees was that continuing high levels of satisfaction recorded in user surveys suggested that the quality of care was holding up. But there was an awareness that recruitment and retention problems, coupled with the retendering of home care contracts, may have disrupted continuity between older people and carers.

The experience of an unstable home care market: Robert's story

I had different care workers nearly every day. Sometimes they didn't even... I mean, one day I was going to the hospital on the hospital patient transport and I had to be ready at nine o'clock and half past eight they hadn't even turned up. And they sent up a manager who just hadn't got a clue. They changed their names four times while I was with them.

And anyway, it then changed... the new firm were just impossible to deal with. The management changed every three, six months and... And the, pardon me, the field care supervisors were, well, I was going to say a jobsworth, they just couldn't care less, that was their attitude, because their jobs, I think, were on the line anyway and then all of a sudden, without any warning, they decided they wouldn't deal with disabled people. So they sent us back to the council, yeah, social services. They then moved me to [another] firm... I thought, great, the manageress was a very nice person, and she'd had her own care company, but she was having difficulty getting staff, so she sold her business... Now, she was very nice, a very nice person, but unfortunately, she started in the July or August, was it, something like that and then in the October she'd gone. Well then one Sunday morning I had a visit, the... they call them CEOs, from [the new firm] and he brought with him a, I suppose, yes, area manager and he stood in the bedroom and he said to me, I couldn't believe it, he said, 'Mr [...], you're not cost effective'. So I looked, I said, 'what do you mean?' He said, 'no, you're not cost effective', but I'm standing here doing nothing and I thought, well, my God, you are the chief executive, you should be leading by example. Within a week of him saying that, chop, out. That was 2013, [20]14.

The view from outside local authorities

There was less confidence about the impact on people among interviewees who worked outside the local authorities. When asked whether the system could still completely miss people with high levels of need, a social care provider reported that they got calls 'every now and again' to assess people in their own homes and sometimes found people living in 'appalling' conditions. In the same area, an interviewee from the voluntary sector claimed that there had been a significant increase in the numbers of people being found dead in their own homes, but did not attribute this directly to a reduction in services. A social care provider in another authority felt that the safety net worked well nearly all of the time, and that complete failures were rare.

In both cases, the source of the information was anecdotal and it was anecdotal evidence that was put forward in our interviews with members of Healthwatch and voluntary and community sector organisations across the case study sites. The following examples come from a focus group of voluntary sector providers in one local authority. It is striking that the shortcomings in care relate to both social care and health services.

> *I've got a man with dementia that's not eating or anything without being prompted. But that's not seen as a need. He can look after himself because he can make a sandwich. It doesn't matter that he doesn't want to make himself a sandwich and eat. And he will just sit there and starve. But he has got a daughter, but they have quite a strained relationship. So that's happened with a lot of them.*

> *There was a gentleman that had prostate cancer and he's been out of hospital for four months. But we're still waiting for the incontinence team to work with him. But he's been incontinent since coming out of hospital from his operation.*

> *We've got a woman in sheltered housing and she's set the flat on fire three times in the last three weeks. And there's no managers there or anything if there's an incident. Just the telecare.*

The absence of hard data on the impact of budget cuts was a concern for Healthwatch interviewees in all four case study sites. One Healthwatch organisation had conducted a consultation with service users to influence the local authority's decision-making on whether to raise Council Tax – 'it was actually talking to real people', which included views from a group of older people: '… and one of them said, "I'll just start practising to eat less from now". It's that sort of stuff'. Healthwatch planned to go back and follow up to generate 'evidence'. A Healthwatch officer in another authority was less confident about their ability to really understand what was happening in relation to older people in their homes, where more and more care is being delivered, because they have no right of entry. The third Healthwatch organisation felt that they had not had a particularly strong focus on adult social care, partly because the failing NHS trust had generated more pressing issues for patients. Their attempts to locate social care users had included outreach to supermarkets, market stalls, GP surgeries, community centres and outpatient departments, with limited success:

> *… although we've done quite a lot of outreach in areas where we would expect people to be in receipt of adult social care or to be a relative of somebody in receipt of adult social care, we get almost no feedback about it from people.*
> (Healthwatch)

It was widely suggested that the next five years were unlikely to bring a solution to the funding pressures facing the health and social care system. The consequence of this for users was felt by some to be extremely serious: 'People will be dying in their homes… alone. Or suffer' (voluntary and community provider).

Pressure on hospitals – the human cost to older people

The experience of discharge: Ann's story

They didn't tell me when I went in, I'd have to be non-weight-bearing for a month. Nobody mentioned that to me. So therefore, I'd have to hop. But they came to see me to say, 'well, we don't think you're ready to come home, so we're going to send you to a nursing home or county hospital'. I said, 'who's going to look after my husband? Are you sending him as well?' Oh no. They now wanted the bed, they wanted to get rid of me. I didn't want to be in the hospital, I wanted to be home, but they said I couldn't come home. So I said, 'I thought I was entitled to a week's care'. They said, 'there isn't any care at the moment'. They are in crisis. There is no care. They haven't got enough trained-up people. They did nothing. Now, I didn't know I could have asked for a social worker, nobody told me that. They said, 'well as you're refusing to go to a nursing home or to a community hospital, we'll have to consult your daughter'. Well I'm afraid that was the final straw, I blew my top and said, 'my daughter doesn't have power of attorney over me. I have all my faculties'. I said, 'I'm looking after two other people, I make my own decisions'. And they said, 'well we'll just discharge you then'. Just like that. And by this time I was so fed up with them, I just thought, get on with it. Get on with it.

So, ten o'clock, Saturday night, I'm sound asleep, the nurse comes in and wakes me up, she said, 'we're moving you'. I said, 'you're not, I'm going home tomorrow. There's all this equipment, all my things'. She said, 'oh we've got to move you, they're bringing someone down from the [X hospital]…' I said, 'then you'll have to drag me out of this bed, because I'm not moving. I'm going home tomorrow, that's that'. She said, 'well I better consult someone higher'. And off she went. She came back at half past eleven, and woke me up to tell me they'd decided not to move me. But the nurse was so… it wasn't the nurses, it's the people controlling the nurses, that is so sad.

The most directly visible element of the health and care crisis lies in the difficulty in getting people out of hospital. As discussed in the next section on the NHS, cuts in local authority budgets are only one dimension of an extremely complex problem. In our interviews, there was a common theme that, regardless of the underlying cause, it was older people and their families who bore the brunt of the problem:

> *It's upsetting from most patients' perspective… people are frustrated – the staff are frustrated for patients and patients are frustrated themselves if they are here when they know they could and should be elsewhere.*
> (NHS provider)

In three case study sites, interviews from the NHS brought evidence – albeit soft evidence – of delays caused by families, possibly attempting to delay having to fund their own care, or worried about the quality of care homes, or disputing whether a person should be going home at all. A similar view was expressed by a local authority director who said they had experienced conflict with families who wanted their relatives to be 'tucked up' in residential care rather than returned home.

While there was no consensus that social care cuts were causing pressure on A&E departments, interviewees across all the case study sites offered examples of 'something' having failed, leading to older people turning to emergency departments as a last option.

> *One of the GPs came to us and said, I have this elderly lady who lives by herself, I went to see her and she said, 'Can you put me in hospital over Christmas just so at least I've got someone to talk to?'*
> (Local authority)

Two interviewees raised concerns about the national policy/narrative to prioritise home care above bed-based care (residential, nursing or intermediate). Although the description of home care being a cheaper option for commissioners was not disputed for short-term goals, it was felt that the increasing acuity of older people's needs meant that this may not be suitable in the future, particularly for those social care users with 'very limited input' because of short visits from carers, who are at risk of isolation (voluntary and community sector provider).

The way we're going is not sustainable, I think we've closed so many homes and the emphasis has been on keeping people within their own home, and for me personally I'm not sure that that always works. There's people with very, very, very heavy need… some of them suffer terribly from loneliness.
(NHS provider)

Not addressing these issues was expected to lead to a 'repeating pattern' of pressure on the NHS, with more people in hospital and more episodes of delayed discharge.

Carers and families

If there was an area in which some of the local authorities felt standards had slipped, it was in relation to carers. Two of the local authorities reported this: one said it was a 'more negative picture' for carers, based on falling satisfaction levels in their carers' survey; another also reported that carer satisfaction had fallen, conceding that they had sometimes 'dropped the ball' in relation to carer assessments.

The experience of organising carers through direct payments: a carer whose mother has MS

We get all the admin to do. We're in such a big package and a big need for care, we then have to employ enough carers to cover the hours and then do a rota – which my sister does – which you'll see on the table up there. I'll make sure that there's carers here to come in when Mum needs them and that they can all cover... And then they're all on holiday because they're all then entitled to holidays and then we have to have... holiday sheets so they can write on when they're on holiday... because we're not experienced employers... I'm not experienced in employment law. And there isn't a lot of back-up for you. There is supposed to be a third party – I can't remember what they're called now – charity. They're a charitable institution that's supposed to help with taking people on at first. But they haven't helped us with any of that recently... And a few of them, we've taken on through word-of-mouth or 'Someone's got a carer that's really good and she's looking for some...' That sort of thing. But there isn't really... We've fallen lucky with our girls but it's a bit difficult to know whether these girls are trained to do what they're doing.

The experience of moving from self-funding to continuing care: Pat's story, as told by her partner

We didn't know anything about care or rights or anything like that. So, at the time the council provided the care and it was 40 hours per week. So, Pat had to put up... because Pat needed from the beginning 24-hour care, Pat had to put money from her pocket, to the point that she had to re-mortgage her house because there was no money to pay for the carers.

But, the breakthrough was probably about three years ago when... I just thought, you know, the money is not going to last Pat, and I started to approach the council again, and it was when the financial crisis happened, so they told us you're wasting your time, you know, what's given is what it is. But, I don't know why, I persevered, and I persevered for over a year... [and] managed to get the acknowledgement that she needed health care and not social care and that's what transformed Pat's life in terms of funding, suddenly she had money to pay the carers a good salary, there was money to pay for training, there was money to pay for holidays, for bank holidays. It is to do with the fact that they acknowledged Pat had health care needs.

The future

> *I think the bigger question that we've got to ask ourselves is what the general public want, what do we want, what does the government want… if we had a better plan… we wouldn't be at this point.*
> (Social care provider)

In all areas interviewees spoke of the need for better self-management by users and greater involvement from families and the wider community in the provision of care for those in need. This was often talked about as a remedy to what was viewed as an almost paternalistic state provision: one interviewee stated, 'We've made people dependent on services' (NHS provider), and another said, at present we are 'sucking people into the social care system' (local authority). Others described this as being a direct result of reductions in public funding – 'care will have to come from people's pockets' because services such as meals on wheels, which have recently been reduced, will not be replaced in the future (voluntary and community provider). In a different (more affluent) area, the local authority prediction was that, in the future, the role of the authority would be to provide information and guidance rather than support.

'Asset-based approaches' and increasing individuals' 'social capital' were frequently described as necessary solutions to the lack of capacity in social care. These were defined as building up local volunteering schemes, 'encouraging neighbourliness', community participation, 'revitalising' the VCS, more involvement from friends and family, and better self-management. However, it was recognised that this required a cultural shift in perceptions that would be difficult to achieve. One interviewee suggested: 'I'm not sure the population are ready'. Another commented that the local authority itself needed to 'articulate better our community offer' in order to make this new approach a success. A Healthwatch interviewee welcomed the introduction of an asset-based approach but thought that while this was 'accepted wisdom' in the council, they had not brought the public with them. It was also suggested that individuals will need to better prepare for the financial cost of their care in later life.

6 The NHS

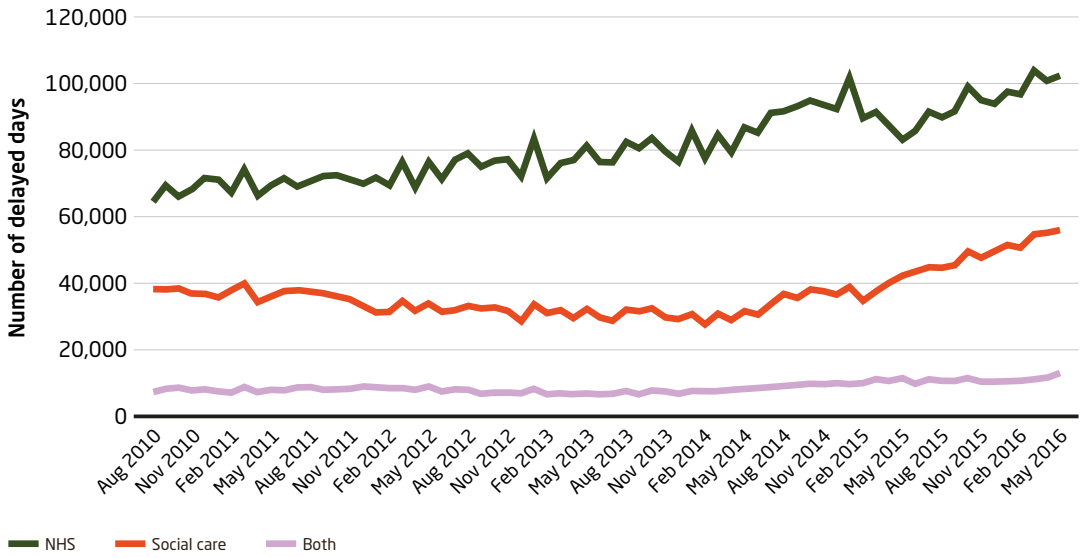
The national picture: what do we know?

Hospitals: rising admissions and delayed transfers of care

Older people are the biggest users of hospital care, accounting for 62 per cent of total bed days in 2014/15; those with longer stays (of seven days or more) accounted for 52 per cent. As the bulk of ill health occurs at older ages, the presence of predominantly older people in hospital is unsurprising, but there is growing concern about the increase in delays over the past five years experienced by older people who are medically fit for discharge but unable to leave hospital ('delayed transfers of care'). It has been estimated that the NHS spends around £820 million a year keeping older patients in hospital who no longer need to be there (National Audit Office 2016).

It is not clear how far the cuts to publicly funded social care have driven this. The official dataset attributes delays to the NHS, social care or 'both'. Although the number of delayed days due to social care reasons has risen sharply over the past 12 months, over the past five years at least 60 per cent of delayed days every month have been attributable to the NHS (*see* Figure 9).

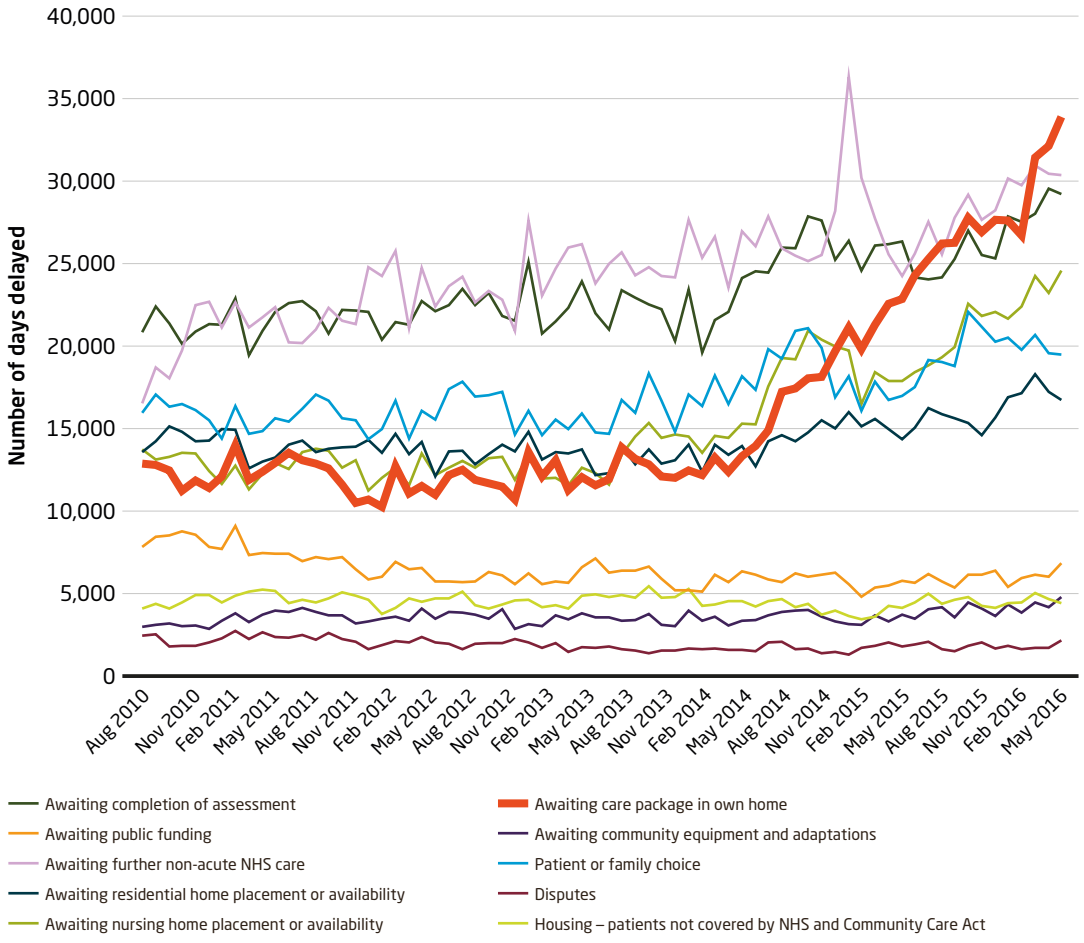
Figure 9 Who is responsible for delayed transfers of care? Delayed days by responsible organisation, 2010 to 2016



Source: NHS England 2016a

Looking beyond organisational responsibility to the underlying causes of delays, there has been a rapid rise in waits for care packages at home (*see* Figure 10), up 163 per cent over the past five years and by 40 per cent in the past year alone. In contrast, waits for public funding are now lower than they were five years ago and have never accounted for more than 4 per cent of all delayed days over the past two years. Escalating numbers of delayed transfers now appear to be symptoms not simply of insufficient money but also of problems of workforce and service capacity as well as poor co-ordination and information sharing between different parts of the system (National Audit Office 2016). They reinforce concerns about the fragile state of the home care provider market discussed earlier.

Figure 10 Delayed transfers of care from hospitals, 2010 to 2016 (number of delayed days by reason for delay)



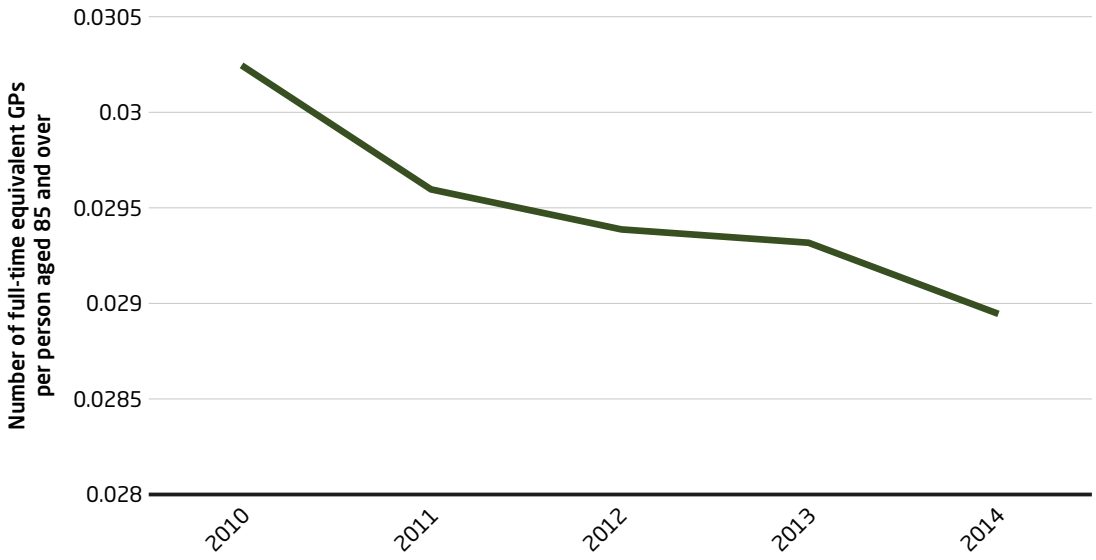
Source: NHS England 2016a

There have also been concerns about the impact of social care budget pressures on the 'front door' of hospitals. In the past five years, emergency hospital admissions of older people have risen by 18 per cent (for the general population it was 12 per cent). Some 50 per cent of older people attending A&E were admitted to hospital, compared with 16 per cent for those aged under 65 (Health and Social Care Information Centre 2015b). There are wide variations between hospitals in the proportions of

older people they admit, how long they stay and how quickly they are discharged (Public Health England *et al* 2015). Social care pressures could be a factor in rising rates of admissions of older people but so could shortfalls in primary and community health services, and the complex clinical needs of patients.

Primary care has also been under pressure. Recent research by The King's Fund found that the number of patient contacts taking place in general practice grew by more than 15 per cent between 2010/11 and 2014/15, with the greatest increase in activity seen among the oldest age groups. The total number of contacts with patients over 85 increased by 28 per cent over the same time period. (Baird *et al* 2016). At the same time, primary care has been experiencing funding and workforce challenges. An overall increase in GP numbers has not kept pace with an ageing population, so the ratio of full-time equivalent GPs to the number of people in the general population aged over 85 has fallen steadily (*see* Figure 11).

Figure 11 Number of full-time equivalent GPs per person aged 85 and over

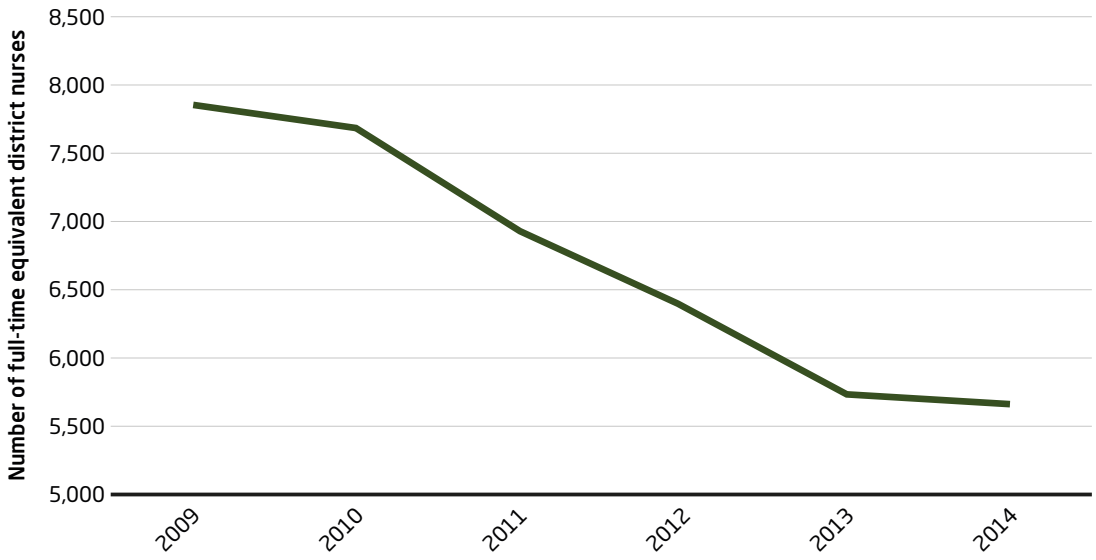


Source: Health and Social Care Information Centre 2015a

Over the same period, funding for primary care as a share of the overall NHS budget fell each year – from 8.3 per cent to just over 7.9 per cent (Baird *et al* 2016). In recognition of the pressures facing general practice, NHS England recently committed to increasing recurrent funding of primary care by an estimated £2.4 billion a year (NHS England 2016b).

There is a lack of clarity about activity and demand in other community-based health services that are essential to keeping people with chronic, complex conditions well enough to live independently and stay out of hospital (Oliver *et al* 2014). For example, there is no robust national data regarding the activity undertaken by district nursing services, but available evidence points to an increase in the volume and complexity of caseloads over recent years (Maybin *et al* 2016). Yet despite increasing demand, there was a 28 per cent reduction in the total number of full-time equivalent district nurses between 2009 and 2014 (*see* Figure 12). Some of this reduction is likely to

Figure 12 Number of full-time equivalent district nurses, 2009 to 2014



Source: Health and Social Care Information Centre 2015c

be accounted for by the transfer of staff to independent providers as part of the Transforming Community Services programme, but this is unlikely to be the sole cause as the decline pre-dates the implementation of the policy (Addicott *et al* 2015). Monthly workforce releases suggest this decline is continuing; the number of full-time equivalent district nurses fell by 13.6 per cent between March 2014 and March 2016 (Health and Social Care Information Centre 2016; Maybin *et al* 2016).

Intermediate care services are most often used by older people, and are designed to prevent unnecessary hospital admissions, support independence following a stay in hospital and prevent people having to move into a residential home where possible. Availability of these services varies widely across England, and has failed to keep pace with demand. The national audit of intermediate care suggests that the current level of spend on intermediate care is consistent with about a half of the capacity required to meet demand; and since 2013 it appears that capacity in health-based intermediate care has remained static while capacity in re-ablement services has reduced (NHS Benchmarking *et al* 2015).

The local picture: what we learned from our case studies

The picture painted in our case studies was of a health system under huge pressure, but one that was reluctant to attribute these pressures in any simplistic way to the budget reductions in social care. Factors contributing to this pressure, across all sites, as identified by those we interviewed were: the growing demand on NHS services in general, the lack of availability of temporary and permanent support packages and placements post-discharge (particularly in the home), and the reduction of NHS community services.

Discharge from hospital

At a national level, delayed transfers of care have become emblematic of problems in social care, and it was the same story in all our case study areas. Although the national data captures 'reasons' for delay, and ascribes causation to either the NHS, social care or 'both' (*see* Figure 9, page 55), most interviewees described a complex and interdependent set of causes behind delays in discharging older people.

Prominent among these factors was a lack of social care services, in particular nursing homes, beds for older people with social care and mental health needs,

re-ablement places and, particularly, home care packages. These services were described as having a mutual dependency, which ultimately had consequences for acute hospitals. For example, if increased demand for home care was not matched with availability, the lack of access to services would then cause a slowdown in the flow of people through re-ablement, which then results in delays in discharging patients from hospital.

As one local authority interviewee commented:

> *I think it is about… accessing home care… what has tended to happen is our enablement service has silted up: can't get people off the other end and that washes back into the hospital situation.*
> (Local authority)

Additionally, the complexity of need people had when leaving hospital or re-ablement-type services was described as an important part of the delays. Getting the right, specialist placement for those with high levels of need or behavioural problems was seen as difficult in two areas.

A few interviewees were reluctant to attribute these challenges solely to reductions in local authority funding. For example, a CCG interviewee suggested that it was too simplistic to argue for a direct causality: 'I don't think you can say local authority budgets have been absolutely plundered, ergo health is now completely on its knees'. This was in part because some of the difficulties in sourcing suitable community-based services were also felt to be in part the fault of NHS commissioners. One local authority interviewee criticised its local CCG for having focused too heavily on its acute trust and not on its community services. A CCG interviewee explained that, in district nurses alone, their local community nursing numbers were short of around 20 staff members. Two areas talked about poor-quality primary care or a lack of capacity development training as the source of much of the pressure facing their local acute and social care services (local authority).

NHS payment mechanisms were seen as compounding the problem by driving negative/unco-operative behaviour in acute trusts. One CCG interviewee, describing the local hospital trust, said: 'because they [the trust] are severely

challenged, it also drives a lot of behaviours that make them try to balance the books'. Another interviewee gave an example of their trust's behaviour – attempting to discharge patients without co-ordinating with the wider strategy:

> *We've got the hospital decanting people into a spot bed, which takes up a residential place that we could probably be better using… you do things because the person who's got the whip isn't interested in the knock-on impact.*
> (CCG)

A third area had commissioned an independent research report into the hospital's discharge of older people, which found that it was creating 'completely unnecessary' bed-based discharges. In the same area, a discharge to assess scheme was set up, whereby patients were automatically discharged into a short-term bed and comprehensively assessed once out of the hospital. This was criticised for having benefited the hospital by shortening the length of stay but using up residential home capacity, in some cases inappropriately. The interviewee noted that the gains for the hospital were only temporary, as the capacity issues in social care meant that they were soon back to having delayed discharge.

Another complicating factor in discharging patients, described by two interviewees, was the requirement of hospitals to consider the patient's choice of post-discharge plans. One interviewee suggested that patients' families feel as though their relative is 'safe in hospital, so there's no rush to find, you know, a home for their mum' (NHS provider). Patients are given the opportunity to wait for a placement that they think better suits their needs, 'And the issue drags on' (local authority). At a national level, delays caused by patient or family choice accounted for 11 per cent of all delays in May 2016 (NHS England 2016a).

From the patient perspective, there were concerns about people's independence when they left hospital after an extended period of admission: 'We have the effect of a lot of patients being here that don't need to be. And it isn't right for them to be here from a health perspective, let alone from an efficiency perspective' (NHS provider). The consequences of this were seen as self-defeating: people waiting in hospital could often become less robust and subsequently require more intense health and social care support when they were eventually discharged.

Increased demand for NHS services

The problems facing the social care sector were also implicated in the rising admissions and pressure on the front door of the hospital, albeit they are harder to quantify:

> *The most visible parts are the delayed transfers because it's easier to count, it's very obvious. But I would say the arrival of patients with a care package who, with an alternative set of options out in the community, never would need to come to the hospital is an equal problem, definitely.*
> (NHS provider)

The increased acuity of need of A&E attendees and those being admitted to hospital was noted by a number of interviewees. One commented that older people were arriving in 'genuine need of care and support' (Healthwatch). This was explained in part by the ageing population. Others, however, suggested that it was as a result of a lack of suitable care in the community and a reduced focus on preventative care. One interviewee outlined the position from her perspective in her area, stating that more older people were becoming unable to cope living at home by themselves, causing an increase in demand in primary care, community services and the acute hospital:

> *It is not necessarily that there are more people that are being admitted: it is that there are people being admitted more times… there's certain parts of the population that are just not getting the response that they need and, therefore, are knocking on many doors.*
> (CCG)

A Healthwatch interviewee summarised the situation as 'talking to GPs I get a feeling that they think people are coming to them because they have a social need rather than a health need'. A social care provider in the same area stated that local authorities' ambitions to care for people in their own homes had resulted in some older people becoming 'expensive', 'revolving door cases' in A&E. Another described the 'vicious circle' caused by focusing social care budgets on those most in need and not providing sufficient preventative, 'downstream' activities that could

minimise falls and other issues that result in admissions to hospital where people 'decompensate' and come out needing more nursing support.

Perceptions of the fragility of support for older people in the community, and the risks facing people with little or no support, were also seen as affecting the decisions of admitting doctors in acute hospitals in two of our case studies. One interviewee described some of the doctors as 'risk averse' and the other suggested that, in some instances, doctors were admitting patients in the absence of alternative available care options.

7 Strategies to improve care and support for older people

The national picture: what do we know?

Many aspects of the national policy framework through which social care for older people is delivered reflect long-standing policy objectives that pre-date the coalition government formed after the general election in 2010. This includes the policy of personalisation, based on the use of personal budgets and direct payments, renewed emphasis on promoting independence through prevention, re-ablement and the use technology, and the continuation of existing strategies for dementia, carers and the social care workforce. The most significant and substantial policy developments in the past five years have been major legislative reform and new initiatives to improve the co-ordination and integration of services.

The Care Act 2014

The Care Act 2014 came into force in in April 2015. The Act was the most significant reform of social care in more than 60 years, consolidating a complicated legal framework dating from the beginning of the welfare state and building in significant new rights and responsibilities. However, implementation of Part 2 of the Act – that would have introduced a cap on care costs and changes to means-testing – has been delayed until April 2020 (Hansard 2015).

The central change in the Act is a shift from defining social care as a set of interventions to the duty to promote wellbeing across a population.

Councils are charged with refocusing their activities from narrow service provision to paying attention to personal and community strengths and preventing care needs, rather than waiting until crises take place to address them. The Act introduces significant new rights for carers, widens access to advocacy and puts good practice

in information provision, co-operation, commissioning, adult safeguarding and integration into statute. It also introduces new national eligibility criteria, replacing the old, locally determined Fair Access to Care framework.

The Act was introduced through a relatively co-operative and cross-party political process, and broadly reflects the aspirations of the sector. But there are real and growing doubts about the feasibility of its ambition in the financially squeezed environment we are now in.

Integration of health and social care

Since 2010, the government has introduced a number of measures to achieve this long-standing policy objective. The Better Care Fund is a national initiative set up to encourage CCGs and local authority commissioners to work together using a pooled budget, worth £5.3 billion in 2016/17 (Department of Health 2016a). The money is intended to be spent on social care services that have a health benefit. Successive payments of funding are predicated on local areas being able to demonstrate success.

In 2013, the government selected 14 integration pioneer sites across England to trial different approaches to joint, integrated working. The process was then repeated when a further 11 pioneer sites joined the programme in January 2015. These 25 sites aim to draw on collective expertise, including from the voluntary and independent sector, to improve quality across health and social care (NHS England 2016c).

Social care is an important element of the new models of care announced in the *NHS five year forward view* published by NHS England and other national NHS bodies in 2014 (NHS England *et al* 2014). A total of 50 'vanguard' sites have been chosen to take a lead on the development of new care models. They will act as blueprints for the rest of the NHS and can be adapted to meet the needs of different local populations. The three types of vanguard model in which social care is most relevant are:

- integrated primary and acute care systems – joining up GP, hospital, community and mental health services
- multi-specialty community providers – moving specialist care out of hospitals into the community
- enhanced health in care homes – offering older people better, joined-up health, care and rehabilitation services.

The November 2015 Spending Review and Autumn Statement announced that all areas would be required to submit plans for integration between social care and the NHS by 2017, to be implemented by 2020 (HM Treasury 2015).

The local picture: what we learned from our case studies

Improved relationships?

Solutions to the challenges facing the health and social care sectors were seen by our four case study areas as emerging from improved relationships between the health and social care sectors. Co-ordinated, joint working was described as a vital step towards creating a culture in which the pressures caused by increased demand, reduced budgets and inefficient processes were seen as a shared problem.

> *We're finding ways of working together between health and social care and across the providers… because there's no point the hospitals just going on and on about the fact that there isn't enough residential home care capacity… there isn't and you can't knit it any time soon.*
> (CCG)

One of the case study sites was moving towards creating a single integrated care organisation with a single commissioning function. In addition to improving processes and the flow of people between sectors, the scheme was also trying to change cultural differences and silo working. One interviewee commented that the 'crisis' situation had forced the services to work more closely together, more effectively, and others noted that the creation of the Better Care Fund had facilitated a new approach to tackling the issues that blurred traditional boundaries between sectors:

> *You had a whole range of offers from the practices, that started to blur… health and social care needs [… the Better Care Fund] has started to get GPs to think beyond the medical.*
> (CCG)

In one of the case study areas, nearly all of the interviewees mentioned the beneficial impact of their System Resilience Group as a way of improving communication between providers and commissioners.

Despite these strategies, some interviewees reported signs of frustration and a lack of understanding between the sectors. For example, one social care provider expressed resentment at local authority budgets being decreased more than NHS budgets, particularly when, in their view, the NHS was unable to manage its own budgets effectively. However, an NHS provider in a different area suggested that, for the local authority, 'money is the driving force' whereas in the NHS, money is important 'but less important compared to the quality in health'. One interviewee suggested that it was 'problematic' having different accountabilities between the NHS and local government, with the director of adult social services as a single point of accountability in the local authority with a great deal of pressure on them not to overspend (CCG). Another CCG interviewee echoed this sentiment by stating that local authorities are held to account by their councillors and public whereas accountabilities are much more diffused in the NHS, spread across CCGs, providers and NHS England.

Similarly, many interviewees outlined the intense demand and cost pressures facing their local acute trusts, summarised by one interviewee as: 'We are the only service around that still says yes to everything' (NHS provider). However, two providers suggested that their acute trust 'sucks' resources and services into it. This was seen to cause tensions between local providers and act as a barrier to new models of care, with commissioners needing to 'wrestle' money out of the trust to spend it on community-based services (social care provider).

Three interviewees described unco-operative and individualistic behaviours among health and social care commissioners. In one area, the local authority was accused of 'cost shunting' because it was reassessing its Continuing Health Care (CHC) files to see if the CCG could be retrospectively charged for some users (CCG). The local authority itself said it was supporting users who were 'obviously' eligible for CHC and that if the CCG tried to fund these additional cases as part of the Better Care Fund plans, it would be 'counterintuitive' and against the 'spirit' of the Better Care Fund. A local authority interviewee in a different area also said that they were supporting an increasing number of users with highly complex needs without receiving any additional funding from the NHS. One social care provider suggested that their care workers were filling the gap left by declining numbers of district nurses and were therefore performing tasks beyond their pay grade.

Integration and the Better Care Fund

Integration of services and funding was a continuing focal point and source of optimism across the four areas. Interviewees described integration as a way of redistributing resources between the sectors, creating more 'equitable funding'. As one CCG interviewee commented, when thinking about the individual in need of care: 'It goes back to the whole point of, "Who's paying?" and "Why does that matter?"'.

In addition to collaboration over commissioning budgets, examples were given of plans to integrate provision over the next five years. One area described its ambition to create a co-designed, integrated pathway for older people, mental health and children's services, to be commissioned through a pooled budget. Another was piloting a multidisciplinary, community care team.

Outside health and social care, one area referenced its collaboration with the local fire service to undertake preventive work and joint assessments. Another talked about the value of working with the breadth of the voluntary and community sector including, for example, harnessing the value of local faith groups.

The pooled budget created by the Better Care Fund was used in our case study sites in a number of different ways, including:

- discharge to assess services
- early multidisciplinary team assessments
- general funding for packages of social care, some specifically to meet unfunded increases in demand due to demographic growth
- seven-day working programmes
- community and district nurses
- hospital-based, salaried social workers
- case management
- therapies and re-ablement services
- investment in improved relationships/communication between the local authority and CCG.

Two areas described the Better Care Fund as being a useful mechanism for improving ways of working between the sectors and, in particular, for encouraging NHS colleagues to think about patient/user care in a more holistic way. Another described the process as being of benefit to the relationship between the commissioning bodies and that they were moving towards integrated commissioning rather than, for example, sharing the costs of salaries.

However, beyond that, opinions on the Better Care Fund were predominantly negative. The administrative process of submitting the plans was described as a 'disaster'; there were difficulties in getting it signed off from NHS England because the CCG's original suggestions were 'further ahead' than what the Fund was trying to achieve (CCG). In one area, a Healthwatch interviewee suggested that, rather than being a shared or joint process, the plans had been dictated by the CCG without much space for collaboration with the local authority.

Two areas made reference to the fact that collaborative working between their local authority and CCG pre-dated the Better Care Fund. In one area, the announcement of the Fund was perceived to have actually set integration plans back by a year and half while the CCG responded to the national policy. Another area echoed this sentiment, stating that their plans were not particularly innovative – 'Frankly, we just took all the budgets we currently shared and bundled them up' (CCG). The interviewee described the process as an 'unnecessary reworking of stuff we're already doing' and, consequently, felt much more confident in the Vanguard new models of care work as a mechanism for innovation (CCG).

There were also some wider concerns about integration. With reference to their local integration initiatives and the need to involve the private and voluntary and community sectors, one social care provider said: 'If we look at working together as a proper team then I think the future is looking quite good, but I'm not holding my breath to be honest'. Another interviewee expressed doubt about the vanguard programme's ability to deliver change at the scale and pace needed (NHS provider).

Improving community-based care to prevent admissions

Establishing better links between care homes and primary and secondary care, or up-skilling staff in care homes, were schemes that three of our areas had established in order to prevent unnecessary admissions to hospital. In two areas, social care

providers outlined their plans to set up NHS-funded support for people with complex health and care needs. One area talked about plans to create medically led rehabilitation or temporary beds with support that would be more intensive than is currently available in nursing homes; these would, therefore, require CQC registration. The ambition was two-fold: to create extra capacity in the care home sector and to support those who otherwise would be taken to A&E:

> *Our referrals ideally would come from GPs and paramedics, they're going to find people who otherwise would be blue-lighted to the acute sector but may be blue-lighted to our ones [homes].*
>
> (Social care provider)

The second example was that of a care home provider that had set up a re-ablement unit for patients being discharged from hospital. This pushed the provider beyond its normal nursing home provision into creating specific units with a gym and a physio to support people to return home.

Two areas had set up multidisciplinary community-based teams that were located in local GP centres. One of these involved a community navigator whose role was to promote social prescribing and other similar activities. The other included wider tasks to tackle social isolation such as befriending and home visits.

Assessment and discharge

All of the case study areas were refining their assessment and discharge models in acute hospitals. Interviewees outlined the complex process of discharging, particularly for hospitals dealing with multiple local authority areas, each with differing eligibility criteria and models of provision. One NHS acute provider was in the process of trying to get agreement among the local authorities in their area for a single, generic social work assessment that would, in their view, reduce length of stay. This would signal a return to when hospitals had an in-house social worker who did all the assessments, rather than waiting for a social worker from a local authority to do the assessment themselves. However, they were facing some resistance from the local authority, which was concerned about an 'impact on their resources' if someone other than its staff conducted the assessment (NHS provider).

In order to reduce the wait for social care funding, one hospital and local authority had changed the way in which funding assessments took place. Rather than having a set quota per week, with the funding board/panel meeting once a week, the local authority had agreed to accept individuals as needed. The result was: '[We are] not having any delays now for local authority funding, which is positive' (NHS provider).

One area had tried to stimulate more efficient ways of managing assessment and discharge by co-locating hospital and social care staff members in order to improve communication. What was previously described as 'quite fragmented and quite distant' was now 'much improved' because of this change (NHS provider).

As mentioned previously, one area set up a discharge-to-assess model. This was described as having improved the flow in hospitals temporarily but subsequently caused delays in accessing social care due to their reduced capacity. The local authority in this area outlined plans to create a single team of occupational therapists operating in local health and care services as well as, alongside that, designing an enablement service that was therapy-led.

Technology

Three areas suggested that the use of digital aids and technology was going to be an important part of improving care in the future. In one case study area, which has an affluent population, a social care provider interviewee described the investments they were making to increase capacity and make better use of technology. This company was building new homes aimed to be 'attractive propositions' to the self-funder market, though it also wanted to get a mix of publicly funded users and work collaboratively with local NHS providers. In this new development, the ambition was to give staff hand-held devices that would allow them to update care records instantaneously. Users and their families, where authorised, would also be able to view this information and be able to send messages via an online portal.

8 Discussion: the future of social care over the next five years

> *Somebody in government, or somewhere, needs to look at whether they care about their old people or not.*
> (Voluntary and community sector provider)

In our conversations with local authorities, social care providers, the voluntary sector and the NHS, we heard an amplification of messages that will be familiar to those who have watched the social care sector over the past five years: social care providers under pressure, struggling to retain staff, maintain quality and stay in business; local authorities making unenviable choices about where next to wield cuts; NHS providers scrambling to get older people out of hospital before they deteriorate; and the voluntary sector keeping services going on a shoestring. Collaboration and innovation are taking place despite the odds, but no one was very optimistic about the future.

We began our study with a question about what all this meant from the perspective of older people. Three things stand out from the interviews in our case studies.

First, no one has a full picture of what has been happening to older people and their carers as local authority-funded social care has taken a battering from austerity. Although it is clear that fewer people are now eligible for social care than in the past, we do not know how well they have managed to put in place support for themselves, or at what cost to their carers' and family members' health and wellbeing.

Second, the gap in experience between those people who happen to have their own resources, or live in an area with more social care, and those who do not has widened. As we have seen, the gap will be greatest in those places where local

authorities have been least able to sustain spending levels. In other words, an unfair situation has become worse.

Third, local authorities' vision of an enabled, independent older citizen, supported at home by family and community, turning to the state for care only in extremis, requires a vibrant voluntary and community sector, family members able and willing to play that role, and health and care services fully geared up to support people in their homes. We have not found evidence of these things being in place.

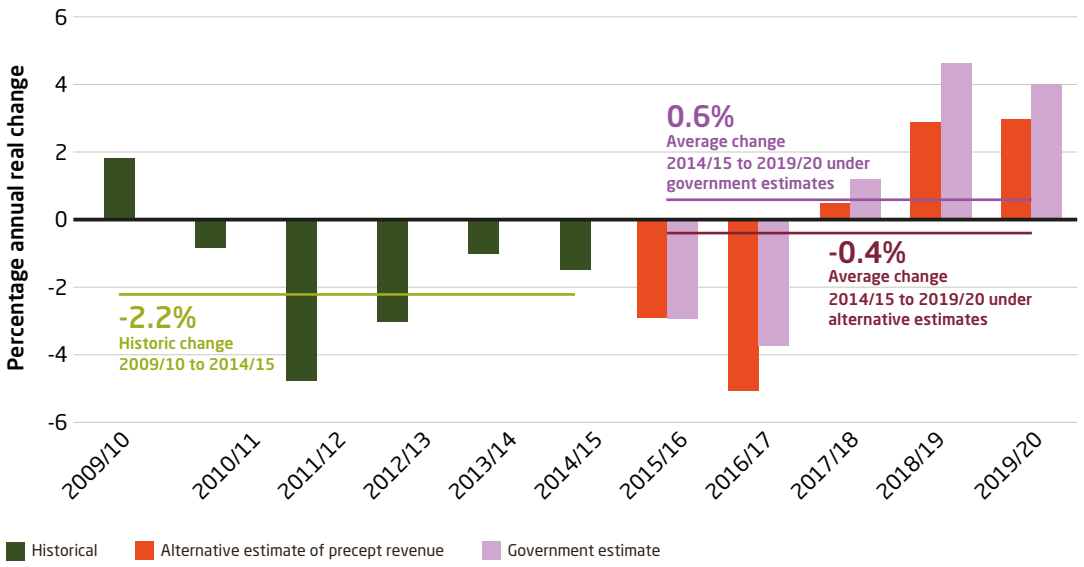
Below, we offer an assessment of the choices ahead, informed by our research and the voices we have heard.

The financial context

Looking ahead, spending on social care is likely to be broadly flat in real terms over this parliament, taking account of the additional Better Care Fund money that will be allocated directly to local authorities from next year, reaching £1.5 billion by 2019/20. The government's current spending plans are based on a reduction in public spending from 40 per cent of gross domestic product (GDP) to 36 per cent by 2021 (noting that these figures will change as a result of the referendum vote to leave the European Union). If the government's current assumptions about how much will be raised by the social care precept over the next five years are correct, spending would rise by an average of 0.6 per cent a year. Under an alternative, less optimistic estimate, spending would fall by an average of 0.4 per cent a year (*see* Figure 13). Local authorities in poorer areas with a low Council Tax base will be able to raise much less through the precept than richer areas – ranging from £5 per head of adult population to £13. These areas also happen to be places with relatively high levels of need for publicly funded social care (Humphries 2015).

These scenarios are an improvement on the past five years, when spending on social care fell by an average of 2.2 per cent a year, but it will not be enough to meet projected cost pressures of 4 per cent a year (**Wittenberg and Hu 2015**). The funding gap by 2019/20 will be £2 billion or £2.7 billion, depending on how much the precept raises. On a conservative assessment, implementing the National Living Wage will add another £800 million to these estimates (**Local Government Association *et al* 2015**). Overall, the social care funding gap is likely to

Figure 13 Social care spending 2009/10 to 2019/20, real annual changes



Source: The King's Fund *et al* 2015

be somewhere between £2.8 billion and £3.5 billion by the end of the parliament. Public spending on social care is set to fall to less than 1 per cent of GDP by 2020 (The King's Fund *et al* 2015).

It is no wonder that with the Care Act 2014 placing new expectations on local authorities, just 36 per cent of directors of adult social services are fully confident that they can meet their statutory duties this year, and only 2 per cent are confident they can do so in 2019/20 (Association of Directors of Adult Social Services 2016).

The policy context

Efforts to place the funding of social care on a sustainable footing have eluded all governments since 1997, despite the work of four independent commissions (the Sutherland Royal Commission in 1999 (Royal Commission on Long Term Care 1999), Wanless in 2006, Dilnot in 2011 (Commission on Funding of Care and Support 2011) and Barker in 2014 (Commission on the Future of Health and Social Care in England 2014)). England remains one of the few major advanced countries that has not reformed

the way it funds long-term care in response to the needs of an ageing population – although it has introduced new legislation, the Care Act 2014, that has raised expectations of what the system should offer.

At the local authority level, the government proposes to replace the central government grant so that councils will become wholly reliant on locally raised revenue through council tax and the retention of business rates (Department for Communities and Local Government 2016). It is not clear how this will affect individual local authorities but making the funding of essential care services dependent on the level of local property wealth and economic activity introduces a new set of uncertainties. This could increase the risk that access to care will depend on where people live rather than what they need.

Uncertainty also arises on a far bigger scale from the referendum vote in favour of leaving the European Union (McKenna 2016). It seems inevitable that social care, along with many other domestic policy issues, may be sidelined while the government gives priority to negotiating the terms of the UK's departure from the EU and new trade arrangements. If there is an economic downturn, this will affect public finances. A further concern is the potential impact on the social care workforce, 5.2 per cent of whom come from EU countries (Independent Age 2016).

So the prospect of any substantial change in the fortunes of social care is remote and it is now even less likely that the current government's commitment to implement the postponed Part 2 of the Care Act (introducing the cap on care costs and improvements to means-testing) by 2020 will see the light of day (Hansard 2015).

The future of social care for older people

The conclusions we draw from national data and evidence, our work with the four local authorities and their partners with very different circumstances, and the messages from older people and their carers are unequivocal. The social care system is on the brink. Although local authorities have absorbed a reduction of more than £5 billion in social care budgets over the past five years, at least 26 per cent fewer older people are getting help, unmet need appears to be increasing and more is being expected of unpaid carers. The needs and circumstances of older people who are no longer eligible for publicly funded care are poorly understood.

Our case studies illustrate that the combined impact of under-investment in primary and community health services alongside inadequate social care will make it harder for older people to get the right care, in the right place, at the right time. This perpetuates a vicious cycle in which older people are more likely to end up in hospital or in long-term care, in turn creating further financial and service pressures. Future prospects for older people will depend as much on where they live and what they can afford as on what they need. Expectations on families and carers will continue to increase, and more people will find themselves paying for their care wholly or partly from their own financial resources. Although new money available to local authorities this year through the new social care precept has enabled them to increase fees to providers, it is unlikely to be sufficient to stabilise the market. The home care market in its current form is not sustainable.

It is clear also that the challenges facing social care are now as much about workforce as they are about money. The availability and quality of care is threatened by mounting problems in staff recruitment and retention, underpinned by a culture of low pay and under-investment in training, and by the reliance in many areas on migrant workers (Kingsmill 2014).

Policy challenges

Based on the national and local evidence we have considered in this report, there are three major strategic challenges facing policy-makers in shaping how the adult social care system could develop over the next five years.

Achieving more with less

If there are no fundamental changes to the level and adequacy of social care funding in the foreseeable future, statutory responsibility for managing the pressures and challenges we have described will rest on the shoulders of local authorities and their partners. This will mean working within the grain of the existing policy framework to achieve better outcomes with existing resources in some of the ways described in our case study sites. These include better management of demand, promoting independence, better commissioning and procurement and implementing models of integrated care that give best outcomes, rather than shunting costs between each other (Bolton 2016b; Local Government Association 2016b). The NHS has a key role,

too, avoiding commissioning practices such as poorly designed 'discharge to assess' schemes that increase costs. There is considerable scope for the NHS to achieve better value and release resources, but this will take time (Alderwick *et al* 2015).

These efforts will be helped by recent attempts to bend national policies towards supporting systems of care rather than the funding and performance of individual organisations (NHS England *et al* 2015). In our four case study sites we heard of the obstacles caused by organisational complexity, fragmented funding and transactional commissioner/provider relationships. A move towards a single pooled budget for the health and care needs of the whole local population will make it easier for local authorities and their NHS partners to agree on the best use of the public pound and to focus on services that can be shown to reduce the need for long-term health and social care, especially community-based services, and intermediate and asset-based approaches that promote independence and maximise the use of community resources. The creation of sustainability and transformation footprints, devolution deals and the emergence of combined authorities offer opportunities to develop approaches to the planning and funding of systems of care rather than individual organisations.

Many of the approaches to achieving savings through efficiency and transformation programmes described in our case study sites are being widely used by local authorities and have been assessed through the Local Government Association's Adult Social Care Efficiency Programme. This concluded that:

> *The challenges over the next few years are immense. Indeed, some councils are beginning to believe that they cannot make the level of savings required without putting their basic services for vulnerable people at risk. They would argue that a combination of increasing demographic pressures (which they can manage down no further) and rising costs (which have been held down for too long), added to the fact that they have undertaken all of the efficiency actions they believe possible, means they can cut no further. Some councils have already afforded a level of protection to social care services (adults' and children's) at the expense of other public services, such as buses, libraries and leisure centres.*
> (Local Government Association 2016a)

This encapsulates the experience and views of all our case study sites. Working within the grain of existing policies and best practice in the way we have described

to achieve 'more with less' is important and necessary but our conclusion is that these efforts will not in themselves be sufficient to meet immediate funding needs. In the words of NHS England Chief Executive, Simon Stevens, 'There is a strong argument that were extra funding to be available, frankly we should be arguing that it should be going to social care.' (Stevens 2016). The forthcoming Autumn Statement should recognise the likelihood of major provider failure over the next two years by bringing forward the additional Better Care Fund money planned from 2018/19 and accelerate progress towards establishing a single pooled budget for health and social care in all areas by 2020.

A major gap in the current policy framework is the lack of a coherent strategy to improve workforce capacity in the social care system. Quite apparent from the immediate pressures, modelling suggests that if the workforce grows in line with demographic trends, 275,000 additional jobs will be needed by 2025 – an increase of 18 per cent (Skills for Care 2016b). More multi-skilled staff will be needed to work across NHS and social care boundaries. The need to develop a fresh strategy for workforce development by the Department of Health, in partnership with independent sector organisations, local authorities and NHS England is now urgent.

Although this did not arise as a significant issue in our case study sites, there is good evidence about the importance of housing in reducing the need for health and social care services and offering care options that achieve better outcomes at lower cost. However, as with integrated care, housing-with-care schemes are not straightforward to design and take time to deliver (Holland 2015; DEMOS 2014). Moreover, proposed changes to how supported housing is funded through the benefits system have created uncertainty about the future of existing schemes and new developments (Wilson 2016).

A different offer

At a local level, our case study sites, like many local authorities, are redesigning their 'offer' to the public to reflect the limits of their resources; this involves greater reliance on individuals, families and communities. There has been little dialogue nationally – or, sometimes, locally – about this fundamental change.

At the national level, no government has ever made it clear to the public that responsibility for paying for care, and for arranging it, rests largely with individuals

and families, with public funding available only for those with the very highest needs and lowest means. Unless there is a major change to the upper means-tested threshold of £23,250, this is now the default trajectory of the adult social care system. Yet, while members of the general public are clear that NHS services are generally free at the point of use, their understanding of who pays for social care is much less clear (IPSOS Mori 2011). Lack of public awareness results in people having inappropriate expectations of the NHS and local authorities, and this creates distress for individuals and their families, distorts the efficiency and effectiveness of services and makes it harder for people to get the help they need. Unless the government is prepared to introduce a different system, it should establish a fresh policy framework that explicitly promotes a clearer public understanding of how the system works and encourages individuals to financially plan ahead for their care needs in the same way as they would for pensions.

This could see, for example, the creation of new financial incentives for individuals to make provision for care costs through the taxation, pension and benefits systems, such as 'care ISAs', and tax relief for spending on care costs; fresh discussions with the financial services industry to stimulate the development of better financial products, such as the promotion of immediate needs annuities; and the strengthening of advice, information and advocacy, possibly by linking it to pensions advice and planning (Association of British Insurers 2014).

An explicit re-casting of the social care system based on individual and family responsibility would have profound consequences for local authorities, the NHS and the social care market. For local authorities, it would confirm their role as operators of a basic safety net for the poorest people with the highest needs and as a system leader and market shaper working strategically with partners, rather than as a direct provider of services. For the NHS, and especially NHS providers, it raises some difficult issues about how care is co-ordinated with thousands of self-funding individuals rather than one local authority, for example at the point of hospital discharge. It will sharpen the division between health care that is free at the point of use and social care that is means-tested, with a risk of more conflict between individuals, professionals and organisations about who should pay. Social care providers, too, face similar challenges in understanding a market in which individuals – not local authorities – are their primary customers; in places with high levels of self-funding, independent providers may find collaborating with each other

in understanding market trends a more attractive proposition than competition. Providers in areas with low levels of self-funding, who are therefore reliant on local authority contracts, face an uncertain future.

While a new and clearer offer could lead to improvements for those who will have to pay for their own care, it will confirm beyond doubt the emergence of a two-tier system of care in which access to care will depend increasingly on where people live – and on their private wealth – not on what they need. As we have described earlier in this report, this is already being reflected in the polarisation of the social care provider market that will increasingly favour the relatively well off and well informed at the expense of the poorest people reliant on an increasingly threadbare local authority safety net and at a higher risk of declining quality and provider failure.

A more open and transparent approach to the respective responsibilities of the individual and the state may involve revisiting some of the new rights and duties created by the Care Act 2014 so that expectations are aligned more realistically with what the government is prepared to fund.

For many, this will be an unpalatable and unacceptable scenario but it is one that is already upon us. Without a coherent national policy framework to support it, social care will continue its unplanned drift by default into a poorly understood, dysfunctional and ineffective system.

Long-term reform of funding

International evidence shows that spending rises on health and social care as the population grows and ages has been reflected in the spending profiles of almost all advanced countries since the end of the Second World War (**Organisation for Economic Cooperation and Development 2014**). The question is not whether these costs will arise but to what extent they fall on the public purse or the private individual. As we have seen, efforts to achieve more with less and delivering better value will not release resources at the pace and scale required to close the widening funding gap.

The Barker Commission questioned whether additional private funding would be sufficient or equitable and recommended that public spending on health and social care should increase to between 11 and 12 per cent of GDP by 2025 (**Commission on the Future of Health and Social Care in England 2014**). Every independent review in the

last 18 years has recommended that the future funding of social care needs as well as health needs should come from public rather than private finance. It is impossible for individuals to predict whether they will need care, how much, for how long and how much it will cost. As the Dilnot Commission put it:

> *The system, conceived in 1948, is not fit for purpose. People are exposed to very high costs, which they are unable to protect themselves against. The system is confusing, unfair and unsustainable. People are unable to plan ahead to meet their care needs.*
>
> (Commission on Funding of Care and Support 2011)

As more of us develop a mixture of health and social care needs, this will expose further the dissonance between some kinds of care that are free at the point of need and others that are met wholly or in part by individuals and families.

A frank and open debate is needed on how to fund health and social care on a sustainable basis into the future, recognising that a long-term strategy will exceed the lifetime of a single parliament. A mechanism is needed to secure cross-party consensus on some shared principles of reform, building on the work of recent independent commissions including the Barker Commission and the House of Lords Select Committee on Public Service and Demographic Change (**House of Lords 2013**). In an earlier review commissioned by The King's Fund, the late Derek Wanless observed:

> *At the heart of the [funding] issue should be a debate about what social care will do in the future. How will it help people? What outcomes should it aim to achieve? Who should it help? Once its purpose is understood and specified, important decisions can then be made about the range and type of services, the size and composition of the workforce, the implications for housing, the use of technology to assist people to live with more control, and the extent of preventative action required to avoid or delay need.*
>
> (Wanless 2006)

Ten years on, the need for that debate has never been more necessary or urgent.

Appendix: Methodology

The research for this report took place between September 2015 and June 2016 and comprised a literature review; analysis of national data; semi-structured interviews with representatives from health and social care in four case study sites (including commissioners, providers and patient representatives); and narrative interviews with older people who have used social care services in recent years. The research was guided by an external reference group, which included members from ADASS, LGA, CQC, the Department of Health and representatives from health and social care provider organisations and patient advocacy groups.

National data analysis

We conducted a comprehensive analysis of national trends in adult social care expenditure and activity for older people since 2009/10 using two datasets:

1. *Personal social services: expenditure and unit costs, England* (Health and Social Care Information Centre 2015e)
   This provides information about the money spent on adult social care by the social services departments of councils with adult social services responsibilities (CASSRs) in England. Prior to 2014/15, this data was sourced from the *Personal social services: expenditure and unit costs return* (PSS-EX1). In 2014/15, this finance return was replaced with a new collection, the *Adult social care finance return* (ASC-FR). There are some differences between these datasets, but councils were also required to submit a limited amount of data on the previous form in 2014/15, enabling ongoing trend analysis.

2. *Community care statistics: social services activity, England* (Health and Social Care Information Centre 2014)
   This provides information about the social care activity of CASSRs in England. It contains information taken from council administrative systems used to record the process of assessing eligibility to state-funded social care and

providing services to eligible individuals. Prior to 2014/15, this data was sourced from the *Referrals, assessments and packages of care return* (RAP) and the *Adult social care combined activity return* (ASC-CAR). In 2014/15, these were replaced with the *Short and long term services collection* (SALT). It is therefore not possible to make direct comparisons between 2014/15 and previous years for most data items.

We also examined related NHS data and trends in independent sector care provision to form a view across the whole system of health and social care.

Case studies

We conducted semi-structured interviews and focus groups with stakeholders from four local authority areas. Sites were selected to represent variations in local authority type; geographical area; rurality; and the deprivation and ethnic mix of the local population. The anonymity of sites is protected.

We asked participants about changes to the funding of social care for older people in their area over the past five years; the impact these have had on social care providers, service users and other services; strategies that commissioners and providers are using to mitigate current pressures; and what they feel this means for the future of adult social care.

Participants included key representatives from local authorities (n=17); clinical commissioning groups (CCGs) (n=5); NHS providers (n=6); independent sector social care providers (n=25); voluntary organisations (n=8); and Healthwatch and other local groups representing people who use services (n=4).

Interviews were audio-recorded and transcribed for thematic analysis. Emerging findings were discussed and further developed in conversation with national stakeholders and the external reference group. The findings were supplemented with analysis of available local and national data for each case study area in order to contextualise our interview findings.

User interviews

Our researchers were commissioned by the Richmond Group of Charities to conduct a small number of narrative interviews to capture the experiences of older people who use social care services. Participants were identified and recruited by the Richmond Group according to agreed recruitment criteria, and interviews were conducted by researchers from The King's Fund and the Nuffield Trust. Audio-recordings of the interviews were transcribed and edited by the researchers. A full account of these interviews has been published by the Richmond Group (Hall and Holder 2016).

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A graduate of the LSE, his professional background is social work, and over the past 35 years he has worked in a variety of roles, including as a director of social services and health authority chief executive (the first combined post in England) and in senior roles in the Department of Health. Richard is a non-executive director of Wye Valley NHS Trust and Housing & Care 21, a national provider of housing and care services. He is also a columnist for the *Local Government Chronicle* and a fellow of the RSA.

Ruth Thorlby is the deputy director of policy at the Nuffield Trust. Her research interests include NHS reform, GP commissioning, accountability, international comparisons and health inequalities. Before joining the Nuffield Trust she was a senior fellow at The King's Fund, where her publications included two major reviews of NHS performance as well as a range of briefing and research papers.

She was a 2008–9 Harkness Fellow, based at Harvard Medical School, where she researched how US physicians and health care organisations understood and tackled racial inequalities in the quality of health services.

Ruth has an MSc in social policy from the LSE. Before moving into health policy research, Ruth was a broadcast journalist, working for the BBC World Service and BBC News and Current Affairs, including *Panorama*.

Holly Holder is a fellow in health policy at the Nuffield Trust. Since joining the Trust four years ago, she has conducted research into the future of primary care, international health and social care systems, and the impact on older people and the NHS of funding reductions in social care, and been involved in evaluations of integrated care initiatives.

Previously, Holly worked for the Centre for Analysis of Social Exclusion at the LSE. Her work there focused on the measurement of equality and human rights in the UK, including inequalities in the outcomes, provision and receipt of health and social care. She also worked on a project exploring how issues related to choice, control and empowerment can be better measured. Before this, Holly worked as a researcher for a social housing management consultancy.

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Anna Charles is a researcher in the policy team at The King's Fund. Her current projects include qualitative research into patient and staff experiences of community health services for older people, an evaluation of the sustainability of social care services and a study exploring changes to activity and demand in general practice.

Anna is also interested in prison health care and related policy, and has published a number of research papers exploring contemporary issues in prison health care. Before joining the Fund, Anna worked as a doctor at Imperial College Healthcare NHS Trust. She holds a medical degree and a BMedSc in health care ethics and law from the University of Birmingham.

Acknowledgements

We would like to thank everyone in the four local authority areas who took part in our interviews and members of the external reference group whose views and feedback helped us to develop and test our thinking and approach. We are grateful to Nick Seddon, former special adviser to the Prime Minister, for hosting a discussion at No 10 Downing Street about early findings.

Rachel Ayling provided invaluable help in analysing local authority expenditure and activity statistics.

We would also like to thank Jo Moriarty and Dwayne Johnson for their help in reviewing the draft report and colleagues at The King's Fund and Nuffield Trust, especially Matthew Honeyman for his help with some of the interviews and Nigel Edwards, Chris Ham, Candace Imison and Richard Murray for their helpful comments and guidance.

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The King's Fund is an independent charity working to improve health and care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

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The need for a clearer understanding of the care available for older people has never been greater. Years of financial constraint and increasing levels of demand mean that the social care system in England is under severe pressure, yet evidence about the relationship between changes in public spending on social care, the quality and quantity of services and the impact on the health and wellbeing of people who use them is extremely limited.

Social care for older people looks at the effect of changes in local authority spending on care for older people, based on an assessment of national data and interviews with representatives from local authorities, clinical commissioning groups, the NHS and independent sector providers, voluntary organisations, Healthwatch and other local groups. Alongside this work, we were commissioned by the Richmond Group of Charities to interview older people about their experiences of social care.

Based on the evidence in the report, the authors recommend that policy-makers address three major challenges in shaping the development of social care for older people over the next five years:

- achieving more with fewer resources – for example, through better commissioning and integrated care – recognising that these initiatives will not be enough to close the funding gap
- establishing a more explicit policy framework, which makes it clear that primary responsibility for funding care sits with individuals and families
- undertaking long-term reform of funding because reliance on additional private funding is unlikely to be sufficient or equitable.

The report concludes that the human and financial costs of social care for older people and their carers are mounting and warns that the potential for most local authorities to achieve more within existing resources is very limited.

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Healthier Communities Select Committee		
Title	Lewisham hospital update (system resilience)	
Contributor	Scrutiny Manager	Item 4
Class	Part 1 (open)	18 October 2016

1. Purpose

University Hospital Lewisham's System Resilience Plans 2016/17 are attached.

3. Recommendations

The Committee is asked to note this information.

If you have any questions, please contact John Bardens (Scrutiny Manager) on 02083149976.

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Lewisham and Greenwich NHS
NHS Trust

Emergency Care
Improvement Programme
SMARTER | FASTER | BETTER

University Hospital Lewisham
System Resilience Plans 16/17
Report to HCSC October 16

Context

Lewisham and Greenwich NHS Trust

- Central funding for system resilience allocated to CCGs and included in 16/17 baseline
- Lewisham CCG figure agreed at £1.4Million to be spent at University Hospital Lewisham
- Initial submission and impact on trajectory agreed with CCGs as part of wider System Resilience and Trajectory Plan in early July
- Schemes initially identified based on those that had shown impact in 15/16
- Complemented work ongoing within Medical Redesign and Enhanced Care and Support Programmes
- Total resilience scheme impact on 4 hour standard predicted to be 2.42%
- Detail of initial schemes, impact of those in place and further plans for schemes to address slippage in other improvements provided in following slides:

Initially Agreed Schemes

Lewisham and Greenwich NHS Trust

	Performance Improvement	Cost	Start month	End month	Lead in at 50% impact
Additional ED SpR Saturday evenings	0.01%	£11,700.00	October	March	0
Additional medic in ED overnight	0.50%	£120,000.00	October	March	0
Additional GP 7 days per week in UCC	0.80%	£400,000.00	July	March	0
ENP Streaming 12 hours per day	0.30%	£227,000.00	July	March	1
RAT in place	0.50%	£566,800.00	August	March	1
Pathway Navigators	0.30%	£120,000.00	May	March	1
Improved Discharge Information	0.01%	£15,000.00	June	March	0
Total	2.42%	£1,460,500.00			

Current Stock Take

Lewisham and Greenwich NHS Trust

A review of the resilience schemes as well as wider improvement programmes has just been completed and identified some delay in three of the schemes:

- GP streaming (commenced this week)
- ENP streaming (plan to commence in October but difficulty in recruiting
- RAT (commenced this week)

UHL Resilience Schemes	Impact	Start Date	In place?
Additional ED SpR Saturday evenings	0.01%	October	Will be in place
Additional medic in ED overnight	0.50%	October	Will be in place
Additional GP 7 days per week in UCC	0.80%	July	Trialled in July, full model from October
ENP Streaming 12 hours per day	0.30%	July	Trialled in July, full model from October
RAT in place	0.50%	August	Delayed start due to recruitment, in place from October
Pathway Navigators	0.30%	May	Yes
Improved Discharge Information	0.01%	June	Yes
Total	2.42%		

In addition it has been identified that the Enhanced Care and Support programme is likely to be delayed in delivering one of its key elements – Home Ward due to recruitment difficulties. There is therefore an opportunity to consider how any slippage within current resilience spending should be used to bridge impact on performance until the Home Ward is in place.

Schemes

Lewisham and Greenwich NHS
NHS Trust

The two schemes already in place are the Navigators and Improved Discharge Information

Navigators
4 Band 4 WTE Navigators started on a 3 month trial basis in May, with the purpose of supporting the wards in ensuring all the necessary paperwork for a supported discharge was completed in a timely manner. They were assigned to wards and enable the Discharge Coordinators to concentrate on the more complex patients.

They made a significant impact on the number of days for CHC paper work to be completed (reduced from an average of 12 days to less than 4) and have been well received by wards and clinical teams. Their appointments have been extended to end of March 2017

Improved Discharge Information
The Trust is now using a specially commissioned database to track all complex discharges, this links with the Icare system and enables all those involved in a patients discharge to update what is happening with the patient and share this with colleagues. We are currently rolling out access to other agencies on site to enable them to input updates directly and reduce time lost whilst awaiting progress updates from panel etc.

Further Schemes

Lewisham and Greenwich NHS Trust

Discussion within the Trust has suggested that there is benefit in supporting the following schemes to increase resilience internally. Exact costings are currently being agreed with finance to enable this:

- Additional nurse in ED 24/7 to increase safety levels due to demand on the department
- Additional pharmacist and pharmacy technician to reduce delays in TTOs and support discharges before 1pm.

In addition Operation Bridge, a project to reduce the number of Ready For Discharge patients from Lewisham CCG within acute beds, which has been running since August and is showing signficant impact, is likely to be extended to cover the gap until Home Ward is in place.

Operation Bridge

Lewisham and Greenwich NHS
NHS Trust

Operation Bridge is funded from CCG held resilience monies (separate to the £1.4Million) and consists of the following:

- Increasing Resource for CHC Nurse Assessment
- Family Caseworkers
- Social Worker Complex Case Manager
- Advocacy
- Flexible funding

It has been running since mid August and has improved the number of Lewisham CCG patients on the Ready for Discharge list to below 40, it has made significant impact on waits for CHC outcome, IMCA (Independent Mental Capacity Assessment) Social work assessment and equipment.

There is further work ongoing to provide increase support at evenings and weekends for families identifying care homes as there are a number of patients delayed while families make these choices.

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HEALTHIER COMMUNITIES SELECT COMMITTEE			
Title	Lewisham Annual Public Health Report 2016		
Key Decision	No		Item No. 5
Ward	Borough Wide		
Contributors	Danny Ruta – Director of Public Health		
Class	Part 1	Date: 18 October 2016	

1. Summary

1.1 This year's Annual Public Health Report (APHR) is themed on tackling obesity. It focuses on the Whole System Approach to Obesity, of which Lewisham is working alongside Leeds Beckett University as one of four national pilot sites and the only pilot site in London. The report also profiles the Jamie Oliver / Sustain Sugar Smart initiative which Lewisham is launching in October 2016; the first London borough to launch.

1.2 The report outlines the current state of obesity in the borough and the health consequences that obesity contributes to. This is followed by a selection of case studies which detail some of the excellent practice currently taking place across the borough in order to tackle obesity. The case studies have been themed as below:

- Breastfeeding
- Early Years
- Primary Schools
- Secondary Schools
- University Hospital Lewisham
- Leisure Centres and Sport
- Trinity Laban
- Parks
- Planning
- The Food Environment
- Transport

2. Purpose

2.1 This report provides members of the Healthier Communities Select Committee with the 2016 APHR, which is themed on The Whole System Approach to Obesity. Wider information on the entire population is also provided through the Public Health Performance Dashboards, which are provided as appendices to the main report.

3. Recommendations

3.1 Members of the Healthier Communities Select Committee are asked to note, and to comment as they wish on the content of the report.

4. Policy context

4.1 The Health and Social Care Act 2012 states that the production of an APHR is a statutory duty of the Director of Public Health, which the local authority is responsible for publishing. The report aims to inform partners, professionals, and other decision makers, as well as the community about the health of the local population.

4.2 The publication of a themed report on The Whole System Approach to Obesity is to complement the work the council is currently undertaking as a pilot alongside Leeds Beckett University. The report also supports the Health and Wellbeing Strategy Priority of 'Achieving a Healthy Weight' and achieving the Sustainable Communities priority for Lewisham of healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and well-being.

4.3 This report will also be submitted to the Health and Wellbeing Board, for information at its meeting on 15/11/2016.

5. The Whole System Approach to Obesity

5.1 Nationally obesity and its consequences cost the NHS £6.1bn per year, with the wider cost to the economy estimated at £27bn. In the UK, the contribution of diet-related risk factors to the burden of illness and disease, including high body mass index (BMI), is second only to tobacco use. The issue is particularly crucial for Lewisham as the borough has a high proportion of adults and children who are overweight or obese. Nearly two thirds of adults (137,000 people) and 40% of 10-11 year-olds are overweight or obese.

5.2 The overarching aims of the Lewisham Whole System Obesity Action Plan are:

- 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;
- Supporting our communities and families to become healthier and more resilient, which will include addressing the wider determinants of health.
- 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 and the Environment.

6. Financial implications

6.1 There are no specific financial implications. However the committee may want to consider future resources and spend on tackling obesity in Lewisham following the report's recommendations.

7. Legal implications

7.1 The requirement to produce an APHR is set out above.

8. Crime and disorder implications

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

9. Equalities implications

9.1 Equalities Implications and the impact they have on health outcomes have been highlighted throughout the body of the report.

10. Environmental implications

10.1 As mentioned in point 5.2 above the Environment is a priority area for the Lewisham Whole System Obesity Action Plan. Therefore the aim is to positively impact the environment in relation to tackling obesity.

11. Conclusion

11.1 The report outlines the current issues around excess weight in Lewisham and demonstrates some of the excellent practice that is currently happening in order to reduce this. It highlights that it is not the sole responsibility of any one sector but that a joint, borough wide approach is needed to gain ground and stem the tide of obesity. By sharing details of best practice and initiatives in this report we aim to engage and recruit stakeholders across the whole community.

Background documents and originator

Lewisham's Annual Public Health Report 2016
Public Health Performance Dashboards
The 2015 Annual Public Health Report focussed on Children and Young People and is available here.

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

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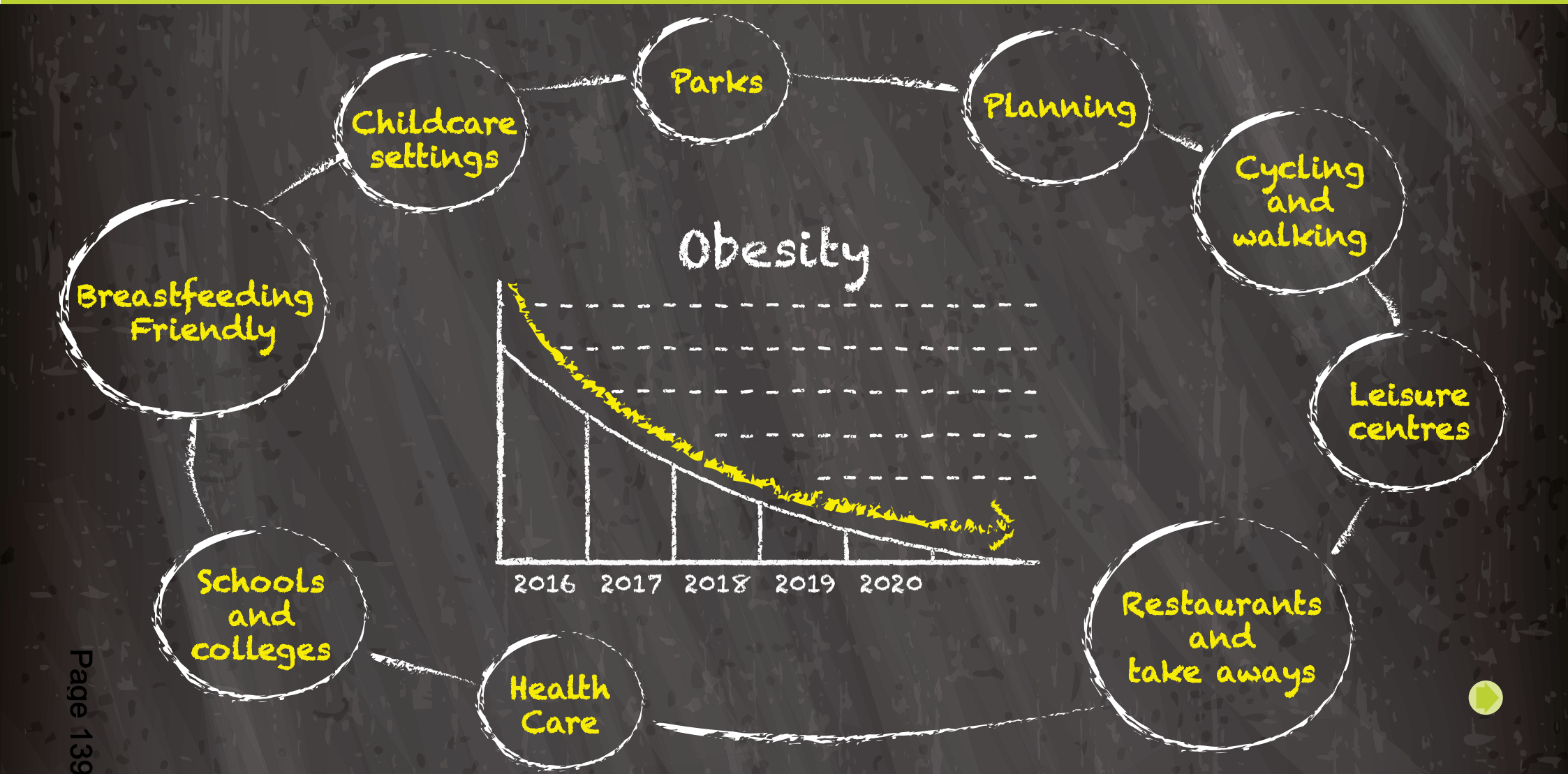
Tackling obesity in Lewisham: a whole system approach

Annual Public Health Report for Lewisham 2016



Foreword

"The return of public health functions to the control of local councils brought great opportunities. However, Government cuts to our funding mean we have tough decisions to make, so that our remaining resources have the most impact on the most vulnerable and needy in Lewisham's communities.

In years gone by, public health work focussed on providing clean drinking water, improving poor sanitation and eliminating epidemic diseases. In the twenty first century, public health interventions have become more sophisticated, tackling health inequalities, addressing issues such as smoking, excess alcohol use and obesity, all precursors of premature mortality.

There is cruel irony in the fact that, whilst, in many regions of our world, people are starving, in Lewisham and elsewhere in the UK, obesity is on the increase. Obesity is a major contributor to health inequalities, and we can all contribute to its remedy. The total amount of sugar we consume is a significant factor in excess calorie intake. We are pleased to be working towards becoming the first Sugar Smart borough in London.

This Annual Public Health Report highlights that it is not just our health colleagues who will deliver this strategy, but every Lewisham Council Directorate has a part to play. Beyond the Council, we must engage employers and businesses so our approach is embedded throughout Lewisham Borough.

We welcome the Annual Report of the Director of Public Health and commend it to our readers."

The Mayor, Sir Steve Bullock
Councillor John Muldoon

Introduction from Director of Public Health – Dr Danny Ruta

The world is hitting the peak of a truly global epidemic of obesity… and that makes it a pandemic. Most people don't think of it that way, because unlike swine flu, the obesity pandemic is taking years to spread through the human race, not months. It may be a slow burn, but the death toll is way higher than any infectious pandemic we've ever seen. It's affecting global populations in different ways; in low income countries for example the highest obesity rates are seen amongst the wealthiest, whilst in high income countries like the UK obesity rates are twice as high amongst the poorest compared with the well off.

The world's scientists agree that however the obesity pandemic is playing out across the globe, the underlying cause is the same… it is a normal response, of normal human beings, to an environment that has become very, very abnormal. We haven't become lazier, or greedier, since the 1980s. What has changed to some extent is the amount of energy we need to burn to get through the day, but what has changed dramatically is the amount of high energy, high fat, and very high sugar food that surrounds us.

When it comes to similar global cities – Paris, New York, Sydney, Madrid – London tops the obesity league table. London's childhood obesity rates are worse than the rest of England, with over 22% of 10–11 year olds classified as obese. Obesity will kill more of our children than smoking, alcohol and drugs, and if we don't reverse the epidemic, then for the first time in hundreds of years, our children might experience a shorter life expectancy than their parents.

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. A whole systems approach not only supports individual behaviour change, 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.

Our whole system approach to reduce the impact of the 'obesogenic' environment includes engaging the wider Lewisham Partnership to form a Lewisham Obesity Alliance. There is already a huge amount of good work taking place in Lewisham, we have made some progress but we need to do even more. The Alliance will initially focus on three key actions to create healthy environments: Sugar Smart Lewisham; the Lewisham Daily Mile; and Use of Lewisham's Parks.

Lewisham's whole systems approach to obesity action plan

The Lewisham Obesity Action Plan has its overarching aims as:

- 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
  - Tackle the weight issues of those who are already overweight and obese

We will strive to do this through work over four priority areas:

- **Children and Young People**
  - Breastfeeding
  - Introducing Solid Food
  - Schools
- **Increased Public Awareness and Engagement**
  - Journeys on foot or bike
  - Supporting active people
  - Knowledge
- **Health and Public Services**
  - Health Services
  - Engagement and Commitment
  - Workplaces
- **Environment**
  - Access to healthy foods
  - Physical environment
  - Public and Community settings

Work has already started on three key actions to create healthier environments, which are discussed in more detail in this report:

Food Become a Sugar Smart Borough
Physical activity Implement the Daily Mile in primary schools
Communities Improve access and appeal of parks for recreation
Wider Obesity Alliance Engage the wider Lewisham partnership into the whole system approach

Our Goals

Change the impact of the obesogenic environment

&

Increase the proportion of residents with a healthy weight

Where Lewisham is now on tackling obesity – the current picture

Childhood Obesity – Reception

Latest figures from the National Child Measurement Programme show that in 2014/15, 23.7% of children in Reception had excess weight (11.2% of which were obese). Levels continue to be significantly higher than the national average.

Children living in the most deprived communities are twice as likely to be obese or overweight as those in the least deprived for both age groups measured.

Childhood Obesity – Year 6

39.3% of children in Year 6 have excess weight (including 24.8% who are obese).

Key:

- Underweight
- Overweight
- Healthy Weight
- Obese

Adult Obesity

A modelled estimate of adult obesity prevalence in Lewisham is 23.7%, (2012) this is not significantly different to the England average, and indicates that around 53,000 residents are obese. Recently published data for Lewisham on the prevalence of excess weight (overweight and obese) in adults is 61.2%, similar to the national average but higher than the London average (57.3%). A similar level of excess weight (57.9%) is seen in adults aged 40-74 years - monitored as part of the NHS health checks programme. A concern is that GP Practices in Lewisham are notably under-reporting obesity.

Maternal obesity

Maternal obesity increases the risk of poor pregnancy outcomes and is a risk factor for childhood obesity. Data from Lewisham Hospital for 2015 indicates that 45.9% of women booking at the hospital in 2015 had excess weight, a slight increase from 2014. 16.1% of this group were obese.

Breastfeeding

Breastfeeding has many benefits which include reducing the risk of obesity and type 2 diabetes. It also reduces the risk to the mother of obesity. In Lewisham over 85% of women initiate breastfeeding, this is notably higher than the national average of 74%. Furthermore women in Lewisham are much more likely to continue breastfeeding as at 6-8 weeks following birth 74% of babies are breast fed, compared to 44% across England. Lewisham now has UNICEF Baby Friendly accreditation for the community with the maternity services working towards stage 3 assessment.

Introducing solid foods

It is recommended that solid foods should be introduced when babies are around 6 months old. National surveys show that most families introduced solids at an earlier age, three quarters (75%) had introduced solids by the time their babies were 5 months old. Babies that are not introduced to solid food before they are ready and introduced to a range of healthy foods are at reduced risk of becoming overweight. Encouraging the intake of a wide variety of healthy foods also helps develop good food habits in children and their families.

Physical activity

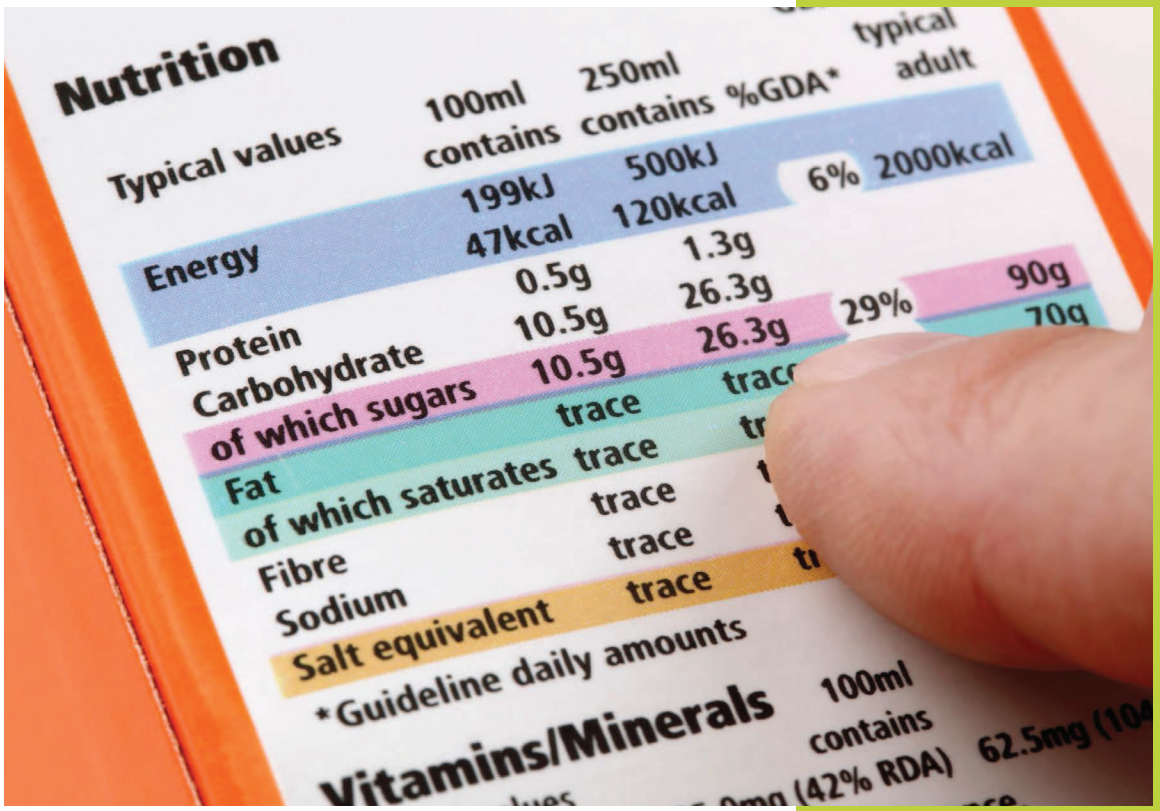
Just over half (57%) of Lewisham adults are classed as Physically Active, (achieving at least 150 minutes of exercise a week). This is in line with the England average. Inactivity levels are also comparable with over a quarter of adults achieving less than 30 minutes activity per week. Men are more likely to take part in sport and recreation than women. For those aged 15, only 11.3% were physically active for at least one hour per day seven days a week.

Diet

National surveys show that overall the population is still consuming too much saturated fat, added sugars and salt and not enough fruit, vegetables, oily fish and fibre. Only 44% of Lewisham adults meet the recommended 5 a day for fruit and vegetables which is lower than the national average.

Deprivation

Though improving Lewisham continues to be amongst the 20% most deprived local authorities in England. People living in the most deprived areas have poorer health outcomes and lower life expectancy compared to the England average. Child poverty though improving remains significantly higher than England at 26.7%. Food poverty has also been identified as a key issue. The Greater London Authority report, Child Hunger in London reported that 21% of parents surveyed reported skipping meals so that their children could eat and 9% of children in London said they sometimes or often go to bed hungry. If these figures were applied to Lewisham it is estimated that 19,000 parents in Lewisham skip meals so their children can eat and 6,000 children in Lewisham sometimes or often go to bed hungry. The inability for families to afford healthy diets for their children is likely to have an impact on our childhood obesity rates. Actions to tackle food poverty are incorporated in the action plans of the Lewisham Food Partnership.

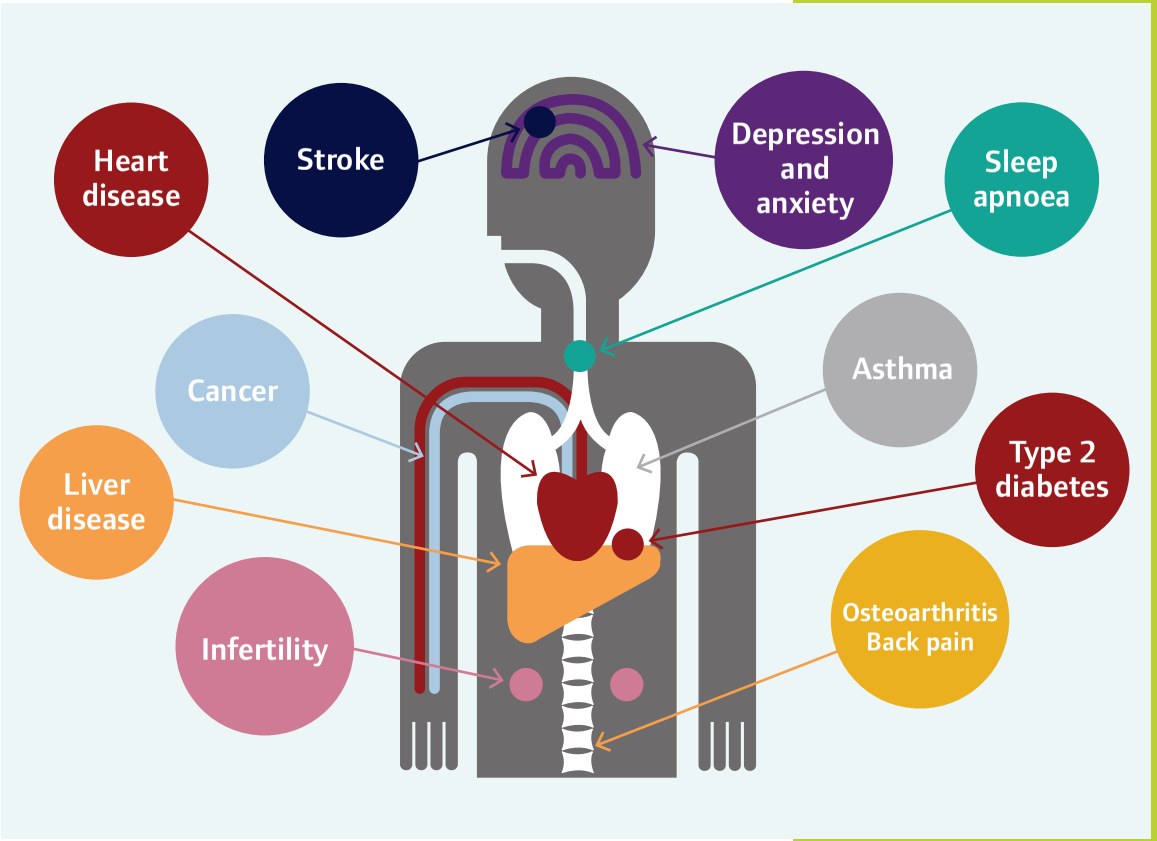


Impact of obesity

Obesity is linked to many serious health risks in both children and adults. These include type 2 diabetes, cardiovascular disease, respiratory illnesses, joint and movement problems and breast and colon cancer. Not only are obese people more likely to develop physical problems they are also more likely to develop psychological problems such as depression and low self-esteem.

Obese adults are seven times more likely to become type 2 diabetic than adults of a healthy weight. Obesity also doubles the risk of dying prematurely.

The disproportionate impact of obesity is critical to Lewisham. As the 48th most deprived local authority in England, Lewisham residents are more vulnerable to becoming obese. Lewisham is also one of the most ethnically diverse areas of the country which also amplifies the issue as a number of black and minority ethnic groups are at higher risk of complications related to obesity such as Type 2 Diabetes.



Causes of obesity

In simple terms obesity is caused when energy intake from food and drink is greater than the energy used through activity. However, the reasons for the recent worldwide increase in obesity are much more complex and include a wide range of factors including behaviour, culture and the environment that impacts on the choices made over which an individual has little control. Long term sustained reduction in obesity levels will only be possible by a whole systems approach aimed at changing the obesogenic environment that we live in.

Obesity and sugar

Consuming too much sugar and too many foods and drinks high in sugar can lead to weight gain, which in turn increases the risk of heart disease, type 2 diabetes, stroke and some cancers. It is also linked to tooth decay.

Current sugar intakes are above the recommendations and is particularly high in school aged children, (teenagers in England are the biggest consumers of sugar sweetened drinks in Europe). Sugar consumption also tends to be highest amongst the most disadvantaged who also experience higher prevalence of obesity and its health consequences. In 2015 it was recommended that the average population maximum intake of sugar should be halved and that consumption of sugar sweetened drinks should be minimised by both adults and children.

The new maximum recommended daily intake of sugar is

Age	Recommended maximum added sugar intake	Sugar cubes
4-6 years	No more than 19g day	5 cubes 
7-10 years	No more than 24g day	6 cubes 
From 11 years	No more than 30g day	7 cubes 

This means that one 330ml can of soft drink with added sugar can contain more sugar than the daily recommendation.

In general the main sources of sugar in the diet are similar for both children and adults and the chart shows the main sources of sugar in the diet for children aged 4-18. Around 30% of the sugar in a child's diet comes from sugary drinks, such as fizzy pop, juice drinks, squashes, cordials, energy drinks and juice.

Where 4–18 year olds get their sugar intake from

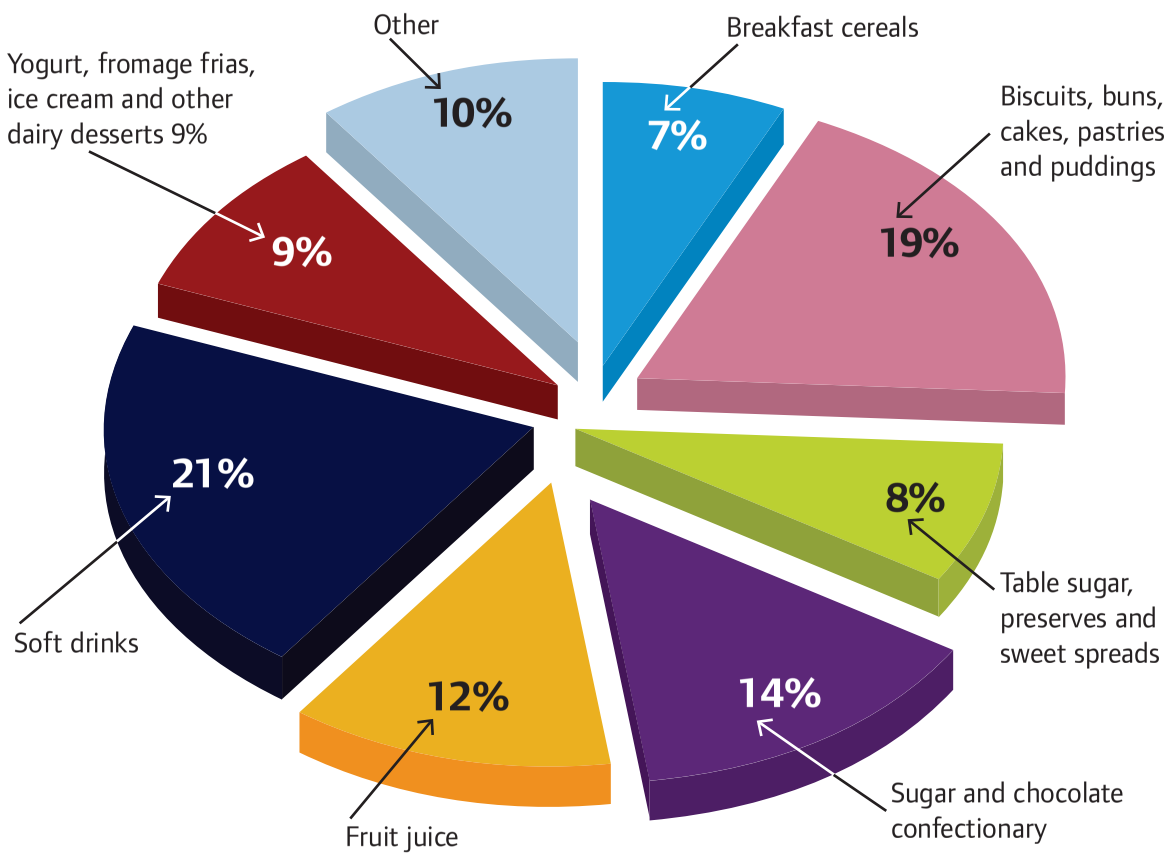
Soft drinks (excluding fruit juice) are the largest single source of sugar for children aged 11 to 18 years and, on average, those who consume them drink around 336ml per day (roughly equivalent to one can of a sugary drink). Soft drinks provide 29% of daily sugar intake, on average, for this age group as a whole. Table sugar and confectionery (21%) and fruit juice (10%) are also large contributors to the sugar intake of 11 to 18 year olds.

For younger children (aged 4 to 10 years) soft drinks; biscuits, buns, cakes, pastries and puddings; breakfast cereals; confectionery; and fruit juice are the major sources.

In adults (aged 19 to 64 years) table sugar; biscuits, buns, cakes, pastries and puddings; and soft drinks are the main sources.

Public Health England stated that no single action will be effective in reducing sugar intake. There is a need for a broad structured programme of measures that influence consumption, reduce the sugar content as well as supporting people to make healthier choices. The Governments childhood obesity - a plan for action included the introduction of a soft drinks industry levy to come into force in 2018 and a challenge to the industry to reduce overall sugar across a range of products that make the largest contributions to children's sugar intake by at least 20% by 2020.

Proportion of young people's sugar intake



Other measures that influence consumption and supporting people to make healthier choices can be tackled in our communities by working together to become a SUGAR SMART borough.

Sugar Smart

SUGAR SMART LEWISHAM

Lewisham together with Greenwich plan to become the first '**SUGAR SMART**' boroughs in London.

SUGAR SMART is an exciting campaign to reduce the amount of sugar in our diets by raising awareness of the health impact of the high levels of sugar in foods and drinks and encouraging action to reduce sugar intake.

Local organisations, businesses and settings that join **SUGAR SMART** will pledge to make simple changes to promote healthier, lower sugar alternatives and limit less healthy choices. This will motivate change by helping local people to get 'sugar smart' and take control of their families' sugar intake.

www.lewisham.gov.uk/sugarsmart

Our vision

To be a Sugar Smart borough where our community is supported to make healthier, lower sugar choices

Join Our Sugar Smart Campaign

Whatever kind of organisation you are, why not join our Sugar Smart campaign

By joining the campaign and be promoted on the website your organisation will need to agree to:

1. **State your commitment:** Tell your employees and the public that you are developing and implementing a Sugar Smart policy in your organisation.
2. **Make 3 simple pledges to make healthy food and drink more affordable, accessible and promoted than less healthy food.**
3. **Spread the word:** Spread the message about reducing the amount and profile of products high in fat, salt and sugar, to your customers, employees, suppliers and other key stakeholders and publicise your involvement in Sugar Smart.

Example pledges include:

- Reduce the amount of fizzy and high sugar drinks you sell and offer healthier options
- Actively promote free drinking water e.g. put in a drinking fountain
- Increase the price of fizzy drinks and sign up to give the proceeds to the Children's Health Fund or a local charity
- Provide information on healthy food e.g. posters, flyers, training
- Run promotions on healthier food and drink options

- Provide more healthy food and drink options
- Remove unhealthy vending machines from your premises, or work with vending suppliers to ensure mainly or only healthy produce is sold

Examples of organisations and settings that are already on the way to be Sugar Smart are provided in the following sections.

Join us in our journey to become a Sugar Smart borough by signing a commitment to be Sugar Smart by sending your details to Alex.Allen@lewisham.gov.uk.

www.lewisham.gov.uk/sugarsmart

Responses from Lewisham Life survey

A survey took place in the 2016 summer issue of the Council's resident magazine, Lewisham Life, which over 2,600 people responded to. The survey asked about people's views on the amount of sugar in food and drink and what actions should be taken to help reduce sugar in our environment.

Respondents were strongly in favour of measures such as supermarkets stopping price promotions on sugary drinks and snacks and reducing the availability of high sugar products in public places.

Q1.
How concerned are you about the amount of sugar in food and drink?

93%

(2139) responded they were very/fairly concerned.

Q2.
Should action be taken to help people in Lewisham cut down their sugar intake?

88%

(2025) agreed with this statement.

Q3.
Do you agree that fewer sugary drinks and snacks should be available in places like leisure centres, shopping centres and hospitals?

88%

(2022) strongly agreed or agreed.

Q4.
Do you agree that supermarkets should do more to promote healthier food and drink and not give price promotions on sugary drinks and snacks?

87%

(1999) strongly agreed/agreed.

Q5.
Do you agree that local restaurants and food outlets should charge a levy of 7p on a can of sugary drink (20p on a litre bottle) and give the money to support work in schools on tackling obesity?

70%

(1603) strongly agreed/agreed but **16%** (381) disagreed/strongly disagreed.

Case study sections

The following pages outline some of the key work which focus on creating healthier environments that is happening across Lewisham, presented as case studies.

Contact details have been provided if you would like to find out more, or get involved.

Baby Friendly Initiative

Breastfeeding improves the health and wellbeing of both mothers and babies. Evidence shows that for both mother and baby, in the longer term, breastfeeding reduces the risk of obesity.

One of the key actions to support more women to breastfeed in Lewisham is working towards achieving UNICEF UK Baby Friendly accreditation through the implementation of the Baby Friendly practice standards. As well as working to protect, promote, and support breastfeeding, the UNICEF Baby Friendly revised practice standards introduced in 2012 also aim to strengthen mother-baby and family relationships for all babies, not only those who are breastfed.

The UNICEF UK Baby Friendly Initiative is an externally evaluated programme recognized to improve breastfeeding rates and the health and wellbeing outcomes of all infants. The process consists of implementing the standards in stages over a number of years.

Stage 1: Assesses the plans and processes to implement the standards

Stage 2: Assesses staff knowledge and skills

Stage 3: Assesses parents experiences when the standards have been implemented

Standards have been developed for maternity, neonatal, health visiting and children's centres.

Lewisham Health Visiting service achieved their Stage 3 award in July 2016 with the support of Lewisham Children's Centres and Lewisham Council's Public Health Team.

Lewisham Maternity services are preparing for their Stage 3 assessment in December 2016

To find out more about breastfeeding support in Lewisham go to www.lewisham.gov.uk/breastfeeding

Breastfeeding support

A range of breastfeeding support services are available across the borough to support women. This has been achieved through collaborative, integrated working across the partnership organisations that make up the Lewisham Breastfeeding working group.

Breastfeeding drop-ins. The informal drop-ins are held in a variety of locations in Lewisham. Trained volunteers and qualified professionals are on hand to answer any questions and give extra support.

Breastfeeding peer support.

One of the key successes has been the peer support programme; 104 local mothers have attended infant feeding education and training since 2010 and there are currently 33 volunteer peer supporters actively supporting mothers in breastfeeding drop-ins and on the postnatal ward. Some volunteers have been supporting women for several years alongside health visitors and midwives.

Breastfeeding friendly

The Breastfeeding Friendly scheme is designed to make it easier for mothers to find places that they are welcomed to breastfeed when they are out and about in Lewisham. Although mothers have the right to feed anywhere, some find going out with a new baby a daunting experience and it can be helpful to know which premises support breastfeeding mothers if they need to feed their baby in public. All Lewisham libraries, leisure centres as well as lots of cafes, restaurants and businesses are already part of the scheme.

Look out for these signs

Early Years Settings

Early Years settings play a vital role in laying foundations for lifelong health and wellbeing and provide the ideal environment to establish healthy eating habits and access to safe and stimulating physical activity opportunities. The most effective way to improve health in Early Years settings is through a whole setting approach that engages children, parents and the wider community.

Settings are encouraged to adopt the 'Eat Better, Start Better' food based guidelines for early years settings and 'Move More' physical activity guidance. Examples of the excellent work that is already in place promoting healthier environments to support healthy eating habits and activity are showcased in this section.

Eat Better Start Better

Blossom Years Nursery, Downham

Issue: Children were observed drinking fizzy sugary drinks on their way into the nursery.
Action: Information about the effects of sugar and the wider impact of fizzy drinks etc was shared with parents via our newsletter. Water and milk are the only drinks provided at snack times and meal times.
Result: The children's behaviour has improved and as a result they are enjoying the activities on offer much more.

Strong Tower Nursery, Deptford

Issue: Children were observed coming into the setting hungry and were consequently very distracted from settling to activities; Parents generally not well informed about healthy eating; Most children still in nappies as it was felt easier than going through potty training.
Action: Provide food whenever necessary, rather than expecting them to wait until the next snack or meal time; Ensuring fresh fruit and vegetables that are cooked on site is always available; parents included in menu planning; redevelopment of the outdoor are to increase physical participation.
Result: Children are much more able to focus and settle and their wellbeing has improved as well as developing their physical skills and remain active.

Strong Tower Nursery

Zeeba Daycare Nursery, Deptford

Issue: Children were observed bringing unhealthy foods into the setting; Parents generally not well informed about healthy eating; Children were underachieving in Personal, Social and Economic Development; Some children overweight and unfit; Some children still in nappies as it was felt easier than going through potty training.

Action: Eat better, start better programme implemented; Parents included in menu planning; Healthy eating encouraged, staff eating with children at meal times; Investment in physical equipment; Partnership with outside agencies; Provide parents with guidance and tools to support potty training – We produced a handbook.

Result: Children have a better understanding of healthy foods; Children are more active and taking part in activities; Most children are potty trained in partnership with parents.

For more information please contact Zeeba Daycare on 020 8694 6980 or lieslh@zeebadaycare.co.uk

Faith Montessori Nursery, Forest Hill

Issue: Children were observed not eating their vegetables. They were picking them out of their food and leaving them on the side of their plates. Staff spoke to the children and found out they hadn't ever tasted them but just 'didn't like them!'

Action: Staff shared stories like Oliver's Vegetables and Oliver's Fruit Salad and provided opportunities for children to engage in messy play and investigate different foods; Supported children to prepare a variety of foods, enabling them to try out new and different tastes; Children got to eat what they had made; A wider variety of foods were provided in the role play areas and children used the familiarity they had gained through the stories to develop their knowledge and understanding.

Result: Children have been much more willing to try out new foods. They have enjoyed and taken pride in preparing and eating their own foods.

Children's Centres

Lewisham has a network of Children's Centres, located across the borough who all play a vital role in improving the health outcomes of families with young children, distributing Vitamin D drops, promoting immunisations and ensuring participation in play sessions. Children's Centres are particularly committed to encouraging healthy eating and preventing obesity as part of a general focus on healthy lifestyles. Breastfeeding is encouraged at all times, and many of the centres have a Breastfeeding Café on site.

Pre-School Learning Alliance 'Food Explorers'

This course encourages children from the youngest possible age to handle, smell and taste new foods, teaches the families about all aspects of nutrition, and supports parents and carers to think about ways healthy eating principles can be part of their everyday lives.

A wide range of food is explored, focusing on different food groups each week, encouraging children to look at the food closely, anticipate the taste and then try it and talk about it. Being with their peers helps children decide to try things they might never try at home.

The course also helps parents and carers understand about food labels, hidden salts and sugars, eating well on a budget and portion size. Evaluations of the course are highly positive, with 90% of parents stating they gained a much better understanding of how to support their child's healthy eating.

Follow-up work is done too – phone calls to parents about 3 months after one course ended highlighted that quite a few parents were struggling with understanding about hidden salts, so they were all invited back to a one-off session just looking at this aspect. At the end of this session, 100% of attendees stated they now understood how to identify hidden salts and what common foods contained them.

Pre-School Learning Alliance Outdoor Learning

PSLA also have an extensive focus on outdoor learning as a means of promoting physical and mental health and wellbeing in children of all ages and their families.

Many of the sessions in PSLA Children's Centres therefore encourage children to be active and immersed in physical play outdoors, and some sessions focus on this specifically such as Mud, Mess and Magic at Bellingham Centre. A new course called OWL BABIES was devised during this year and run at Manor House Children's Centre – this focuses on encouraging the youngest babies to be active in the open air.

In many of the PSLA pre-schools OWL (outdoors while learning) is also a focus. At Cherry Blossom Pre-school in Beckenham Place Park, children are outdoors all day, using the indoor area as a resource for their play only. A huge mud kitchen encourages children to use their muscles to lift pots full of mud, ladle 'dinner' and transport mud around, and a rope swing suspended from a large tree encourages children to feel the joy of moving and being active outdoors.

www.lewisham.gov.uk/myservices/education/earlyyears/childrens-centres/

Primary schools

The school environment is hugely influential on children's behaviour, both through the influence of the curriculum, and the culture of the school. There is a growing evidence base on the effectiveness of school-based intervention to promote health, diet and physical activity. Schools also provide a range of valuable opportunities for engaging families and the wider community.

This section provides information on three whole school approaches that support healthier lifestyles for our children together with case studies on the benefits for schools.

Daily Mile

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 as a whole school approach, and several more are planning to start in September 2016.

The scheme was created by Elaine Wyllie, a primary school headteacher in Scotland, who wanted to tackle poor levels of fitness in her school. Children are encouraged to run or walk a mile every day in their playground with their classmates and teachers. 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.

St George's CE Primary School

St George's CE Primary School in Forest Hill was one of the first schools in Lewisham to introduce the daily mile as part of regular school activities. The whole school takes it in turn to run or walk for 15 minutes every day. The Daily Mile has gone down a storm, with pupils collectively clocking up enough miles to reach Australia since it was introduced in September 2015.

The Daily Mile
children fit for life

Our vision

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.

Geraldine Constable, St George's CE Primary School headteacher, introduced the activity in her school after seeing the impact of the scheme. She said: "We decided to adopt the Mile a Day having seen a BBC report on a school in Scotland. To me it seemed the ideal way to allow our children to have an opportunity to engage in daily exercise additional to their PE lessons and playtimes. We have found that doing the mile during the school day actually helps re-energise children and improve their focus back in the classroom. This initiative has been so popular with children and staff that we are now looking to develop a parents' 'Mile a Day' group in the local park!"

Councillor Paul Maslin, Cabinet Member for Children and Young People, recently joined pupils for their daily run along with Perry Vale ward councillor and Daily Mile champion, Susan Wise. He said: "The benefits of regular exercise on improving the health and wellbeing of children are well documented and this is a fantastic way of getting children physically active. I can clearly see how much St George's pupils are enjoying this and that can only be a good thing. I know that there are many schools in Lewisham that are interested in taking up this initiative and I heartily encourage them to do so."

For more information and resources on The Daily Mile see www.thedailymile.co.uk

Join us in becoming a Daily Mile schools, contact Alex.Allen@lewisham.gov.uk

Sugar Smart

St William of York have agreed to be Lewisham's first Sugar Smart Primary School. They will help produce resources and pledges to support other schools to sign up to the campaign. The school has already been proactive in highlighting the amount of sugar in the diet and makes sure that healthy eating is embedded in the curriculum.

Sharon Lynch the headteacher at St William of York said when she heard about the Sugar Smart campaign "This sounds very exciting! We would be more than happy to be involved'. In a primary school, we don't 'sell' much sweet food, but we do have a 'healthy tuck shop' so we could certainly do a bit more analysis of the sugar content. Our Year 6 recently had a great display highlighting how much sugar is in various drinks which was on the main thoroughfare into school. It was really eye catching, and shocking, and generated a lot of discussion. It was just after Jamie got the 'sugar tax' announced in the budget."

www.lewisham.gov.uk/sugarsmart

Healthy Schools Programme

Healthy Schools London is an Awards Programme that supports schools that are working to improve children and young people's well-being. It is based on a whole school approach through 5 themes:

- Personal, Social, Health and Economic Education
- Healthy Eating
- Physical Activity
- Emotional Health & Wellbeing
- Environment

Evaluation of the national Healthy Schools programme showed positive outcomes on physical activity and healthy eating. Participating schools also reported reduced incidence of bullying, improved behaviour and improved attendance.

Many Lewisham schools are already promoting and supporting health promotion interventions at their schools to encourage health and wellbeing, like Active Travel, cookery programmes and other healthy lifestyle initiatives. The awards are for schools to recognise their achievements in supporting the health and wellbeing of their pupils and over 30 schools in the borough have already signed up to the award. Four schools have already achieved bronze award, these are Sir Francis Drake, Greenvale, Downderry and Stillness Infant.

Headteacher of Downderry, Tracey Lewis comments: "We are delighted to announce that Downderry Primary School in Downham has achieved the Healthy Schools Bronze Award following our review of practices in promoting health and wellbeing. This award recognises how as a school we support the health and wellbeing of the school community. The areas included in the scheme are those of Healthy eating, Physical activity, Emotional health and well-being, and Personal, Social Health Education (PSHE).

Our main aim is to help our children stay healthy and happy as they grow up: to lead a healthy lifestyle, to make healthy food choices at lunchtime and to be active at and on the way to school. We also want to help them learn about their health, and develop their motivation and self-respect to make healthy choices. The school will continue to work towards achieving a Silver Award and eventually a Gold Award."

For more information on the Healthy School Programme visit www.healthyschools.london.gov.uk

Secondary schools

Bonus Pastor Catholic College in Downham is set to become the first Lewisham Sugar Smart Secondary School.

Headteacher Ruth Holden states, "I am excited about becoming Lewisham's first Sugar Smart School because there is a clear and visible correlation between unhealthy eating and high sugar foods and drinks, and general underperformance. Foods that are high in sugar do make children behave in a negative way; they are either completely hyper active and cannot behave appropriately, or they are tired and lethargic and cannot work.

Paying attention to this matter and aiming to keep the school and students sugar smart, will help battle with this problem and I am sure will impact positively on students' achievement."

Sugar Smart Pledges which the school are considering include:

- Increasing the use of parent mail rather than students having money to pay for food.
- Ensuring that Chartwells our caterer do not serve any sugary drinks
- Debating the sugar tax law through our student voice and British Values agenda
- Using our Citizenship programme to educate further on nutritional advice and healthy choices workshops
- All students to receive Nutritional workshops through their core Physical Education lessons – starter activities for every core PE lesson

- In Food Technology lessons for Year 7 and 8 students, we could adapt schemes of work to promote the benefits of healthy choices
- Bring in outside experts to model healthy cooking and menus and develop a buzz around health
- Introduce a healthy schools week
- Student voice and student council – taking on and leading on healthy eating and drinking following their own produced audit and survey
- Use of professional role models to advise on their own experiences
- Display and promotion around the school of healthy foods and drinks
- Have access to drinking fountains
- Run competitions of health foods through our House system

www.lewisham.gov.uk/sugarsmart

Healthy street food offer

Chartwells who deliver the council school meal contract have been undertaking exciting new work on the school menus' offer for secondary schools. Bonus Pastor was one of a small group of pioneer national schools to trial out a new healthy street food style offer. The process involved student and staff insight and feedback, parent / governor tastings and kitchen staff development training.

The insights gave some clear themes that would need to be considered when building the food offer. Students are increasingly influenced by the high street and are eating a wider variety than they have done in the past. Customisation and choice in what their meal is made up of was important with pupils preferring grab and go to a traditional plated meal. They expected a variety of cuisine but also the need to feature the favourite Italian and American dishes.

The new offer includes a range of global dishes, high street inspired food offers (American/Tex Mex, Wings and things, Speedy Italian) and Light and Simple cold grab and go meals.

The trial of the new food offer has been a success with a marked increase in engagement and uptake levels with the student population. The next phase will see this healthy street food offer launched in all Lewisham secondary schools this academic year.

"Students attitudes and expectations around food are changing"

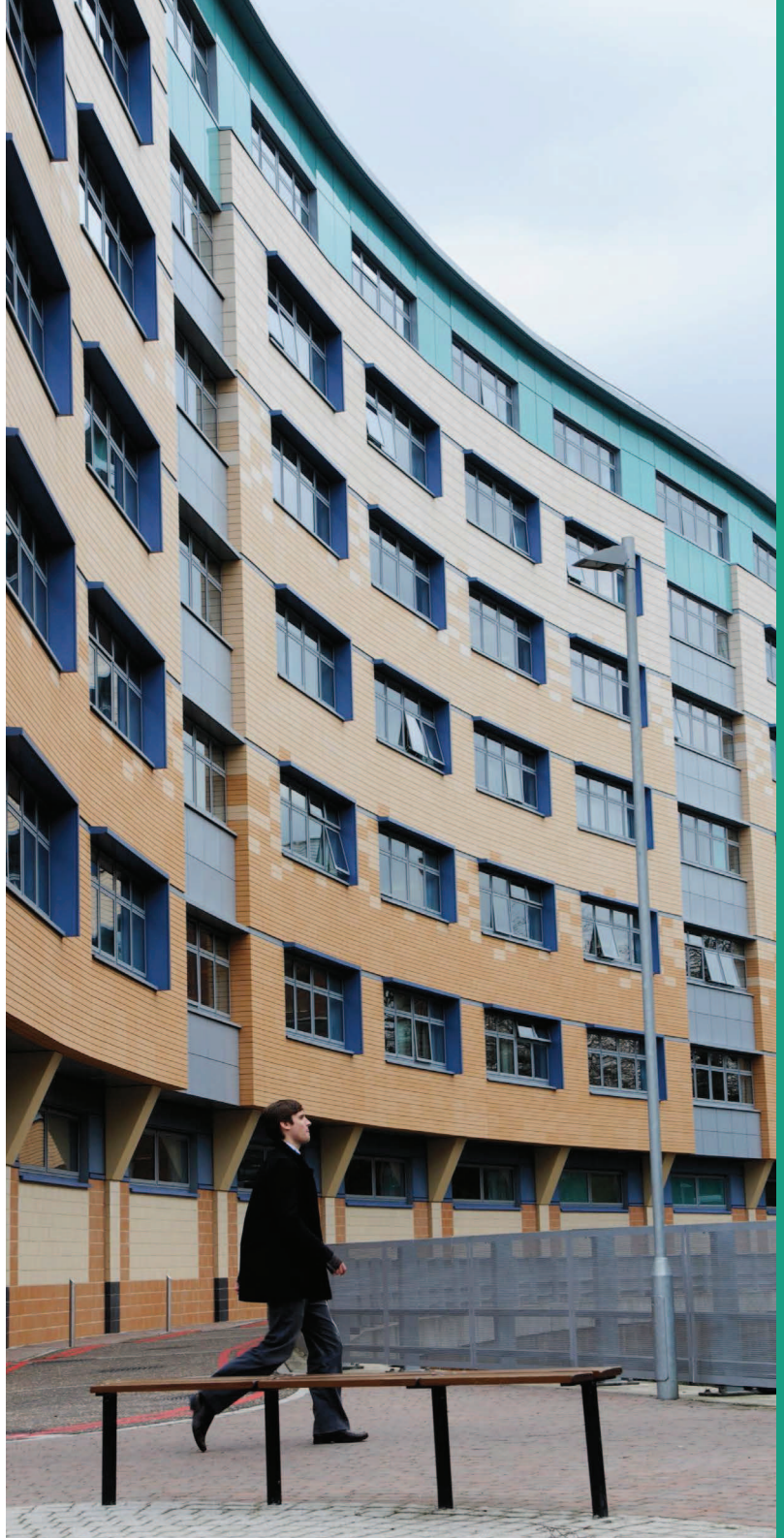
University Hospital Lewisham

Lewisham and Greenwich NHS Trust (LGT) is an acute and community healthcare provider, employing over 5700 members of staff. The Trust delivers services across two large acute hospital sites, University Hospital Lewisham and Queen Elizabeth Hospital, Greenwich and within community settings.

This year the NHS included a national scheme to improve the health and wellbeing of their workforce. Not only will staff benefit from the scheme but evidence outlines a link between better staff health and impact on patient care.

An area of action in the national scheme is providing healthier food for staff, visitors and patients. One reason for changing the food environment in NHS premises is that it has previously been estimated that many (over 50%) of NHS workforce are overweight or obese. Diet plays an important role and on average we consume too much sugar which is leading to high rates of tooth decay, obesity and type 2 diabetes.

Keith Howard, Director of Estates & Facilities for Lewisham and Greenwich NHS Trust has signed the Trust up to SUGAR SMART and has pledged to provide more healthy food and drinks options and to work towards healthy food standards and to encourage the Trusts' retailer partners to do the same for staff, visitors and patients visiting the Trust.



SUGAR SMART
LEWISHAM

Keith Howard said: "I am delighted to support the Sugar Smart Initiative and for the Trust to be playing its part in the reduction in the consumption of sugar that has led to increasing obesity and Type 2 diabetes within our local community".

The Trust is working on a number of initiatives which include:

- Removing chocolate and crisps from till points.
- Publishing nutritional information on the coffee shop menu board, this will include the fat content and sugar content.
- Improving the vending machine options by offering healthier eating food and drink items for example low calorie drinks, small portion sizes of chocolate bars and healthier eating snack bars.
- Advertising the nutritional content of food and drink items on vending machines across site.
- Promoting healthy 'meal deal options'. In the restaurant at University Hospital Lewisham the meal deal will include a jacket potato, fresh fruit and low calorie drink.
- In the retail outlets chocolate bar and crisp promotions have been moved away from the till points and healthy alternatives are being offered in prominent positions.

The Trust is working in collaboration with our retails partners to undertake regular monthly audits to review progress on healthy eating and identify any areas of opportunity. Our retailers are included in the Trust's catering working group meetings where healthy eating initiatives and the CQUIN targets are discussed with clinical staff and our dietician along with opportunities for advertising healthy eating products.

www.lewisham.gov.uk/sugarsmart

Sports and Leisure Centres

Opportunities to get fit and keep active are available right across the borough in nine leisure centres and beyond. The council works in partnership with two leisure management companies to run these centres.

www.lewisham.gov.uk/inmyarea/sport/facilities

Fusion Leisure Centres

In 2015/16 there were 1.26 million visits across the Fusion sites, an increase of 8% on the previous year.

Various healthy lifestyle events and initiatives that have recently been run at Fusion centres include:

- 8 weeks free girls football sessions at Bellingham Leisure & Lifestyle Centre, delivered by Dalmain Athletic Girls Football Club; plus two tournaments for local schools.
- Glass Mill is delivery and collection hub for Lee Greens community veg scheme
- Breastfeeding Welcome
- Fusion have worked with Contact a Family, (a charity for families of disabled children) to promote what the venues offer for disabled residents
- Ladywell Arena hosted the annual disability sports day at the centre. The event attracted users from across South east London, with over 150 participants
- Glass Mill have hosted weight management classes for young people in the borough in conjunction with MyTime Active
- The Bridge Leisure Centre hosted a Great British Tennis Weekend in partnership with the LTA

Downham 1Life Leisure Centre

In 2015/16 there were 484,750 visits to the centre, an increase of 7% on the previous year.

Various healthy lifestyle events and initiatives are constantly running at Downham including:

- Healthy Walks are run in partnership with Lewisham & Greenwich NHS Trust
- Family open days with free gym and swimming
- Healthy lifestyle advice sessions and stand in the centre
- Breastfeeding Welcome
- The personal training offer has been re-launched to make it more attractive for the customers and staff alike. There are now new personal trainers on board, who are additional to the fitness instructor team and are now delivering an average of 20 per week. The Leisure Centre also hosted its first biggest loser course.
- The 1life activity camp runs during the school holidays, in partnership with Fit for Sport. The camp regularly saw over 40 children per day

- Awarded external funding to run sessions for young people, which have included circuits, boxing, girl's football and group ride.
- The embedded sessions for older people at the centre continue to run successfully, for example line dancing, who are still attracting over 50 participants per week and regular 60+ classes of 60+ Aqua and Zumba Gold.

1Life
Live more. Live well.

How we're doing:

- Swim school take-up is at its highest level to date in both Fusion and 1Life leisure centres
- School swimming and galas continue to be delivered
- Free swimming available for residents over 60s
- Be Active provides concessions and free access to leisure activities across the borough. Across Lewisham there were almost 4,000 Be Active members in 2015–16.

For more information on the Be Active scheme including who is eligible please see www.lewisham.gov.uk/inmyarea/sport/be-active-discounts

Sport in the borough

A number of sports receive grant funding to increase participation including Basketball, Boxing, Football and Tennis.

Basketball

London Thunder is an affiliated basketball club based in Lewisham. The club exists for the benefit of those who wish to develop their skills in the sport of basketball. The ethos of the club is through basketball to offer participants the opportunity to be healthy, enjoy, achieve and have fun in a safe and supportive environment. There are various basketball schemes running across the borough aimed at a variety of ages, many of which are based from the purpose built facility 'The Thunderdome' in South Bermondsey.

The club also offers the chance to train as a coach and a wheelchair programme.

Additionally London Thunder runs Basketball Clubs in secondary school sites across the Borough. The clubs run for 30 weeks at each school on selected days targeting 11–18 year olds, but are also open to linked local primary school pupils and Not in Education Employment or Training (NEET) 18–24yr olds.

www.thunderbasketball.net

Tennis

We have also recently entered into a long term partnership with the Lawn Tennis Association which has resulted in a development plan to refurbish tennis courts in the borough's parks. Sport England has recently provided some funding that will help us to develop a Playing Pitch Strategy to make better use of our current facilities.

GoodGym

GoodGym Lewisham launched in January 2016 and meets weekly at the Glass Mill Leisure Centre when the group runs to complete tasks for the local community. There have been over 1,300 sign ups since the scheme began. Projects worked on include the upkeep of community gardens and parks in Lewisham with visits to Honor Oak Adventure Playground, Goldsmith's Community Centre and the Woodpecker Youth Club.

What is GoodGym?

GoodGym is a community of runners that get fit by doing good. We support isolated older people and do manual labour for community organisations as part of our workouts. As a result, we reduce social isolation, bring communities together and motivate people to get fit.

www.goodgym.org/areas/lewisham

Wheels for Wellbeing – Disability Cycling

Wheels for Wellbeing (WfW) is an award-winning charity supporting disabled people of all ages and abilities to enjoy the benefits of cycling. Cycling can be easier than walking, a way to keep independent, fit and healthy, a mobility aid, and a useful form of everyday transport.

The programme includes:

- weekly inclusive cycling 'drop-in' sessions
- led rides around Ladywell Fields during the summer months
- children/young people sessions in school holidays
- creating cycling 'mini-hubs' at local venues so that they can support access to cycling as flexibly as possible, for their own users

The programme also came in response to parents and carers of disabled children expressing a desire for increased physical and social activities for their children, including activities where their children can learn specific skills.

Over 100 participants a year take part in Lewisham.

www.wheelsforwellbeing.org.uk

Trinity Laban

Trinity Laban Conservatoire of Music and Dance is the UK's only conservatoire of music and contemporary dance. Leaders in music and contemporary dance education, they also provide exciting opportunities for the public to encounter dance and music, and access arts health programmes.

The '**Retired not Tired**' programme of work has been running since 2011. The programme is specifically targeted at older people aged 60 and above from Lewisham and includes a mixture of music, dance and combined music and dance groups, providing regular opportunities for participants to take part in creative activity, interact socially and develop new skills. Sessions are led by experienced practitioners from the Trinity Laban's Learning and Participation department, supported by its team of project managers.

Each group has a creative focus: practitioners work with participants' ideas, skills and creative talents to produce their own creative outputs. Groups have been specifically programmed in different geographical locations around the borough and reach a range of different sub-groups of older people, in terms of age, ethnic and socio-economic backgrounds. The four groups comprise:

- All Singing All Dancing – a joint music and dance group originally based in Catford and now meeting in Bellingham;

- Dance for Health – a group combining movement with Pilates based at the Laban Centre, Deptford;
- Arts Befriending Group – social arts group based in Sydenham partnered with Ageing Well, Lewisham;
- Bellingham 'Young at Heart' Club – a social and creative group based in Bellingham Green.

Research suggests the programme has a powerful social impact on participants. Survey responses from 'Dance for Health' and 'All Singing All Dancing' also suggested high levels of perceived health benefits. This was recorded in general terms (>90% state a "significant" or "huge" impact on their health) and across specific domains, with participants noting improvement in postural awareness, balance confidence and flexibility.

PULSE is a week intensive dance programme for 7-13 year olds, aimed at young people in Lewisham who do not access dance/physical activity and/or are above a healthy weight. Pulse took place for the first time in August 2013. During the programme participants were able to learn different dance styles, learn about healthy ways to fuel the body, watch professional dance performances, and create dances to show to family and friends.

PULSE not only embraces the National Obesity Observatory advice of introducing children to improved nutrition and increased levels of physical activity, the programme also tackles the issues of deprivation and diversity by providing the free classes via the inclusive, team-building, medium of dance.

For more information about Trinity Laban's Dance and Health Programme, please contact Louisa Borg-Costanzi Potts, Learning and Participation (Dance) Programme Manager.

T: 020 8305 3964
E: l.potts@trinitylaban.ac.uk

Parks

Lewisham has a wealth of green spaces however currently only 13.2% of Lewisham adults make use of outdoor space for exercise or health reasons.

Nature's Gym is a great way to improve fitness and help the environment by taking part in conservation activities in Lewisham parks and nature reserves. It is free of charge and all equipment is provided. It is a joint initiative run by Lewisham Council and Glendale, the council's parks' maintenance organisation, to increase physical activity and encourage people to come and volunteer in an outdoor environment. It helps people to get closer to nature and benefits mental well being as well as physical health.

The sessions take place every Thursday and once a month on a Saturday from 11am –2pm. Nature's Gym cater for a range of abilities and there are usually a variety of tasks to carry out. Tools and refreshments are provided and there is a mid-session tea break. Nature's Gym provides a great opportunity to meet people, find out about the local area, learn new practical skills and make a positive contribution to the local environment.

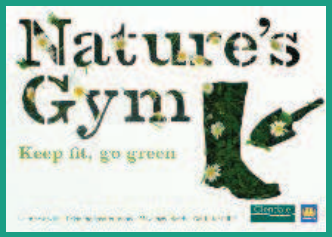
A recent survey has shown many volunteers come to get fit in an outdoor environment . Earlier this year, volunteers were asked why they come to Nature's Gym with responses such as 'wanting to get some exercise' and "keeping fit by working in the outdoors".

Work completed by volunteers this year

- planted hundreds of metres of hedgerow habitat for nesting birds and invertebrates, planted trees, bulbs and flowers.
- removed hundreds of invasive plants from Lewisham rivers.
- cleaned up litter, created pathways and natural fences for improved accessibility and protection of woodland flora; including huge swathes of bluebells in Beckenham Place Park creating a beautiful public display.
- created new meadow habitats (the rarest habitat in Lewisham important for declining bees and butterflies).
- maintained several ponds to encourage amphibians, built several stag beetle log piles, planted community orchards and worked with park friends groups to help them maintain their local parks and nature reserves.
- In 2015 Nature's Gym provided 2685 volunteer hours to help Glendale maintain the parks.

For more information on Nature's Gym please see their blog: www.natureconservationlewisham.co.uk

If you'd like to join a session of Nature's Gym please contact: naturesgym@lewisham.gov.uk.



Outdoor Gym

What are Outdoor Gyms?

Outdoor gyms include much of the same equipment found in an indoor gym, but the difference is that they are specifically designed for outdoor use.

Outdoor gyms are suitable for people of all ages and fitness levels, and you don't need any experience to use them. Low impact and intuitive to use – and instructions are included. Best of all, there are no expensive membership fees to pay so it is perfect for those who cannot afford to use a gym.

These gyms have now become a regular sight in open spaces across the UK, often near children's playgrounds, which encourages parents to use them while their kids play.

These spaces have been designed to provide low-impact training in an intuitive and easy way. The various machines target the lower body, upper body and core, not to mention cardiovascular and weight-based strength exercises.

The spaces appear to appeal to individuals who normally struggle to find the time or money to attend a regular gym, and 26% of users are new to exercise.

Outdoor Gyms are also located in Home Park, Bell Green and Northbrook Park in Lee.

Home Park outdoor gym

For more information on Outdoor Gym's and other exercise and fitness activities in Lewisham Parks:
www.lewisham.gov.uk/inmyarea/openspaces/activities/

Or contact Glendale
Tel: 020 8318 3986
www.glendale-services.co.uk

Mayow Park, Sydenham

A public consultation was undertaken in October 2014 asking park users what preference they had with regards either outdoor gym equipment or trim trail equipment, together with any comments or suggestions they had. The results were that both types of equipment were welcomed.

The works were completed February 2015.

On 25 March 2015 local councillors, Lewisham Greenscene officers and Glendale officers attended the official opening of the gym facilities in the park, which had been provided and installed by HAG-SMP.

Cllrs Best and Onikosi spoke about the value of this equipment as a way of developing personal health and how it would enhance the park experience. They thanked the officers who had been involved in bidding for funds and choosing the equipment and they cut the ribbon. Martin a Personal Trainer from HAG-SMP was on hand and able to show people how to get the best from the equipment.

70%

of respondents said they had used the outdoor gym, within this group, almost half said they used it at least once a week.

Planning

Through its Planning Core Strategy Lewisham is committed to improving health and well-being and to reduce health inequalities across Lewisham by providing decent quality housing, access to employment and training, and encourage healthy lifestyles and opportunities for increasing physical activity (such as walking, cycling and running). By being dedicated to **Building a sustainable community** Planning play a vital role in providing opportunities for people to live healthy lifestyles and improve well-being. This is as important to older people as it is to the young. Health is far more than the absence of illness, rather it is a state of physical, mental and social well-being. A person's health is therefore linked not only to age and gender but also to wider factors such as education, employment, housing, social networks, air and water quality, access to affordable nutritious food, and access to social and public services in addition to health care. It is about lifestyle: physical exercise, improved diet, cleaner air, and mental well-being through stress reduction, engagement and socialisation (including employment).

According to the National Obesity Observatory, Lewisham has the 13th highest density of hot food takeaways per head of population in England. Concerned about high levels of obesity and comparatively high levels of deprivation, Public Health and Planning colleagues began to investigate a locally specific policy that could reduce the number and location of takeaways as part of its existing healthy weight strategy. The teams worked closely over two years to prepare an evidence base document setting out the local issues and rationale for a planning policy that could restrict takeaways. This joint approach proved pivotal to later success.

"Thanks to this, fast food shops by the school gate in Lewisham have had their chips"

Councillor Alan Smith

The Council adopted a restrictive planning policy in relation to hot food takeaway uses as part of its Development Management Local Plan in November 2014. The policy seeks to prevent the establishment of new hot food takeaways within 400 metres of any primary or secondary school. In areas further away from schools, the policy seeks to limit the number of takeaways by applying a maximum percentage in town centres and parades. As the Local Plan progressed through the decision-making process, the policy gained leverage in planning decisions. In the latter stages of preparation and following adoption **the policy was used successfully to refuse five applications in 2015/16 alone**. The policy has been used in discussion with applicants resulting in a number of withdrawn applications.

"This is a success story in making connections, joining up our health aspirations and our powers as a planning authority. Thanks to this, fast food shops by the school gate in Lewisham have had their chips."
Councillor Alan Smith, Lewisham Council's Cabinet Member for Growth and Regeneration

New residential developments within the borough take physical activity into consideration within the planning process. The Catford Green development by Catford stations has opened up a new cycling and walking link to Ladywell Fields.

New cycling and walking link to Ladywell Fields

The Food Environment

Lewisham Food Partnership

Lewisham has established a partnership of community members, public and voluntary services to help secure a healthier and sustainable food future for the borough. The aim of the food partnership is to transform the food environment as part of the whole system approach to obesity, reducing health inequalities and improving the health outcomes of our residents.

Bringing together a wide variety of partners allows a more joined-up approach, improving collaboration and increasing awareness of what is going across the borough.

The partnership developed action plans to help address a wide range of issues, including access to healthy foods, building community knowledge and skills, food waste, procurement and food poverty. Examples of some of the initiatives to transform the food environment are included in this report.

The borough has now signed up to the Sustainable Food Cities Network in order to share ideas and learn from others working towards similar goals.

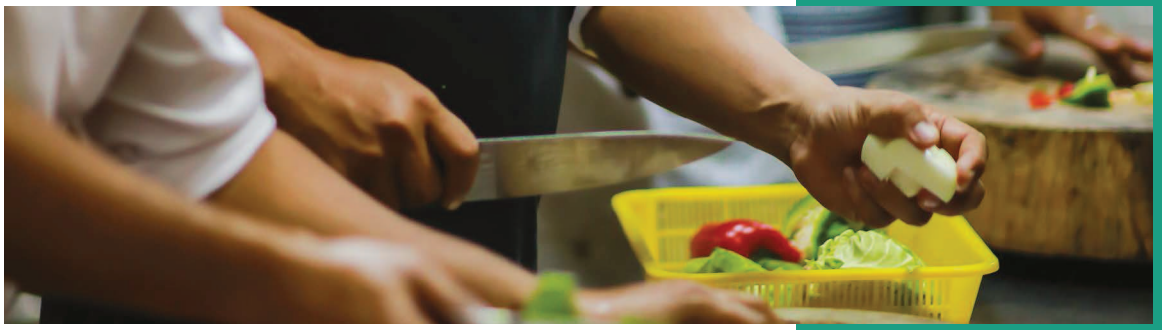
For more information on Lewisham Food Partnership contact:
Gwenda Scott, Public Health Lewisham
Gwenda.scott@lewisham.gov.uk

Lewisham was recognised as a leader borough in the 2015 Good Food for London awards for being consistently in the top five boroughs for their involvement in improving London's food. The report measured progress over 10 actions to support healthy and sustainable food.

Healthier catering commitments

The scheme developed for London supports food businesses to make straightforward changes to menus and food preparation which helps make food healthier. The small changes not only improve diet but also help the business itself save money. The simple steps help to reduce the salt, fat and sugar content of meals offered. This year the Sugar Smart campaign will be embedded in the scheme and food businesses will be asked to make an additional pledge on sugar.

The focus of the Healthier Catering Commitments will be on fast food outlets and businesses near schools. This will include supporting 14 local businesses to renew their commitment to the scheme. These small changes to improve the food offer will have an impact on thousands of meals served each year.



LEWISHAM
training kitchen

"The Training Kitchen run by Chartwells as part of the school meal contract is an amazing facility and community project that is all about helping people of all ages to cook and eat well. The team includes a training and development chef and nutritionist. The Training Kitchen based at the Green Man is available to the whole Lewisham community, with a focus on primary and/or secondary school children on Tuesdays and Thursdays and the local community on Fridays.

"The Training Kitchen doesn't just teach people to cook; it teaches them to take fresh seasonal ingredients and turn them into simple, nutritious balanced dishes. This is particularly important for children; enabling them to develop healthy habits from a young age and utilise these skills as they leave home and go on to full-time work or further study". *Chartwells nutritionist*

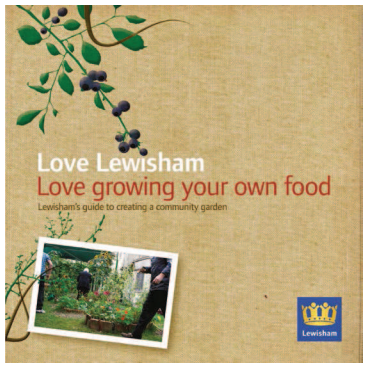
Community food growing

Lewisham now has more than 60 community gardens including orchards, kitchen gardens, and flower gardens. Some of the gardens are within parks or work with friends of parks groups. The majority are self-running and have their own support networks including a vibrant website which provides information on activities, events such as open days and training opportunities. www.lewishamgardens.webs.com

Two Lewisham gardens took part in Capital Growth's Urban Harvest Feast in September. Activities at Wildcat Wilderness in Catford included baking bread on a campfire, showing visitors how to make chutneys and jams and teaching people about bees and beekeeping. During the evening they hosted a community BBQ and lantern evening.

Sydenham Gardens held an open volunteer session, tours and community day at their new site, the De Frene Market Garden.

The council has also produced a guide to community gardens which provides general advice about starting, developing and running a community garden, as well as outlining some of the key issues involved.



Be Inspired Lewisham

Greenwich Co-Operative Development Agency recently began delivering a range of community nutrition and physical activity initiatives in Lewisham. The service aims to improve people's knowledge and skills on food choices through training, workshops and working with community organisations to stimulate volunteering around good food and physical activity.

The service also delivers community cookery clubs, including three for Lewisham Homes. Two of the cookery club tutors are Lewisham residents. The cookery clubs consist of 5 weeks cooking sessions combined with healthy eating messages followed by a visit to a local community garden in the sixth week.

Attending the cookery clubs not only brings about positive changes in food choices around sugar, fat and salt but also improvements in wellbeing.

"After five weeks of attending a participant fed back how much of a difference the cookery club had made to her well being. She was much more confident within herself, the cookery club enabled her to improve her social and communication skills, she no longer feels nervous and feels a lot happier within herself".

A participant attended the Lewisham Library Cookery club in September 2014. She enjoyed the sessions so much she expressed an interest in taking healthy eating further – doing the Open College Network (OCN) Healthy Eating and How to Run a Cookery Club course available as part of Lewisham's Health Improvement training offer. She went on to successfully complete the OCN 12-week training course. She then volunteered on two series of cookery clubs and also at community events. She will now be mentored at the Green Man cookery club over 5 weeks. Upon successful completion she will Tutor one of the November cookery clubs.

gcda.coop/2016/04/28/run-cookery-club-training-course/

Lewisham cookery club participant

↓

Accredited training

↓

Volunteer

↓

Cookery Club Tutor

Transport

Quietway Route

Lewisham is part of London's first Quietway which opened for cyclists and pedestrians in June 2016. The new Quietway (Q1) is a continuous sign-posted route that links Greenwich and Waterloo by traffic-free paths and quieter backstreets.

The 9km route passes through four London boroughs – Greenwich, Lewisham, Southwark and Lambeth. It is clearly marked with distinctive purple branded wayfinding signs and includes over 2km of traffic-free paths for cyclists and improved pedestrian facilities throughout. Pedestrians will benefit from new or improved crossing facilities and wider footways alongside the improvements for cyclists, which will make the route safer and more attractive for walking as well as cycling.

The Lewisham section of the route runs from the new cycling and walking shared use path which runs round the back of Millwall FC's New Den stadium, along Surrey Canal Road, through a number of quiet streets in Deptford before crossing Deptford Creek at Half Penny Hatch Bridge into the Royal Borough of Greenwich.

The route was delivered in partnership with four south-east London boroughs, Transport for London and Sustrans, the cycling and walking charity.

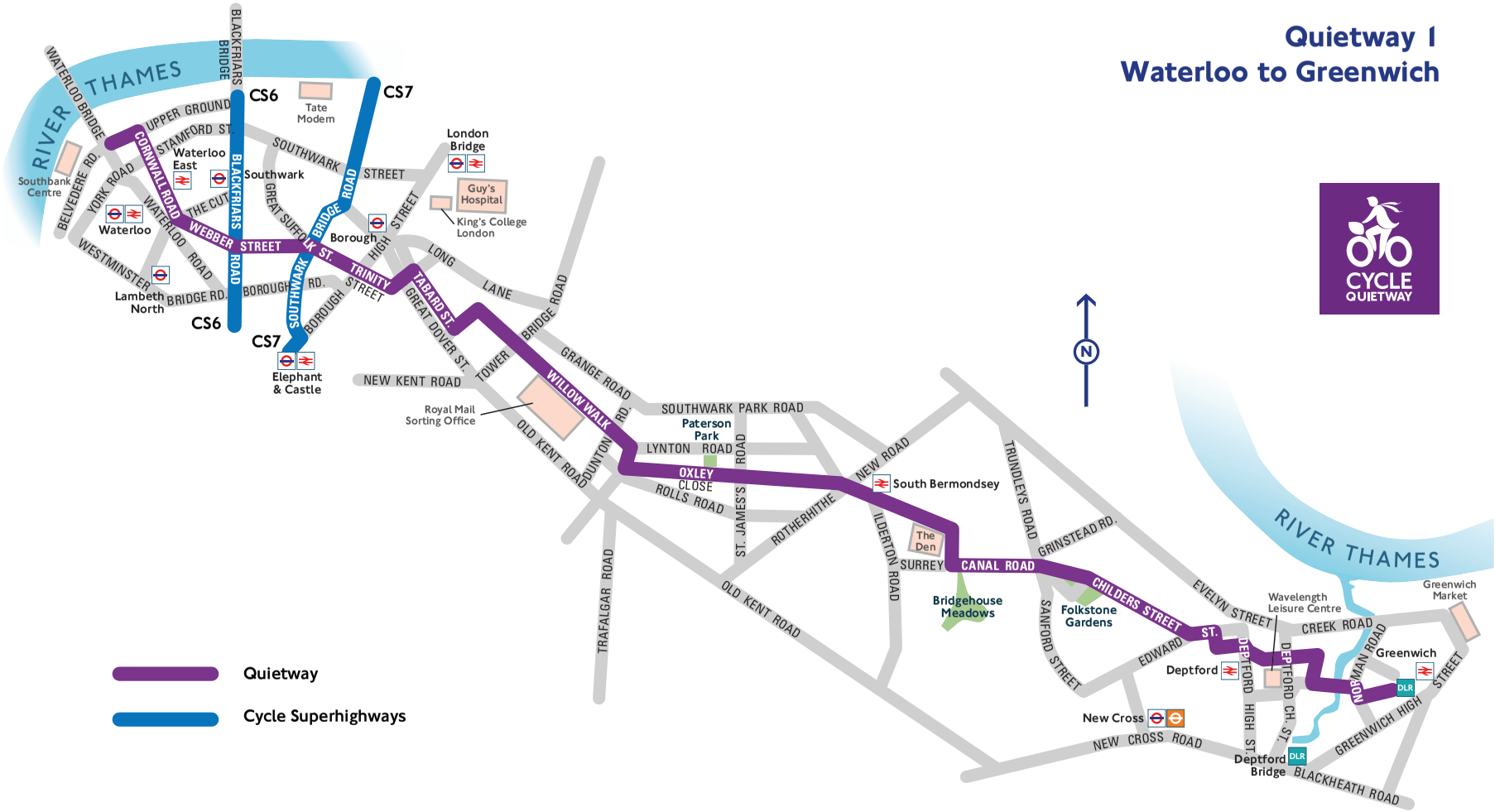
Edwards Street Cycle Track

It is the first Quietway route to be opened with six more additional routes due to be completed by spring next year. The route is being advertised to new and novice cyclists as an ideal way of getting in to central London on the safest and quietest route possible.

"Q1 is amazing, it has changed my commuting routine consistently, thank you so much!"

Sara

Quietway 1
Waterloo to Greenwich



CYCLE QUIETWAY

Correct as of July 2016

MAYOR OF LONDON

TRANSPORT FOR LONDON
EVERY JOURNEY MATTERS

Dr Bike

Dr Bike sessions are offered throughout the year to help people get their bikes back on the road. Often the biggest cause for not cycling is that the bike is off the road. The habit of not cycling takes hold and a cyclist can be lost to public transport. By offering free servicing and checks on bikes it helps keep people on their saddle. The checks are usually held in cafes around the borough, advertised through the café and on the Lewisham website.

At other events such as Exchanging Places, where cyclists can experience sitting in the seat of a lorry, Dr Bikes are the lure for them to stop and take some time with the Police and road safety staff to talk about the blind spots on lorries.

www.lewisham.gov.uk/myservices/transport/cycling

Adult Cycle Loan Scheme

As one of the largest employers in the borough, the Council has an important role in setting an example to other organisations of the need to travel in sustainable ways. It is also responsible for promoting general road safety to its own staff, people working within the borough and residents.

Lewisham is committed to improving cycling facilities, both infrastructure and education and training, as well as the safety perception of cyclists travelling through or within the borough.

The Road safety Team have offered courses designed to attract cyclists of all ages, and genders to take up cycling as a real alternative to driving or public transport use.

A key challenge has been trying to fill a missing link between taking a lesson or two and actually investing in a bike.

Lewisham made a decision to offer anyone who works, studies or lives in the borough an opportunity to borrow a bike for £10 for one month in conjunction with London Cycling Campaign (LCC).

For one month an adult can borrow a new or very nearly new bike to try out. At this point the bike is fitted to the rider, a cycle helmet, high visibility waistcoat, bike lights and maps are given. A cycle instructor is available to offer tips for riding if needed and the opportunity to book a lesson or have a route planning ride is offered.

When the bike is dropped off the following month, the bikes are serviced and checked for the next pick up session. No bikes go straight back out to new cyclists without a service and check.

Every participant receives a 1 year membership of the LCC, cycling goodies such as lights, a pump etc, and the knowledge that in the month loan period they will know that cycling fits in to their lifestyle.

www.lewisham.gov.uk/myservices/transport/cycling/Pages/Cycle-loan-scheme

Since the scheme started over 1,200 people have taken up the cycle loan and results have been highly positive:

- 46% of cyclists are using their loan bikes more than 3-5 times a week with 11% using the bike daily.
- 60% of those using a loan bike are cycling more than they initially expected!
- 66% said they feel safe when riding in Lewisham.
- 89% are now looking to buy a bike, of which 45% buy a bike through the scheme, ie. the bike they have borrowed for a month!
- 30% of cyclists are using the bike for commuting, with a further 48% for fitness and leisure.

Positives of the scheme:

- people can try out a bike without having to spend too much In times of austerity this has been well received and highly appreciated by residents and employees alike
- the scheme supports the Road Safety Plan in getting more people cycling more safely
- participants can take one to one lessons, or take part in a 5 session adult bikeability course
- there is a ripple effect, those involved in the scheme are influencing their friends and relatives

Resources and information

Change for Life – Sugar Smart Website
www.nhs.uk/sugar-smart/home

Lewisham Health Improvement Training
www.lewisham.gov.uk/myservices/socialcare/health/improving-public-health/Pages/Health-improvement-training.aspx

Eat Better Start Better
www.childrensfoodtrust.org.uk/childrens-food-trust/early-years

Breastfeeding Friendly Scheme
www.breastfeedingnetwork.org.uk/bfn-breastfeeding-friendly-scheme

The Baby Friendly Initiative
www.unicef.org.uk/babyfriendly

The Daily Mile
www.thedailymile.co.uk

Physical activity for early years – every movement counts
www.bhfactive.org.uk/userfiles/Children_under_5_infographic_FINAL.pdf

Healthy School Programme
www.healthyschools.london.gov.uk

Sport Facilities in Lewisham
www.lewisham.gov.uk/inmyarea/sport/facilities

Making Every Contact Count
www.makingeverycontactcount.co.uk

Lewisham Health and Wellbeing information
www.lewisham.gov.uk/health

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London Borough of Lewisham October 2016

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Public Health Outcomes: Reduce Alcohol Harm

Key Messages

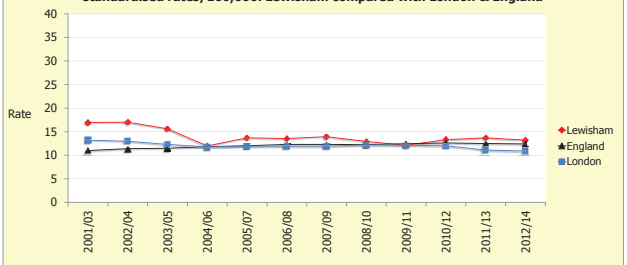
- Under 75 mortality for liver disease is increasing in England. The increase in Lewisham males appears to be at a faster rate, however it is not statistically different from England.
- Alcohol related admissions in Lewisham have been steadily rising since 2011/12 and were higher than London and similar boroughs in 2014/15.
- The proportion of those having NHS Health checks who were screened for alcohol has increased from 74% in 2013/14 to 87% in 2015/16 and AUDIT C is now embedded in the programme.
- About 11% of those having a health check have excess alcohol intake (600 people in 2015/16).
- Alcohol related violent Accident & Emergency attendances at Lewisham Hospital appear to be decreasing.
- Front line workers continue to be trained in Brief Interventions, including relating to Alcohol.
- Performance by the specialist provider has improved in terms of numbers reached for alcohol interventions, however these are still far below the numbers of people estimated to be alcohol dependent in Lewisham (3,650). Current performance represents only about 5% in treatment.

Health and Wellbeing Board Performance Metrics

Indicator	Latest period of availability	Lewisham	London	England	England benchmark	Direction from previous period
Alcohol related admissions (ASR per 100,000 population)	2014-15	644	526	641	similar	↑
Number of practitioners attending Brief Intervention Training	2015-16	110	-	-	-	-

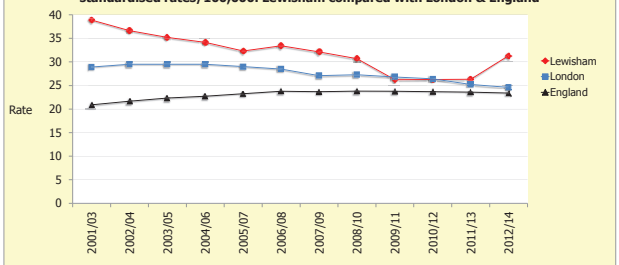
Trends/Benchmarks

Chart 1: Mortality from liver disease in females under 75. Directly age-standardised rates/100,000. Lewisham compared with London & England



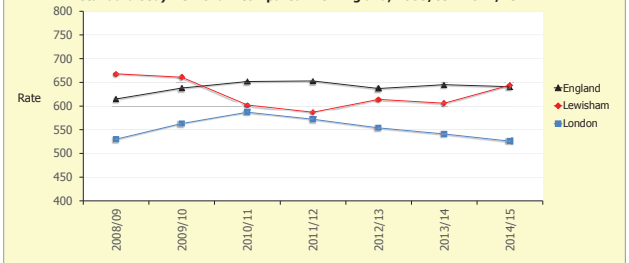
Source: Public Health Outcomes Framework, Public Health England

Chart 2: Mortality from liver disease in males under 75. Directly age-standardised rates/100,000. Lewisham compared with London & England



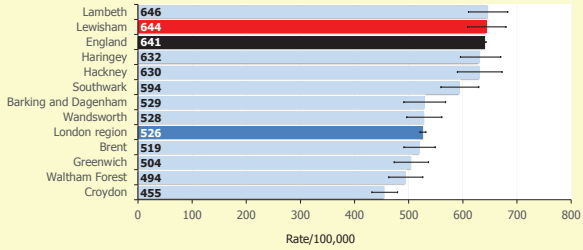
Source: Public Health Outcomes Framework, Public Health England

Chart 3: Rate of Alcohol Related Hospital Admissions per 100,000 (age-standardised). Lewisham compared with England, 2008/09 - 2014/15



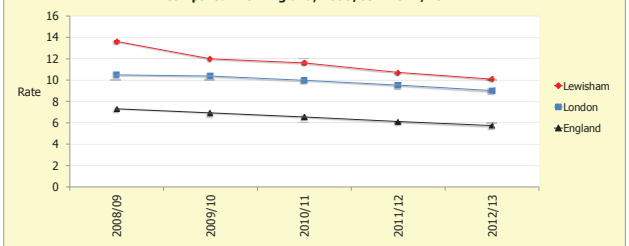
Source: Public Health Outcomes Framework, Public Health England

Chart 4: Rate of Alcohol Related Hospital Admissions per 100,000 (age-standardised). Lewisham compared with its similar CCGs, London and England, 2014/15



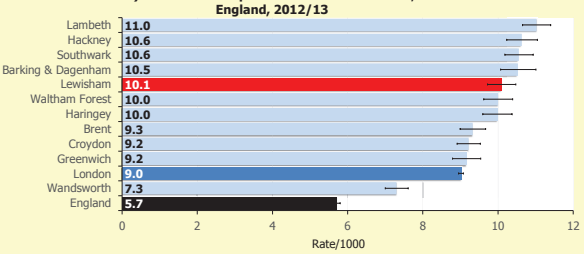
Source: Public Health Outcomes Framework, Public Health England

Chart 5: Rate of Alcohol Related Recorded Crimes per 1000. Lewisham compared with England, 2008/09 - 2012/13



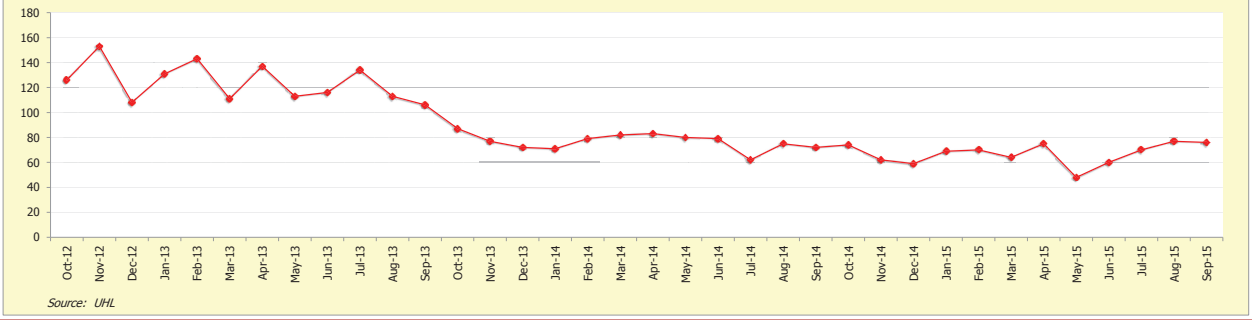
Source: http://www.lape.org.uk/

Chart 6: Rate of Alcohol Related Recorded Crimes per 1000 (age-standardised). Lewisham compared with its similar CCGs, London and England, 2012/13



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

Chart 7: Number of Alcohol and Violence A&E Attendances



Source: UHL

Activity Performance

Alcohol related admissions to hospital. Age-standardised rates per 100,000 population	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Lewisham	668	661	602	587	614	606	644
number				1351	1430	1434	1516
increase from previous year					79 (6%)	23 (2%)	82 (5%)
London	530	563	587	572	554	541	526
England	615	638	652	653	637	645	641

Identification and Brief Advice (IBA)	2013/14	2014/15	2015/16
Number of front line workers trained in IBA	195	245	110

NHS Health Checks	2013/14	2014/15	2015/16
Number of patients who have received NHS Health Checks who have been screened for alcohol (AUDIT C)	(71%) 5216	(86%) 5236	(89%) 4793
Number of patients identified with excess alcohol intake	(12.5%) 655	(11.5%) 696	(10.1%) 545

Public Health Outcomes: Reduce Alcohol Harm

Specialist Treatment Service

Adults: Diagnostic Outcomes Monitoring Executive Summary (DOMES)

1. Successful completions as a proportion of all in treatment

Baseline period: April 2014 - Mar 2015		Previous Period:		Latest Period: April 2015 to Mar 2016		National average
(%)	(n)	(%)	(n)	(%)	(n)	
43.6%	125/287	**31.3%**	100/319	**32.7%**	111/339	**39.2%**

2. Proportion who successfully completed treatment in the first 6 months of the latest 12 month period and re-presented within 6 months

Baseline period: Completions: April 2014 - Sep 2014 Re-presentations: up to March 2015		Previous Period: Jan 2015 to Jun 2015 Re-presentations: up to Dec 2015		Latest Period: Apr 2015 to Sep 2015 Re-presentations: up to Mar 2016		National average
(%)	(n)	(%)	(n)	(%)	(n)	
11.8%	9/76	**15.5%**	9/58	**11.4%**	5/44	**9.3%**

3. Abstinence and reliably improved rates at 6 months review in the last 12 months

Abstinence rates				Expected range for Lewisham clients	Reliably improved
Previous period: Oct 2015 to Dec 2015		Latest period: Jan 2016 to Mar 2016			
(%)	(n)	(%)	(n)	(%)	(%)
19.1%	26/136	**17.1%**	27/158	**14.6% - 27.2%**	**18.4%**

4. Percentage of clients waiting over three weeks to start first intervention

Previous Period: Oct 2015 to Dec 2015		Latest period: Jan 2016 to Mar 2016		National average	Number over 6 weeks
(%)	(n)	(%)	(n)	%	(n)
1.0%	1/96	**1.6%**	1/62	**4.2%**	0

5. Proportion of new representations who had an early unplanned exit (before 12 weeks)

Previous Period: Oct 2014 to Sept 2015		Latest period: Jan 2015 to Dec 2015		National average
(%)	(n)	(%)	(n)	%
21.3%	44/207	**20.8%**	46/221	**14.5%**

6. Proportion in treatment who live with children under the age of 18

Previous period: Jan 2015 to Dec 2015		Latest period: Apr 2015 to Mar 2016		National average
(%)	(n)	(%)	(n)	%
21.3%	61/286	**18.9%**	64/339	**24.7%**

7. Proportion of new presentations to treatment who live with children under the age of 18

Previous period: Jan 2015 to Dec 2015		Latest period: Apr 2015 to Mar 2016		National average
(%)	(n)	(%)	(n)	%
23.4%	51/218	**20.5%**	52/254	**23.9%**

Young people: YP Specialist Substance Misuse Interventions

Number in specialist services	2014-15	2015-16	National
No. of young people under 18 in specialist services in the community	85	99	14133
No. of young adults, 18-24, in 'young people only'specialist services in the community	79	104	2934
No. of young people under 18 in specialist services within the secure estate	10	10	1314

	2015-16		
Referral sources	Local	Local%	England
Youth justice (incl the Secure Estate)	41/102	40%	27%
Education Services	14/102	14%	26%
Self, family and friends	25/102	25%	12%
Children and family services	13/102	13%	19%
Other substance misuse services	1/102	1%	3%
Health and mental health services (excl A&E)	5/102	5%	7%
A&E	1/102	1%	1%
Other	2/102	2%	4%

Achievements

- There has been a continued focus on enforcement regarding the availability and supply of alcohol and a new statement of Licensing Policy has been released.
- Increase in numbers screened for alcohol - All pregnant women are now screened for alcohol.
- The proportion of those having NHS Health checks screened for alcohol has increased and is now embedded in programme.
- Increase in number of front line workers trained to identify alcohol and deliver brief interventions.
- Specialist alcohol services have become increasingly effective at reaching dependent drinkers in A & E and as hospital inpatients.

Public Health Outcomes: Cancer

Key Messages

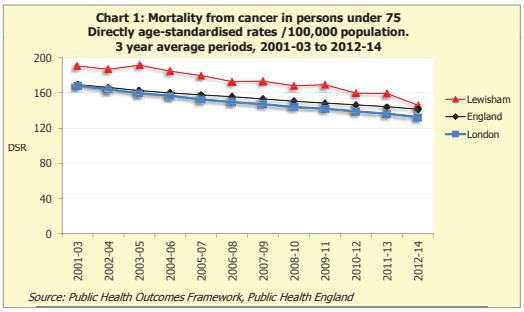
- Over the past ten years premature mortality (under 75) from cancer has decreased in England, London and Lewisham. However premature mortality from cancer in Lewisham remains significantly higher than London (Charts 1 and 2). The latest data indicates that the gap between Lewisham and the other areas is closing.
- In 2015/16, cancer was the main cause of death in Lewisham (Chart 3), accounting for 28% of all deaths.
- Breast and Lung cancer survival has seen a slight upwards trend, however the picture is more mixed for Colorectal cancer.
- The proportion of cancer diagnosed at an early stage (1-2) in Lewisham is not significantly different from neighbouring boroughs or England (Chart 8).
- The rate of two week wait referrals per 100,000 population (Chart 9) has increased since the previous period and is above all comparator boroughs.
- Breast screening coverage in Lewisham does not meet the national target of 70% and has remained at approximately 65% for the past 7 years (Charts 10 and 11)
- Cervical screening coverage has fallen compared to the previous year. The Lewisham level is significantly above London but significantly below England (Charts 12 and 13)
- Uptake of bowel cancer screening in Lewisham is below the national target of 60% (Chart 14) and significantly below the national average.

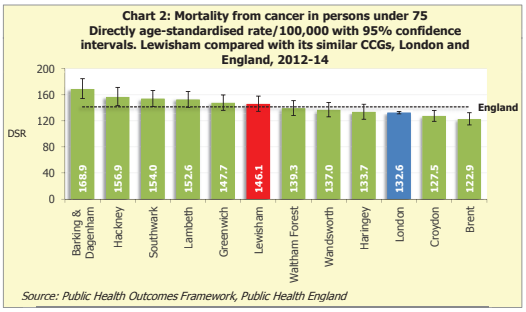
Health and Wellbeing Board Performance Metrics: Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years

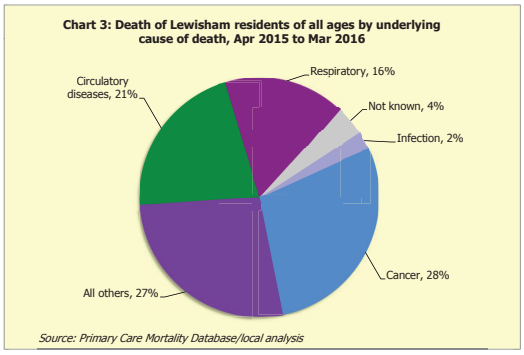
Indicator	Latest period of availability	Previous period (Lewisham)	Latest period (Lewisham)	London	England	England benchmark	Direction of Travel
Breast cancer screening coverage (%)	2015	65.0%	65.7%	68.3%	75.4%	Significantly lower	↑
Cervical cancer screening coverage (%)	2015	73.7%	71.7%	68.4%	73.5%	Significantly lower	↓
Bowel cancer screening coverage (%)*	2015	-	43.3%	47.8%	57.1%	Significantly lower	-
Early diagnosis of cancer (%)	2014	45.6%	47.3%	48.2%	50.7%	Similar	↑
Under 75 mortality from all cancers (DSR)	2012-14	159.2	146.1	132.6	141.5	Similar	↓

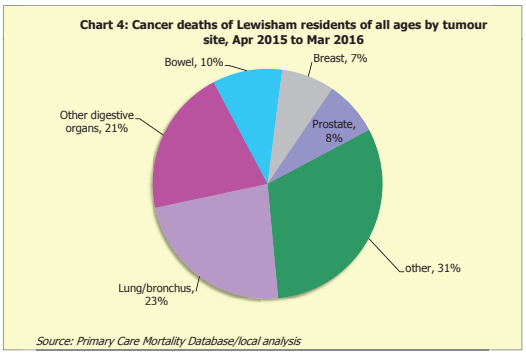
* The latest figure for bowel cancer screening cannot be compared to previous years as it is based on local authority of residence as opposed to PCOs on a registered popultion basis

Mortality: Trends/Benchmarks

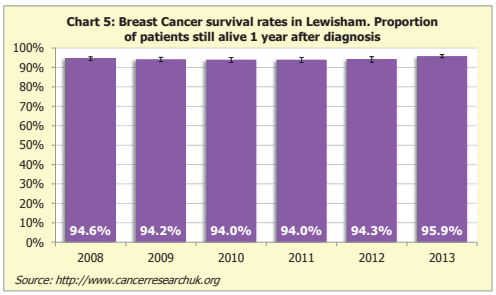


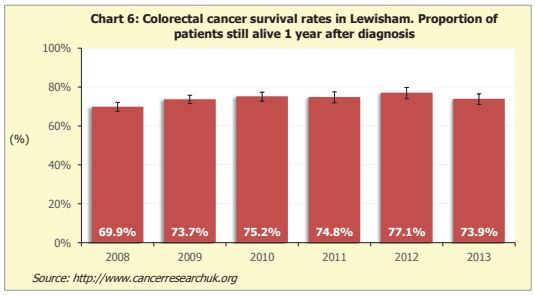


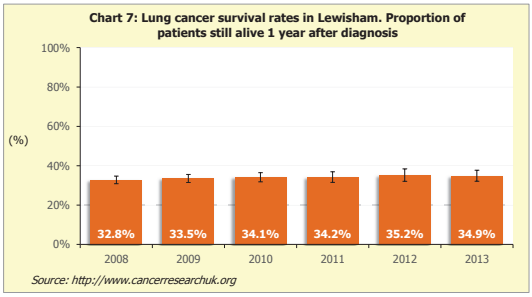




Survival: Trends/Benchmarks

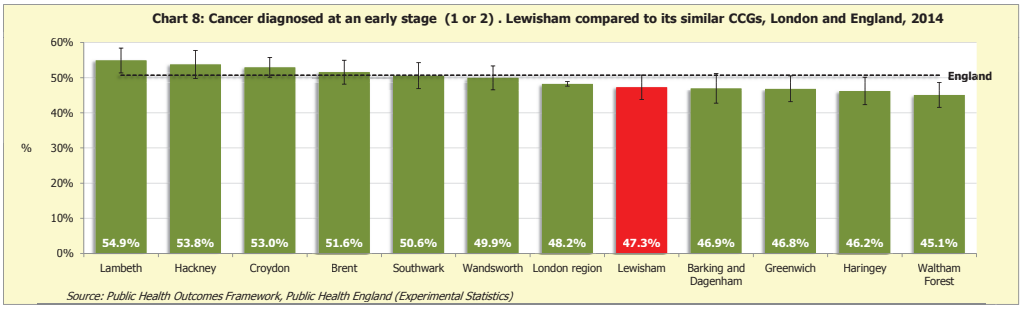




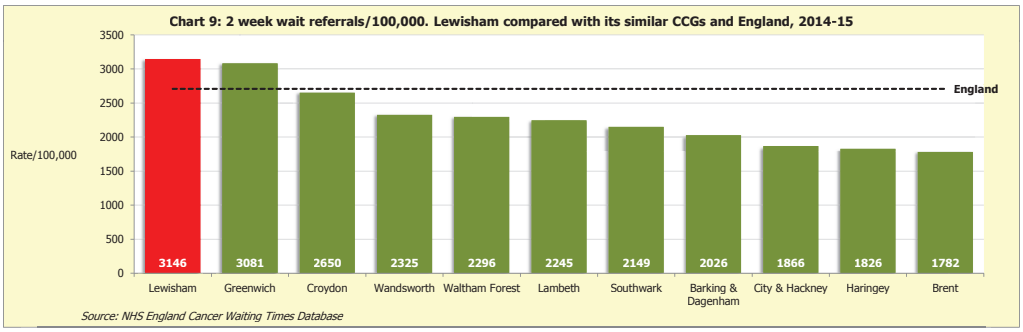


Public Health Outcomes: Cancer

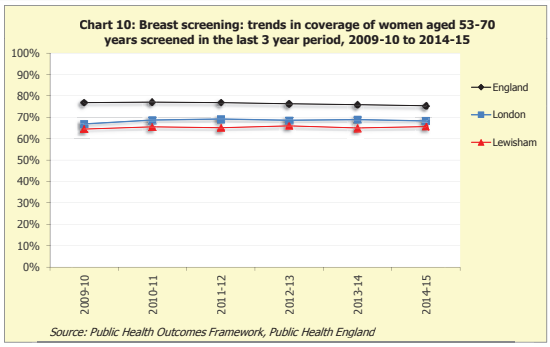
Early Diagnosis: Trends/Benchmarks

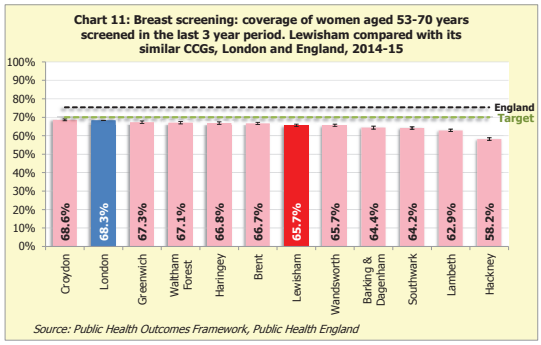


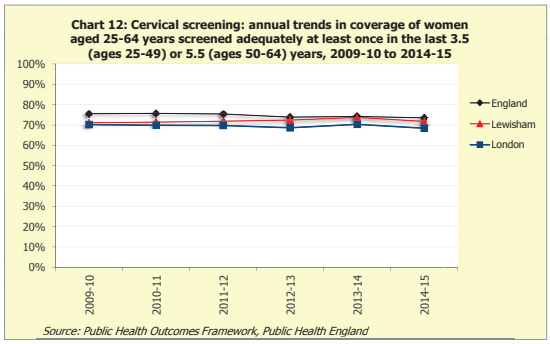
2 Week Waits: Trends/Benchmarks

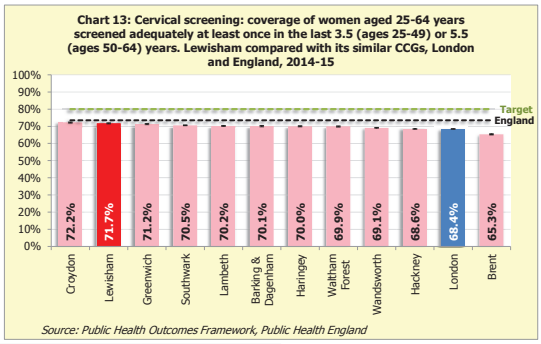


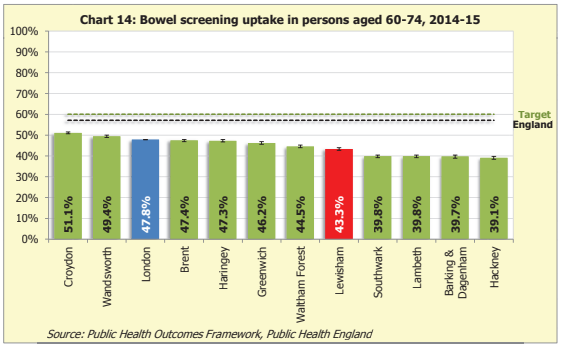
Screening: Trends/Benchmarks











Achievements

- A Health and Wellbeing Strategy Priority has been to increase the number of people who survive colorectal, breast and lung cancer. As part of implementing this, a number of actions have been undertaken including the following:
- Review of Cancer: CCG and Public Health have completed a review of cancer in February 2014. Reducing variation in early detection has been incorporated into the work of the CCG Primary Care Development Strategy Board.
- Cancer awareness raising: Public Health incorporated cancer awareness raising as part the services delivered by the Community Health Improvement Service in Lewisham & Greenwich Trust
- Be Clear on Cancer Campaigns: Public Health England's National Be Clear on Cancer Campaigns that have focussed on Bowel Cancer, Bladder and Kidney Cancer, Lung Cancer, Ovarian Cancer and Breast cancer in older persons have been promoted to Primary care and communities
- Lewisham now has a specific Macmillian Cancer GP who is working closely with the Community Outreach Service
- A Bowel Cancer Screening Post which has been vacant, is being proposed to be adapted to also work across breast, lung and prostate cancer screening.

1. Key Messages - Communicable Diseases

Tuberculosis (TB)

- London has a higher TB rate compared to the rest of the UK. Lewisham has a lower rate compared to the London average at 19.8 cases per 100,000 population (*Jul 15 - Jun 16 rates based on ONS population estimates for 2015*)
- TB incidence has been declining in Lewisham since 2011. This is in line with a downward trend in London and the rest of the country. There has been a slight year on year rise in the proportion of TB cases completing treatment since 2010.
- Lewisham Public Health works closely with PHE and the CCG to monitor incidence locally, and to provide oversight of TB incidents with public health implications.
- In line with key recommendations from the National TB Strategy, there are plans locally to implement a latent TB infection screening in primary care settings across Lewisham in 2016/17. Commissioners and Public Health are working together on this, drawing on funds provided by NHS England.

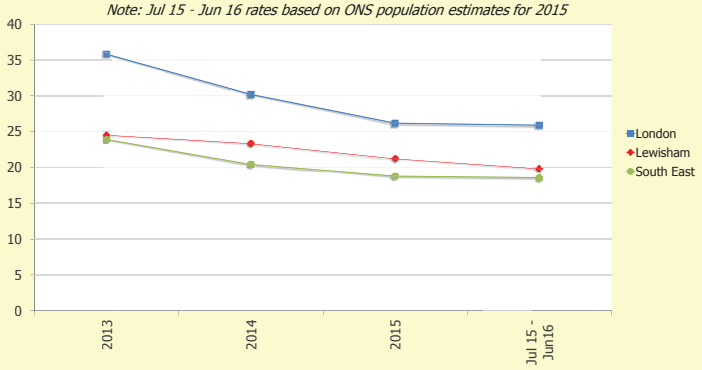
Vaccine Preventable Diseases

- There was an outbreak of measles in London and the South of England. London recorded 60 cases between February and April 2016. There would normally be 10 cases in such a time period. 4 out of 5 cases are in people aged 15 and over. People affected are those who are unimmunised or partially immunised (not had two doses of the MMR vaccine).
- Lewisham has had 5 confirmed cases of measles since February 2016, higher than would normally be expected but lower than the borough of Lambeth which has been badly affected.
- Lewisham Public Health has communicated key messages to Health Visitors and School Nurses. This included the importance of checking the immunisation status of children when opportunities arise, and of referring those who are either unimmunised or have incomplete records to see thier GP. Public awareness was also raised through the Council's website and publicity channels during the World immunisation Week in April.
- Latest figures show that the numbers of mumps and whooping cough cases in Lewisham are as low as, or lower than neighbouring boroughs in South East London. However, the data presented is for numbers rather than rates (Population data table below).

Trends/Benchmarks - Communicable Diseases

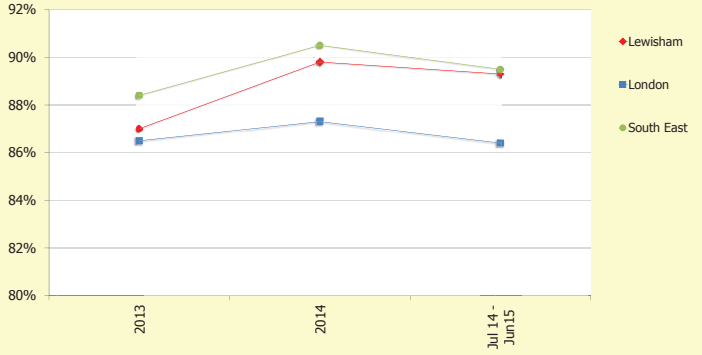
Chart 1: Rate per 100,000 population of new TB notifications. Lewisham compared with London and the South East

Note: Jul 15 - Jun 16 rates based on ONS population estimates for 2015



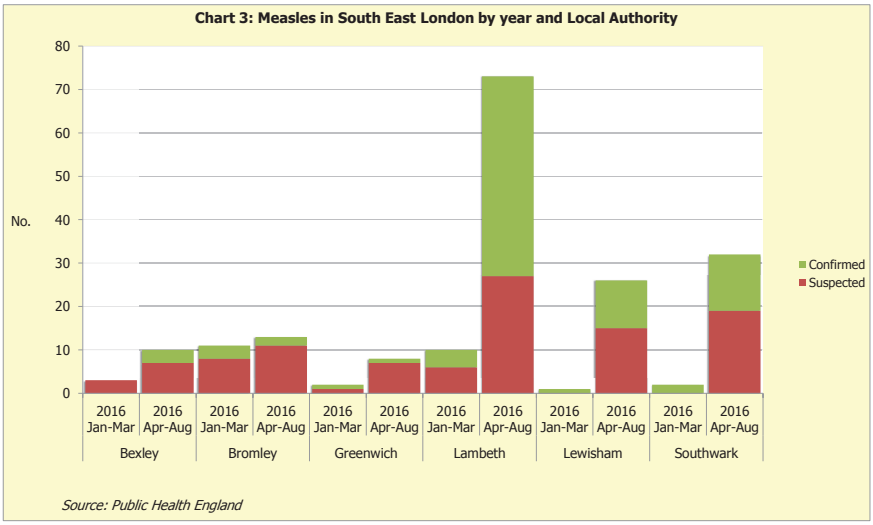
Source: Public Health England/ONS

Chart 2: Proportion of new TB notifications completing treatment within 1 year of notification. Lewisham compared with London and the South East



Source: Public Health England/ONS

Chart 3: Measles in South East London by year and Local Authority



Source: Public Health England

Population Data - Communicable Diseases

Measure	Goal	Most recent data	SE London	Period
Incidence Rate TB/100,000	<30	19.8	18.6	Jul 15 - Jun 16
% TB Cases Rx complete	85.0%	89.3%	89.5%	Jul 14 - Jun 15
Avg No cases/mth of measles	0.0	0.6	6	2015
Avg No cases/mth of mumps	0.0	1.7	12	2015
No cases of pertussis	0.0	1.4	15.4	2015

Key Messages - Healthcare Acquired Infection

Antimicrobial Stewardship

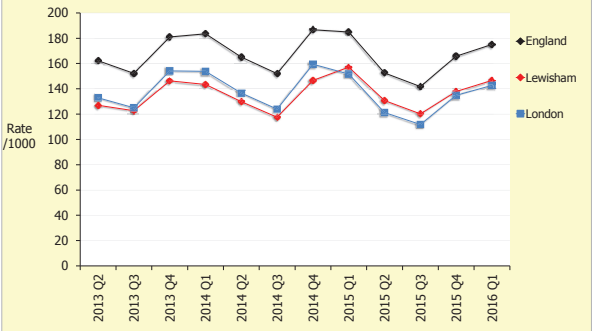
- Primary care antibiotic prescribing guidelines have been reviewed by a multidisciplinary team across a number of CCGs and Trust, including Lewisham and Greenwich Trust, and Lewisham CCG.
- Lewisham CCG's Prescribing Incentive Quality Scheme indicators will again reflect NHS England's Quality Premium initiatives.
- Antibiotic prescribing is broken down by GP practice in the graphs below. Despite progress made in 2012/13, the volume of broad spectrum antibiotics prescribed remains greater than average compared to other CCGs, with wide variance across Lewisham practices.

MRSA and Clostridium difficile

- Despite a zero tolerance policy for cases of MRSA bacteraemia in place for all healthcare organisations, Lewisham recorded five cases in the year 2015/16. 41 cases of C. diff were recorded in that year which exceeds the target of 33 cases set by the Department of Health for Lewisham.
- Lewisham Public Health works closely with stakeholders (including the local acute trust, the CCG, and Gp practices) to prevent Healthcare Aquired Infections.
- Public Health and the CCG are currently reviewing their infection control arrangements. The aim is to improve infection control practices within primary care, and to establish an improved delivery function for Post-Infection Reviews and Root Cause Analyses within the CCG.
- Lewisham Public Health will continue to have oversight of the work, which will enable the DPH to retain assurance responsibilities for Post Infection Reviews and Root Cause Analysis.

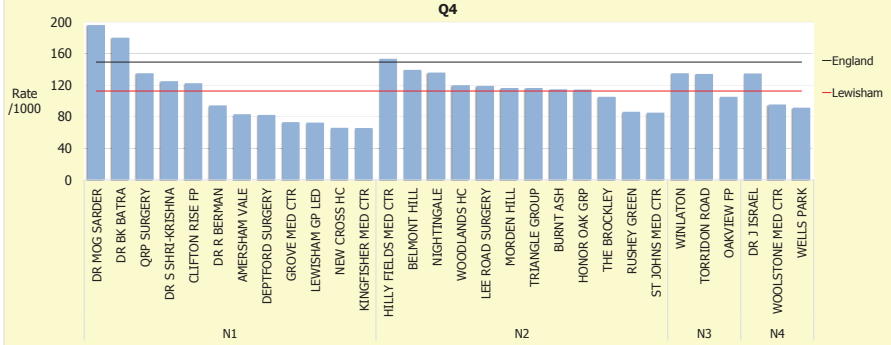
Antimicrobial Stewardship - Healthcare Acquired Infection

Chart 4: Antibiotics: total number prescribed/1000 persons. Lewisham CCG compared with London and England.



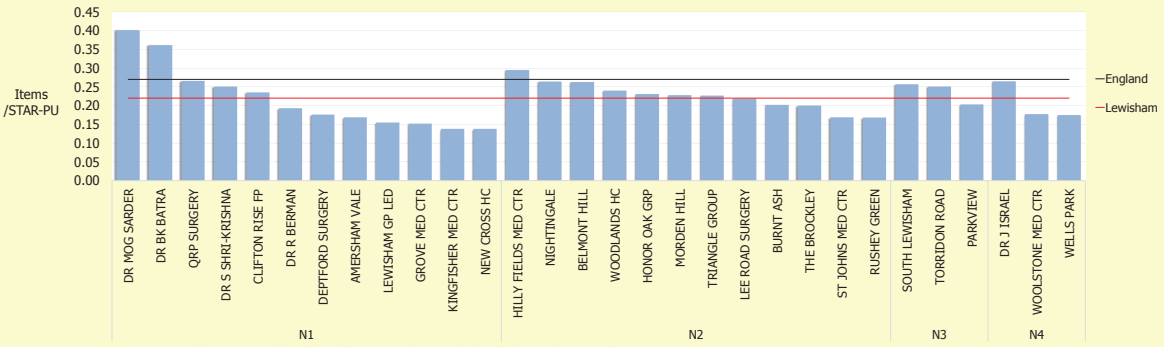
Source: Public Health England (http://fingertips.phe.org.uk/profile/amr-local-indicators/

Chart 5: Total number of prescribed antibiotic items per 1000 registered patients in Lewisham, 2015 Q4



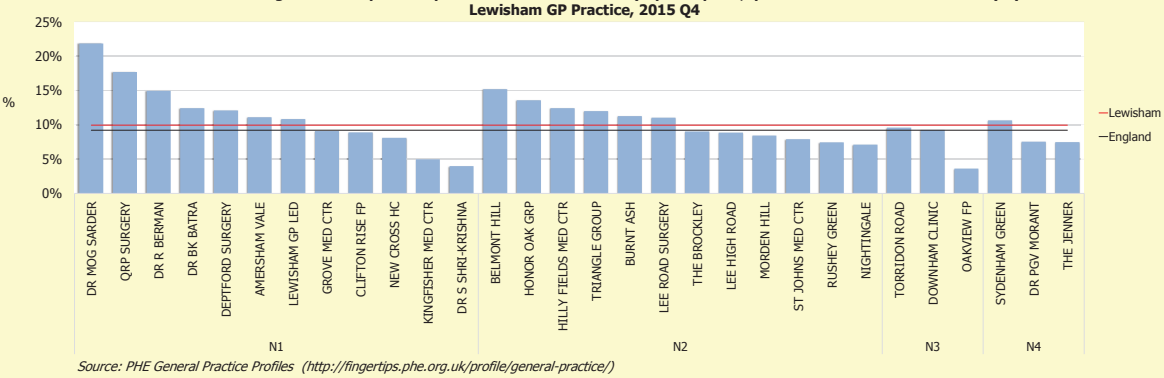
Source: PHE General Practice Profiles (http://fingertips.phe.org.uk/profile/general-practice/)

Chart 6: Total number of prescribed antibiotic items per STAR-PU by Lewisham GP Practice, 2015 Q4



Source: PHE General Practice Profiles (http://fingertips.phe.org.uk/profile/general-practice/)

Chart 7: Percentage of broad spectrum prescribed antibiotic items (cephalosporin, quinolone and co-amoxiclav class) by Lewisham GP Practice, 2015 Q4



Source: PHE General Practice Profiles (http://fingertips.phe.org.uk/profile/general-practice/)

Trends/Benchmarks - Healthcare Acquired Infection

Number of Clostridium Difficile & MRSA healthcare acquired infections for Lewisham CCG

Period 2007/08 to 2015/16

Source HCAI Data Capture System/PHE

Healthcare Acquired Infection		2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Clostridium Difficile	Observed	16	59	77	62	34	39	52	41
	Target								33
MRSA	Observed	<5	10	7	6	<5	<5	6	5
	Target								0

Achievements

- Latent TB infection screening pilot has now gone live in Lewisham
- C. Diff infections are on the decline

Public Health Outcomes: Increase Uptake of Immunisation

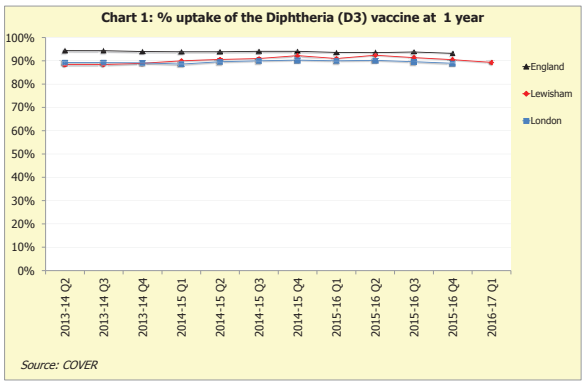
Key Messages

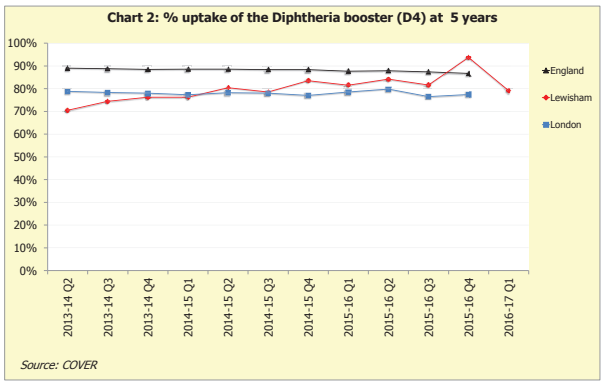
- Increasing the uptake of immunisation is one of the priorities of the Be Healthy element of the Children and Young People's Plan and has been identified as one of its priorities by the Lewisham Health and Wellbeing Board.
- Uptake of all four key childhood immunisations has improved. This is most marked for the substantial increase in Measles, Mumps and Rubella 2 at five years 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.
- The latest data for HPV vaccine uptake shows a decline on the previous year. Public Health and school nursing are developing an action plan for the 2016/17 academic year to address the fall in HPV vaccine coverage and the challenge of protecting teenagers against a range of meningococcal diseases. This decline in uptake 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.
- Uptake of flu vaccine in 2014/2015 was considerably better than in previous years. At the end January our uptake showed improvements for all the main groups targeted. This means that we were the most improved borough in London and safely put us in the top ten performers in the Capital. Lewisham's performance improved most in relation to the uptake of flu vaccine in pregnant women in Lewisham: we ranked fourth in London and achieved an increase of 11% over last year's

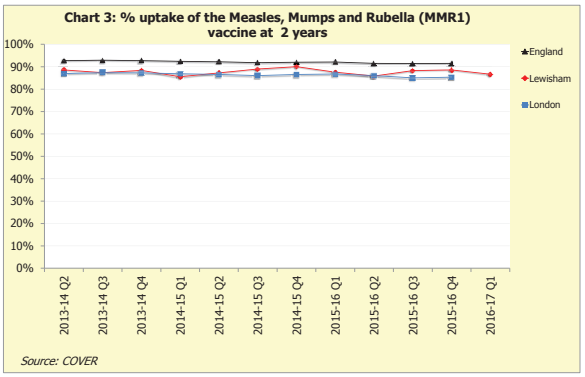
Health and Wellbeing Board Priority: Improving Immunisation Uptake

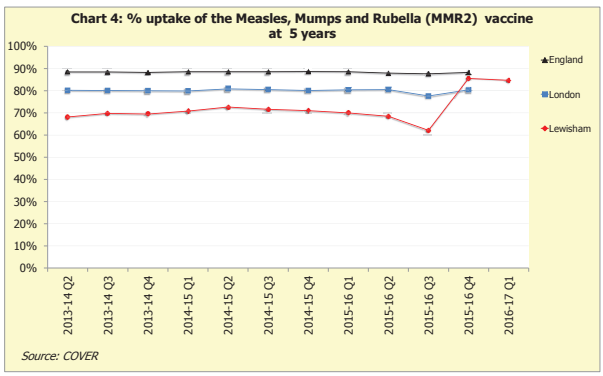
Indicator	Latest period of availability	Previous period of availability	Latest available period	London	England	England Benchmark	Direction of Travel
Uptake of the Measles, Mumps and Rubella Vaccine at five years of age (%)	2015-16	71.5	71.5	79.5	88.0	significantly lower	
HPV Vaccine Uptake (%)	2014-15	82.9	73.4	79.2	-	-	
Uptake of Flu vaccine in persons 65+	2014-15	70.2	71.4	69.2	72.7	similar	

Trends/Benchmarks









Source: COVER Data (please see Notes)

Percentage Uptake of Key Vaccines in Childhood

Vaccine	Target	2015-16 Q2	2015-16 Q3	2015-16 Q4	2016-17 Q1	London (2015-16 Q4)	England (2015-16 Q4)
D3 at 1 year	91.9%	92.4%	91.4%	90.5%	89.3%	88.9%	93.2%
MMR1 at 2 years	90.8%	85.6%	88.2%	88.5%	86.6%	85.3%	91.5%
Hib/Meningitis C booster at 2 years	90.3%	85.4%	87.2%	86.9%	83.1%	85.1%	91.5%
Pneumococcal booster at 2 years	90.8%	85.5%	86.9%	87.8%	85.9%	84.8%	91.3%
D4 at 5 years	91.1%	84.2%	81.6%	93.7%	79.1%	77.4%	86.7%
MMR2 at 5 years	91.1%	68.4%	62.1%	85.5%	84.7%	80.4%	88.2%

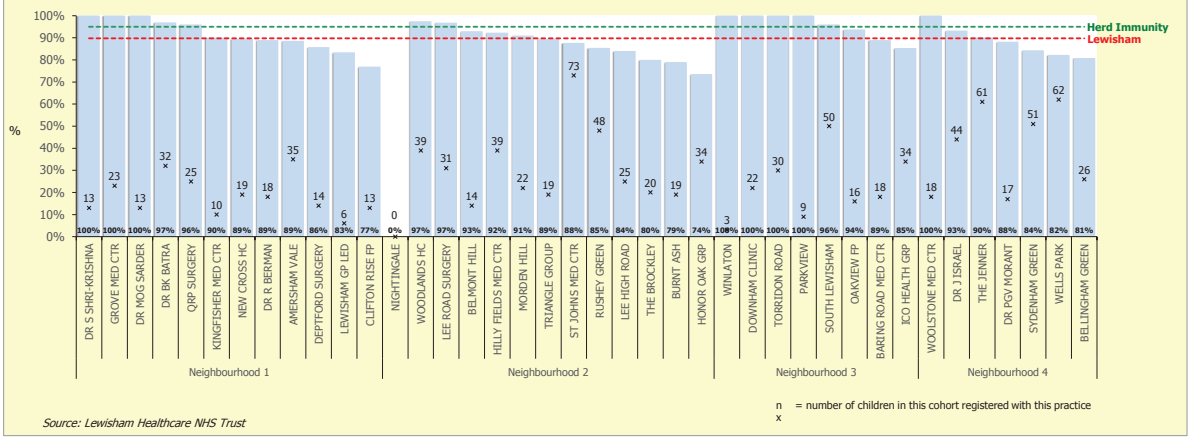
Notes

- London and England data are for the quarter for which thie most recent data is available.
- Uptake of the third dose of Diphtheria vaccine (D3) is an indicator of completion of the primary course of immunisation of children under 12 months that aims to protect children against diphtheria, tetanus, whooping cough, polio, Haemophilus influenzae b and Group C Meningococcus.
- MMR aims to protect children against measles, mumps and rubella. Two doses are required: MMR 1 at 12 months and MMR 2 at any time after three months have elapsed since MMR1, but before five years of age.
- Hib/ MenC and PCV boosters (bstr) are given at 12 months and aim to protect children against Haemophilus influenzae B, Group C Meningococcus and Pneumococcus. These are relatively new to the programme – hence the apparent rapid increase in uptake of these vaccines.
- D4 is the fourth dose of diphtheria vaccine. This is a key component of the preschool booster, which should be given at any time from the age of three years and four months but before the child starts school. The preschool booster completes the protection of children against diphtheria, tetanus, whooping cough and polio.

Public Health Outcomes: Increase Uptake of Immunisation

Supporting Information

Chart 5: % uptake of MMR1 by Neighbourhood for babies born in 2013-14 Q4 (vaccination given Feb 2016). Comparison by GP Practice



Source: Lewisham Healthcare NHS Trust

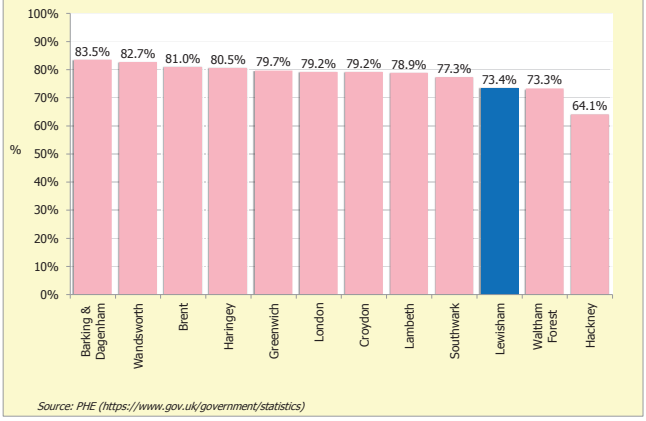
% uptake of MMR1 by Neighbourhood for babies born in 2013-14 Q4 (vaccination given Feb 2016). Comparison by GP Practice				
Neighbourhood 1	Neighbourhood 2	Neighbourhood 3	Neighbourhood 4	Lewisham
92.3%	87.7%	94.5%	87.5%	89.8%

* This illustrates the relative performance of practices in ensuring children receive their first dose of MMR. It is based on the most recent and complete data

Chart 6: Pre-School Booster uptake % by Lewisham GP Practice for children aged 5. Comparison by Lewisham GP Practice, 2015/16 Q4

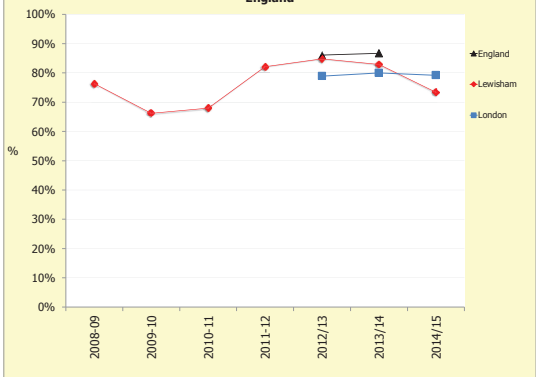
Source: WILMA

Chart 7: Percentage of females aged 12-13 who have received all doses of the HPV vaccine. Lewisham compared with statistical comparators, 2014/15



Source: PHE (https://www.gov.uk/government/statistics)

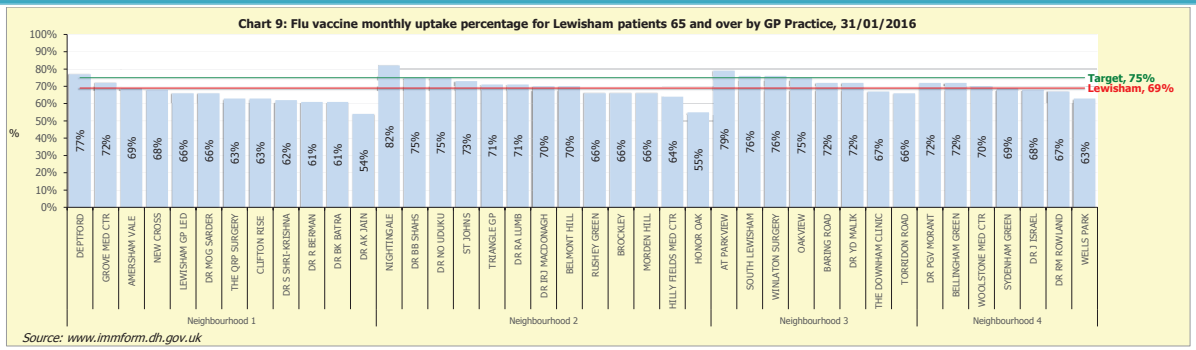
Chart 8: Percentage of females aged 12-13 who have received all doses of the HPV vaccine. Lewisham compared with London and England



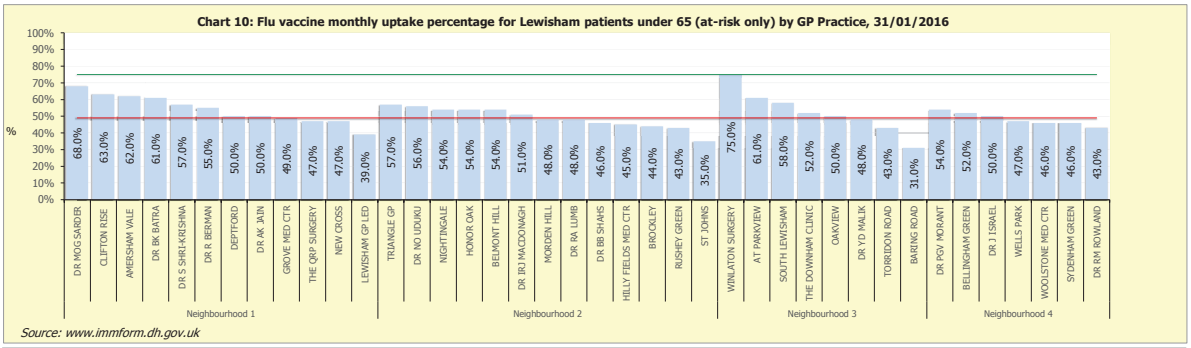
Source: www.phoutcomes.info

Public Health Outcomes: Increase Uptake of Immunisation

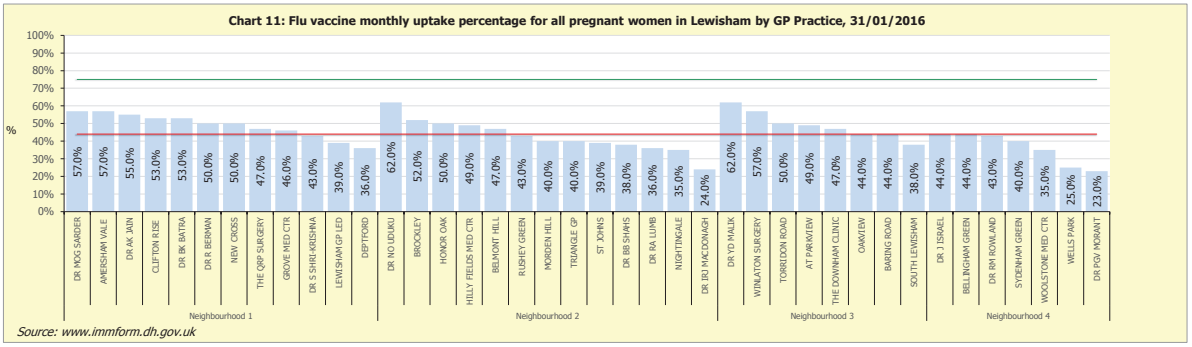
Influenza Vaccination



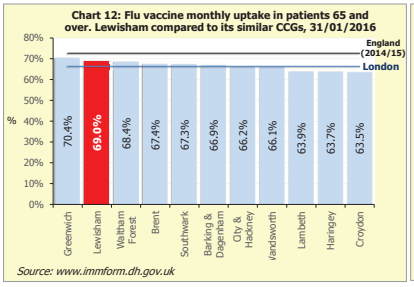
Source: www.immform.dh.gov.uk



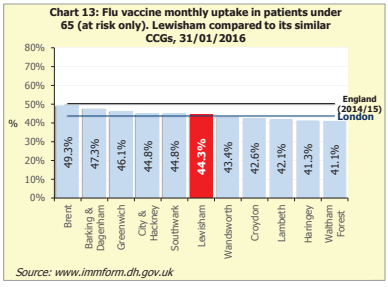
Source: www.immform.dh.gov.uk



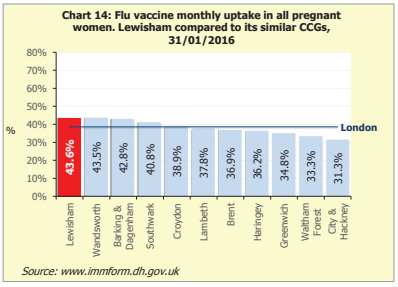
Source: www.immform.dh.gov.uk



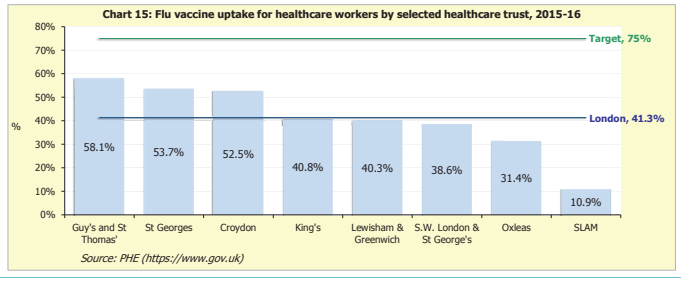
Source: www.immform.dh.gov.uk



Source: www.immform.dh.gov.uk



Source: www.immform.dh.gov.uk



Source: PHE (https://www.gov.uk)

Achievements

- Signifcant improvement in recording of Measles, Mumps and Rubella 2 at age five, resulting in dramtically improved performance in Quarter 4 of 2015/16.
- Flu vaccination has also been an area of notable improvement.

Public Health Outcomes: Maternal & Child Health

Key Messages

Pregnancy

- Early access to maternity care is a national key performance indicator with a national target of 90% (women booked for maternity care by 13 weeks of pregnancy). Lewisham borough rate is 92.7% but UHL is 86.1%. This latter figure is an improvement, likley to be due to the audit carried out which pinpointed system and process improvements.
- Maternal obesity increases the risk of poor pregnancy outcomes and is a risk factor for childhood obesity. The Lewisham proportion for excess weight has increased, however is still below levels seen between 2010 and 2012. This has also been the subject of a CQUIN in 2015-16.

Birth

- The rate of low birthweight in Lewisham has declined significantly over the past eight years and has now stablised to be comparable to London as a whole. Despite this the Lewisham rate of low birthweight is still significantly greater than the country as a whole. Maternal smoking is the single biggest contributor to low birthweight. Also, a significant proportion of low birthweight babies are pre-term. Premature births remain higher in Lewisham than in both England and London. Extreme prematurity is the single most important cause of mortality in childhood in Lewisham.

Antenatal and Newborn Screening

- Assurance systems for the antenatal and newborn screening programme were reviewed in 2015 following discussions with NHSE and PHE. UHL is meeting most screening KPIs with the exception of newborn bloodspot avoidable repeats, referral of Hepatitis B positive women to specialist services and timely testing of partners when women are found to be of sickle cell disease carrier status. However, a verbal report from the Antenatal and Newborn screening co-ordinator suggest a significant improvement in the Hepatitis B KPI indicating that in Q4 2015/16, 100% of women referred were seen by a GastroEnterologist within 6 weeks of results being available. This data is still to be confirmed by PHE.

Mortality

- In the past, perinatal mortality and in particular stillbirth rates, have been significantly higher in Lewisham than in England and London as a whole. Most recent data suggests that local infant and child mortality rates are now similar to the England average. Continued scrutiny of these important indicators of maternal and child health is necessary.

Promoting a Healthy Weight

- Breastfeeding initiation continues to remain consistenly above 85% for the most recent data available but had risen to 79.7% at 6-8 weeks in Quarter 3 of 2015/16. These rates continue to out perform both London and England.
- Actions to increase breastfeeding rates include working towards UNICEF Baby Friendly accreditation in the borough. The community and hospital achieved stage two accreditation in 2014 and are jointly working towards achieving stage 3 by Autumn 2016. Children's centres are supporting the assessment by working closely with health visitors and maternity services in supporting mothers to breastfeed.
- Childhood obesity: Rates remain significantly higher than the England rate and for 2014/15 Lewisham falls within the top quintile (highest) of Local Authority obesity prevalence rates for Reception and Year 6. As in previous years the proportion of obese children in Year 6 was more than double that of Reception year children, similar to the national results. Actions to address this problem include building the local capabilities of the workforce though training on a variety of topics to promote healthy weight, provision of targeted and specialist weight management services accessible in community venues and the development of a 'Health in Lewisham' webpage on the council website to provide information and advice to support families achieve a healthy lifestyle.

Injury

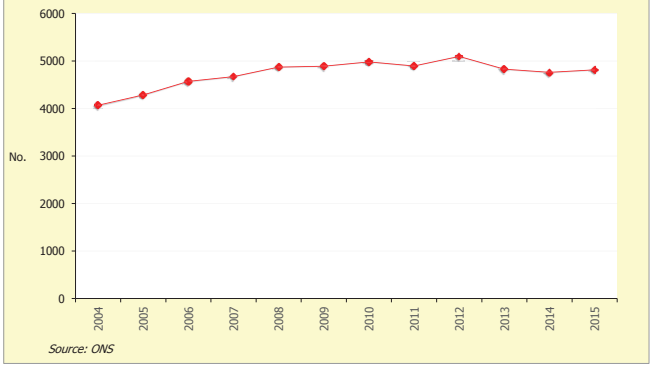
Locally, the rate of admission of children to hospital due to injury of any kind has increased over recent years and rose again in 2014/15. This rise is counter to the nation decline in such admissions. The numbers of deaths and serious injuries of Lewisham children on the roads, on the other hand, has declined in recent years and is now directly comparable to rates in London and in England as a whole. The rise in admissions, therefore requires further investigation.

Health and Wellbeing Board Performance Metrics

Indicator	Latest period of Availability	Previous Period of Availability	Lewisham	London	England	England Benchmark	Direction of Travel
Low Birth Weight of all babies (%)	2014	7.8%	7.8%	7.7%	7.4%	similar	→
Excess Weight in Reception (%)	2014-15	24.6%	23.7%	22.2%	21.9%	sig high	↓
Excess Weight in Year 6 (%)	2014-15	39.3%	38.9%	37.2%	33.2%	sig high	↓
Maternal Excess Weight (%)	2015-16	42.0%	45.8%	-	-	-	↑
Breastfeeding Prevalance 6-8 weeks (%)	2015-16	73.9%	76.3%	-	43.8%	sig high	↑
Smoking Status at Time of Delivery (%)	2015-16	4.9%	4.6%	4.8%	11.4%	sig lower	↓

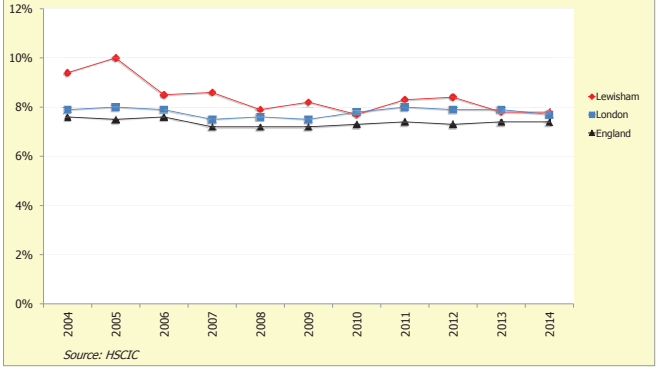
Trends/Benchmarks

Chart 1: Live births in Lewisham



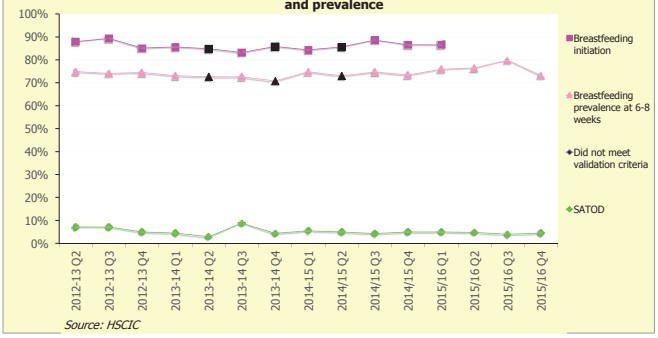
Source: ONS

Chart 2: Low birthweight births in Lewisham



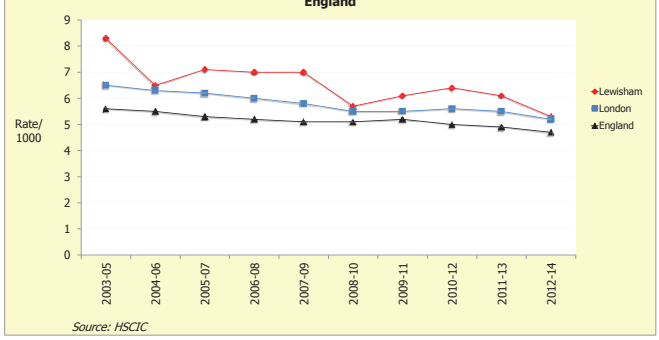
Source: HSCIC

Chart 3: Smoking status at time of delivery (SATOD) & breastfeeding initiation and prevalence



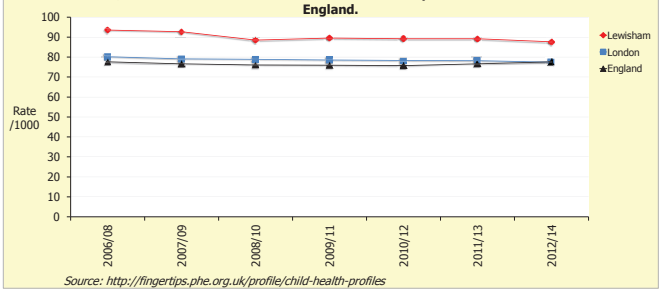
Source: HSCIC

Chart 4: Stillbirth rate/1000 total births. Lewisham compared with London and England



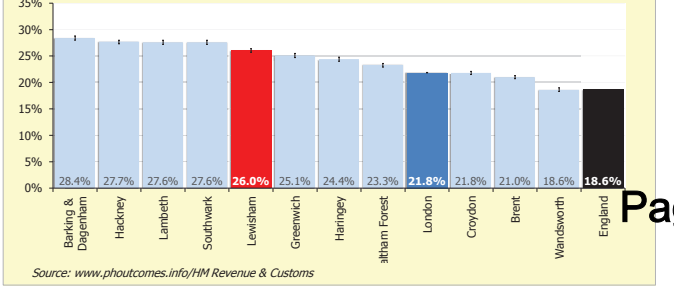
Source: HSCIC

Chart 5: Premature (gestational age < 37 weeks) live birth and still birth rate/1000 live births and stillbirths. Lewisham compared with London and England.



Source: http://fingertips.phe.org.uk/profile/child-health-profiles

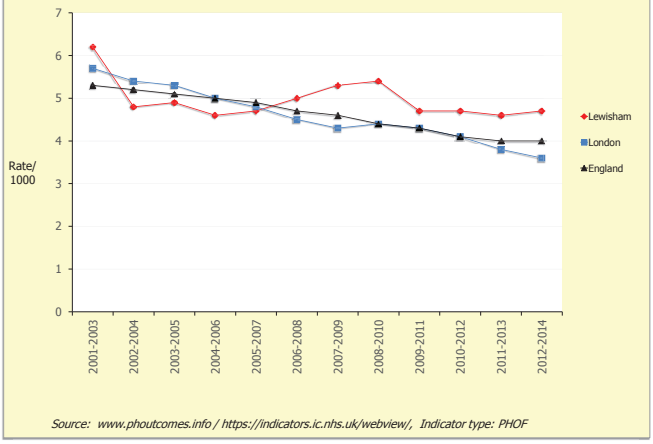
Chart 6: % of children under 16 in poverty, 2013



Source: www.phoutcomes.info/HM Revenue & Customs

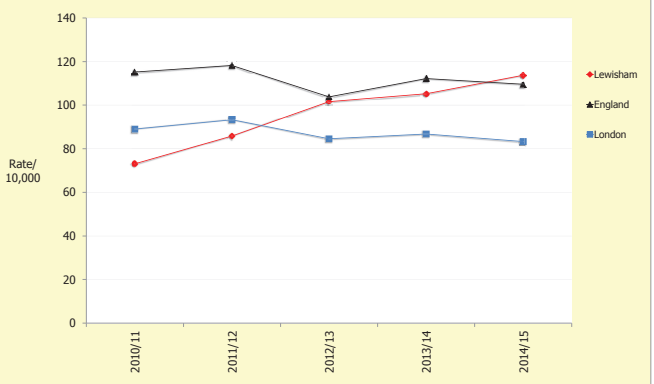
Public Health Outcomes: Maternal & Child Health

Chart 7: Infant mortality rate /1000. Lewisham compared with London and England



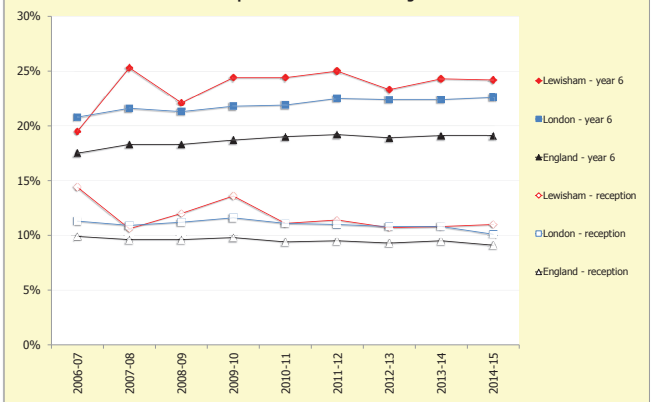
Source: www.phoutcomes.info / https://indicators.ic.nhs.uk/webview/, Indicator type: PHOF

Chart 8: Hospital admissions caused by unintentional and deliberate injuries in children (ICD 10: S00-T79 and/or V01-Y36) aged 0-14 years. Rate/10,000



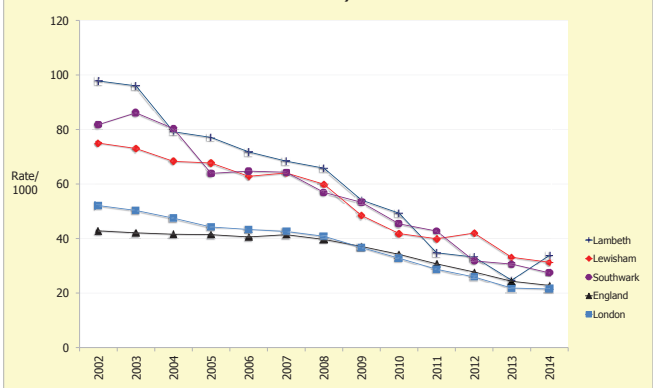
Source: www.phoutcomes.info, Indicator type: PHOF

Chart 9: % of children in reception and year 6 who are obese. Lewisham compared with London and England



Source: http://www.hscic.gov.uk/ncmp

Chart 10: Under 18 conception rate: annual trends (rate/1000 females aged 15-17)



Source: *http://www.ons.gov.uk*

Population Data

Measure	Goal	Lewisham	London	England	Period	Comment
Number of Births (all births)		4843	130,261	667,351	2015	
Premature (gestational age < 37 weeks) live birth rate/1000 live births and stillbirths		87.7	77.5	77.60	2012-14	
Bookings>12+6	90%	92.7%	96.2%	102.1%	2014/15 Q3	
Stillbirth Rate/1000	5.5	5.3	5.2	4.7	2012-14	
Neonatal Mortality Rate/1000	3.0	3.1	2.5	2.8	2012-14	
Infant Mortality Rate/1000	4.5	4.7	3.6	4.0	2012-14	
Low birth-weight births	7.2%	7.8%	7.7%	7.4%	2014	
Maternal Smoking Status At Time Of Delivery	5.4%	4.5%	4.9%	10.6%	2015/16	
Breastfeeding Initiation	89.3%	86.5%	85.5%	73.8%	2015/16 Q1	
Breastfeeding Prevalence at 6-8 weeks	77%	73.2%	* 47.6%	43.7%	2015/16 Q4	* indicates data did not meet validation criteria
NBBS Coverage by 17/7 (NB1)	95%	97.8%	97.4%	96.2%	2015/16 Q4	
NBBS-coverage (NB4) - data to follow					2015/16 Q3	
Hospital admissions caused by unintentional and deliberate injuries in children aged 0-14 years. Rate/10,000		113.7	83.3	109.6	2014/15	
Uptake of healthy start vitamin D - Children registered	5%	1172			2015/16 Q4	Uptake is 20% for the whole year
Uptake of healthy start vitamin D - Mothers registered	2%	1080			2015/16 Q4	Uptake is 8% for the whole year
Childhood obesity - Reception	12.2%	11.0%	10.1%	9.1%	2014/15	N=398
Childhood obesity - Year 6	24.0%	24.2%	22.6%	19.1%	2014/15	N=691
Childhood admissions from dental decay						
Hospital admissions for asthma (under 19 years). Rate/100,000		263.4		216.1	2014/15	
Childhood poverty <16 years		26.0%	21.8%	18.6%	2013	
Child mortality 1-17 years DSR/100,000		10.6	12.0	12.0	2012/14	

*** Data did not meet validation criteria**

Public Health Outcomes: Maternal & Child Health

Lewisham Healthcare (Trust) Data

Measure		Goal	Most recent data	Period	Red flag? (Y/N)	Previous Data	Period	Comment
Activity								
Number of births per month (maternities)		350	339	Mar/2016	Y	347	Mar/2015	
% Bookings > 12+6		90%	86.1%	Mar/2016	Y	83.4%	Mar/2015	
Preterm births	< 37 weeks		12%	2013/14				
	< 32 weeks		3%	2013/14				
Total C/S rate (planned and unscheduled)		<24%	27.7%	Mar/2016	N	28.2%	Mar/2015	
Stillbirths >= 24 weeks (number)		0	1	Mar/2016	N	1	Mar/2015	
Public Health Indicators								
Smoking status at time of delivery		5%	3.8%	Mar/2016	N	4.3%	Mar/2015	
Breastfeeding initiation		95%	86.4%	Mar/2016	N	86.5%	Mar/2015	
Overweight mothers			27.5%	2015-16		24.9%	2014-15	
Obese mothers			16.1%	2015-16		15.1%	2014-15	
Morbidly obese mothers			2.2%	2015-16		2.0%	2014-15	
Screening								
Antenatal HIV testing coverage (ID1)		90%	99.9%	2015/16 Q4	N	99.8%	2015/16 Q3	
Antenatal Hep B Referral in 6/52		70%	85.7%	2015/16 Q3	N			
Down's Syndrome Form Complete (FA1)		97%	99.3%	2015/16 Q4	N	99.3%	2015/16 Q3	
Antenatal (AN) Sickle cell and Thalassaemia (SCT) coverage (ST1)		95%	99.9%	2015/16 Q4	N	100.0%	2015/16 Q3	
Avoidable Repeat NB Blood Spot (NB2)		2%	2.7%	2015/16 Q4	Y	1.4%	2015/16 Q3	

Achievements

- Breastfeeding rates remain significantly higher than England.
- Smoking status at time of delivery has fallen again and continues to be lower than London and signicantly below England.
- A research study, supported by Public Health and South London CLAHRC is due to start this year at Lewisham University Hospital to look at the impact of providing a continuity of carer model of care on pre-term birth rates in women with risk factors. Pauline Cross, Public Health Consultant Midwife is on the steering group for this research and has also run a series of service-user events for parents of pre-term babies to ensure the whole pathway for this group is improved.
- Pauline Cross and Gwenda Scott, Public Health Strategist wrote an obesity CQUIN for LGT in 2015/16 in collaboration with CCG colleagues, which has resulted in the introduction of a new pathway for pregnant women with excess weight. They have also supported LGT in designing an evaluation process to measure the outcomes of this pathway and service-user satisfaction.

Public Health Outcomes: Mental Health

Adult Mental Health

Key Messages

- There are higher rates of mental illness in Lewisham compared to London and England as a whole, although they are similar to those of our neighbouring boroughs. As a result there are high levels of service usage and spending on mental health in the borough.
- The adult community mental health teams were reorganised into a new structure which aims to support recovery, prevent relapse and crisis and enable service users where appropriate to step down from specialist mental health care to primary care.

Health and Wellbeing Board Performance Metrics - Improving Mental Health and Wellbeing

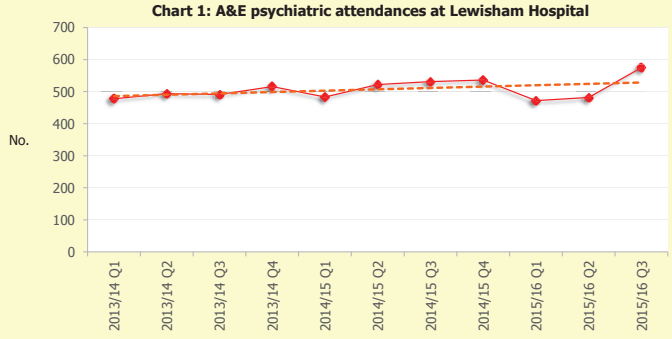
Indicator	Latest period of availability	Lewisham	London	England	England Benchmark	Direction of Travel
Prevalence of serious mental illness (%)	2014-15	1.28	1.07	0.88	sig high	↑
Prevalence of Depression (%)	2014-15	6.40	5.33	7.30	sig lower	↑
Improving Access to Physiological Therapies referrals entering treatment (%)	2014-15	6.9	-	-	-	-
Proportion of those accessing IAPT who moved to recovery (%)	2014-15	35.0	-	-	-	-

Activity Performance

The number of A&E Psychiatric attendances has increased in Quarter 3 of 2015/16. (Chart 1) We are awaiting data for Quarter 4.
There is also a general upwards trend for the number of patients detained under the Mental Health Act, which is broadly witnessed in Lambeth and Southwark (Chart 2).
The 3 year average (2012-14) directly age-standardised rate for suicide per 100,000 population was 7.6, compared to 7.8 in London and 10.0 in England. (Chart 6)
New three year rolling averages have been released by ONS on Wellbeing, Lewisham residents are more likely to have a high anxiety score than both London and England. (Chart 4)
Lewisham has consistently had a higher rate of people on a Care Programme Approach (CPA), compared to Lambeth and Southwark. (Chart 5)

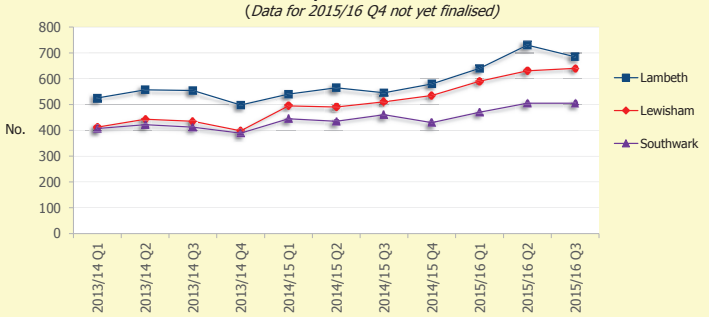
Trends/Benchmarks

Chart 1: A&E psychiatric attendances at Lewisham Hospital



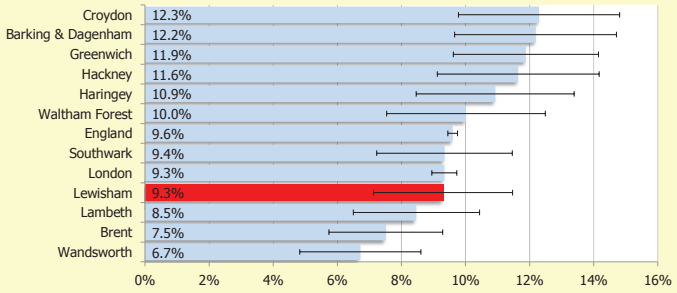
Source: South London & Mausley NHS Trust (SLAM)

Chart 2: Number of Lewisham patients detained under the Mental Health Act
(Data for 2015/16 Q4 not yet finalised)



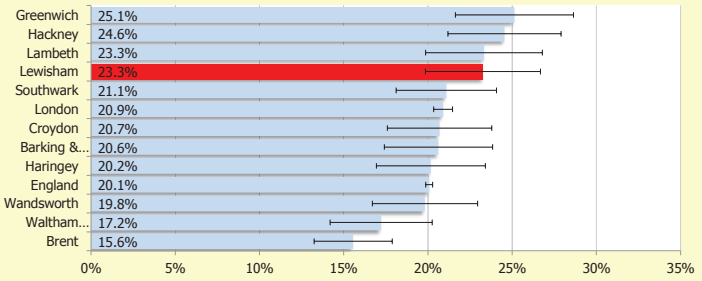
Source: MHLDS (http://www.hscic.gov.uk/mhldsreports)

Chart 3: Self-reported well-being: people with a low happiness score. Lewisham compared with its similar CCGs, London and England, 2012/15



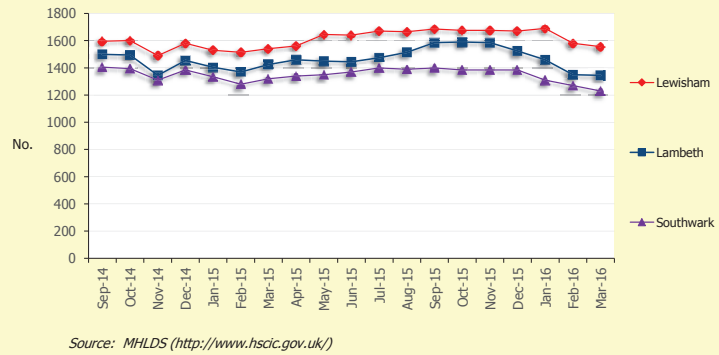
Source: www.ons.gov.uk/

Chart 4: Self-reported well-being: people with a high anxiety score. Lewisham compared with its similar CCGs, London and England, 2012/15



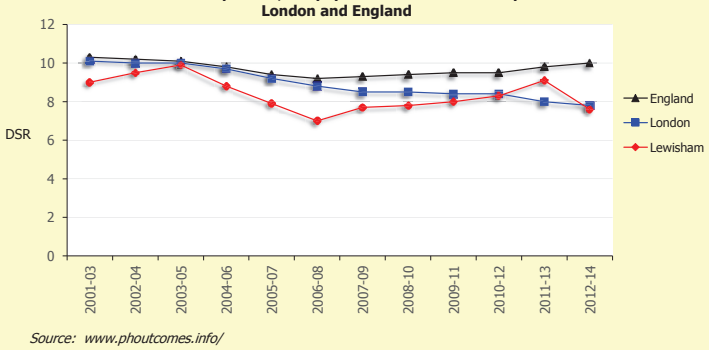
Source: www.ons.gov.uk/

Chart 5: Number of Lewisham patients on Care Programme Approach (CPA)



Source: MHLDS (http://www.hscic.gov.uk/)

Chart 6: Mortality from suicide for persons of all ages. Directly age-standardised rates per 100,000 population. Lewisham compared with London and England



Source: www.phoutcomes.info/

Commentary

Suicide rates have seen the first rolling three year average decrease since 2006-08. The actual numbers of deaths remain small but the Lewisham figure is not significantly lower than England.

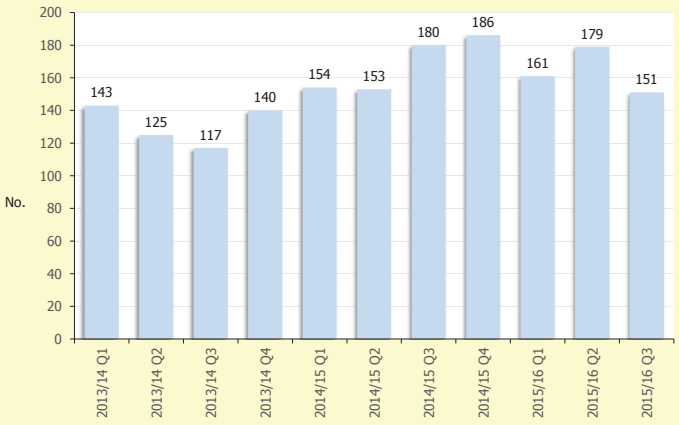
Older Adults Mental Health

Key Messages

- The focus for adult mental health services in Lewisham is improving the care for people with dementia. In particular, increasing diagnosis at the earliest stage as possible.

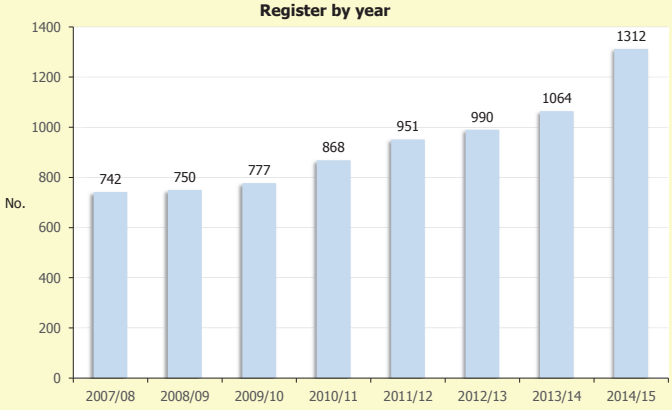
Trends/Benchmarks

Chart 7: Referrals to Lewisham Memory Service



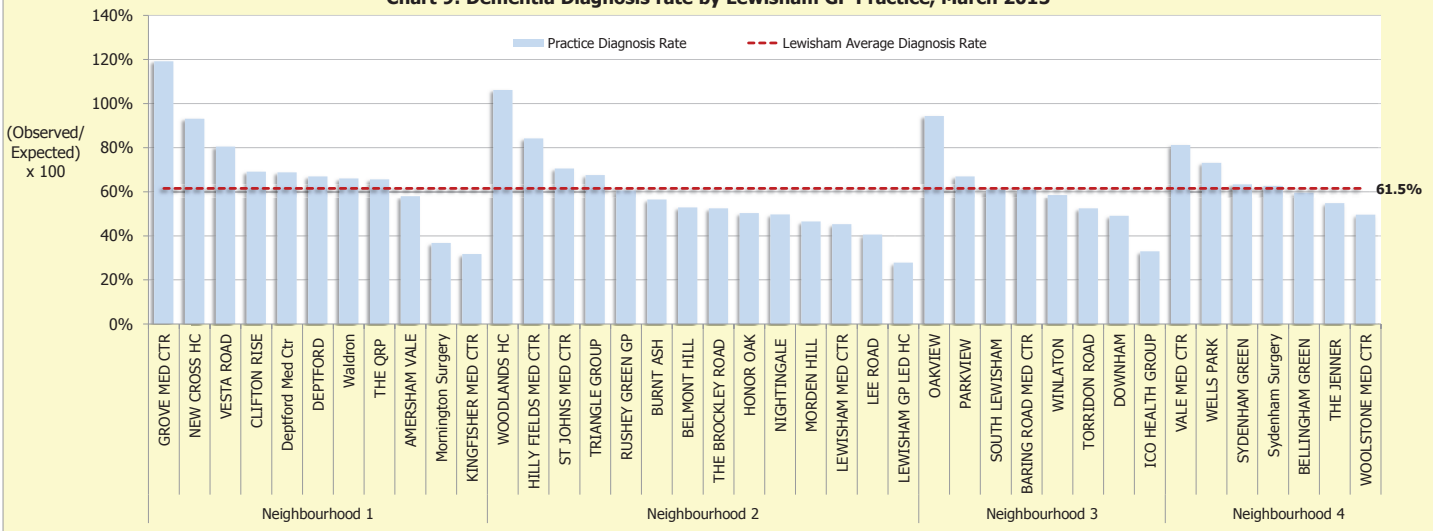
Source: Lewisham SLAM

Chart 8: Number of Patients on Lewisham GP practice Dementia Register by year



Source: QOF/HSCIC

Chart 9: Dementia Diagnosis rate by Lewisham GP Practice, March 2015



Source: National Dementia Prevalence Calculator **Prevalance based on Dementia UK figures for 2007

Commentary

The Lewisham Memory Service was established in April 2011 as a single point of access service. The referrals to the service have continued to fluctuated but remain above the levels seen in the inital quarters. Encouragingly the size of GP Dementia Registers have increased year on year. However, the graph shows that the gap between the diagnosed and expected rates of diagnosis vary greatly between GP practices suggesting that GPs performance in diagnosing and consequently caring for their dementia patients is also variable.

Public Health Outcomes: Mental Health

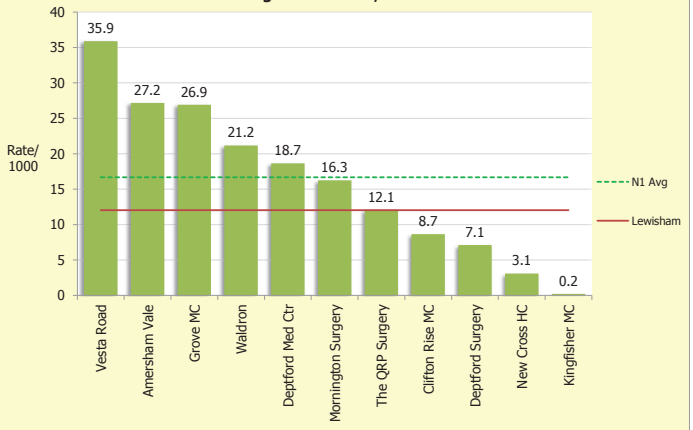
3. Improving Access To Psychological Therapies (IAPT)

Key Messages

- Between April 2015 and March 2016 8,377 referrals were made to the Lewisham IAPT service. Neighbourhood 2 continues to receive the highest number of referrals (37%).
- 6,039 patients entered treatment, which equates to meeting 16% of need for people with depression and anxiety in Lewisham and exceeds the local target set for the service, of 5,664.
- 47% of referrals were made by GPs (previously 56%); 48% were self referrals.
- 66% of people referred to the service were women; 34%, men.
- BME Groups were under-represented in referrals.
- 26% of referrals reported having a long term health condition and 19% of referrals to the service reported having a disability.
- The average wait time in actual days from referral to first attended appointment was 29 days.
- The service Did Not Attend (DNA) rate, for all appointments, is 9%; whilst the DNA rate for assessment appointments was just under 19%.

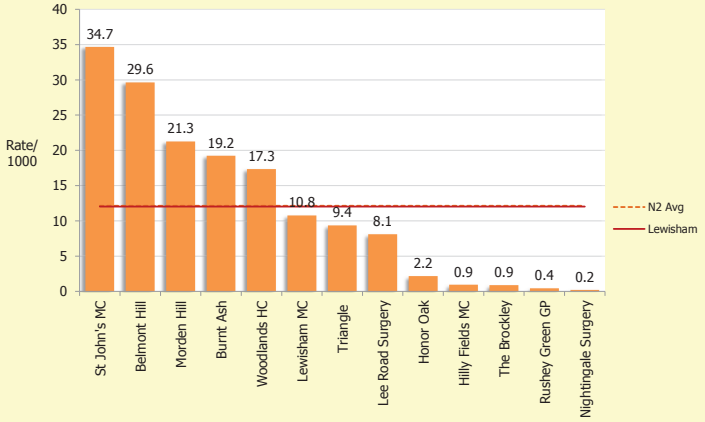
Trends/Benchmarks

Chart 10: Referral rate/1000 to IAPT services by GP Practice in Neighbourhood 1, 2015-16



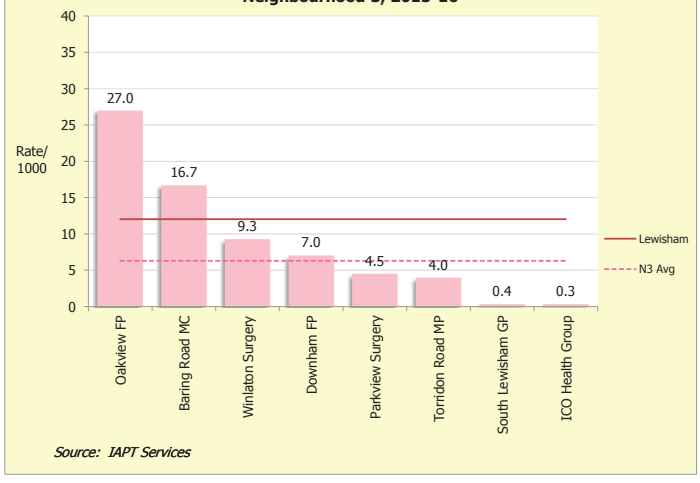
Source: IAPT Services

Chart 11: Referral rate/1000 to IAPT services by GP Practice in Neighbourhood 2, 2015-16



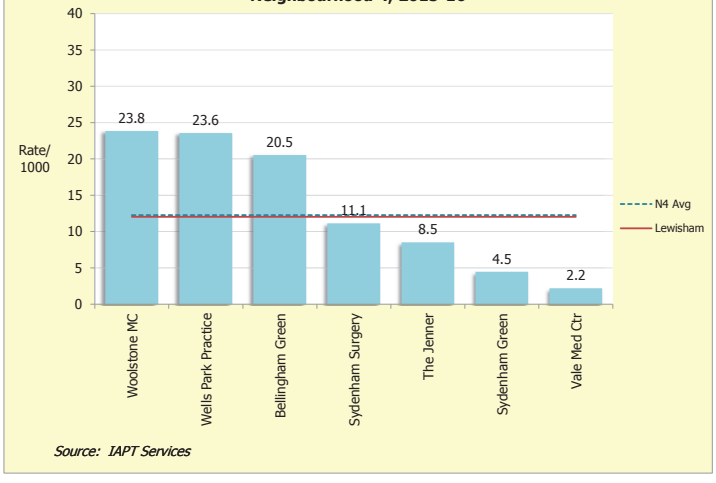
Source: IAPT Services

Chart 12: Referral rate/1000 to IAPT services by GP Practice in Neighbourhood 3, 2015-16



Source: IAPT Services

Chart 13: Referral rate/1000 to IAPT services by GP Practice in Neighbourhood 4, 2015-16



Source: IAPT Services

Public Health Outcomes: Mental Health

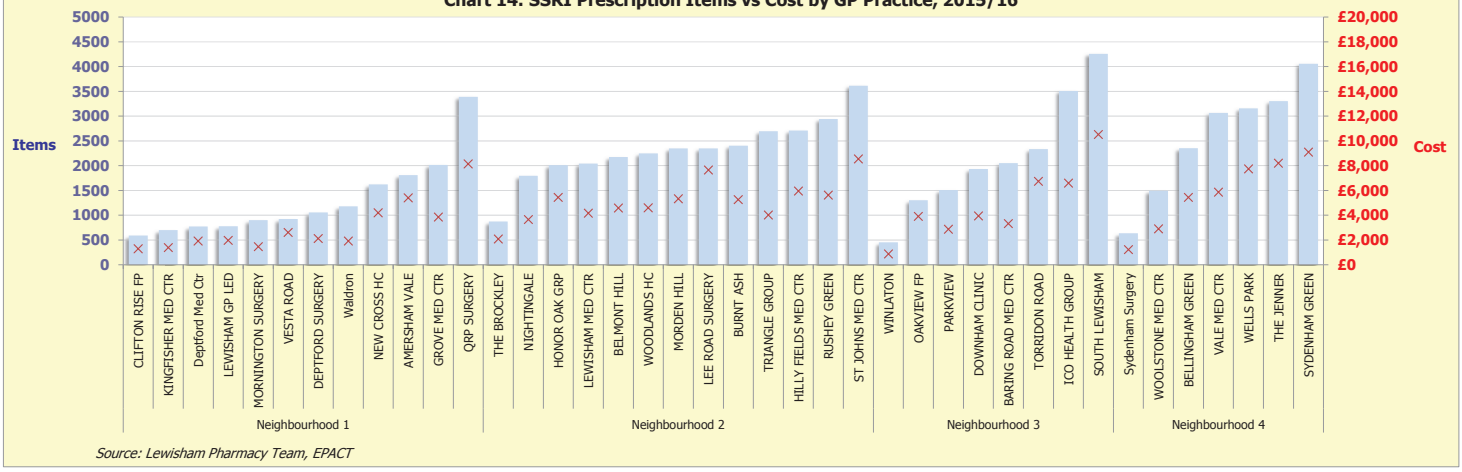
Primary Care/Secondary Care Interface

Key Messages

The primary/secondary care interface is of increasing importance as specialist mental health services work to step down service users who no longer require specialist care. Following the implentation of the new adult mental health model, community teams have moved from a three team structure to a four team structure to mirror the primary care neighbourhoods in the borough. There is also additional support for GPs to manage their mental health caseload.

Trends/Benchmarks

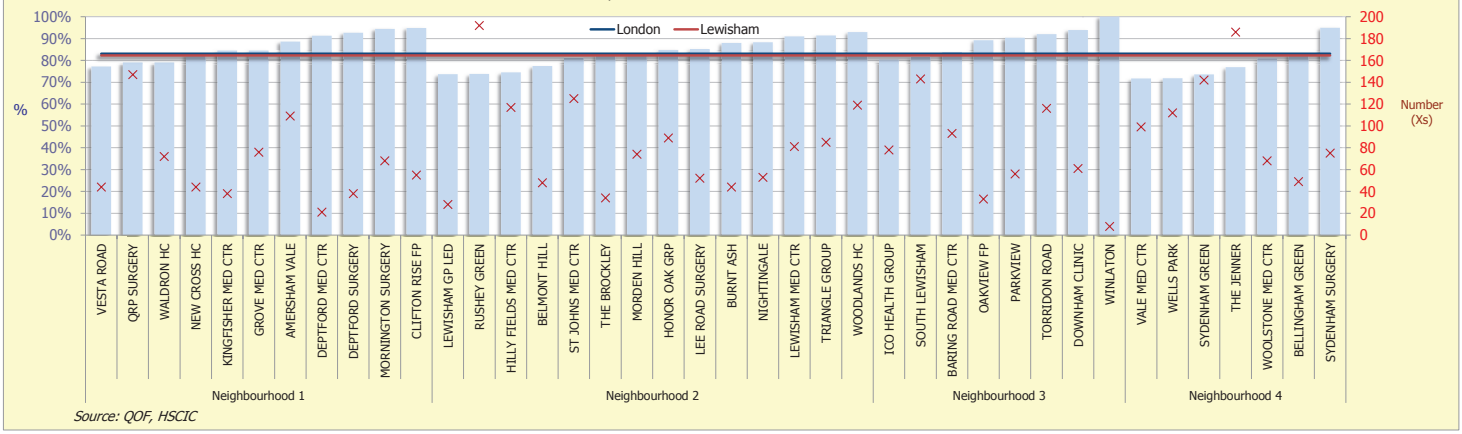
Chart 14: SSRI Prescription Items vs Cost by GP Practice, 2015/16



Source: Lewisham Pharmacy Team, EPACT

Chart 15: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months (MH003), 2014/15

2015/16 data should be available in October



Source: QOF, HSCIC

Commentary

- There remains wide variation in the number of SSRI items prescribed by GP practice.
- The BMI measure is no longer available and has been substituted with a blood pressure check. Again there is variation in and between Neighbourhoods. This remains a potentially important indicator of how well practices are managing the physical health of their mental health patients.
- The is a great variation in the rate of admissions by GP practice for mental health reasons. Some of this will be related to the number of patients on their registers with a mental health diagnosis and the serverity of the condiditon. The concentration of admissions in some practices and neighbourhoods suggest there could be value in practice based initiatives to prevent admissions.

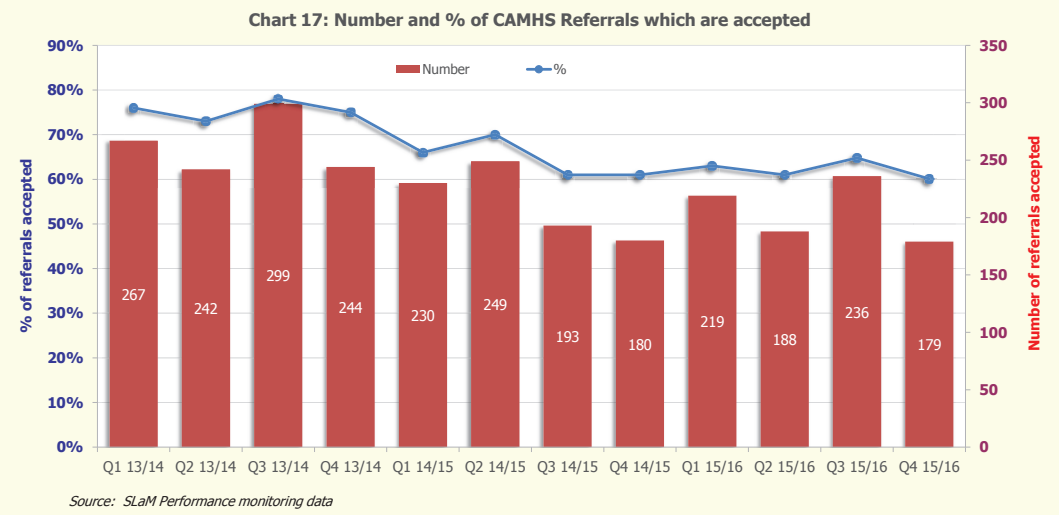
Public Health Outcomes: Mental Health

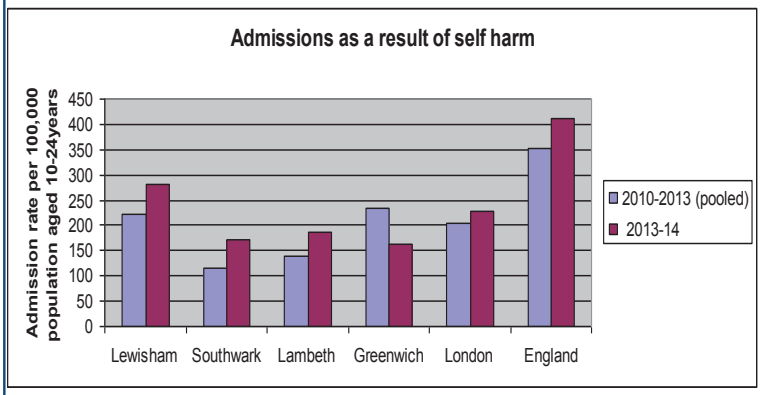
Child and Adolescent Mental Health

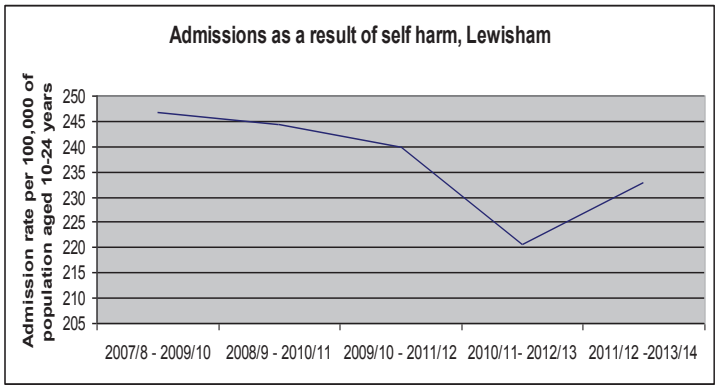
Key Messages

- Both the number and proportion of CAMHS referrals which are accepted has seen a decline since 2013/14. The most common source of referral is from GPs, followed by Schools; A&E and Social Services. (Chart 17)
- An online counselling service has been run by Kooth as part of the Headstart project. There was a total of 762 registrations oin 2015/16, however young women have been four times more likely to register compared to young men.
- Chart 18 shows standardised rates of self-harm in per 100,000 population aged 10-24 years in Lewisham compared to neighbouring boroughs, London and England. This data refers to admissions from A&E, to another ward, i.e. psychiatric ward, short stay/assessment unit or mental health inpatient ward.
- Chart 19 shows the trend for Lewisham for self-harm admissions in young people

Trends/Benchmarks







Achievements

- The number of patients on GP Practice Dementia Register continues to increase
- Work is being undertaken regarding the Mental Health of Older Adults (65+)
- The IAPT service exceeed its target for number of patients seen

Public Health Outcomes: Improve Sexual Health

Overall Key Messages

- Under 18 conceptions remain signifcantly higher than the national average (Chart 1)
- Chlamydia positvity rates remain high and are now higher than all similar CCGs (Chart 4)
- The number of new STIs has decreased for both Heterosexual and MSM since 2014 (Chart 8)

Health and Wellbeing Board Performance Metrics - Improving Sexual Health

Indicator	Latest period of availability	Lewisham	London	England	England Benchmark	Direction from previous period
Rate of chlamydia detection per 100,000 young people aged 15 to 24 (crude rate)*	2015	5434	2200	1887	sig high	↓
People presenting with HIV at a late stage of infection (%)	2012-2014	40.7	36.6	42.2	similar	↓
Legal abortion rate/1000 women of all ages	2015	25.6	20.7	16.2	sig high	↑
Teenage conceptions (rate per 1000 15-17 yr olds)	2014	31.3	21.5	22.8	sig high	↓

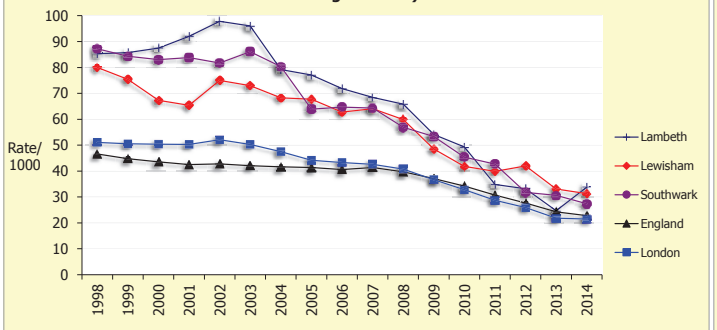
* the direction of travel for this indicator can be debated as we also wish to ensure that we are screening the correct young people

Young Person's Sexual Health (under 19s)

- In 2014, there were 144 conceptions recorded among under 18s in Lewisham which was down from 152 in 2013.
- Lewisham's under 18 conception rate has declined by 60.9% since 1998, comparing favourably with the decline of 51.1% across England.
- While the gap has narrowed, Lewisham is one of only 5 London boroughs where conception rates remain significantly higher than the national average.
- As a consequence, the under 18 abortion rate is also relatively high but the proportion of conceptions ending in abortion is similar to the average.

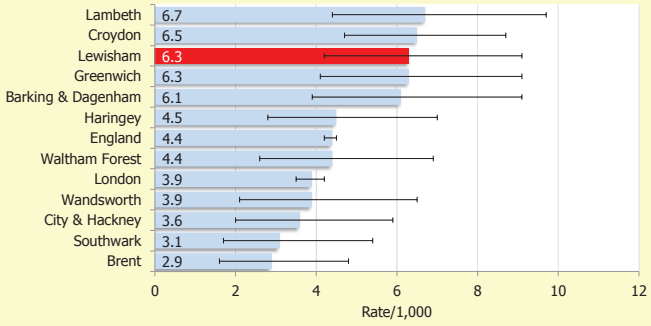
Trends/Benchmarks

Chart 1: Under 18 conception rate: annual trends (rate/1000 females aged 15-17)



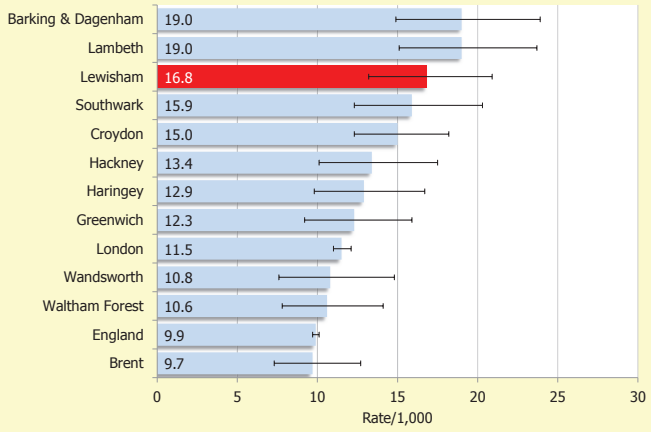
Source: Sexual Health Profiles

Chart 2: Under 16 conception rate/1000 females aged 13-15, 2014



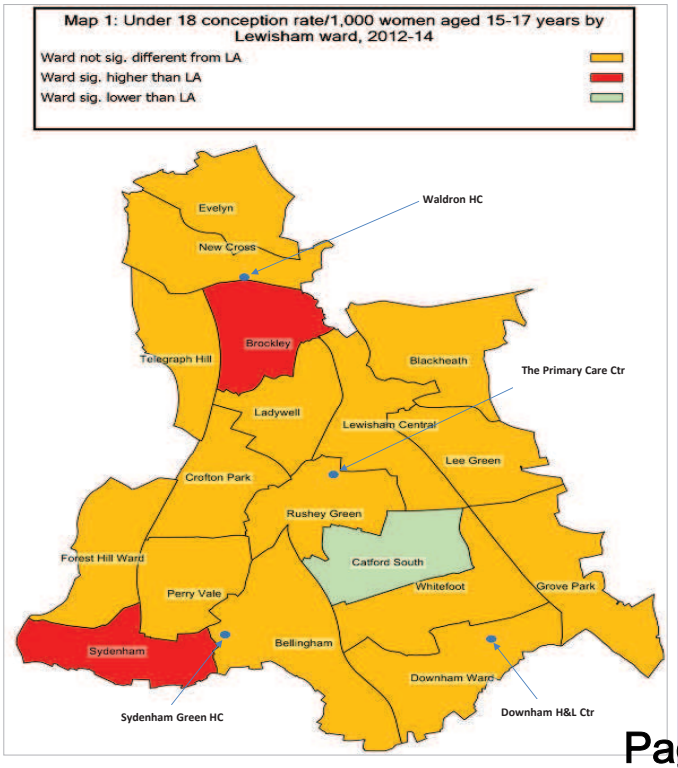
Source: Sexual Health Profiles

Chart 3: Legal abortion rates/1000 women aged under 18. Lewisham compared with its similar CCGs, London and England, 2015



Source: Sexual Health Profiles

Map 1: Under 18 conception rate/1,000 women aged 15-17 years by Lewisham ward, 2012-14



Public Health Outcomes: Improve Sexual Health

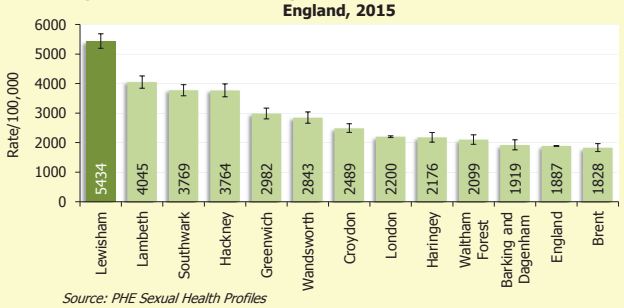
Sexually Transmitted Infections

Key Messages

- Although Chlamydia screening coverage has decreased, it still compares favourably with similar CCGs and the London and England average. (Charts 4 & 5)
- A decrease in the number of new STIs was seen which is counter to the trend of recent years. This was seen in both heterosexual and MSM residents. (Chart 8)
- Pelvic Inflammatory Disease is high, further work is being undertaken to better understand this. (Chart 7)
- Gonorrhoea is seeing an upwards trend nationally but particularly in London. Lewisham's rate remains above London but has stablised. (Chart 10)

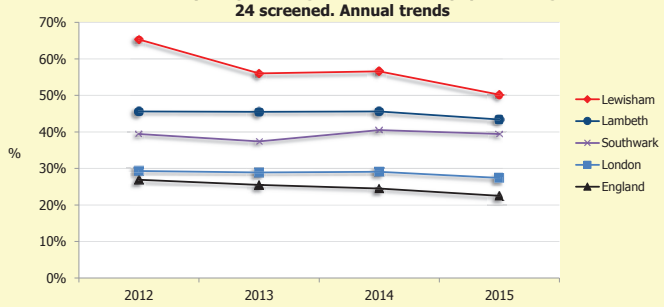
Trends/Benchmarks

Chart 4: Chlamydia: detection rate/100,000 resident population aged 15-24. Lewisham compared with its similar CCGs, London and England, 2015



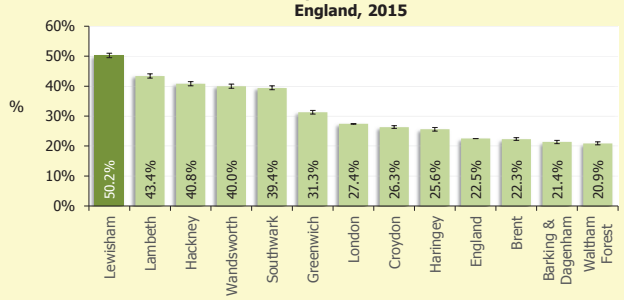
Source: PHE Sexual Health Profiles

Chart 5: Chlamydia: percentage of the resident population aged 15-24 screened. Annual trends



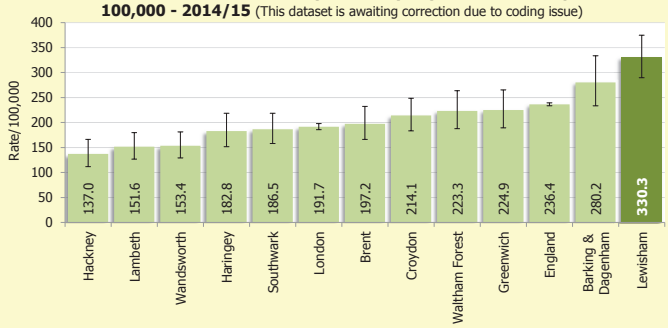
Source: PHE Sexual Health Profiles

Chart 6: Chlamydia: percentage of the resident population aged 15-24 screened. Lewisham compared with its similar CCGs, London and England, 2015



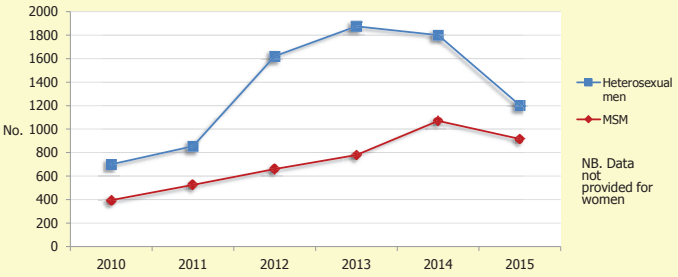
Source: PHE Sexual Health Profiles

Chart 7: Pelvic Inflammatory Disease (PID) admission rate per 100,000 - 2014/15 (This dataset is awaiting correction due to coding issue)



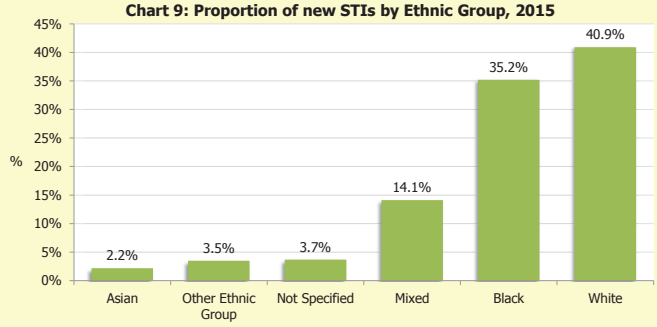
Source: PHE Sexual Health Profiles

Chart 8: Number of new STIs, chlamydia, gonorrhoea, syphilis, genital warts and genital herpes in Lewisham (GUM diagnoses only)



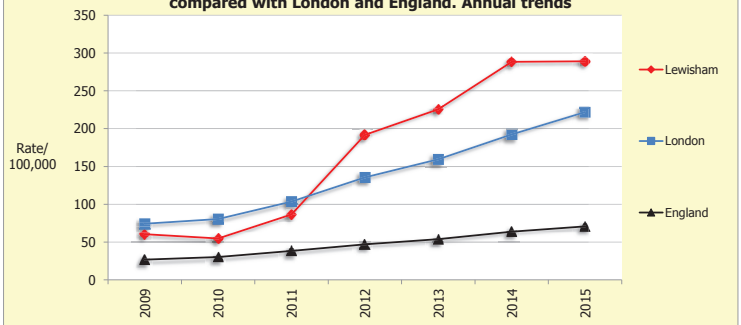
Source: HPA Web Portal

Chart 9: Proportion of new STIs by Ethnic Group, 2015



Source: HPA Web Portal

Chart 10: Gonorrhoea diagnosis rate per 100,000 population. Lewisham compared with London and England. Annual trends



Source: PHE Sexual Health Profiles

Commentary

- 6,346 new STIs were diagnosed in residents of Lewisham in 2015, a rate of 2,174 per 100,000 residents.

Public Health Outcomes: Improve Sexual Health

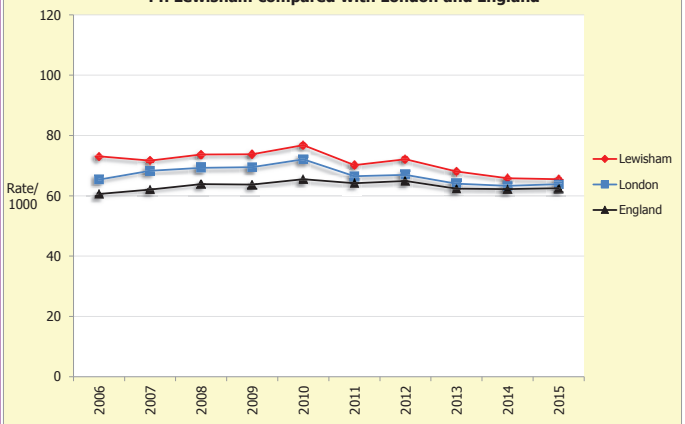
Contraception

Key Messages

- The Lewisham General Fertility Rate has dropped fractionally to bring it closer to both the London and England average. (Chart 11) The overall conception rate has seen a more notable decrease yet still remains higher than the London and England average (Chart 12).
- Whilst Lewisham sees a lower rate of GP Prescribed LARC compared with similar CCGs, the trend for LARC at Contraception and Sexual Health Clinics is positive. (Charts 13 & 14)
- Both Black African and Black Caribbean women are disproportionately 'over represented' in the numbers receiving emergency contraception (Chart 16).

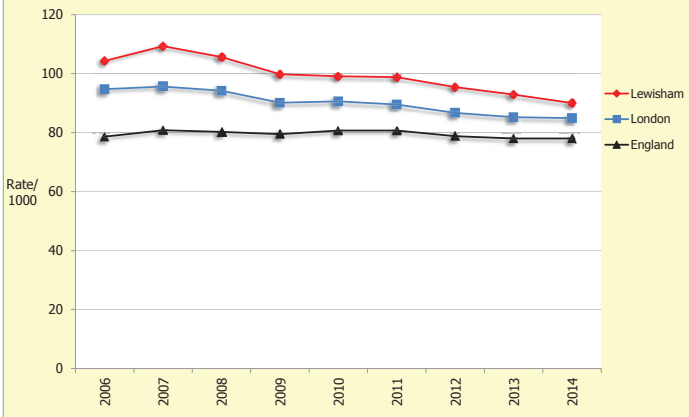
Trends/Benchmarks

Chart 11: General fertility rate (live births)/1000 women aged 15-44. Lewisham compared with London and England



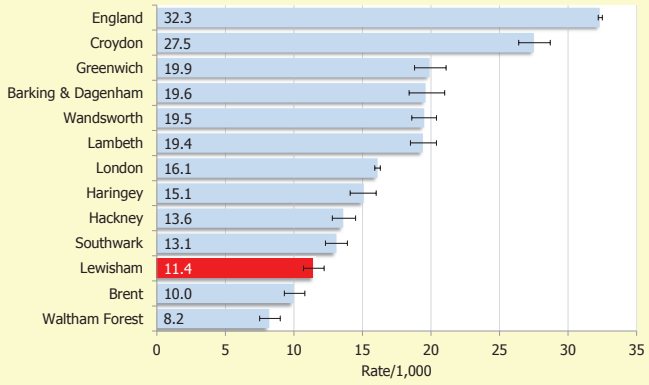
Source: http://data.london.gov.uk/dataset/births-and-fertility-rates-borough

Chart 12: Overall conception rate: annual trends (rate/1000 females aged 15-44)



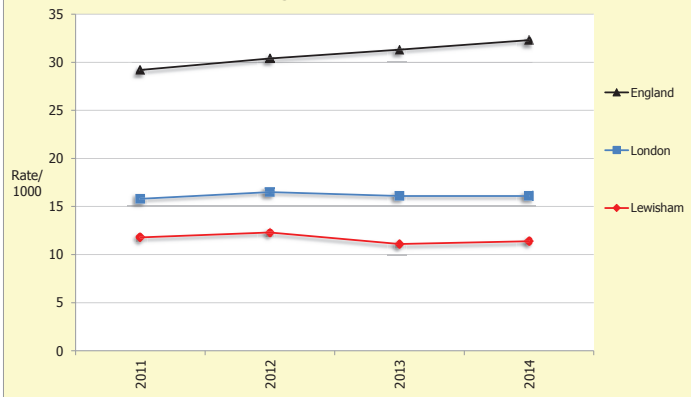
Source: ONS (http://www.statistics.gov.uk)

Chart 13: GP prescribed Long-Acting Reversible Contraceptive (LARC) rate/1000 females aged 15-44. Lewisham compared with its similar CCGs, London and England, 2014



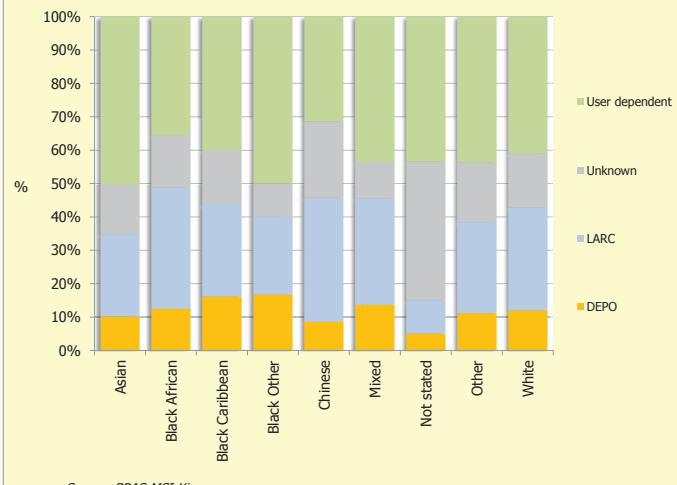
Source: Sexual Health Profiles

Chart 14: GP prescribed Long-Acting Reversible Contraceptive (LARC) rate/1000 females aged 15-44. Lewisham compared with London and England. Annual trends



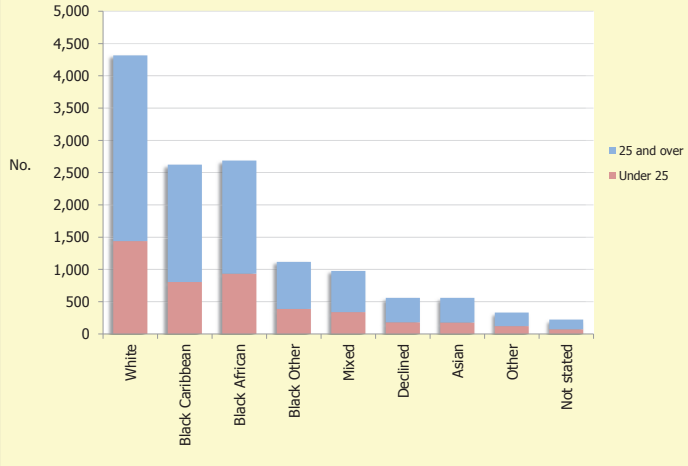
Source: Sexual Health Profiles

Chart 15: Contraception following abortion in Lewisham by contraception method and broad ethnic group, 2015



Source: BPAS-MSI-Kings

Chart 16: Number of Lewisham pharmacy supplied Emergency Hormonal Contraceptions (EHC) by broad ethnicity and age group, April 2015 to Mar 2016



Source: PharmOutcomes

Public Health Outcomes: Improve Sexual Health

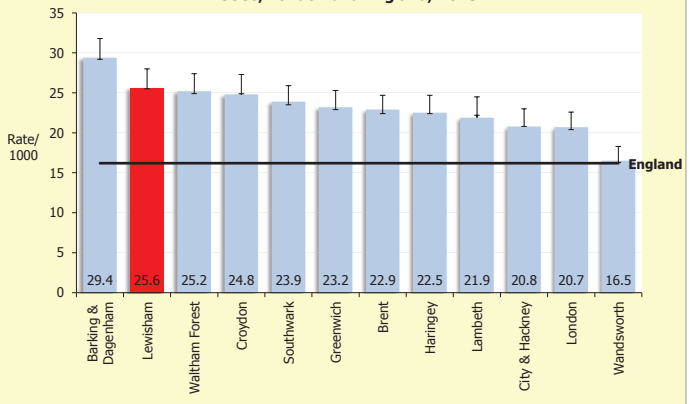
Abortions

Key Messages

- 1,905 abortions took place on Lewisham residents in 2015, this was an increase on 2014 (Chart 18).
- The 2015 total abortion rate per 1000 population was only available for 152 local authorities in 2015. Of these Lewisham was second, just behind Barking and Dagenham.
- The rate of women of Black African ethnicity having an abortion, is over twice the Lewisham average rate. Black Caribbean women are also far more likely to have an abortion than other ethnic groups. (Chart 21)

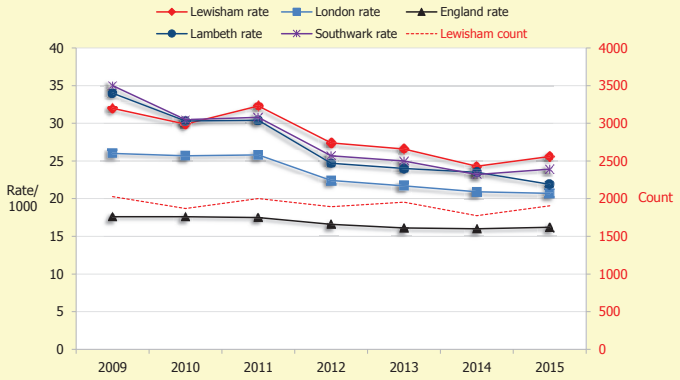
Trends/Benchmarks

Chart 17: Legal abortion rates (ASR with 95% confidence intervals) per/1000 women aged 15-44. Lewisham compared with its similar CCGs, London and England, 2015



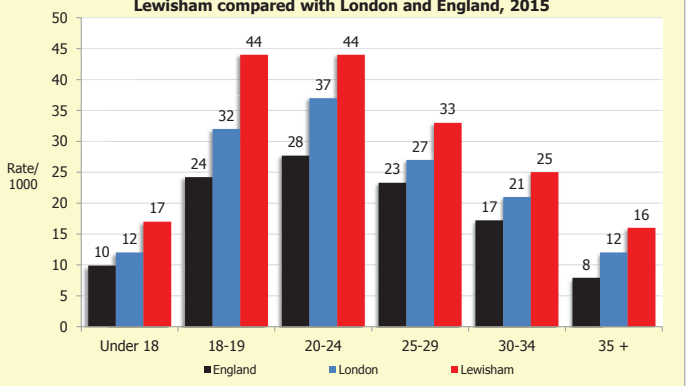
Source: https://www.gov.uk/government/organisations/department-of-health

Chart 18: Legal abortion rates (ASR) per/1000 women aged 15-44. Lewisham compared with Lambeth, Southwark, London and England. Annual trends



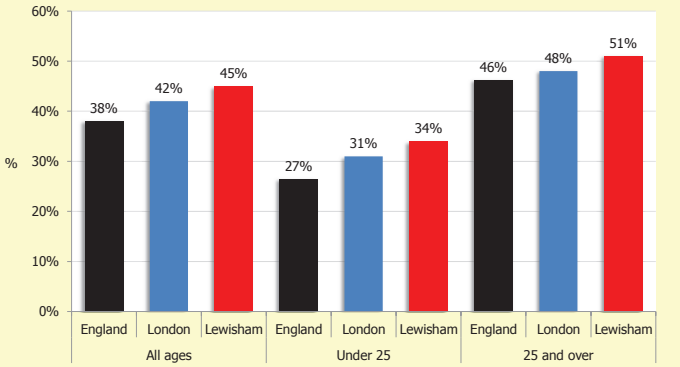
Source: https://www.gov.uk/government/organisations/department-of-health

Chart 19: Legal abortion rates/1000 women by age group. Lewisham compared with London and England, 2015



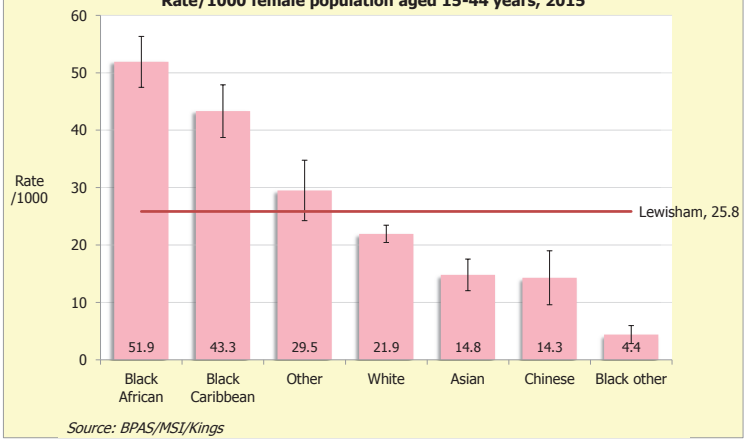
Source: https://www.gov.uk/government/organisations/department-of-health

Chart 20: Legal abortions : % of repeat abortions by selected age bands. Lewisham compared with London and England, 2015



Source: https://www.gov.uk/government/organisations/department-of-health

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



Source: BPAS/MSI/Kings

Commentary

Among NHS funded abortions, the proportion of those under 10 weeks gestation was 83.7%, in 2015 while in England the proportion was 80.3%. The earlier abortions are performed the lower the risk of complications. Prompt access to abortion, enabling provision earlier in pregnancy, is also cost-effective and an indicator of service quality and increases choices around procedure.

Public Health Outcomes: Improve Sexual Health

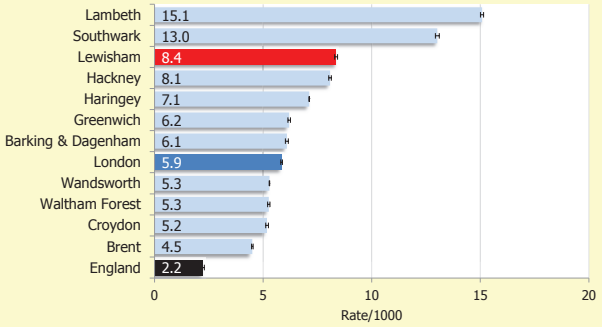
HIV

Key Messages

- HIV Diagnosis is high compared to similar local authorities, the new HIV Diagnosis rate is also relatively high. (Chart 22)
- Neighbourhood 1 (North Lewisham) sees the highest concentration of residents who are HIV Positive. (Map 2)
- New data is on Antenatal HIV Positivity is included, however this is just for women booking at UHL, not necessarily residents. 2015/16 saw a slight increase compared to 2014/15. (Chart 24)

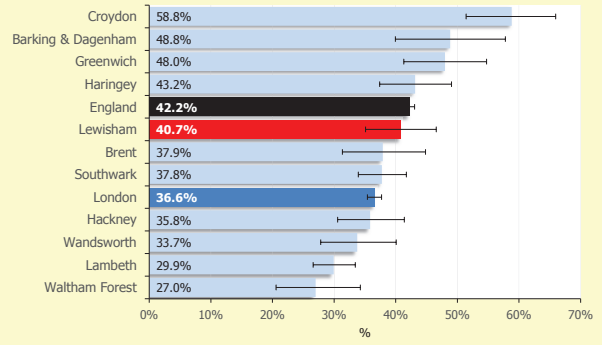
Trends/Benchmarks

Chart 22: HIV diagnosis prevalence/1000 for persons aged 15-59 years, 2014



Source: Sexual Health Profiles

Chart 23: People presenting with HIV at a late stage of infection (CD4 cell count < 350mm3). Proportions with 95% confidence intervals, 2012-14



Source: Sexual Health Profiles

Map 2

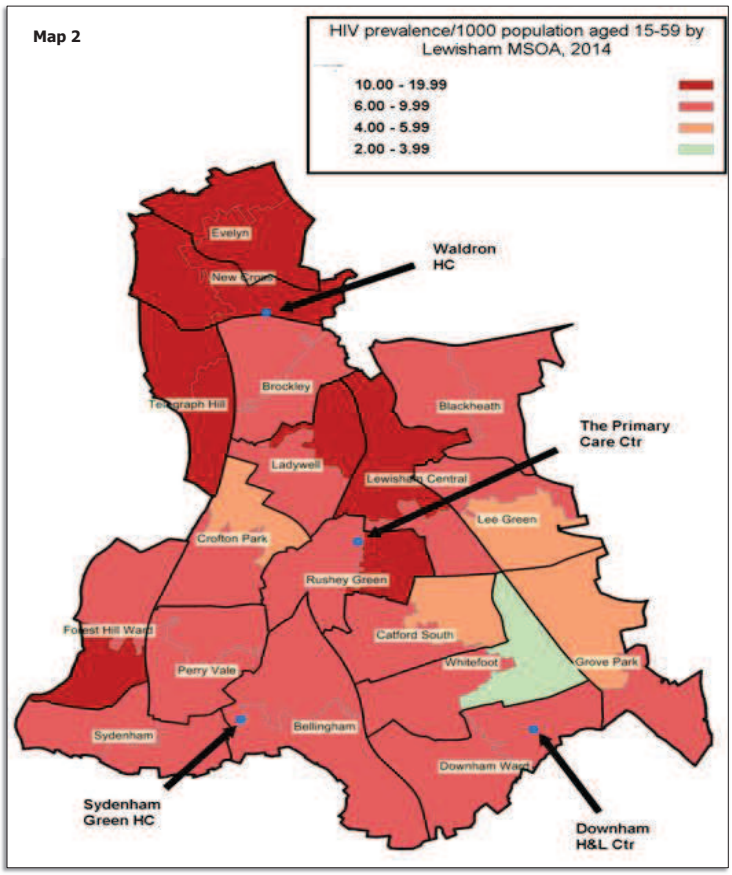
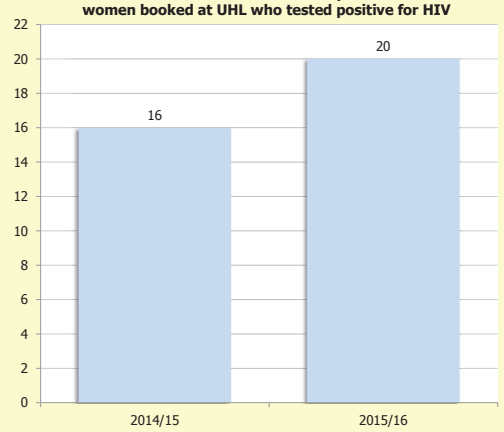
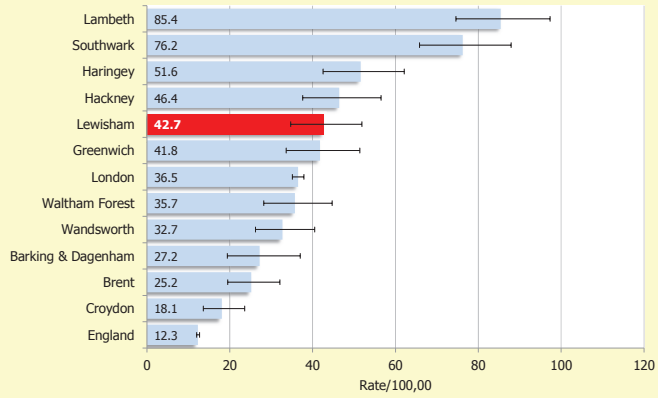


Chart 24: Antenatal HIV Positivity - Number of women booked at UHL who tested positive for HIV



Source: UHL

Chart 25: New HIV diagnosis rate/100,000 persons aged 15+. Lewisham compared with its similar CCGs, London and England, 2014



Source: Sexual Health Profiles

Public Health Outcomes: Improve Sexual Health

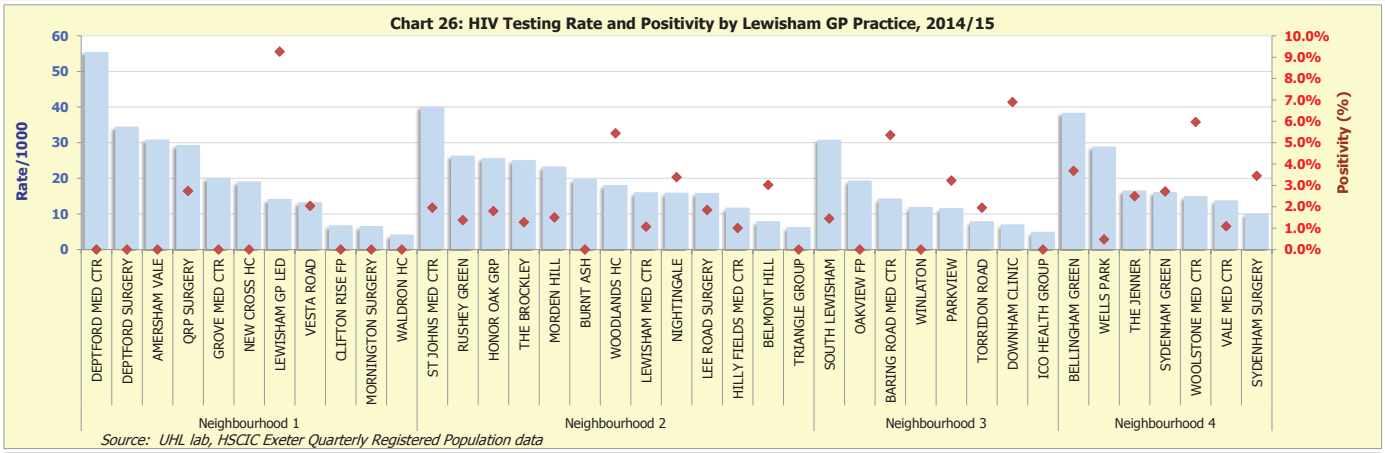
Primary Care

Key Messages

The rate of STI testing and the positivity rates varies by GP practice as does the abortion rate.

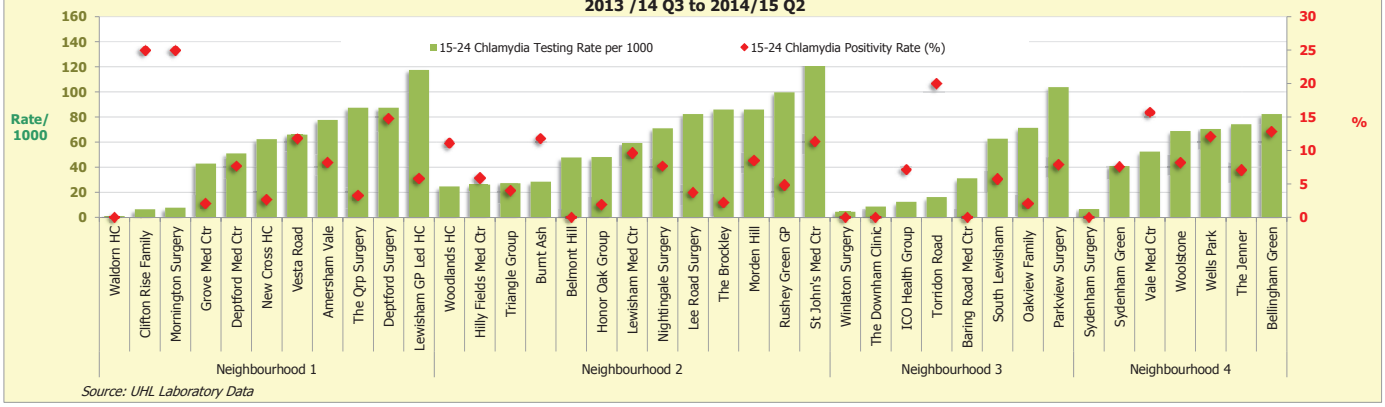
Trends/Benchmarks

Chart 26: HIV Testing Rate and Positivity by Lewisham GP Practice, 2014/15



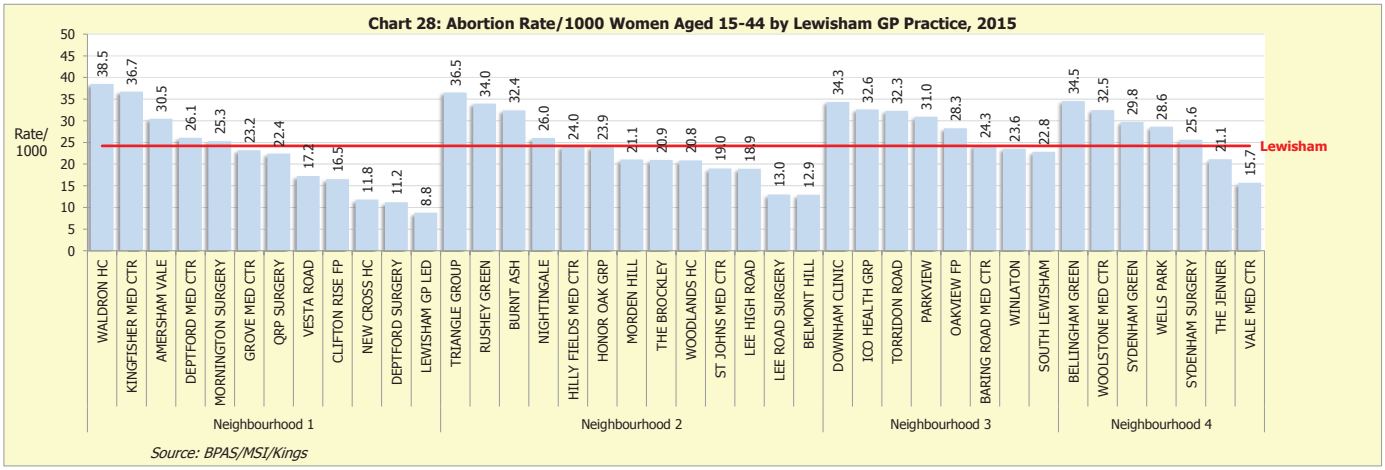
Source: UHL lab, HSCIC Exeter Quarterly Registered Population data

Chart 27: Chlamydia Testing and Positivity Rate by Lewisham GP Practice, 15-24 2013 /14 Q3 to 2014/15 Q2



Source: UHL Laboratory Data

Chart 28: Abortion Rate/1000 Women Aged 15-44 by Lewisham GP Practice, 2015



Source: BPAS/MSI/Kings

Achievements

- Teenage conception rates continue to fall
- Chlamydia positvity rates remain high and are now higher than all similar CCGs (Chart 4)
- The number of new STIs has decreased for both Heterosexual and MSM since 2014 (Chart 8)

Public Health Outcomes: Tobacco Control

Key Messages

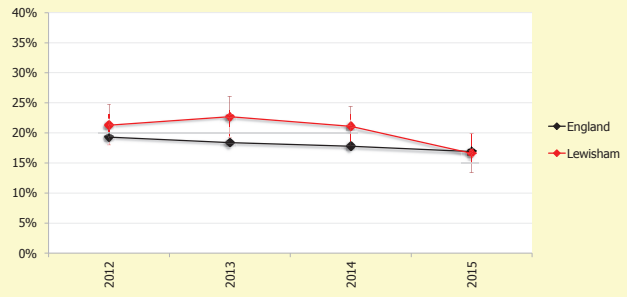
- More people smoke in Lewisham compared with London and England. 1 in 5 people continue to smoke in Lewisham, which rises to ith 1 in 4 for those in routine and manual occupations.
- The number of smoking quitters has remained stable after falling in previous years.
- The Stop Smoking Service is very successful at reaching heavily addicted smokers such as pregnant women and people with mental health problems, with a strong correlation between deprivation (shown through areas with low IMD scores) and smoking quitters and an increasing number of smokers quitting from more deprived wards.
- Continued focus on illegal and underage sales and large quantities of illegal tobacco seized, through the use of sniffer dogs and the Enforcement Team.
- Smoking attributable hospital admissions and mortality are statistically higher than England and London.
- New data is being used to understand smoking prevalance in young people, via the WAY Survey (Chart 3), which indicates less 15 year olds in Lewisham smoke than in England, however the confidence intervals for this indicator are wide at borough level.

Health and Wellbeing Board Performance Metrics - Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking

Indicator	Latest period of availability	Previous period of availability	Lewisham	London	England	England Benchmark	Direction from previous period for Lewisham
Smoking Prevalance (%) aged 18+: current smokers (APS)	2015	20.6%	16.6%	16.3%	16.9%	similar	↓
4 week smoking quitters (crude rate per 100,000)	2015-16	680	547	473	440	-	↓
Smoking status at time of delivery (%)	2015-16	4.9%	4.5%	4.9%	10.6%	significantly lower	↓

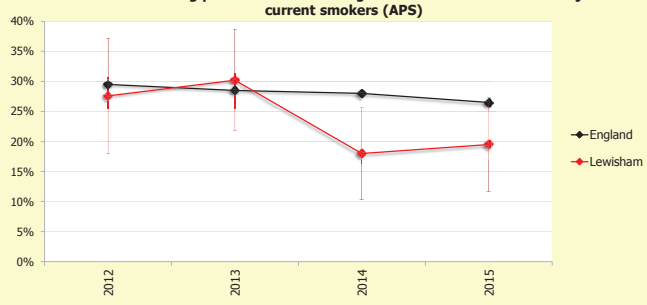
Trends/Benchmarks

Chart 1: Smoking prevalence of adults aged 18+: current smokers (APS)



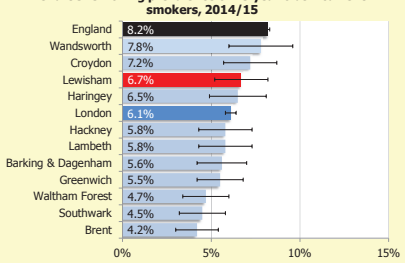
Source: http://www.tobaccoprofiles.info/Annual Population Survey

Chart 2: Smoking prevalence of adults aged 18+ in routine and manual jobs: current smokers (APS)



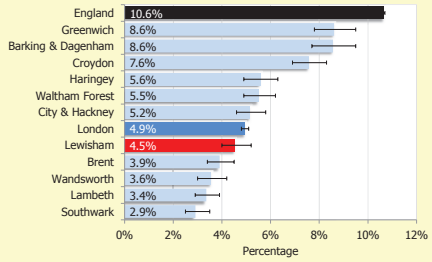
Source: http://www.tobaccoprofiles.info/Annual Population Survey

Chart 3: Smoking prevalence of 15 year olds - current smokers, 2014/15



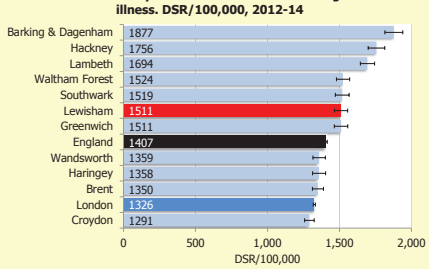
Source: What About Youth Survey, HSCIC

Chart 4: Smoking status at time of delivery, 2015/16



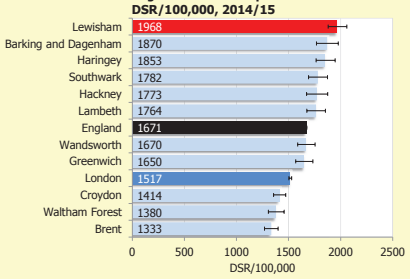
Source: http://www.hscic.gov.uk/

Chart 5: Potential years of life lost due to smoking related illness. DSR/100,000, 2012-14



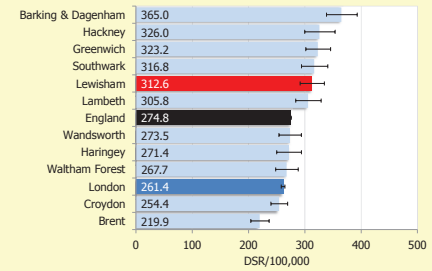
Source: http://www.tobaccoprofiles.info/ONS

Chart 7: Smoking attributable hospital admissions. DSR/100,000, 2014/15



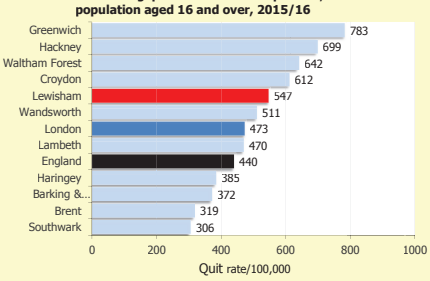
Source: http://www.tobaccoprofiles.info/

Chart 8: Smoking attributable mortality. DSR/100,000, 2012-14



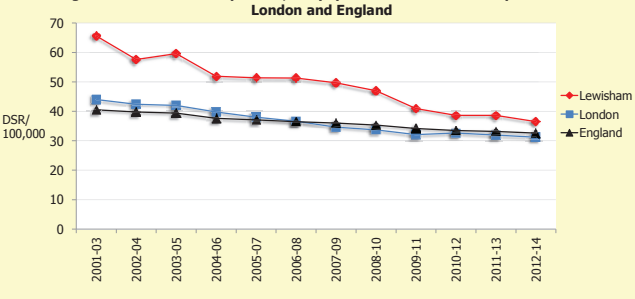
Source: http://www.tobaccoprofiles.info/

Chart 9: Smoking quit rate at 4 weeks per 100,000 population aged 16 and over, 2015/16



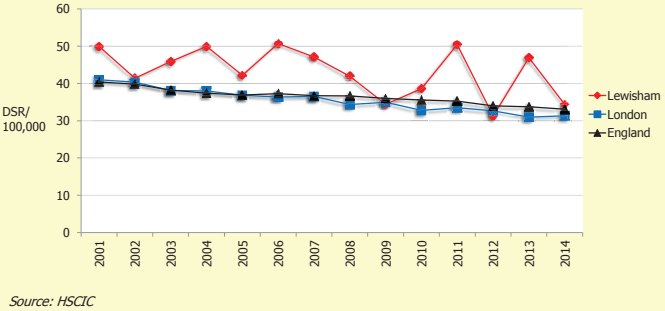
Source: http://www.hscic.gov.uk/

Chart 10: Under 75 mortality from respiratory disease in persons. Directly aged-standardised rate per 100,000 population. Lewisham compared with London and England



Source: http://www.phoutcomes.info/

Chart 11: Under 75 mortality from lung cancer DSR/100,00



Source: HSCIC

Public Health Outcomes: Tobacco Control

Stop Smoking Services

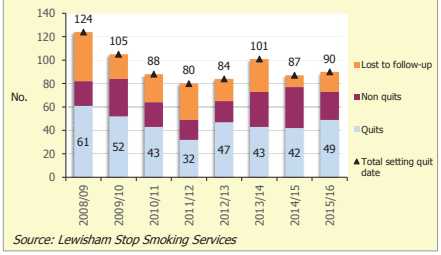
Achieve the annual DH target: 4 week quits in 2015/16 and quarterly targets

Annual 4 weeks quits	Target	Actual	Quit rate	Pregnancy
2015/16	1500	1291	44%	49 (54%)
2014/15	1900	1573	44%	42 (48%)
2013/14	1800	1703	45%	43 (43%)
2012/13	1800	1803	46%	47 (56%)

Breakdown of 4 week quits by quarter

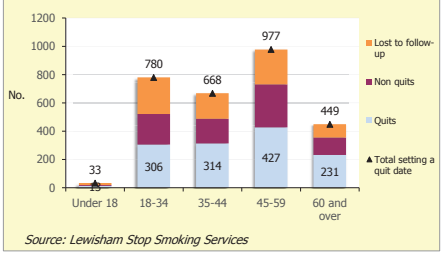
Quarterly 4 week quits	2015/16 Target: 1500	2014/15 Target: 1900	2013/14 Target: 1800	2012/13 Target: 1800
Q1	369	377	396	392
Q2	277	369	371	372
Q3	310	411	391	350
Q4	335	416	545	689

Chart 12: Number of pregnant smokers in Lewisham who had quit at 4 week follow-up



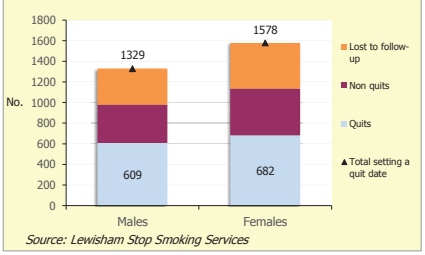
Source: Lewisham Stop Smoking Services

Chart 13: Number of smokers in Lewisham who had quit at 4 week follow-up by age group, 2015/16



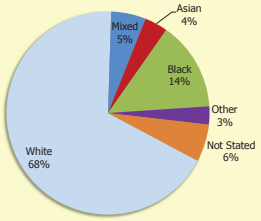
Source: Lewisham Stop Smoking Services

Chart 14: Number of smokers in Lewisham who had quit at 4 week follow-up by gender, 2014/15



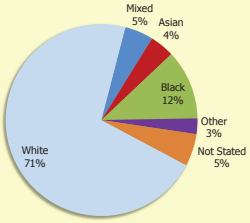
Source: Lewisham Stop Smoking Services

Chart 15: Ethnic breakdown of number of smokers in Lewisham setting a quit date , 2015/16



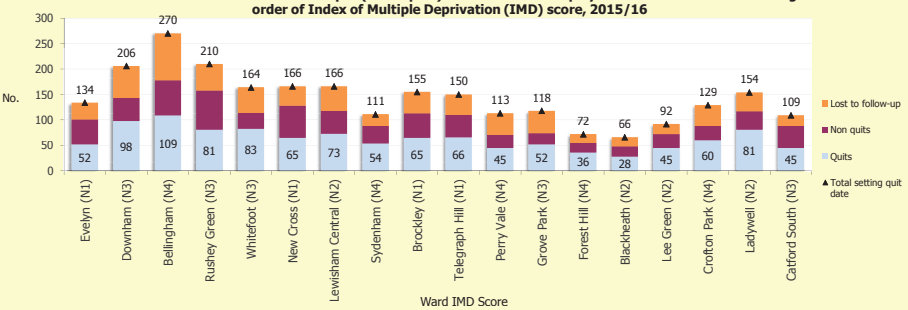
Source: Lewisham Stop Smoking Services

Chart 16: Ethnic breakdown of number of smokers in Lewisham who quit, 2015/16



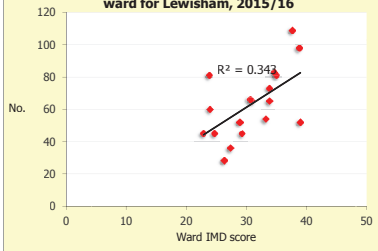
Source: Lewisham Stop Smoking Services

Chart 17: Number of smokers who quit (self-report) at 4 week follow-up by Lewisham ward in descending order of Index of Multiple Deprivation (IMD) score, 2015/16



Source: Lewisham Stop Smoking Services

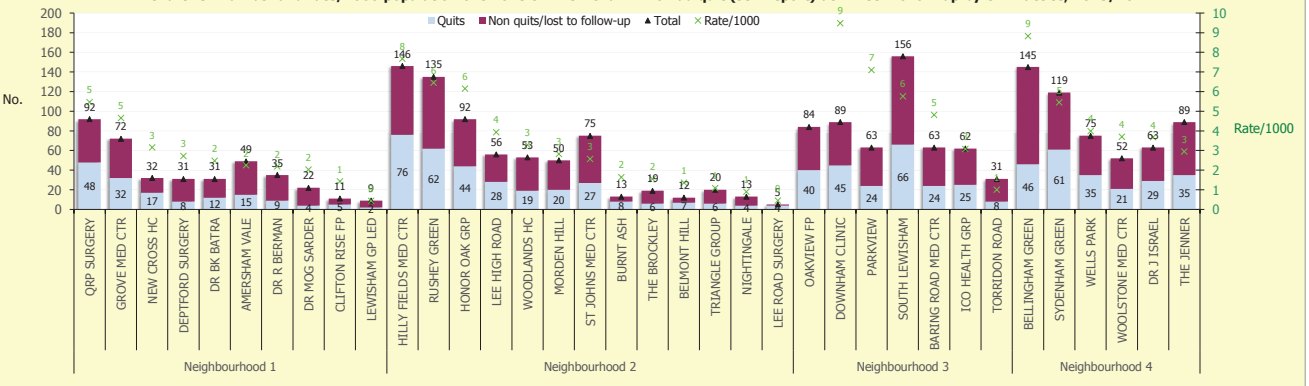
Chart 18: Correlation between IMD scores by ward and number of successful quitters by ward for Lewisham, 2015/16



P-value = 0.002: The correlation is statistically significant at the accepted 5% level

Source: Lewisham Stop Smoking Services

Chart 19: Number and rate/1000 population of smokers in Lewisham who had quit (self-report) at 4 week follow-up by GP Practice, 2015/16



Source: Lewisham Stop Smoking Services

Achievements

- Smoking status at time of delivery remains less than half that of England (SATOD) and almost half of pregnant smokers who are referred to the Stop Smoking Service successfully quit.
- There are a number of key actions identified at a local level in addition to national measures to reduce smoking prevalence. These include continued focus on enforcement (there has been significant success in seizures of illegal tobacco) and a stop smoking service for heavily addicted smokers.
- There has also been particular success in reaching smokers and encouraging them to quit in more deprived areas of the borough.

Public Health Outcomes: CVD and Health Checks Programme

Key Messages

- The rate of CVD mortality for persons under 75 in Lewisham is decreasing faster than that for England. However the Lewisham rate does remain higher than the London and national average (Chart 1).
- Benchmarking data by CCG is now available for Abdominal Aortic Aneurysm screening. Lewisham ranks in the middle of its peers, however fares signifcantly worse than England. (Chart 3)
- Stroke admissions have increased only slightly over the last three years but remain significantly higher than England. (Chart 5) Coronary Heart Disease admissions are decreasing slightly. (Chart 4)
- The NHS Health Check programme aims to prevent heart disease, stroke, diabetes and kidney disease, and raise awareness of dementia both across the population and within high risk and vulnerable groups. In April 2013 the NHS Health Check became a mandated public health service in England. Local authorities are responsible for making provision to offer an NHS Health Check to eligible individuals aged 40-74 years once every five years. At least 20 per cent of the eligible population have been offered a health check annually. The annual % uptake rate is 32.6% in 2015/16 (Chart 9), which was a decrease from 38.7% in 2014/15 and falls below the London level of 38.7% and England (44.4%) for 2015/16.
- The Health Check programme is increasingly reaching more men (46% in 2015/16, up from 44% in 2014-15) (Chart 16). The majority of people attending are in the younger age group (40-55 years) with 40-44 year olds alone making up 9% of the total. (Chart 14)

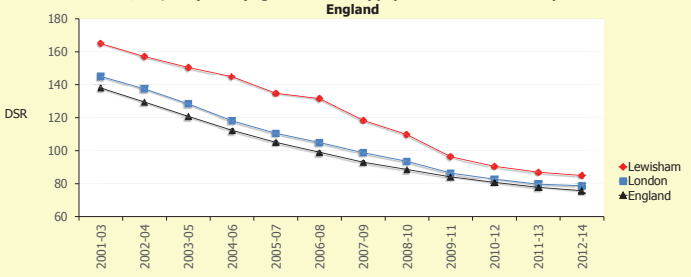
Health and Wellbeing Board Performance Metrics

Indicator	Latest period of availability	Previous period	Lewisham	London	England	England benchmark	Direction from previous period	Source
Under 75 Mortality from CVD (rate per 100,000)	2012-14	87.0	84.9	78.7	75.7	similar	↓	PHOF

CVD - Trends/Benchmarks

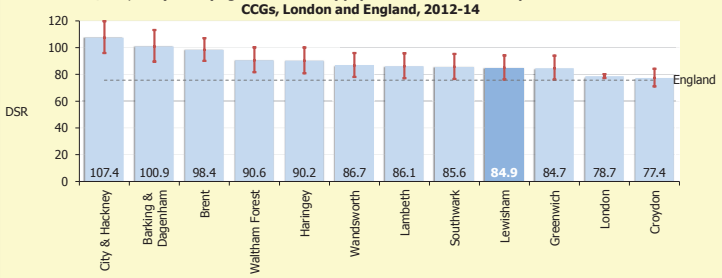
3 year rolling average		2001-03	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14
U75 CVD mortality rate/100,000	Lewisham	164.9	157.1	150.5	144.8	134.9	131.6	118.4	109.7	96.2	90.5	87.0	84.9
	England	138.0	129.5	120.9	112.3	105.1	99.0	93.1	88.6	84.0	80.8	77.8	75.7

Chart 1: Mortality rate from all circulatory diseases (ICD10 I00-I99) in persons aged < 75/100,000 (directly age-standardised) population. Lewisham compared to England



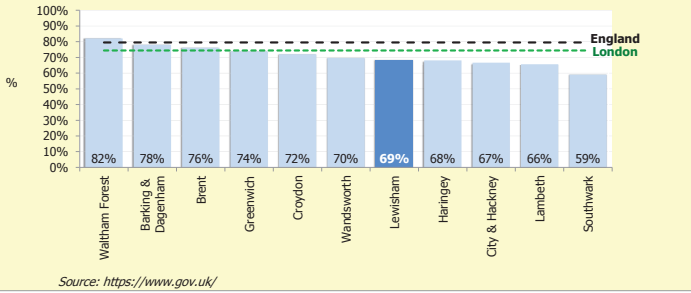
Source: http://www.phoutcomes.info

Chart 2: Mortality rate from all circulatory diseases (ICD10 I00-I99) in persons aged < 75/100,000 (directly age-standardised) population. Lewisham compared to its similar CCGs, London and England, 2012-14



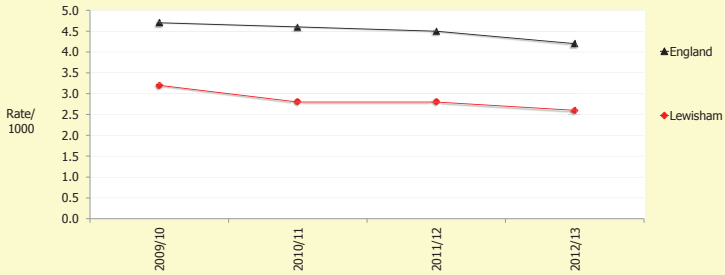
Source: http://www.phoutcomes.info

Chart 3: Percentage uptake of males aged 65+ screened for Abdominal Aortic Aneurysm. Lewisham compared to its similar CCGs, London and England, 2014/15



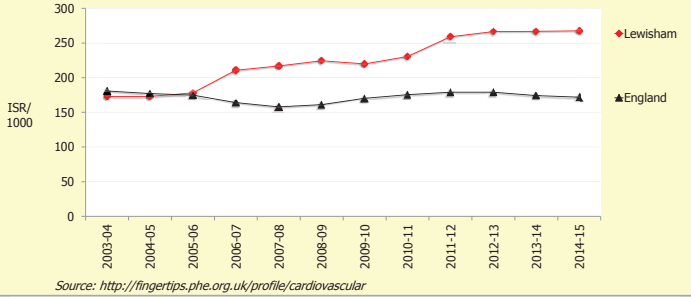
Source: https://www.gov.uk/

Chart 4: CHD total admissions per 1000 population. Lewisham compared with England. Annual trends



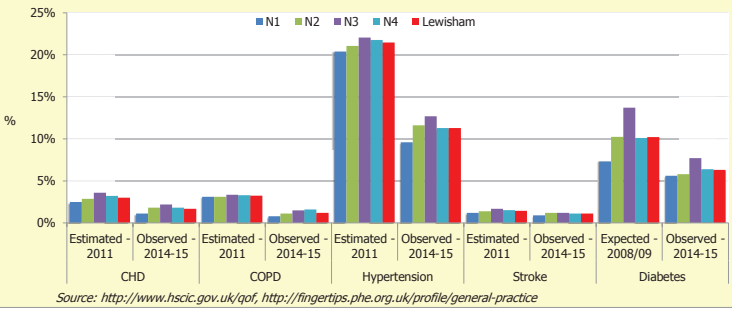
Source: http://fingertips.phe.org.uk/profile/general-practice

Chart 5: Stroke admissions for persons of all ages. Directly age-standardised rates (DSR) per 100,000 population. Lewisham compared with England. Annual trends



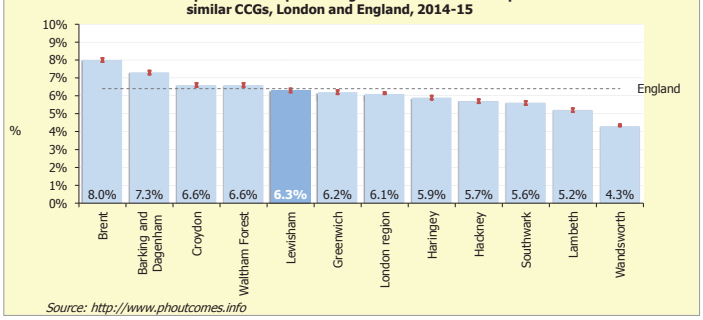
Source: http://fingertips.phe.org.uk/profile/cardiovascular

Chart 6: Observed and expected conditions prevalence by Lewisham neighbourhood



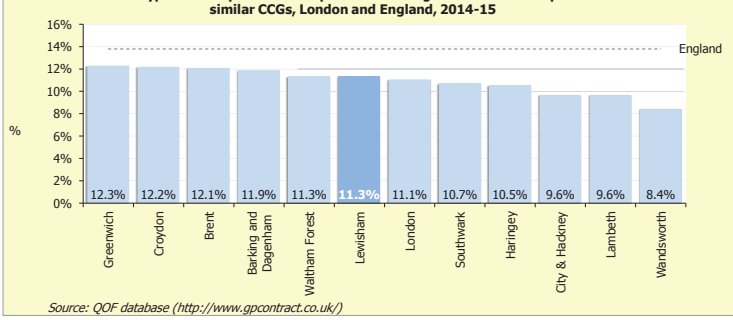
Source: http://www.hscic.gov.uk/qof, http://fingertips.phe.org.uk/profile/general-practice

Chart 7: Diabetes prevalence in persons aged 17+. Lewisham compared to its similar CCGs, London and England, 2014-15



Source: http://www.phoutcomes.info

Chart 8: Hypertension prevalence in persons of all ages. Lewisham compared to its similar CCGs, London and England, 2014-15



Source: QOF database (http://www.gpcontract.co.uk/)

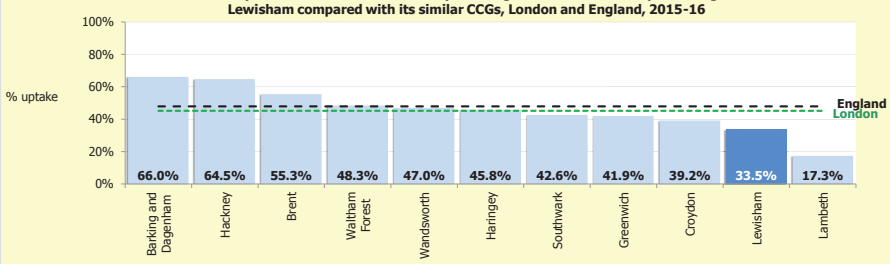
Public Health Outcomes: CVD and Health Checks Programme

Activity Performance - NHS Health Check Programme

Period		Lewisham 2015/16	Lewisham 2016/17
Q1	Number Offered	3362	5561
	Number Completed	1388	2033
	% uptake	41.3%	36.6%
Q2	Number Offered	3449	
	Number Completed	1334	
	% uptake	38.7%	
Q3	Number Offered	2951	
	Number Completed	1201	
	% uptake	40.7%	
Q4	Number Offered	6295	
	Number Completed	1462	
	% uptake	23.2%	
YTD	Total Number Offered	**16057**	**5561**
	Total Number Completed	**5385**	**2033**
	% Uptake Lewisham	**33.5%**	**36.6%**
	% Uptake London	**45.2%**	
	% Uptake England	**47.9%**	

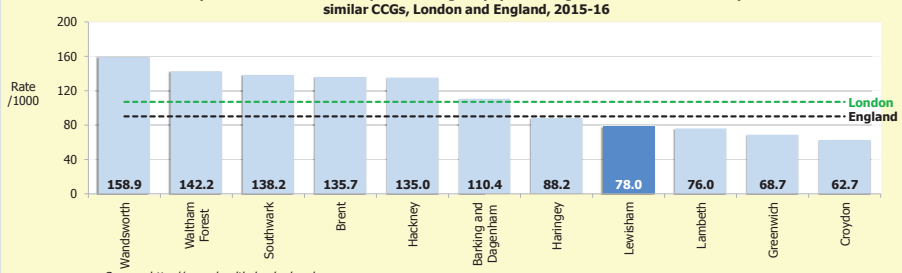
Source: QMS Health Check Focus

Chart 9: Completed NHS health checks as a percentage of those offered to persons aged 40-74 Lewisham compared with its similar CCGs, London and England, 2015-16



Source: http://www.healthcheck.nhs.uk

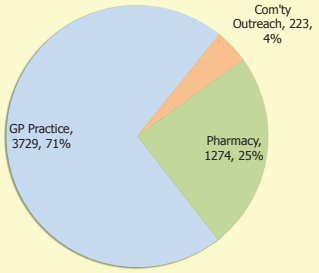
Chart 10: Completed NHS health checks per 1000 eligible population aged 40-74. Lewisham compared with its similar CCGs, London and England, 2015-16



Source: http://www.healthcheck.nhs.uk

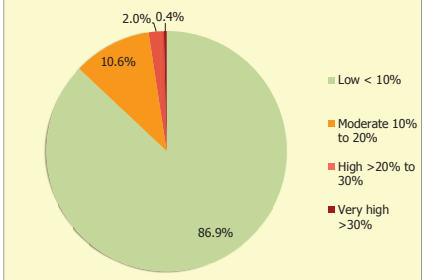
Service Data

Chart 11: Total number of NHS health checks by Lewisham provider, 2015-16



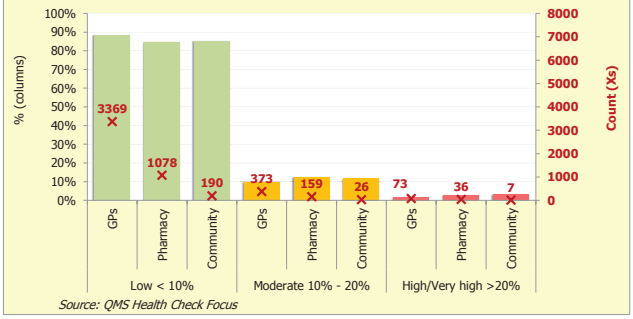
Source: QMS Health Check Focus

Chart 12: CVD risk (QRISK2) of Lewisham health checks by risk category, 2015-16



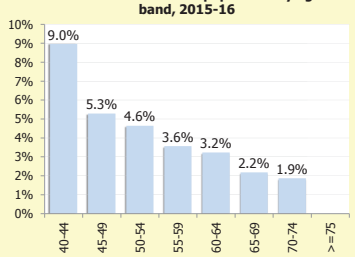
Source: QMS Health Check Focus

Chart 13: CVD risk of Lewisham health checks by provider, 2015-16



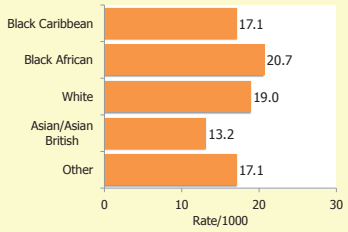
Source: QMS Health Check Focus

Chart 14: Completed health checks as a % of GLA estimated total population by age band, 2015-16



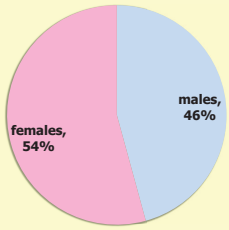
Source: QMS HC Focus/2014 GLA Pop. Projections

Chart 15: Rate of health checks per 1000 population aged 40-74 by ethnicity, 2015-16



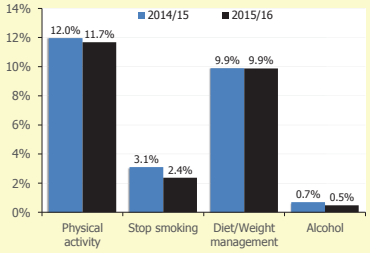
Source: QMS HC Focus/2013 Low GLA Pop. Projections

Chart 16: Health checks by gender, 2015-16



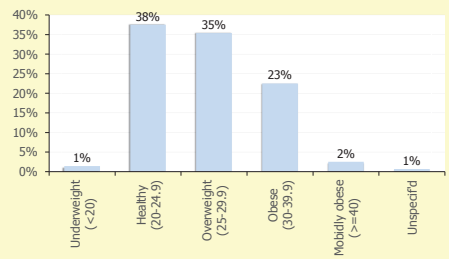
Source: QMS Health Check Focus

Chart 17: Referrals to lifestyle services as a percentage of all Health Checks



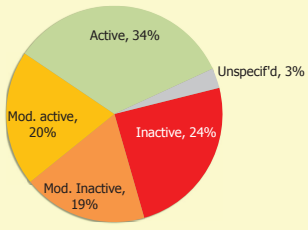
Source: QMS Health Check Focus

Chart 18: Health checks by BMI status, 2015-16



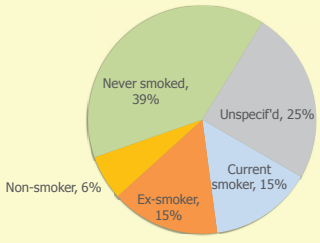
Source: QMS Health Check Focus

Chart 19: Physical activity status, 2015-16



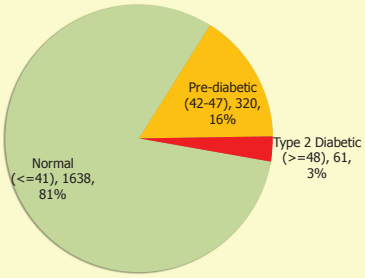
Source: QMS Health Check Focus

Chart 20: Smoking status, 2015-16



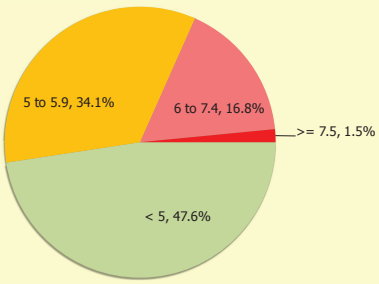
Source: QMS Health Check Focus

Chart 21: Health checks by HbA1c screening/diabetes filter, 2015-16



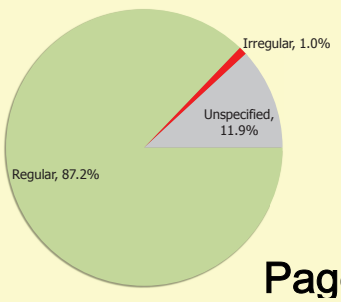
Source: QMS Health Check Focus

Chart 22: Health checks by cholesterol level, 2015-16



Source: QMS Health Check Focus

Chart 23: Health checks by pulse rhythm, 2015-16



Source: QMS Health Check Focus

Public Health Outcomes: CVD and Health Checks Programme

Prevalence diagnosis in Lewisham

QOF Indicator	2012/13		2013/14		2014/15	
	Recorded prevalence (%)	Expected prevalence (%)	Recorded prevalence (%)	Expected prevalence (%)	Recorded prevalence (%)	Expected prevalence (%)
Atrial Fibrillation	0.7%		0.8%		0.8%	
Hypertension	11.0%		11.3%		11.3%	
Coronary Heart Disease	1.8%		1.8%		1.7%	
Stroke/Transient Ischaemic Attack	1.1%		1.1%		1.1%	
Heart Failure	0.5%		0.5%		0.5%	

Achievements

- The NHS Health Check programme is now in the 5th year which means local residents are now receiving a second inviation five years on.
- Point of Care Blood Testing for cholestrol and HbA1C has been introduced into 20 GP surgery sites. These sites have seen an increase in Health Check numbers since their introduction.
- The Health Check programme is increasingly reaching more men (46% in 2015/16). The majority of people attending are in the younger age group (40-55 years).
- In 2015/16 the programme has identified 300 Lewisham residents at high risk of developing diabetes.

Public Health Outcomes: Whole System Approach to Obesity

Key Messages

Prevention and early intervention are the key to tackling obesity. To achieve this involves working in partnership to minimise the impact of the obesogenic environment and supporting a healthier built environment that encourages healthier eating and being active. Lewisham is a national pilot for the whole systems approach to obesity, working with Leeds Beckett University to understand what works to tackle obesity and share learning.

Environment: Actions to support healthier eating and being active include being a key partner in developing a sugar smart campaign, promoting the uptake of the Daily Mile initiative in primary schools, a restrictive planning policy on new hot food take away establishments and a new borough wide community service to support communities on healthy eating and activity.

Childhood obesity: Rates remain significantly higher than the England rate and for 2014/15 Lewisham remains in the top quintile (highest) of Local Authority obesity prevalence rates for Year 6. Reception year performance has improved and Lewisham is now in the second quintile. As in previous years the proportion of obese children in Year 6 was more than double that of Reception year children, similar to the national results. Local analysis of the data reveals that for the nine years data has been collected (2006/7 to 2014/15) there is slight variability but no consistent trend over the period in obesity rates in either cohort of children. Actions to address this problem include building the local capabilities of the workforce though training on a variety of topics to promote healthy weight, provision of targeted and specialist weight management services accessible in community venues and the development of a 'Health in Lewisham' webpage on the council website to provide information and advice to support families achieve a healthy lifestyle.

Breastfeeding: Rates for both initiation and 6-8 weeks show improvement since 2013-14. All submitted data continue to meet the national validation criteria whereas many London boroughs still fail to meet the validation criteria. Actions to increase breastfeeding rates include working towards UNICEF Baby Friendly accreditation in the borough. The community and hospital achieved stage two accreditation in 2014 and are jointly working towards achieving stage 3 by the end of 2016. Lewisham Health Visiting service achieved their Stage 3 award in July 2016 with the support of Lewisham Children's Centres and Lewisham Council's Public Health Team. Lewisham Maternity services are preparing for their Stage 3 assessment in December 2016.

Maternal obesity: Maternal obesity increases the risk of poor pregnancy outcomes and is a risk factor for childhood obesity. Data from Lewisham Hospital for 2015 indicates that maternal obesity rates are lower than those recorded in 2010-12 although there has been a slight increase in 2015. Whether this reflects a change in the ethnicity of women booking for maternity care at the hospital is currently being investigated. Actions to address this problem 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. Preconceptual advice on healthy weight is also available for women themselves on the public health pages on Lewisham Council website (www.lewisham.gov.uk/health), links to which exist on the Trust website. The PH 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.

Adult Obesity: The prevalence of obesity in adults and children in England has more than doubled in the last twenty-five years. A modelled estimate of adult obesity prevalence in Lewisham is 23.7% which is not significantly different to the England average, and indicates that around 53,000 residents are obese. Recently published data for Lewisham on the prevalence of excess weight (overweight and obese) in adults is 60.7%, similar to the national average but higher than the London average (58.4%). (Chart 12) A similar level of excess weight (57.9%) is seen in adults aged 40-74 years – monitored as part of the NHS Health Check programme. Chart 11 shows that GP Practices in Lewisham are notably under-reporting obesity.
Actions to address this problem include building the local capabilities of the workforce though training on a variety of topics to promote healthy weight, and provision of a range of weight management services.

Physical Actvity - Adults: Physical inactivity is the fourth largest cause of disease and disability in the UK. Reducing inactivity could prevent up to 40% of long term conditions (PHE 2014). In Lewisham the proportion of Adults (16+) classified as physically active is 58.8% which is not significantly different from that of England. Nationally, over one in four adults (28.7%) do less than 30 minutes of physical activity a week, and are classified as 'inactive'. The Lewisham proportion is similar at 27.1%. NICE suggests all 'inactive' adults should be offered a PA BA intervention. Lewisham residents are less likely to use outdoor space for exercise/health reasons than the England (13.2% compared to 17.9%). Over four in ten NHS Health Checks reveal that the patient is inactive to some extent (43%).

Physical Actvity - Children: National surveys show that only a small proportion (20%) of children aged 5 to 15 years meet the Government recommendation for physical activity with children leading increasingly sedentary lifestyles. No information is available locally on activity levels of young children, but new data is now available from the WAY Survey for 15 year olds which shows just 11.3% are physically active for one hour every day.

Sport: Males particpipation in Sport has remained stable over the last ten years but women 's has decreased from a smaller starting point.

Health and Wellbeing Board Performance Metrics - Achieving a Healthy Weight

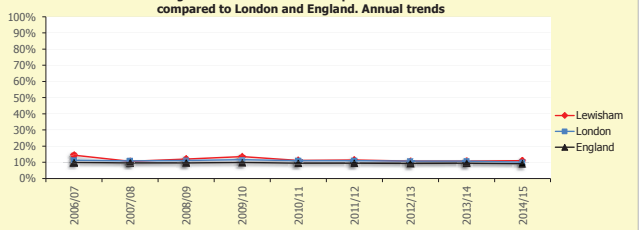
Indicator	Latest period of availability	Lewisham	London	England	Direction from previous period	Source
Excess weight in Adults (%)	2012-14	60.7	58.4	64.6	↓	Active People Survey
Excess weight in Children - Reception (%)	2014-15	23.7	22.2	21.9	↓	NCMP
Excess weight in Children - Year 6 (%)	2014-15	38.9	37.2	33.2	↓	NCMP
Maternal Excess Weight (%)	2015-16	45.8	-	-	↑	LGT
Breastfeeding Prevalance at 6-8 weeks (%)	Q1 2015/16-Q4 2015/16	75.7	-	42.8	↑	NHS England

Performance Targets - Children

	Reception Year					Year 6				
	2007/08	2011/12	2012/13	2013/14	2014/15	2007/08	2011/12	2012/13	2013/14	2014/15
Percentage of children with height and weight recorded who are obese (target)	10.6%	12.0%	12.3%	12.0%	12.0%	25.3%	24.3%	24.0%	24.0%	24.0%
Percentage of children with height and weight recorded who are obese (actual)	10.6%	11.4%	10.7%	10.8%	11.0%	25.3%	25.0%	23.3%	24.3%	24.2%
Number of children with height and weight recorded	2,625	3,223	3,565	3,487	3,615	2,522	2,420	2,442	2,672	2,857
Percentage of children with height and weight recorded (target)	87.0%	87.0%	87.0%	87.0%	87.0%	89.0%	89.0%	89.0%	89.0%	89.0%
Percentage of children with height and weight recorded (actual)	87.0%	92.5%	93.3%	95.5%	94.0%	89.0%	93.4%	91.9%	93.1%	92.0%

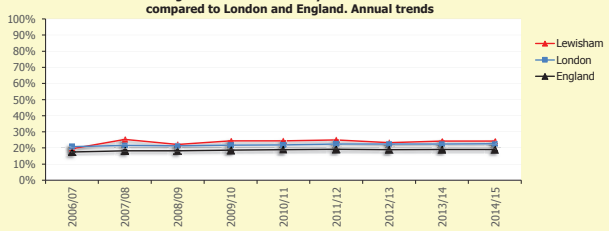
National Child Measurement Programme - 2014/15

Chart 1: Percentage of school children in reception who are obese. Lewisham compared to London and England. Annual trends



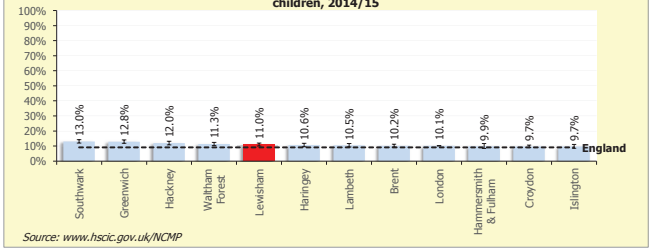
Source: www.hscic.gov.uk/NCMP

Chart 2: Percentage of school children in year 6 who are obese. Lewisham compared to London and England. Annual trends



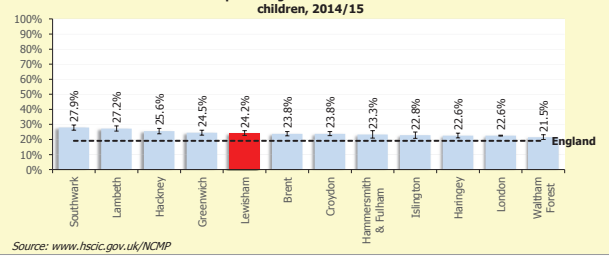
Source: www.hscic.gov.uk/NCMP

Chart 3: Reception year: annual percentages with 95% confidence intervals of obese children, 2014/15



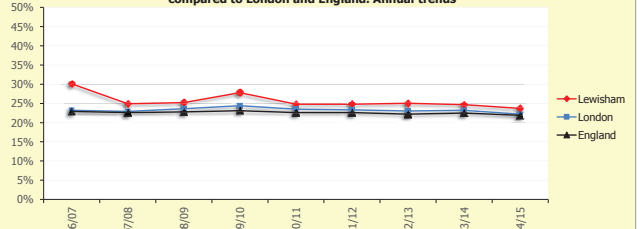
Source: www.hscic.gov.uk/NCMP

Chart 4: Year 6: annual percentages with 95% confidence intervals of obese children, 2014/15



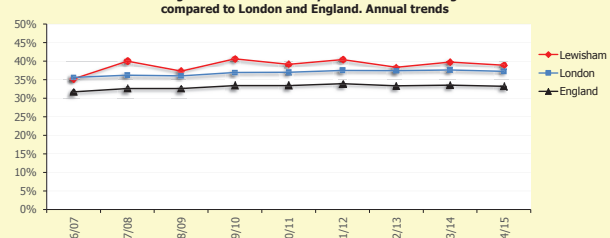
Source: www.hscic.gov.uk/NCMP

Chart 5: Percentage of school children in reception with excess weight. Lewisham compared to London and England. Annual trends



Source: www.hscic.gov.uk/NCMP

Chart 6: Percentage of school children in year 6 with excess weight. Lewisham compared to London and England. Annual trends

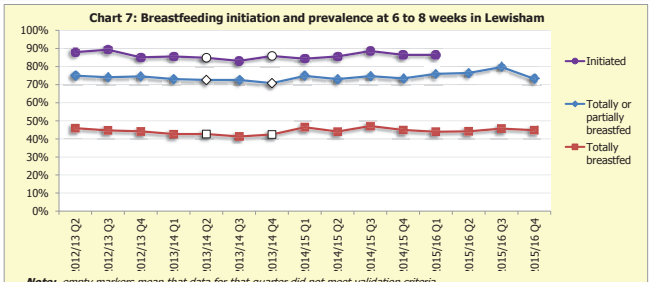


Source: www.hscic.gov.uk/NCMP

Public Health Outcomes: Whole System Approach to Obesity

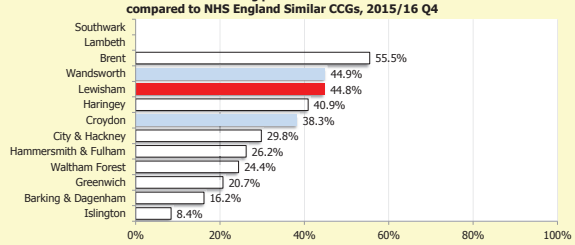
Breastfeeding

Chart 7: Breastfeeding initiation and prevalence at 6 to 8 weeks in Lewisham



Note: *empty markers mean that data for that quarter did not meet validation criteria*
Source: NHS England/Department of Health

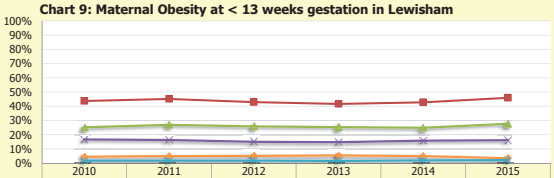
Chart 8: Exclusive breastfeeding prevalence at 6 to 8 weeks in Lewisham compared to NHS England Similar CCGs, 2015/16 Q4



Note: *empty bars mean that data did not meet validation criteria; missing bars denote no submission*
Source: NHS England/Department of Health

Trends/Benchmarks - Adults Weight

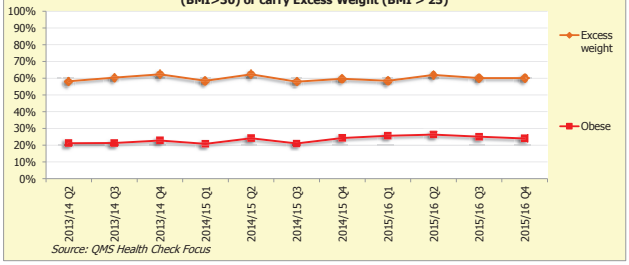
Chart 9: Maternal Obesity at < 13 weeks gestation in Lewisham



	2010	2011	2012	2013	2014	2015
Underweight	4.6%	5.0%	5.2%	5.5%	5.1%	3.5%
Overweight	25.2%	27.0%	25.9%	25.3%	24.9%	27.7%
Obese	16.7%	16.4%	15.1%	14.8%	15.9%	16.1%
Excess Weight	43.7%	45.2%	42.9%	41.7%	42.8%	45.9%
Morbidly obese	1.8%	1.8%	1.9%	1.6%	2.0%	2.2%

Source: Lewisham and Greenwich NHS Trust

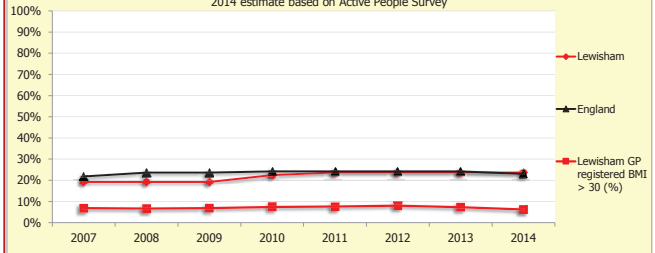
Chart 10: NHS Health Checks, Lewisham - % of persons aged 40-74 who are Obese (BMI>30) or carry Excess Weight (BMI > 25)



Source: QMS Health Check Focus

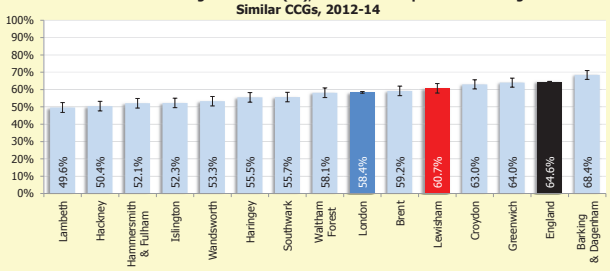
Chart 11: Adult obesity modelled estimates: % of persons 16+ in Lewisham with GP registered BMI > 30

2007-2013 estimates based on Health Survey for England
2014 estimate based on Active People Survey



Source: http://fingertips.phe.org.uk/profile/health-profiles

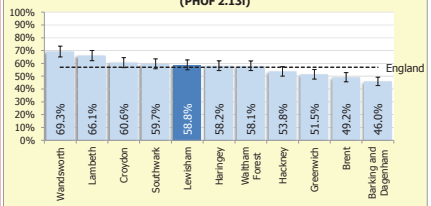
Chart 12: Excess weight in Adults (%), Lewisham compared to NHS England Similar CCGs, 2012-14



Note: *Hammersmith &Fulham /Islington included for CYP Benchmarking*
Source: www.phoutcomes.info/

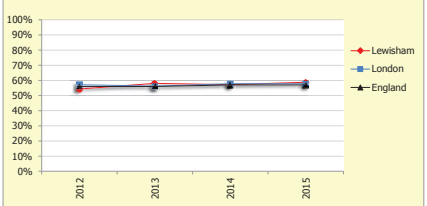
Physical Actvity - Trends/Benchmarks

Chart 13: Adults (16+) classified as physically active, i.e., achieving at least 150 minutes of physical activity/week. Lewisham compared to its similar CCGs and England, 2015 (PHOF 2.13i)



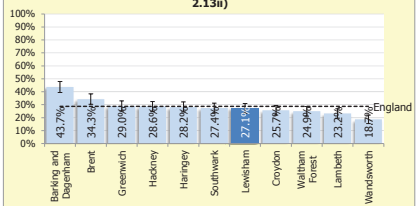
Source: Active People Survey (www.phoutcomes.info)

Chart 14: Adults (16+) classified as physically active, i.e., achieving at least 150 minutes of physical activity/week. Lewisham compared to London and England (PHOF 2.13i)



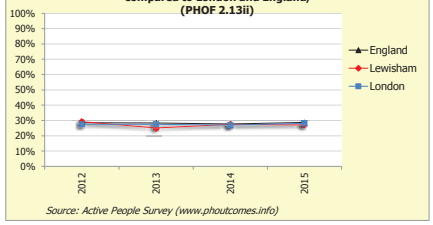
Source: Active People Survey (www.phoutcomes.info)

Chart 15: Adults (16+) classified as physically inactive. (less than 30 minutes exercise per week) Lewisham compared to its similar CCGs and England, 2015 (PHOF 2.13ii)



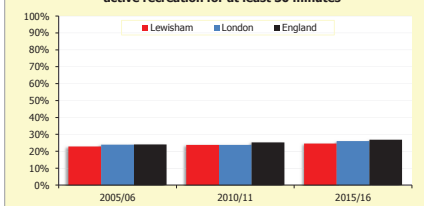
Source: Active People Survey (www.phoutcomes.info)

Chart 16: Adults (16+) classified as physically inactive. (less than 30 minutes exercise per week) Lewisham compared to London and England, (PHOF 2.13ii)



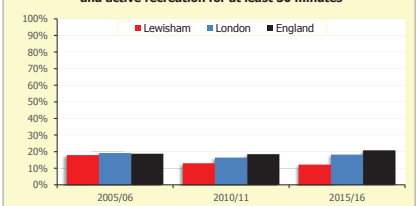
Source: Active People Survey (www.phoutcomes.info)

Chart 17: CMO 3 x 30: % Male participation in at least 3 days (on at least 12 days in last 4 weeks) sport and active recreation for at least 30 minutes



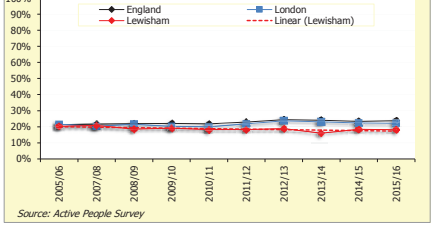
Source: Active People Survey

Chart 18: CMO 3 x 30: % Female participation in at least 3 days (on at least 12 days in last 4 weeks) sport and active recreation for at least 30 minutes



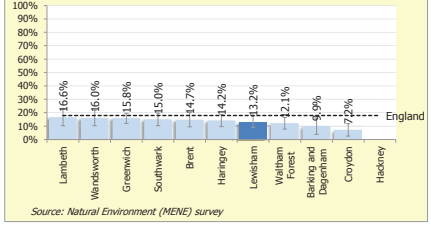
Source: Active People Survey

Chart 19: % Total adult participation in at least 3 days (on at least 12 days in last 4 weeks) sport and active recreation for at least 30 minutes



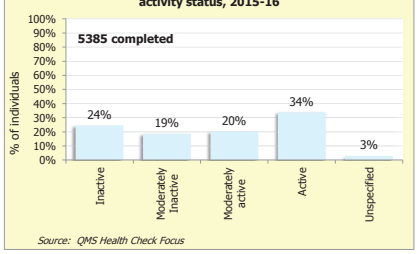
Source: Active People Survey

Chart 20: Adults (16+) using outdoor space for exercise/health reasons. Lewisham compared to its similar CCGs and England, Mar 2014 - Feb 2015 (PHOF 1.16)



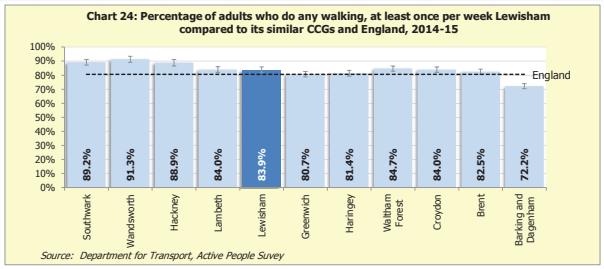
Source: Natural Environment (MENE) survey

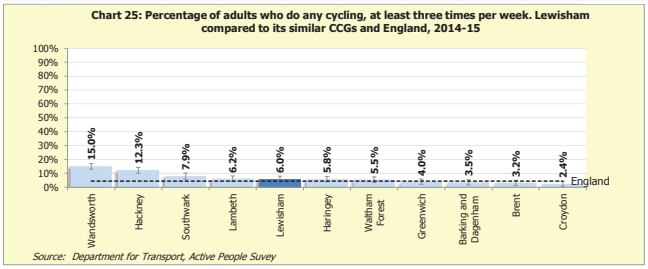
Chart 21: Lewisham NHS Health Checks by physical activity status, 2015-16

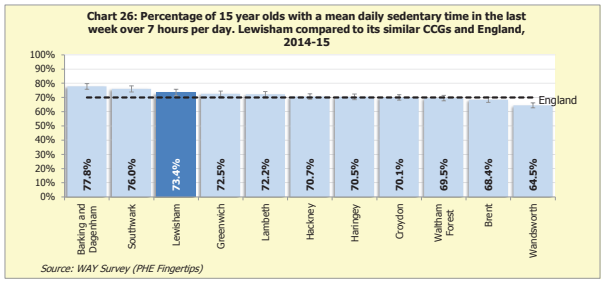


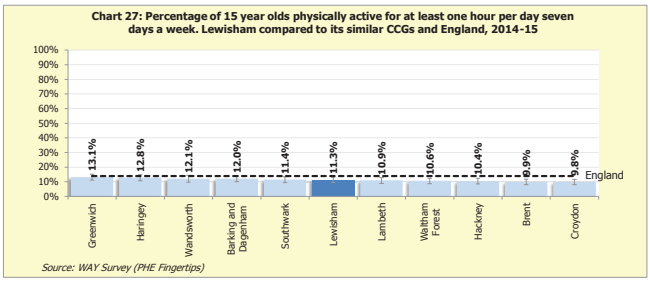
Source: QMS Health Check Focus

Public Health Outcomes: Whole System Approach to Obesity









Key Performance Indicators

Area		Indicator (and frequency of reporting)	Previous data Period	Previous data Value	Current data Period	Current data Value
Environment		Change 4 Life sugar swap signups	2013/14	1230	2015	1225
		Change for Life Get Moving Signups			2015/16	1189
		Use of outdoor space for exercise health reasons	2013/14	8.7%	2014/15	13.2%
		Planning applications for fast food outlets refused	2014/15	5	2015/16	2
		Number of Breastfeeding Welcome venues			2015	60
		Number signed up to the sugar smart campaign				
		Number attending community cookery clubs	New		2016/17 Q1	38
Training		Childhood obesity training staff	2015/16 Q4	34	2016/17 Q1	12
		Every Contact Counts Training			2015/16	133
		Participants attending nutrition/weight management training	2015/16 Q1-2	69	2015/16 Q3-4	194
Vitamin D		Number of children registered	2015/16 Q3	1152	2015/16 Q4	1172
		Number of children's drops issued	2015/16 Q3	3740	2015/16 Q4	4069
		Number of parents registered	2015/16 Q3	1056	2015/16 Q4	1080
		Number of tablets issued - pregnant women	2015/16 Q3	632	2015/16 Q4	579
		Number of tablets issued - post-natal women	2015/16 Q3	1829	2015/16 Q4	1488
Fruit and Veg Intake		Proportion of the population meeting the recommended '5 a day' on a usual day	2014	48.1%	2015	44.0%
School meals		% take-up KS1 Universal Infant FSM (yrs R,1,2) Month	Dec-15	87%	Mar-16	87%
		% take-up KS2 paid school meals (yrs 3-6)	Dec-15	63%	Feb-16	60%
		% take-up KS2 free school meals (yrs 3-6)	Dec-14	92%	Mar-16	85%
		% total take-up Secondary school meals	Dec-15	43%	Mar-16	41%
		% take-up Secondary free school meals	Dec-15	46%	Mar-16	77%
Weight management Children	Mend	Numbers referred	2015/16 Q4	181	2016/17 Q1	267
		Numbers recruited		55		145
		Numbers completed		12		46
Weight management Adults	Weight Watchers	Weight watchers number referred	2015/16 Q3	339	2015/16 Q4	285
		% completed programme	2015/16 Q3	54%	2015/16 Q4	54%
		% completed with >5% weight loss	2015/16 Q3	50%	2015/16 Q4	53%
	Dietetic Weight Management Servce	Number referred	2015/16 Q2	134	2015/16 Q3	120
		% completed programme	2015/16 Q3	41.3%	2015/16 Q4	31.0%
		>5% weight loss	2015/16 Q3	26.0%	2015/16 Q4	25.0%
		No increase in BMI at 12 months	2015/16 Q3	63.0%	2015/16 Q4	51.0%
Exercise on Referral (EOR)		Number of EOR (16+) referrals received (Fusion Leisure Data).	2015/16 Q1+2	735	2015/16 Q3+4	447
		Number of EOR referrals (16+) attended initial group assessment (Fusion Leisure data)	2015/16 Q1+2	249	2015/16 Q3+4	428
		Number of EOR completers (Fusion Leisure Data)	2015/16 Q1+2	122	2015/16 Q3+4	75
		Number of EOR referrals received (1Life)	2014/15	465	2015/16 Q1-3	195
		Number of EOR initial assessments completed (1Life)	2014/15	284	2015/16 Q1-3	149
		Number of EOR completers (1Life)	2014/15	21	2015/16 Q1-3	16
Healthy Walks		Total number of adults participating in the regular walks (on average at least once a week)	2014/15 Q1+2	1432	2015/16 Q1	601
		Total number of new walkers	2014/15 Q1+2	132	2015/16 Q1	86
		Percentage of new walkers reporting doing more physical activity	2014/15 Q1+2	82%	2015/16 Q1	85%
Walking		Percentage of Adults who do any walking, at least fives times per week (Department of Transport, Active People Survey)	2014/15	60.9%		
Local Cycling Initiatives		Number of adult cycle lessons delivered to beginners and improvers 16+ years	2014/15	129	2015/16 (Q1-3)	450
		Number of adults who have taken up bike loan offer	2014/15	300	2015/16 (Q1-3)	397
Cycling		Percentage of Adults who Do Any Cycling (PHE Fingertips)	2014/15	16.1%		
Children		Number of pupils particpating in the Daily Mile			2016/17 Q1	900
		Number of Year 6 participating in Bikeability cycle training (Level 1 and/or level 2 training)			2016/17 Q1-Q2	533
		Number of under 9's learn to ride sessions with parents	2015/16 (Q1-3)	224	2016/17 Q1-Q2	148
		Walking to School Once a Week (School Travel Plan)				
Other		Number of adults, 60+ yrs accessing free swimming	2014/15	5071	2015/16	13.2%

Achievements

- Breastfeeding: Community and maternity services achieved UNICEF Baby Friendly Initiative stage 2 award in 2014.
- Nutrition initiatives: Implementation of a universal vitamin D scheme reached 30% of eligible women and 50% of infants under 1 year.
- Physical activity: Implementation of a 20mph zone across Lewisham
- Healthier built environment: Successful in bid to be a national pilot for the Whole Systems approach to obesity.
- Obesity surveillance: High participation was achieved in the National Child Measurement Programme. Also weight management support, providing a range of programmes available for children and adults as part of a tiered referral pathway accessed by nearly 2,500 residents a year.
- Implementation of the Daily Mile: Currently 4 Primary Schools are taking part.
- Use of Outdoor Space for exercise/health reasons has increased.

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Healthier Communities Select Committee		
Title	Healthwatch Mental Health Forum	
Contributor	Scrutiny Manager	Item 6
Class	Part 1 (open)	18 October 2016

1. Purpose

The report of the Healthwatch Mental Health Forum is attached.

3. Recommendations

The Committee is asked to note this information report.

For further information, please contact John Bardens, Scrutiny Manager, on 02083149976.

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Healthwatch Mental Health Forum

4th August 2016

The Healthwatch Croydon Forum, meeting quarterly, advises on our priorities & associated work programmes. The focus of this meeting was mental health, looking at the support residents require, the services they access, and how we, as a community, can raise awareness and maximise support.

Working in partnership with Healthwatch Lewisham, Southwark and Lambeth, the event was attended by mental health service users, and their carers, from the boroughs served by South London and Maudsley NHS Foundation Trust (SLaM).

At the table discussions, delegates raised issues around medication, service accessibility, information and advice, user involvement, awareness and carers. The following themes emerged:

Medication

It was commented that medication 'can have side effects that can worsen, not improve a person's wellbeing' and delegates considered whether clinicians were 'target bound' to prescribe medication, overlooking alternative approaches and talking therapies.' In one personal experience, a psychiatrist was persistent in offering medication that was not wanted, and implied 'discharge was conditional on acceptance'.

The Forum said:

Patients should be respected when reporting side effects, and alternative therapies considered should the patient clearly not want, or has concerns about medication offered. Is it appropriate for clinicians to 'pressure' patients, or make service aspects (such as discharge) conditional on acceptance of medication?

Service Accessibility

Most services are now promoting online services - this will save resources but can be 'extremely problematic' when trying to speak to someone. It was noted that referrals to Improving Access to Psychological Therapies (IAPT) can take a long time and social worker allocation 'may take up to ten months'. It was noted that eligibility criteria for services is 'shifting to a crisis', rather than a preventative model.

The Forum said:

Getting 'a human response' is very important and automated systems should facilitate access to staff or volunteers. There needs to be 'better access' to talking therapies and social services in particular, with less waiting time. Would self-referral, or greater use of key workers, assist in expediting treatment and care? In terms of prevention, is there adequate focus and provision locally?

Information and Advice

Delegates said 'we need clear information on mental health services', including what is available, opening times, and what to do if you can't get access. It was felt there is too much 'clinical-speak' and residents need language they can understand.

The Forum said:

Services should use plain language wherever possible. Could we make better use of the voluntary sector to advertise and to signpost - they already hold a 'wide array of information'. A one-stop-shop for information would be welcome.

User Involvement

One person commented 'it's only when you have mental health issues, you realise what mental health is' and delegates felt that having a 'hidden condition' is harder because services may try to 'fit you into a medical model'. Mental health and learning disabilities are often ignored or overlooked, especially if clients have learned to mask their condition in order to cope, or fit in with society.

The Forum said:

We need more integrated working and information sharing between services, to achieve a holistic approach. Services need to be better at recognising and diagnosing mental health conditions, this means they need to listen to patients, families and carers.

Awareness

Some ethnic minority communities feel 'mental health is a western idea', and lack of understanding may deter people from accessing services. Men generally can be reluctant to seek help, with high rates of suicide in males up to 43 years of age.

The Forum said:

There is need to create awareness among communities - publicity in social venues such as churches and pubs would reach a wider section of society. People 'should be respected in their own needs' and this requires person centred approaches which recognise culture, age and gender.

Carers

'Care for the carers – who does?' It was felt that families and carers need more support, with better access to respite and carers assessments. Many carers 'don't want to discuss their own mental health needs', and the only time they come forward 'is with an issue'.

The Forum said:

The mental health and wellbeing of carers should not be overlooked. Carers should be encouraged and supported to get assessed, and access entitlements such as respite.

Our database contains emerging themes on mental health. In the afternoon session, we asked the following questions, framed in various sentiment, so see which resonated with the delegates. The trends may form the basis of future work on mental health.

Agree or Disagree?

"Doctors can be too quick to reach for the medication. What about alternatives?" *Agree*

"There is adequate funding for mental health services." *Disagree*

"I would like a greater choice of services. I feel like a square peg in a round hole sometimes." *Agree*

"I wasn't on the waiting list for too long." *Disagree*

"The impact of mental health on carers and family members is not fully recognised." *Agree*

"My condition was diagnosed very quickly." *Disagree*

"I got six sessions, but could really do with twice that…" *Neither agree or disagree*

"I am not too worried about the side effects of my medication." *Disagree*

"I find it easy to talk about my condition within the community." *Neither agree or disagree*

"Getting a referral was a hassle, to be honest!" *Agree*

"GPs are very knowledgeable about mental health." *Disagree*

"I find that services do work together and are joined-up." *Disagree*

"Getting through to someone on the phone can be difficult." *Agree*

"I know what to do in a crisis." *Neither agree or disagree*

"I have been given a good level of advice and information." *Disagree*

"I can usually get a GP appointment without difficulty." *Disagree*

"I have a named key worker." *Agree*

"Hidden conditions are much harder to treat than physical conditions." *Agree*

"I feel listened to." *Disagree*

Appendix 1 contains all comments posted by delegates during the day. We would like to thank Healthwatch Lewisham, Southwark and Lambeth for supporting the event, and all those who attended and assisted on the day.

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Healthier Communities Select Committee		
Title	Healthwatch report: People that don't speak English and Access to Health and Wellbeing Services in Lewisham	
Contributor	Scrutiny Manager	Item 7
Class	Part 1 (open)	18 October 2016

1. Purpose

The Healthwatch report *People that don't speak English and Access to Health and Wellbeing Services in Lewisham* is attached.

3. Recommendations

The Committee is asked to note the report.

For further information, please contact John Bardens, Scrutiny Manager, on 02083149976.

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Seldom Heard Speak Up

People that don't speak English and Access to Health and Wellbeing Services in Lewisham

May 2016

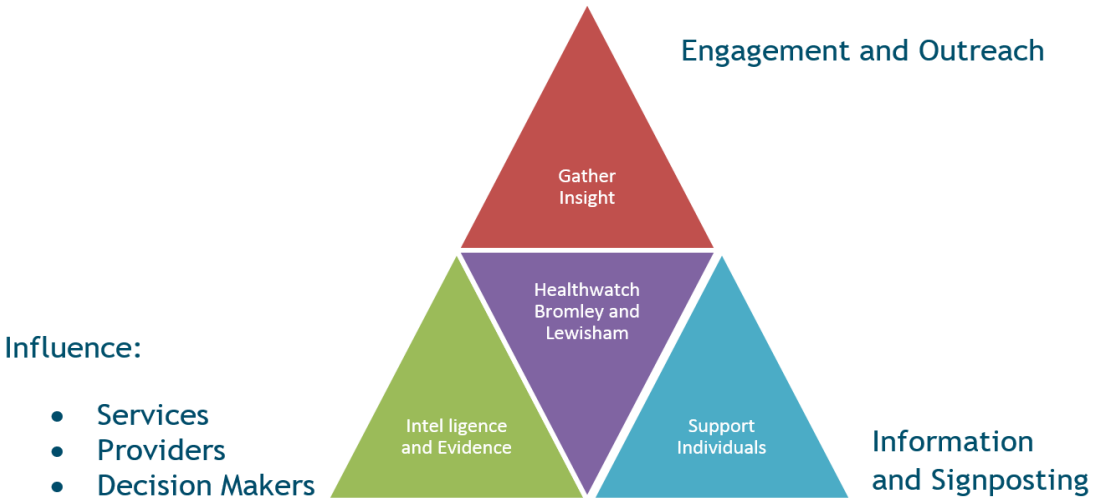
Community House, South Street, Bromley, BR1 1RH, 0208 315 1916

Contents

1. What is Healthwatch Lewisham?

Healthwatch Lewisham (HWL) 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 is as an independent health and social care organisation, representing the voice of local people and ensure that health and social care services are designed to meet the needs of patients, social care users and carers.

Healthwatch also supports children, young people and adults in Lewisham to have a stronger voice in order to influence how health and social care services are purchased, provided and reviewed within the borough.



Healthwatch's core functions are:

1. Gathering the views and experiences of service users, carers, and the wider community,

2. Making people's views known,

3. Involving locals in the commissioning process for health and social care services, and process for their continual scrutiny,

4. Referring providers of concern to Healthwatch England, or the CQC, to investigate,

5. Providing information about which services are available to access and signposting,

6. Collecting views and experiences and communicating them to Healthwatch England,

7. Work with the Health and Wellbeing board in Lewisham on the Joint Strategic Needs Assessment and Joint Health and Wellbeing strategy (which will influence the commissioning process).

Who we engaged with?

In late 2015, Healthwatch Lewisham engaged with communities that don't speak English as their first language including Vietnamese, Tamil, Polish, Turkish and Refugee groups. We engaged with 95 individuals which covered a broad range of demographics. Many people engaged with were parents or carers and many recognised themselves as being disabled. The full breakdown of equality and diversity data can be found in our individual reports.

Healthwatch is aware that due to limited resources we engaged with a relatively small samples of people from individual communities, especially in relation to refugees. Within this group we spoke to a small number of participants of Chinese and African origins. Healthwatch Lewisham would welcome the opportunity to conduct a broader research in future if additional resources become available.

During the engagement HWL asked participants to share their experiences of health and social services both positive and negative. The questions asked covered access and general comments around health and social care.

Healthwatch believes that it is important to highlight the issues faced by the communities as part of intelligence which can be used by providers and commissioners for learning and improvement of services.

Summary

Healthwatch discovered that people who don't speak English as the first language often face similar issues to the general public such as difficulties in accessing GP services, problems with referrals and staff attitudes. However, we also found that there are additional barriers that participants experienced, such as lack of knowledge about local services available; lack of knowledge about how the system works and what to expect; difficulties in accessing translation services; and lack of clarity around eligibility.

Some issues were specific to the communities and they were:

- Lack of trust towards medical professionals amongst some Polish participants, lack of referrals that leads to delayed diagnosis and treatment and use of private Polish clinics.
- Lack of clarity of eligibility to translation services and translation quality for Vietnamese participants combined with cultural differences and lack of knowledge about local service provision and access
- Self-selection of GPs that speak Tamil amongst Tamil participants (this finding is reflected in the number of translation requests for primary care – low and social care – high).
- Turkish elders were generally happy with the GP services but there was a distinct lack of clarity around waiting times for referrals. Many participants were not happy with medicine replacements offered by pharmacies or doctors prescribing low quality medicine.
- Refugee participants of Chinese origin complained about the lack of health checks available for younger people.

Summary of findings

NHS positive comments

It is important to note that many of the focus group participants praised the NHS and said they are happy with the services they received in primary and secondary care settings. Many participants said they received excellent care and were treated appropriately. Others praised the excellent care they received from their GPs, maternity services and hospitals.

GP positive comments

Despite negative issues raised in regards to GP services, many participants confirmed they are very happy with their GPs. The most praised trait was their listening skills which ensured participants trusted their GPs and felt they were treated with respect. Most importantly those patients were happy with their treatment and the overall service they received. Participants agreed that *'when the doctor listens, it makes the communication barrier narrower'*. Participants also pointed out the importance of a positive attitude including a caring approach, making eye contact and making an effort to understand in spite of possible language barriers. Being referred for medical tests, explaining a diagnosis and treatment plans were also mentioned as being of a good standard. Being treated with respect, as opposed to looking at a computer screen, was also highlighted as positive attitude that made a big difference to participants.

- *Vietnamese participant: He (the GP) listened to my limited English. I showed him the old prescription so he understood'.*

Difficulties in booking GP appointments

The research found that access to GP services is by far the biggest problem for the majority of the participants across all communities and age groups. There were

three subthemes that emerged: the waiting time for a pre-booked appointment; difficulties in booking urgent appointments; and an urgent appointment booking system.

Many people, especially elderly and parents, complained they can only book appointments two, or three weeks in advance and these are not appropriate if you need to see a doctor urgently.

Tamil elder: 'At our age every day is a bonus. One day you might be OK but another you might not be. As a result you should be able to see a GP when you need to, not wait two weeks… There should be more urgent appointments available.'

Healthwatch heard that people struggle with booking urgent appointments and that the booking system and appointment availability creates an impossible barrier that participants felt they cannot overcome. This issue was universal and shared by members of most communities.

Vietnamese participant: Getting an appointment is so hard. They always say to ring back tomorrow'. But the same things happen the next day.'

Tamil elder: When you call in the morning the phone is engaged till 8.40am. You can hear the message 'We're very busy right now'. When you finally get through you hear: 'all the appointments are gone'.

Refugee, mother: 'My daughter was unwell. I called the surgery from 8am, but the phone was engaged. When I finally got through there were no appointments left.'

Refugee participant: 'I use three phones and ring on all of them and this way I can get an appointment.'

Tamil elder: 'I had to fight for it'.

Polish participant: I don't use GPs as I can never book an appointment even if I try…'.

Some participants complained about the booking system in surgeries. Those particularly unhappy were pointing out that in order to book an appointment they needed to queue outside the surgery which was particularly difficult for elderly participants and those with long term conditions. Healthwatch also heard many negative stories of phones being constantly engaged when they needed to book an urgent appointment.

An elderly Vietnamese participant: 'If I want to see a GP on that day I need to be ready by 7am.'

Vietnamese participant: My son had a problem. He had a high temperature but the phone was always engaged. By the time I got through there were no more appointments.'

Using A&E and other services as a result of difficult GP access

As a result of difficulties in booking urgent appointments many participants (both young and old) told Healthwatch they go to Accident and Emergency (A&E) to ensure they were treated.

A refugee, mother: When you're unwell and try to book an appointment they say the earliest one is in two weeks. I can't hold on for two weeks. So I have no choice but to go to A&E.'

Vietnamese participant: 'I would go to the hospital (A&E) and wait there until I'm seen and treated'.

Some participants use private health clinics if they can't access GP services or they ae unhappy with the service.

GP appointment time

Some participants from various communities told Healthwatch they feel that the length of the appointment is too short and doesn't allow them to fully communicate their problem. They felt that the appointments are rushed and not thorough which can jeopardise safety and effectiveness. Short appointment times made parents and the elderly anxious for their own or their children's wellbeing.

Refugee, mother: 'I started explaining my daughter's symptoms. The doctor replied 'That's too much. It's an emergency only appointment. Just tell me specifically what's wrong with her now.'

Refugee, mother: 'I didn't expect that from a doctor (not giving the patient enough time to explain the symptoms in full)… Why am I here, if I can't tell you what's wrong?'

Refugee mother: 'I booked an appointment to see my doctor. I had three problems. I only got 10 minutes. They said if you have three problems, make three appointments. I just wanted to get reassurance.'

Continuity of care – seeing the same GP

Seeing the same GP and consultants was important for participants when having appointments. Many complained that they rarely see the same person and need to start explaining issues from the beginning. Healthwatch noted that having the same GP or consultant creates a good patient – doctor relationship, builds trust, and saves appointment time.

Refugee mother: 'They keep reading and reading (patient's notes) which takes ages.'

Refugee mother: 'I want to see my own doctor. They don't let me see him.'

Staff Attitudes

Doctors including GPs

Many participants complained about the way doctors including GPs interact with them. Not listening to the patients and lack of eye contact combined with looking at a computer were often mentioned. Another negative observation was the doctor's inability to engage with patients, some people felt their doctor was not listening and treated patients in an impersonal way.

Refugee mother: 'Doctors don't listen anymore.'

Polish participant: 'He [GP] is only looking at a computer. He treats me like a number'.

Receptionists

Healthwatch heard many participants agree that the reception staff at GP practices were not welcoming and impolite. This concerned participants and often created an obstacle at the first access point to services.

Refugee mother: 'When you ring to book an appointment, the receptionists are rude.'

Refugee mother: [When she rings the surgery] 'The response is not welcoming. They don't speak to you politely.'

Refugee mother: 'The Rude receptionist discourages me from ringing for my appointment. As a result I go to A&E as I don't want to book or ring again.'

Vietnamese participant: 'GP receptionists should treat people with more respect' and 'be more mindful when dealing with people who don't speak English as their first language.'

Inadequate treatment

Referrals

Many participants complained about their GPs not referring them to services. In their eyes it delays diagnosis and treatment of conditions experienced by patients. Participants said some GPs are not interested in getting '*to the bottom of the problem*' but prescribe medicine to control the symptoms. A few participants shared their experience of waiting for months, even years, to be diagnosed and treated. One patients said her husband passed away as a result of a late diagnosis of cancer, despite trying to raise the issue several times with their GP.

Polish participant: '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 to have tests and diagnosis for serious illnesses such as cancer. We were waiting 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'.

Polish participant: 'My husband fainted and had a seizure but he didn't get a referral for an MRI scan or any other tests'.

Polish participant: 'I had to fight for it [A referral to a medical test]'.

Polish participant: 'It's very hard for an elderly person to receive a referral despite requesting one…'.

Paracetamol and low quality medicine

Some participants were unhappy with the quality of the treatment they received from GPs and told Healthwatch Lewisham that '*Doctors here cannot give anything but paracetamol'* often not finding the route of the problem. Conversely one participant praised her doctor saying *'She doesn't just prescribe paracetamol.'*

Others complained about the low quality of medicine that doctors prescribe and the replacement medication that pharmacists dispense as an alternative to the original prescription. Participants told Healthwatch they believe the original works better than the alternative medication they received. Some participants also complained about the low quality of medicine prescribed.

Inconsistency

Healthwatch found out that there was an inconsistency of care especially in relation to GPs services (including standard of care and attitude) and interpreting. It is worth pointing out that many participants were unhappy with the care they received whereas others had an opposite experience and praised their doctors for being caring and listening.

Vietnamese participant: [The quality of service] 'depends on who you see.'

Vietnamese participant: 'Some GPs are good and some are very bad. I had to change my 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.'

Cultural differences

This theme was varied according to the specific communities engaged with. Many participants seemed to project experiences of their previous health systems on the NHS, such as expectation for the front line staff to be qualified pharmacists and an expectation to be eligible for an annual health check as a preventative measure. Healthwatch found that lack of knowledge about the NHS system and local service accessibility created confusion and unnecessary frustration amongst participants. Due to language barriers some participants found it difficult to access information about services provided both locally and nationally.

Mental Health

Healthwatch noted a distinct lack of experiences related to mental health issues. However the evidence indicates many participants were experiencing issues with their mental health, with many community leaders indicating this is an issue that many people are affected by. Community members were interested in Improving Access to Psychological Therapies (IAPT) services and many asked Healthwatch for information about the referral process and contact details. During our engagement we collected information in relation to long term conditions and we noted some participants referred to experiencing stress, low mood and feeling depressed. This suggests that mental health is shrouded in stigma and members of the community do not disclose their problems openly. In addition, we discovered that language barriers makes the diagnosis of mental health conditions such as dementia and depression difficult and decreases access to services including talking therapies.

Interpreting

Many members of the communities did not express the need to access interpreting services and the need for the service differed amongst the communities. Those who needed to access the interpretation services had varied experiences with some being content with the service whilst others often used family members to help out. Other people struggled with problems in relation to translation services including availability criteria, quality, and cancellation of translation sessions resulting in cancellation of appointments (including hospital appointments). Healthwatch found that the Vietnamese community experienced the most negative issues relating to interpreting services. One of the suggestions this community raised is to have access to an advocate service with Vietnamese speaking personnel who could translate medical letters and help to book appointments and navigate the system.

Vietnamese participant: 'I've waited for half an hour for an interpreter, despite my appointment being booked in advance.'

Vietnamese participant: 'I waited 20 minutes for an interpreter at a hospital. No interpreter was provided and I was told to go home and bring a relative to the re-booked appointment.'

Vietnamese participant: [Interpreters are] 'Young students who don't understand Vietnamese people who live in London and don't know the medical language very well.'

Vietnamese participant: 'The current interpreters don't know patients and can't communicate the message properly. It's important to understand cultural differences and (different) Vietnamese accents.'

Conclusion

Healthwatch found that a lot of issues faced by communities that do not speak English as their first language experience similar issues as the general population such as difficulties in accessing GP services and dissatisfaction with NHS staff attitudes. Positive comments that were common to many groups were general satisfaction with NHS, appropriate treatment and satisfaction with doctors. Each group had individual issues that were important to them and this was often driven by the demographic of the participants. For example the refugee group consisted mainly of mothers and the comments focused on access to services when children were unwell; the Tamil participants who were mainly elderly with multiple long term conditions commented on the short time (5-10 minutes) during GP appointments. Another significant issue for this group was choosing GPs who speak Tamil in order to enable easier communication and to remove the access barrier.

The issues experienced by people who do not speak English as their first language are often exacerbated by communication barriers and by a lack of knowledge about NHS provision both locally and nationally.

Recommendations

As a result of our findings through our engagement with people who don't speak English as their first language in the borough, Healthwatch Lewisham sets out the following recommendations to improve access to services for those communities.

COMMISSIONERS AND PROVIDERS:

GP Services

- Improve access to GP services including improving access to urgent appointments and improving booking systems. Consideration should be given to people with communication barriers especially elderly, parents of young children and those with long term conditions.
- Increase the length of GP consultation appointments for people who experience communication problems especially the elderly, parents and those with long term conditions to allow safe and effective diagnosis and treatment.
- Improve waiting times at GP services and provide information and explanations for delays when they occur.
- Make appointments with a named GP more readily available.

Staff attitudes

- Identify, promote and encourage existing good practice amongst GPs including a caring approach, good listening skills and strong communication when faced with communication barriers.

- Improve staff attitudes towards patients by increasing the emphasis on listening to the patient, and by taking time to understand the community members.

Cultural Awareness

- Provide appropriate training for staff to enable improved communication and cultural awareness.

Information

- 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 the form of a booklet or as information sessions delivered through local groups.

Interpreting

- Clarify and publicise the eligibility criteria for interpreting services for Lewisham residents.
- Improve access to interpreting services.
- Consider investing in local service providers for the provision of face to face interpreting services and advocacy.

Mental Health

- Improve diagnosis and support for people with mental health issues who don't speak English as their first language.

Referrals

-Inform the patient about the expected waiting time for a referral. Provide an acknowledgement so the patient is reassured of the access to service.
- Explain to patients what tests they are being referred for and the reason for the referral.
- Ensure patients understand the treatment plan and treatment options available to them such as medical test or escalation to the specialists.

Medicine

- Clearly explain the reason for prescribing a particular medicine and keep the patient informed and involved when an alternative is offered.

- Enable and encourage health professionals to seek confirmation that the patient understands how the prescribed medicines work, the side effects and the correct dosage and to give patients the opportunity to ask questions about their medicines.

Health Improvement

- Continue to support and fund established groups to deliver health improvement training including self care for long term conditions and a healthy eating courses.

Appendix 2 - Healthwatch'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 Lewisham on the Joint Strategic Needs Assessment and Joint Health and Wellbeing strategy (which will influence the commissioning process).

Seldom Heard Speak Up – People who don't speak English as their first language and Access to Health and Wellbeing Services in Lewisham.

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Healthier Communities Select Committee		
Title	Healthwatch report: The Refugee Community and Access to Health and Wellbeing Services in Lewisham	
Contributor	Scrutiny Manager	Item 8
Class	Part 1 (open)	18 October 2016

1. Purpose

The Healthwatch report *The Refugee Community and Access to Health and Wellbeing Services in Lewisham* is attached.

3. Recommendations

The Committee is asked to note the report.

For further information, please contact John Bardens, Scrutiny Manager, on 02083149976.

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

May 2016

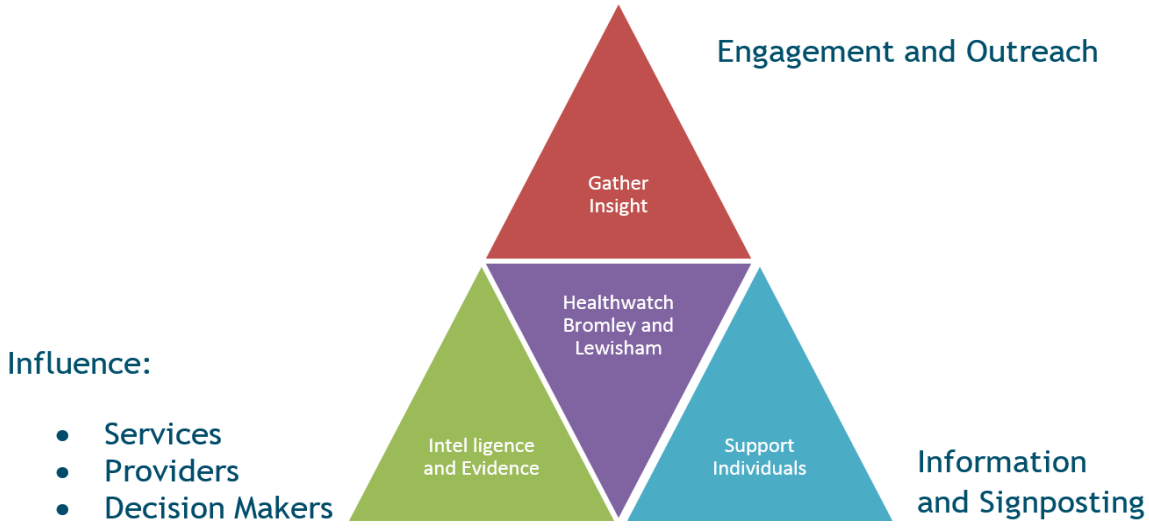
Community House, South Street, Bromley, BR1 1RH, 0208 315 1916

Contents

1. About Healthwatch Lewisham

Healthwatch Lewisham (HWL) 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 is as an independent health and social care organisation, representing the voice of local people and ensure that health and social care services are designed to meet the needs of patients, social care users and carers.

Healthwatch also supports children, young people and adults in Lewisham to have a stronger voice in order to influence how health and social care services are purchased, provided and reviewed within the borough.



Healthwatch's core functions are:

1. Gathering the views and experiences of service users, carers, and the wider community,

2. Making people's views known,

3. Involving locals in the commissioning process for health and social care services, and process for their continual scrutiny,

4. Referring providers of concern to Healthwatch England, or the CQC, to investigate,

5. Providing information about which services are available to access and signposting,

6. Collecting views and experiences and communicating them to Healthwatch England

7. Work with the Health and Wellbeing board in Lewisham on the Joint Strategic Needs Assessment and Joint Health and Wellbeing strategy (which will influence the commissioning process).

2. Acknowledgements

Healthwatch Lewisham would like to thank Action for Refugees in Lewisham for providing a platform to engage with their 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 Lewisham to amplify this voice.

3. The Refugee community of Lewisham

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 (BME) background. [1]

Figure 1 shows the breakdown of ethnic groups in the borough cited in the Lewisham Joint Strategic Needs Assessment (JSNA) 2016. Non-white ethnic groups in Lewisham account for 41% of the population.

Action for Refugees in Lewisham support 130 refugees and asylum seekers a week through their advice services. [2]

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

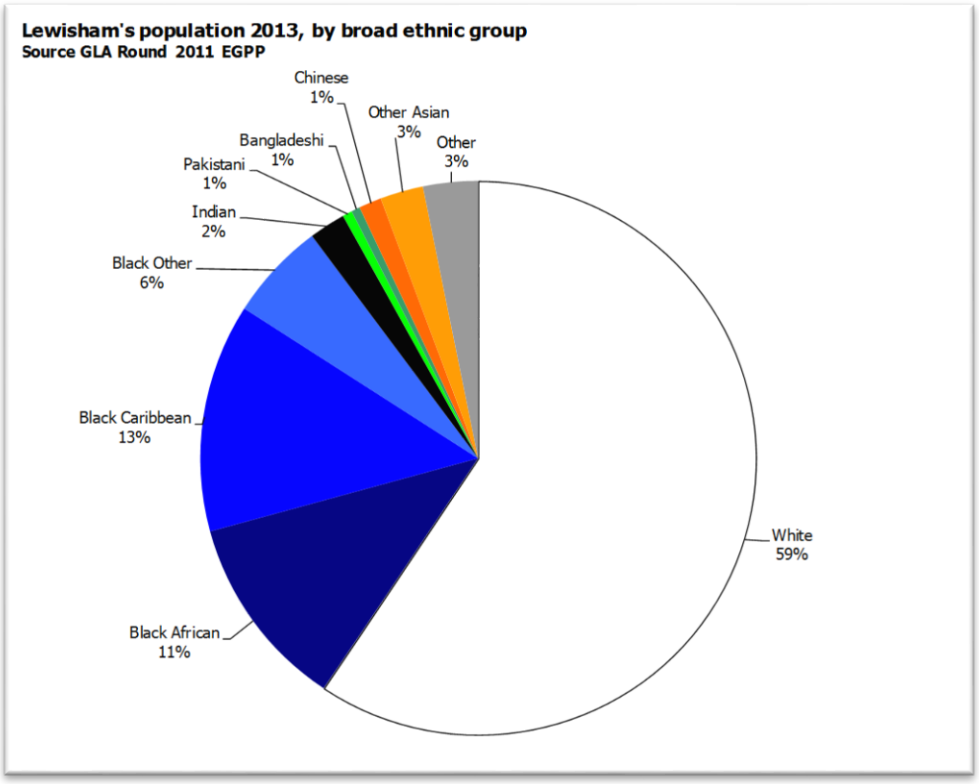


Figure 1 [3]

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.[4] These include the need for cultural issues to be respected, the need for information, communication and education as well as the need for emotional support.

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

[3] Lewisham JSNA, 2016
[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215159/dh_132788.pdf

Emergency, higher rates of hospital admission, and the likelihood of more complex, intrusive interventions.[5]

Asylum seekers are at risk of developing poor health as a result of a number of issues such as difficulty in accessing healthcare services, lack of awareness of entitlement, problems in accessing primary and community healthcare services and language barriers.[6] Asylum seekers may experience conditions which originate from physical or mental torture, trauma or harsh conditions. They also experience a higher rate of mental health issues. Research suggests that health problems increase during an asylum seeker or refugee's time in the UK. In addition failed asylum seekers postpone treatment of minor medical problems that may develop into more serious illnesses (in order to reach a threshold at which they will be treated in Accident & Emergency services). [7]

In addition to the health inequalities many asylum seekers and refugees in Lewisham who have experienced violence and deprivation may have limited knowledge of English and lack support systems. Families supported by Action for Refugees in Lewisham (AFRIL) live in poverty, and some are destitute; they do not have regular meals and often cannot afford suitable clothing.[8]

Through this report, Healthwatch Lewisham draws attention to the experiences of access to health and social care services faced by members of the refugee 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 the 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 Lewisham website.

[5] Good Access in Practice, BME Health Forum 2010
[6] http://www.fph.org.uk/uploads/bs_aslym_seeker_health.pdf

[7] http://www.refugee-action.org.uk/assets/0000/5833/Department_of_Health_-_Review_of_access_to_the_NHS_for_foreign_nationals.pdf
[8] According to Action for Refugees in Lewisham (AFRIL)

5. Methodology

The evidence in this report was gathered through a focus group organised in partnership with Action for Refugees in Lewisham in the latter part of 2015. The group consisted of women from Chinese and African backgrounds.

In order to ensure that people felt comfortable about sharing their experiences, engagement was supported by an interpreter who was known to the participants and was part of the community. The interpreter was invaluable in supporting the process and acted as a bridge between HWL and this close knit community.

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

HWL gathered equality and diversity data alongside that evidencing the prevalence of long term conditions amongst the participants. This can be found in Appendix 1.

6. Findings: The Themes

6.1 Difficulties in booking GP appointments

The majority of participants said that booking an appointment was extremely difficult. They were unhappy that they faced problems at the very first stage of trying to access the service. Most of the participants were mothers who explained that the inability to access a GP when they needed was problematic. They felt concerned when their children were unwell and needed to seek advice from a medical professional, however this was not always possible. One participant said *'My daughter was unwell. I called the surgery from 8am, but the phone was engaged. When I finally got through there were no appointments left.'* Another participant shared a method she uses to ensure she gets through to a surgery on the phone. '*You need more than two phones. I use three and ring on all of them and this way I can get an appointment.'* Although it works for her, she acknowledged that not everyone has the resources and time to do this. Another participant who has young children mentioned that the booking system is too strict and if *'you miss the narrow time slot in which you can ring, there is no chance to see a doctor that day.'* She said that being a busy mum and having a lot on her mind can mean that it is difficult to remember or be available to call during a limited time frame.

6.2 Using A&E as a result of not being able to see a GP

Many participants confirmed that they have used a Walk in Centre in the past, however the majority agreed they go to Accident and Emergency (A&E) to access medical help for their children or themselves. One participant summed up the group's experience by saying: *'When you are unwell and try to book an appointment they say the earliest one is in two weeks. I can't hold on with the sickness for two weeks. So I have no choice but to go to A&E'.*

6.3 GP appointment duration

The majority of participants expressed their concern about not having enough time during an appointment. They felt that the appointments are rushed, not thorough and as a result unsafe and ineffective. Many participants told Healthwatch that this makes them feel anxious for their children's health and wellbeing. One participant told Healthwatch her experience at a GP appointment and a reaction she received: *'I started explaining my daughter's symptoms. The doctor replied "That's too much. It's an emergency only appointment. Just tell me specifically what's wrong with her now.'* The patients felt shocked and anxious. She felt all the symptoms were important as this could impact on the diagnosis of the condition. She was extremely worried about her daughter's health and left the appointment very upset. She expressed her frustration saying: *'I didn't expect that from a doctor... Why am I here, If I can't tell you what's wrong?'* Another participant expressed her sympathy towards doctors and blamed the system explaining it is set up to fail both patients and doctors. Later she added that *'The*

doctors pass the pressure onto us.' Participants felt it was a waste of everyone's time to book separate appointments for different issues. They felt that the appointments are difficult to arrange so once a person manages to book one, they should be able to express all their concerns or have enough time to address an issue in full. Another participant agreed: *'I booked an appointment to see my doctor. I had three problems. I only got 10 minutes with them. They said if you have three problems, make three appointments. I just wanted to get reassurance.'* Another participant added that when she tries to describe her symptoms doctors say: *'no that's enough'* and don't let the patients express their concerns in full.

6.4 Service availability when children are unwell

The theme of service availability touches upon issues previously mentioned in this report, however it is important to highlight, as it captures a specific issue faced by mothers of young children and was shared by the majority of the participants. The mothers said they were confused about where they can go when their children are unwell. The GPs were hard to access and at A&E they were told the problems were too trivial for the service. This left them worried about their children's health and wellbeing. They felt left with no options and did not know where to go to get help. The participants understood that children are often unwell but were extremely worried to see their children with symptoms such as high temperature, vomiting, tired and listlessness amongst others. Participants agreed they needed a service that they could access without barriers to reassure them and rule out any potentially dangerous conditions.

6.5 Staff attitudes

Some participants felt there was an issue with staff attitudes. This applies to two categories of staff: GPs and receptionists

In relation to GPs participants said that some doctors are not good listeners. One participant said *'Doctors don't listen anymore'.* This is linked with not having enough time during appointments and as a result participants felt that GPs didn't appear concerned about patient wellbeing. The research found that in many cases there is no relationship between doctors and patients which indicates a lack of trust.

Comments reflecting on reception staff at GP surgeries were mostly negative. For example, one participant highlighted *'When you ring to book an appointment, the receptionists are rude.'* Another participant added *'The response is not welcoming. They don't speak to you politely.'* More participants echoed this issue. One participant said that having a *'rude receptionist discourages me from ringing for my appointment. You go to A and E as you don't want to book or ring again.'*

6.6 Continuity of care

For some participants continuity of care was an issue. They felt seeing the same GP was important in order to ensure good and safe care especially for those with long term and chronic conditions. Having the same doctor not only ensured a good patient-doctor relationship but could speed up the appointment time. A female participant complained about seeing different doctors each time she booked an appointment: *'They keep reading and reading which takes ages'*. Despite many participants valuing continuity of care, they hardly ever saw the same doctor. When requesting to see a particular GP a participant reported the receptionist usually says that the doctor of their choice is *'not available to see you'*. Another participant added: *'I want to see my own doctor. They don't let me see him.'*

6.7 Issues in relation to A&E

A few participants mentioned experiences that didn't come under the main themes, however it is important to include these in the report.

A participant described a situation where someone she know fainted. This person was alone at home with her primary school age child. The child rang an ambulance and asked for help. He got asked a series of questions he couldn't answer and he was asked to pass the receiver to his mum who at that time could not speak. The child grew anxious and confused. As a result he gave up trying to speak on the phone and got upset. The ambulance did not respond to his call. Luckily a passer-by spotted the situation through the window and called an ambulance, which eventually arrived accompanied by the police. Participants were worried about this situation and felt the ambulance crew should have arrived even though the protocol questions were not answered. They also felt the ambulance call handler should have been sensitive and responsive about the fact that a child called instead of an adult. It was a very worrying and potentially dangerous situation and participants were concerned this could happen to single parents or when they are alone with their children.

Another participant shared her experience during a visit with her child to A&E. After her child was assessed she was told to go home and give the child paracetamol. She told the doctor she did not have any at home and did not currently have money to buy some. It was late in the evening and she asked to be given enough medicine to last a few doses. The medical staff weren't sympathetic to her request, and the mother grew anxious her child would be left without the medication.

6.8 Mental Health

Despite no individuals sharing any mental health related experiences, many participants were interested in the Improving Access to Psychological Therapies (IAPT) service signposted by Healthwatch and noted down the details of the service. Many were not aware that they could access support including talking

therapies to lower mood and stress. This suggests that there is lack of awareness amongst the community about the services available to them locally. A report from Mind in 2009 asserted that refugees experience a higher incidence of mental distress than the wider population. Some of the distress can be linked to experiences in their home countries, however there is evidence that many refugees can develop poor mental health as a result of difficult living circumstances experienced in the UK.[9] Based on the fact that the majority of the participants were not aware of the IAPT service but were interested in the service suggest that many mental health issues that refugees are experiencing might not be diagnosed and/or treated.

6.9 Health checks

The majority of participants of Chinese origin were concerned about the lack of health checks that they said were available in China. The health checks included a GP visit and various phlebotomy tests. The reason for the health checks would be to determine any conditions that might be *'hidden'*, at early stages without showing obvious symptoms. Participants worried that this might prevent them from catching the early onset of a condition and that they might be suffering from something that they were unaware of. This attitude suggests that there is not clarity amongst the community about differences in the health system in China and the UK and what services they can access locally. This might cause unnecessary visits to GPs and frustration and anxiety amongst patients.

6.10 Translation

A significant number of individuals were happy with the translation services they received and said it was of good quality. They confirmed the services were available if requested. Some participants said they have access to a face to face translation which they valued.

On occasions that participants did not use translation services they communicated in English supported by body language.

7. Conclusion

The refugee community especially mothers and carers of children face barriers and challenges in access to primary care.

Children's health and wellbeing was the main issue highlighted through the research. It was linked to difficulties in obtaining GP appointments coupled with not having enough time during an appointment and not seeing the same GP. As a result the participants confirmed they used A&E to ensure their children were

[9] (Department of Health – Review of access to the NHS for foreign nationals February 2011, Refugee Action)

given medical attention and this provided mothers/carers with much needed reassurance.

8. Recommendations

As a result of the findings through the engagement with refugee community members in Lewisham, Healthwatch Lewisham sets out the following recommendations to improve access to services in the borough.

COMMISSIONERS AND PROVIDERS:

- Improve access to GP services including improving access to urgent appointments and improving booking systems. Consideration should be given to refugees, people with communication barriers and children.
- Make appointments with a named GP more readily available.
- Increase the length of appointments where necessary to allow safe and effective diagnosis and treatment.
- Improve staff attitudes towards patients by increasing the emphasis on listening to the patient, and by taking time to understand the community members.
- Provide appropriate training for front line reception staff and clinical staff to enable improved communication, cultural awareness and health inequalities faced by minority groups and refugees.

COMMISSIONERS:

- Increase the provision of information for seldom heard groups including the refugees on provision of and access to local services.

9. Appendices

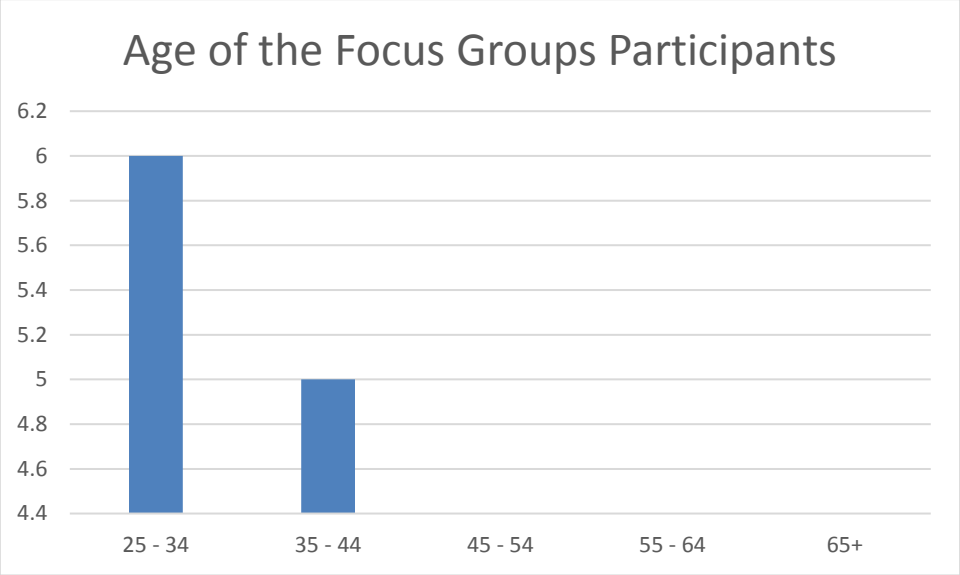
Appendix 1 - Equality and Diversity Data and Long Term Conditions

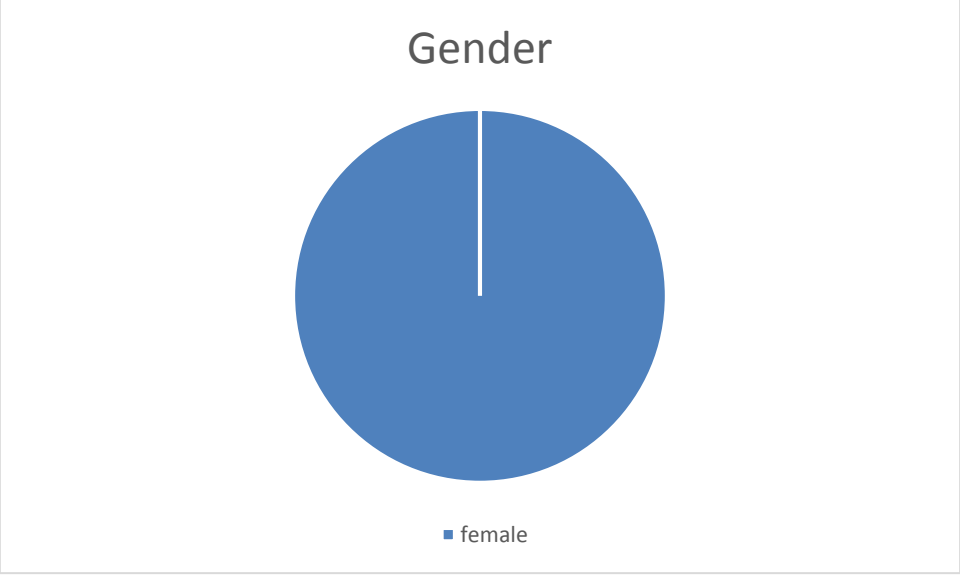
Healthwatch engaged with people from the Refugee Community in the borough through a focus group organised through Action for Refugees in Lewisham attended by 11 people. All participants returned the equality and diversity questionnaires.

All respondents were parents or guardians of a child/children under 16 years of age and two were carers.

Long Term Conditions

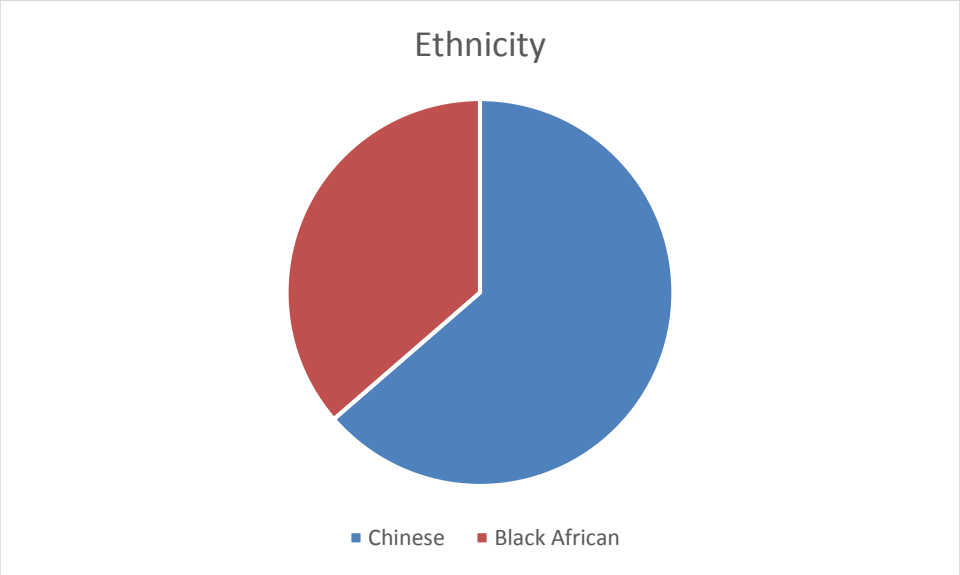
Only one person reported having High Blood pressure.





Disability

None of the respondents consider themselves as disabled.



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

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Healthier Communities Select Committee		
Title	Healthwatch report: The Turkish Community and Access to Health and Wellbeing Services in Lewisham	
Contributor	Scrutiny Manager	Item 9
Class	Part 1 (open)	18 October 2016

1. Purpose

The Healthwatch report *The Turkish Community and Access to Health and Wellbeing Services in Lewisham* is attached.

3. Recommendations

The Committee is asked to note the report.

For further information, please contact John Bardens, Scrutiny Manager, on 02083149976.

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

April 2016

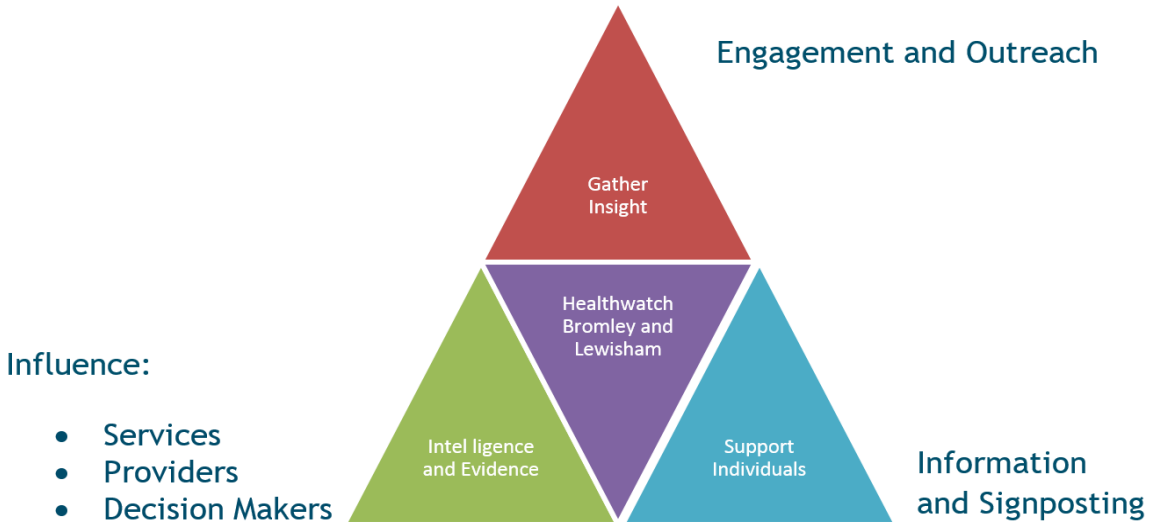
Community House, South Street, Bromley, BR1 1RH, 0208 315 1916

Contents

1. About Healthwatch Lewisham

Healthwatch Lewisham (HWL) 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 is as an independent health and social care organisation, representing the voice of local people and ensure that health and social care services are designed to meet the needs of patients, social care users and carers.

Healthwatch also supports children, young people and adults in Lewisham to have a stronger voice in order to influence how health and social care services are purchased, provided and reviewed within the borough.



Healthwatch's core functions are:

1. Gathering the views and experiences of service users, carers, and the wider community,

2. Making people's views known,

3. Involving locals in the commissioning process for health and social care services, and process for their continual scrutiny,

4. Referring providers of concern to Healthwatch England, or the CQC, to investigate,

5. Providing information about which services are available to access and signposting,

6. Collecting views and experiences and communicating them to Healthwatch England,

7. Work with the Health and Wellbeing board in Lewisham on the Joint Strategic Needs Assessment and Joint Health and Wellbeing strategy (which will influence the commissioning process).

Acknowledgements
Healthwatch Lewisham would like to thank the Turkish Elders Club for providing a platform to engage with their 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 Lewisham to amplify this voice.

2. The Turkish community of Lewisham

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 (BME) background. [1]

Figure 1 shows the breakdown of ethnic groups in the borough cited in the Lewisham Joint Strategic Needs Assessment (JSNA) 2016. Non-white ethnic groups in Lewisham account for 41% of the population.

According to the 2011 Census there are 27,826 people from White other ethnic minority groups living in Lewisham.[2] There are 1,294 people born in Turkey living in Lewisham.[3] However according to the same source, Turkish is the fifth most spoken language in Lewisham (0.8% of the total population) which suggest the number is closer to 2300.[4] Furthermore, the majority of the members of the Turkish Elders Club considered themselves as White British which implies that data collected by the census may not reflect the actual number of Turkish people living in Lewisham.

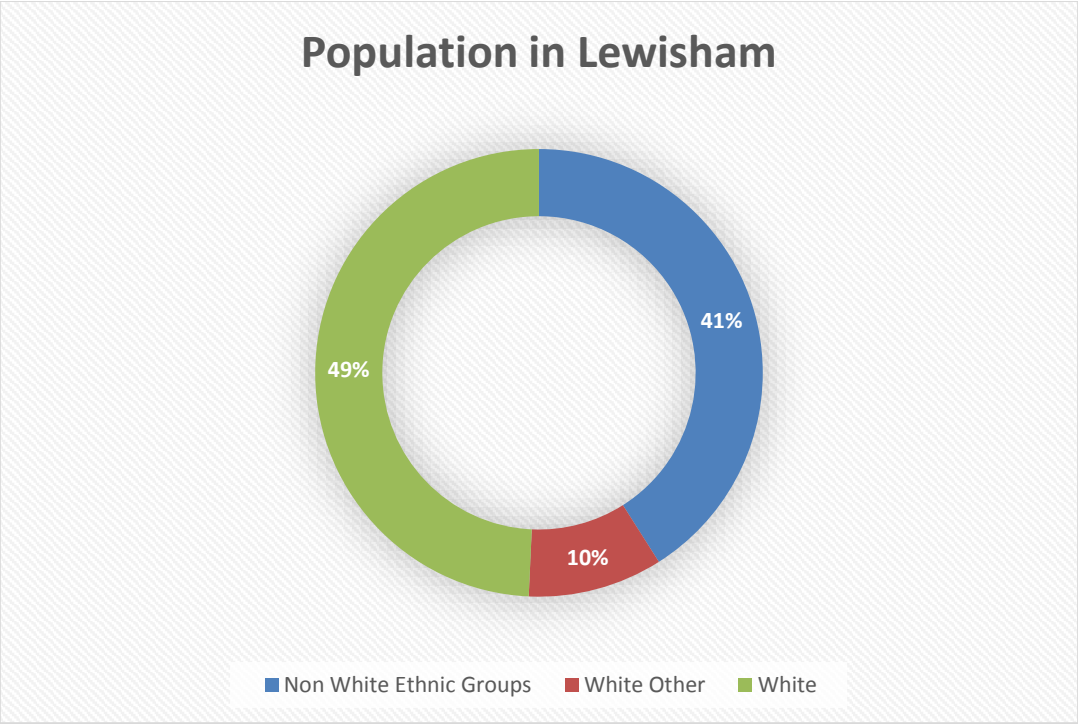
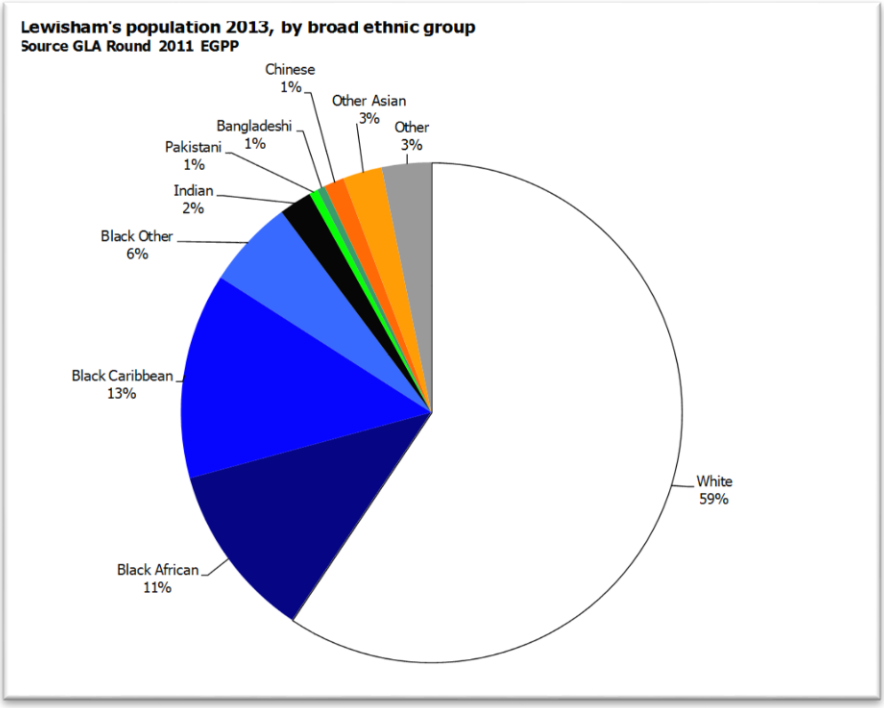


Figure 1 [5]

[1] Lewisham's Joint Strategic Needs Assessment 2016 (http://www.lewishamjsna.org.uk/)
[2] https://lewisham.gov.uk/inmyarea/Documents/2011CensusSecondReleaseDec2012.pdf
[3] http://sprc.info/wp-content/uploads/2013/07/DayMer-Final-Report-final.pdf
[4] http://localstats.co.uk/census-demographics/england/london/lewisham
[5] Lewisham JSNA, 2016



3. 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.[6] These include the need for cultural issues to be respected, the need for information, communication and education as well as the need for emotional support.

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.[7]

[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215159/dh_132788.pdf

[7] Good Access in Practice, BME Health Forum 2010

Through this report, Healthwatch Lewisham draws attention to the experiences of access to health and social care services faced by members of the Turkish 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 Lewisham website.

4. Methodology

The information gathered about access to services for Turkish people living in Lewisham came through a focus group in partnership with the Turkish Elders Club attended by 21 people.

The group agreed to support Healthwatch in communication with participants who didn't speak English by support with translation.

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

HWL gathered equality and diversity data alongside the prevalence of long term conditions amongst the participants. This can be found in Appendix 1.

5. Findings: The Themes

5.1 Good practice – GPs

The majority of participants said they are happy with their GPs and praised their GPs for 'listening' to them. This virtue was particularly important for the community and participants said that if doctors listened and are willing to emphasise then the communication barrier will be reduced.

5.2 Waiting times at GPs

The biggest issue for the members of the Turkish Elders Club was waiting times at GP surgeries. Some participants said they waited for over an hour despite having a booked appointment. Participants said, the typical response when they enquired about the reason was *'IT system change'*.

5.3 Referrals

Some participants told Healthwatch they had issues with delayed referrals. Participants were worried about the time it takes to receive any form of response after being referred. One elderly man who had knee problems had not heard any news about his appointment following a referral four months ago. At the time of speaking he had booked a GP appointment to enquire about this. Many participants echoed this problem explaining that when they are referred it is not always clear when they will hear back. They suggested that it would be worth having an acknowledgement with information about the waiting time. Without this participants were not sure if they were forgotten or simply still waiting in a queue for appointments. This also suggests that people visit their GP just to enquire about their referral progress.

5.4 Interpreting needs

The participants had varied translation needs; some needed support and others communicated in English. In general participants said they were confident when talking to their GP about minor issues, however if they have more serious medical problems they need an interpreter. Many participants said they use a family member to translate when attending hospital appointments.

5.5 Low quality medicine

Healthwatch recognised another big issue for this group was the quality of medicines. The majority of participants agreed that the medicine they are getting is a cheap version of the one their doctor has prescribed or the doctor is not giving *'good medicine'* in the first place. One patient told Healthwatch she has been suffering with a leg problem but was given a prescription for a *'cheap cream'* from her GP. She would prefer to get 'a good medicine' to help the problem. *'The current one is not helping'* she told Healthwatch. Other participants confirmed they had experienced the same issue saying the replacement medicine did not work as well as the original drug despite professionals assuring them it would. The lack of trust in the prescribed medicines could potentially deter patients from using the medicine leading to unnecessary waste and worsening of the condition.

5.6 Standalone issues:

Healthwatch heard some issues that were unique to individual participants. However we felt it was important to include these in the report.

5.7 Dental treatment and mental health

A participant's family member has refused dental treatment despite being referred to the hospital. Their family is worried and are adamant the refusal of treatment is a result of a mental health issue. However the health professionals involved with the care for this patient do not recognise the mental health issue and do not cooperate with the family to have this person treated.

5.8 Long term condition not recognised

A participant's relative suffered an accident and as a result needed an operation. During the treatment, the doctors were unable to pick up that the patient had a long term condition. The family was unhappy as this caused complications and impacted upon the patient's recovery.

5.9 Pharmacies and prescriptions system, staff attitudes

A participant with a long term condition which has severe symptoms is undergoing chemotherapy. She made a complaint to Healthwatch about the repeat prescription service and pharmacy staff attitudes. She told Healthwatch her medicine was not ready when she came to collect it at her assigned pharmacy. She was then send to another pharmacy who then sent her back to the original one. After back and forth trips her case was finally looked into and her medicine found at the original destination. The participant felt she was not treated seriously by some staff due to the level of her spoken English.

6. Conclusion

From the data collected it was evident that the focus group participants were generally happy with the NHS. This relates to experiences that were shared by the group as well as experiences expressed individually.

By far the most comments received were about waiting times at GP services. This was closely followed by lack of clarity around waiting times for referrals coupled with long waiting times which made the participants worry as they were unsure if their referral had been lost or whether there were simply long waiting delays. A third issue that was expressed by this community as significant was poor quality medicine and replacement medicines offered by pharmacists.

7. Recommendations

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

COMMISSIONERS AND PROVIDERS:

- Improve waiting times at GP services and provide information and explanations for delays when they occur.

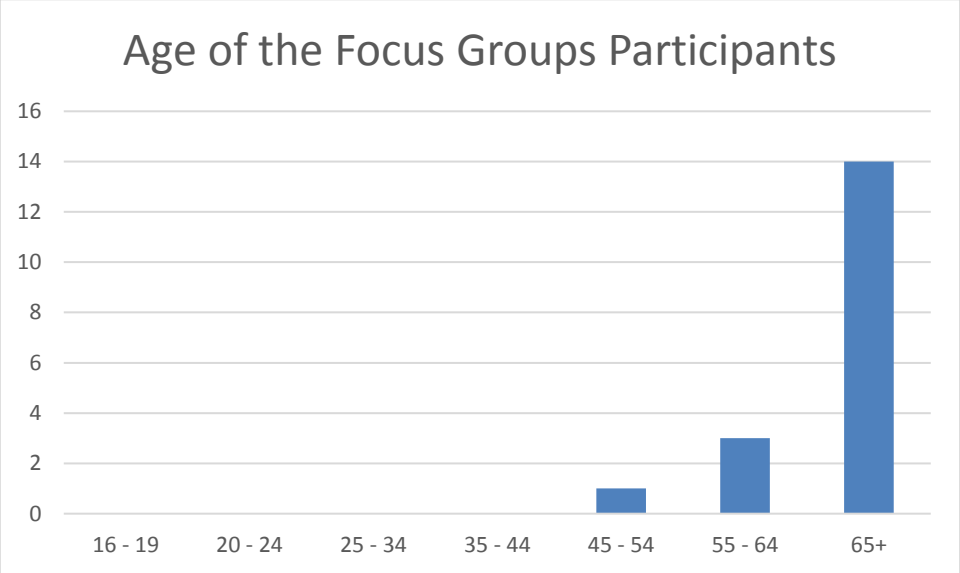
- Inform the patient about the expected waiting time for a referral. Provide an acknowledgement so the patient is reassured of the access to service.

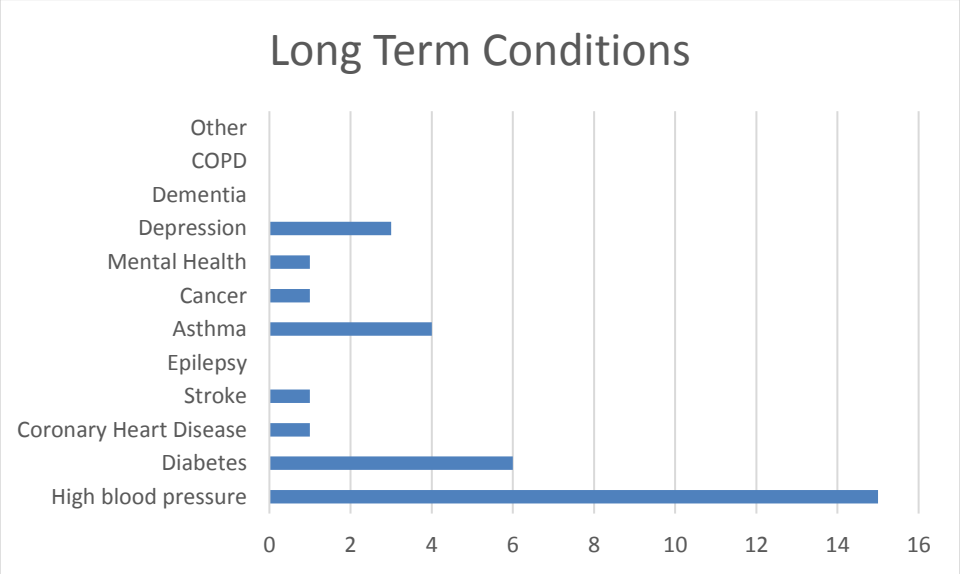
- Providers should explain the rationale for prescribing particular medicine and keep the patient informed and involved when an alternative is offered.

8. Appendices

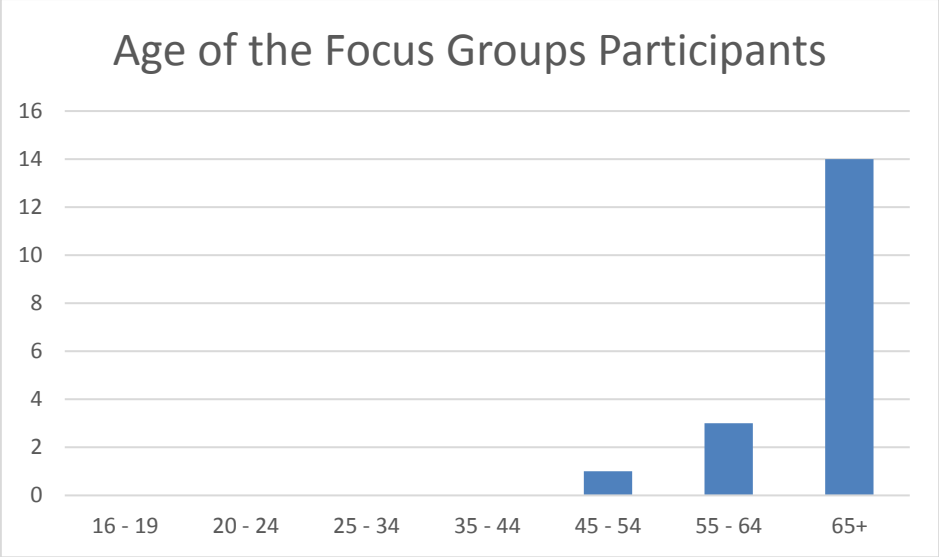
Appendix 1 - Equality and Diversity Data and Long Term Conditions

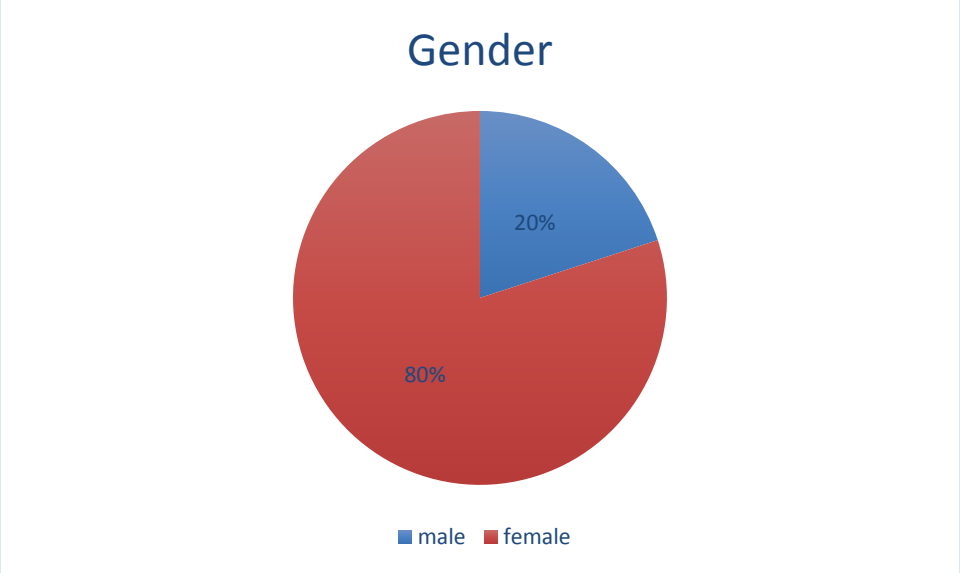
Healthwatch engaged with people from the Turkish Community in Lewisham through organising a focus group attended by 21 people. Out of those we collected 20 feedback forms.

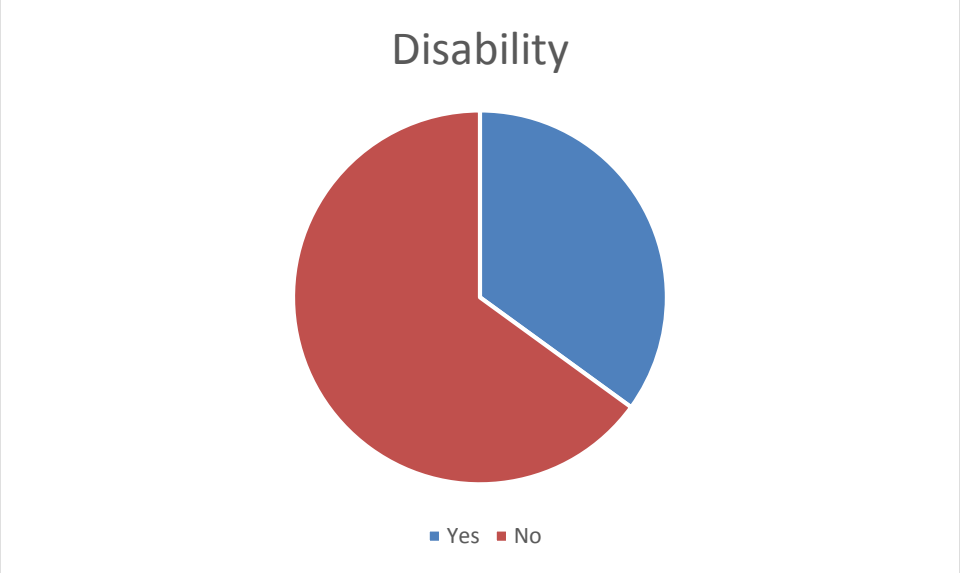




*Others consisted of: Cholesterol x 8, Osteoporosis, Thyroid problems, Eye Problem, Glaucoma, Leg Problem x 4, Back Pain.

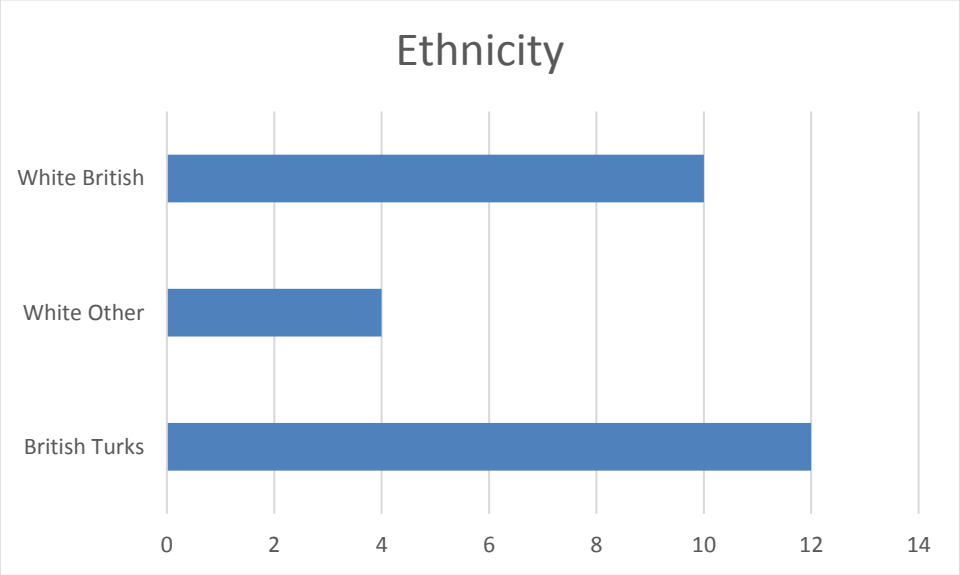

Age of the Focus Groups Participants
16
14
12
10
8
6
4
2
0
16 - 19
20 - 24
25 - 34
35 - 44
45 - 54
55 - 64
65+


Gender
20%
80%
male
female


Disability
Yes
No

Majority of the participant described themselves as White British. Some used two characteristics to describe their ethnicity.

- Five participants described themselves as White British and British Turks
- One participants described themselves as White Other and British Turks



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

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Healthier Communities Select Committee			
Title	Select Committee work programme		
Contributor	Scrutiny Manager	Item	11
Class	Part 1 (open)	18 October 2016	

1. Purpose

To advise Members of the proposed work programme for the municipal year 2016-17, and to decide on the agenda items for the next meeting.

2. Summary

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

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

3. Recommendations

3.1 The Committee is asked to:

- note the work plan attached at **Appendix B** and discuss any issues arising from the programme;
- specify the information and analysis required in the report for each item on the agenda for the next meeting, based on desired outcomes, so that officers are clear about what they need to provide;
- review all forthcoming key decisions, attached at **Appendix C**, and consider any items for further scrutiny;

4. The work programme

4.1 The work programme for 2016/17 was agreed at the Committee's meeting on 19 April 2016.

4.2 The Committee is asked to consider if any urgent issues have arisen that require scrutiny and if any existing items are no longer a priority and can be removed from the work programme. Before adding additional items, each item should be considered against agreed criteria. The flow chart attached at **Appendix A** may help Members decide if proposed additional items should be added to the work programme. The Committee's work programme needs to be achievable in terms of the amount of meeting time available. If the Committee agrees to add additional item(s) because they are urgent and high priority, Members will need to consider

which medium/low priority item(s) should be removed in order to create sufficient capacity for the new item(s).

5. The next meeting

5.1 The following reports are scheduled for the meeting on 24 November 2016:

Agenda item	Review type	Link to Corporate Priority	Priority
Health and adult social care integration	In-depth review	Active, healthy citizens	High
Elective orthopaedics	Standard item	Active, healthy citizens	High
Transition from children's to adult social care	Standard item	Active, healthy citizens	Medium
LCCG commissioning intentions	Standard item	Active, healthy citizens	Medium

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

6. Financial Implications

There are no financial implications arising from this report.

7. Legal Implications

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

8. Equalities Implications

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

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

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act

- advance equality of opportunity between people who share a protected characteristic and those who do not.
- foster good relations between people who share a protected characteristic and those who do not.

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

9. Date of next meeting

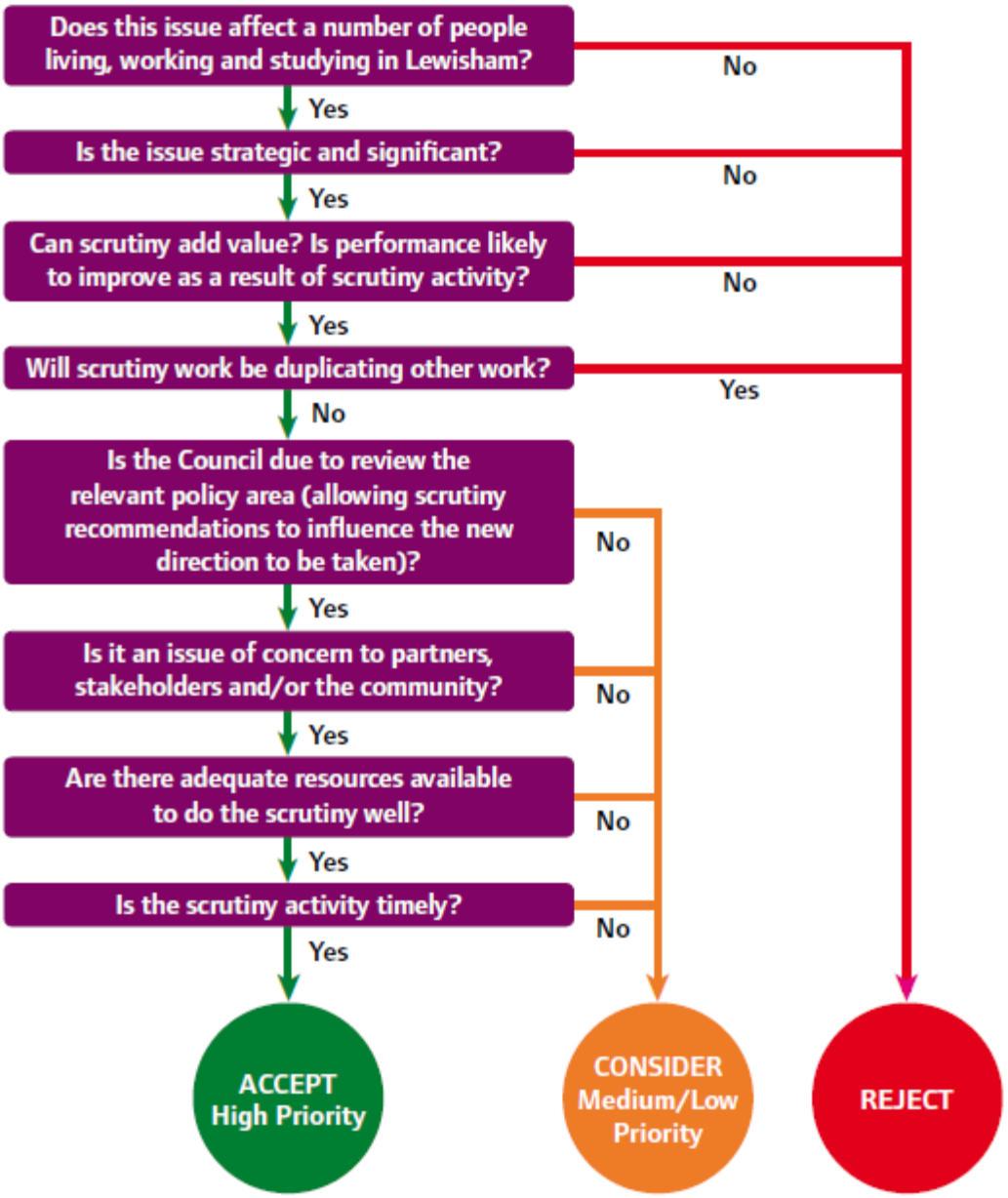
The date of the next meeting is Tuesday 24 November 2016.

Background Documents

Lewisham Council's Constitution

Centre for Public Scrutiny: the Good Scrutiny Guide

Scrutiny work programme – prioritisation process



Healthier Communities Select Committee work programme 2016/17

Programme of work

Work item	Type of item	Priority	Strategic priority	Delivery deadline	19-Apr	18-May	28-Jun	13-Sep	18-Oct	24-Nov	12-Jan	01-Mar
Lewisham future programme	Standard item	High	CP9	Ongoing								
Confirmation of Chair and Vice Chair	Constitutional req	High	CP9	Apr								
Select Committee work programme 2016/17	Constitutional req	High	CP9	Ongoing								
Sustainability and Transformation Plans	Standard item	Medium	CP9	Apr								
SLaM place of safety changes	Information item	High	CP9	Apr								
Health and social care integration	Standard item	Medium	CP9	May								
Health and adult social care integration	In-depth review	High	CP9	March '17		Scope		Evidence session	Evidence session	Evidence session	Report	Referral
SLaM quality account	Performance monitoring	Medium	CP9	May								
Free swimming	Standard item	High	CP9	May								
Healthwatch reports on the Polish and Tamil communities' access to health and wellbeing services in Lewisham	Standard item	Medium	CP9	May								
Lewisham and Greenwich NHS Trust Quality Account	Standard item	Medium	CP9	Jun								
Public health commissioning intentions and consultation	Standard item	High	CP9	Jun								
HIV services	Standard item	High	CP9	Jun								
Obesity/sugar-smart pilot	Information item	Low	CP9	Jun								
Sustainability and Transformation Plan	Information item	High	CP9	Jun								
Public health savings	Standard item	High	CP9	Jun								
Devolution pilot business case	Standard item	High	CP10	Sep								
Healthwatch annual report	Information item	Medium	CP9	Sep								
Adult safeguarding	Standard item	High	CP9	Oct								
Public health annual report	Performance monitoring	Low	CP9	Oct								
Lewisham hospital update (systems resilience)	Standard item	High	CP9	Oct								
Elective orthopaedics	Standard item	High	CP9	Nov								
LCCG commissioning intentions	Standard review	Medium	CP9	Nov								
Transition from children's to adult social care	Standard item	Medium	CP9	Nov								
Adult learning Lewisham annual report	Performance monitoring	Medium	CP9	Jan								
Primary care transformation and access to GP services	Standard item	Medium	CP9	Jan								
Implementation of the Care Act	Performance monitoring	High	CP9	Jan								
Place-based care and neighbourhood care networks	Standard item	Medium	CP9	Mar								
Delivery of the Lewisham Health & Wellbeing priorities	Performance monitoring	High	CP9	Mar								
Leisure centre contract	Performance monitoring	Medium	CP9	Mar								

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

Meetings					
1)	Tue	19 April	5)	Tue	18 Oct
2)	Wed	18 May	6)	Thu	24 Nov
3)	Tue	28 Jun	7)	Thu	12 Jan
4)	Tue	13 Sep	8)	Wed	01 Mar

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FORWARD PLAN OF KEY DECISIONS

Forward Plan October 2016 - January 2017

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

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

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

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

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

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
February 2016	**Insurance Renewal**	09/16 Overview and Scrutiny Business Panel	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2016	**Carer Specialist Information Advice and Support Service Contract**	20/09/16 Overview and Scrutiny Business Panel	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
August 2016	**Review of Highway Maintenance Contract Variation**	20/09/16 Overview and Scrutiny Business Panel	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
August 2016	**Accounts 2015-16**	21/09/16 Council	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2016	**Gypsy and Traveller Local Plan Consultation**	21/09/16 Council	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
August 2016	**Gypsy and Traveller Local Plan**	21/09/16	Janet Senior, Executive		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
	Site Selection	Council	Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
August 2016	**LGO Report against Lewisham**	21/09/16 Council	Kevin Sheehan, Executive Director for Customer Services and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2016	**Recommendations of the Broadway Theatre Working Group**	28/09/16 Mayor and Cabinet	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
August 2016	**Catford Housing Zone Funding Award and Terms**	28/09/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Damien Egan, Cabinet Member Housing		
February 2016	**Health and Social Care Devolution Pilot**	28/09/16 Mayor and Cabinet	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
August 2016	**LIP Annual Spending Submission 2017/18 and**	28/09/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources &		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
	2016/17 Update		Regeneration and Councillor Alan Smith, Deputy Mayor		
August 2016	**Lewisham Future Programme**	28/09/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
May 2016	**Lewisham Homes Loan Acquition Programme parts 1 and 2**	28/09/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
August 2016	**Outcome of Public Health Savings Consultation and Approval to Procure**	28/09/16 Mayor and Cabinet	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
August 2016	**Private Rented Sector Discharge Policy**	28/09/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
August 2016	**Secondary School Re-organisation/Expansion Proposal Permission for Consultation**	28/09/16 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
			Children and Young People		
February 2016	**Contract Award/s Planned Preventative Maintenance, Repairs, Building Cleaning and Related Services**	28/09/16 Mayor and Cabinet (Contracts)	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
August 2016	**Occupational Therapy Services for Concessionary Award Schemes**	04/10/16 Overview and Scrutiny Business Panel	Kevin Sheehan, Executive Director for Customer Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
April 2016	**Autistic Spectrum Housing**	19/10/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
August 2016	**Deptford Reach Development**	19/10/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
June 2016	**Options for 118 Canonbie Road**	19/10/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
August 2016	**Discretionary Rate Relief**	19/10/16	Aileen Buckton,		

FORWARD PLAN – KEY DECISIONS					
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	Review	Mayor and Cabinet	Executive Director for Community Services and Councillor Kevin Bonavia, Cabinet Member Resources		
February 2016	**Disposal of Copperas Street Depot Creekside**	19/10/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
August 2016	**Financial Forecasts 2016/17**	19/10/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2016	**Heathside & Lethbridge Phase 5 Compulsory Puchase Order**	19/10/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
August 2016	**Heathside & Lethbridge Phase 6 Parts 1 & 2**	19/10/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
January 2016	**New Bermondsey Housing Zone Bid Update**	19/10/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		

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May 2016	**Schools with License deficits**	19/10/16 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
August 2016	**Treasury Management Mid-Year Update**	19/10/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2016	**Update on action plan following Education Commission Report**	19/10/16 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
August 2016	**The Wharves Deptford - Compulsory Purchase Order Resolution**	19/10/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
August 2016	**Family Support Service Contract Award**	19/10/16 Mayor and Cabinet (Contracts)	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young		

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			People		
August 2016	**Footways Contract Award**	19/10/16 Mayor and Cabinet (Contracts)	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
September 2016	**Supported Living Services to Adults with Learning Disabilities Call-Off contracts**	19/10/16 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
September 2016	**Children and Young People's Personalised Care and Support Preferred Provider Framework Contract Extension**	19/10/16 Mayor and Cabinet (Contracts)	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
August 2016	**Re-Procurement Managed Service Interpretation, Translation and Transcription Services Contract award**	01/11/16 Overview and Scrutiny Business Panel	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
May 2016	**Annual Complaints Report**	09/11/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Joe Dromey, Cabinet Member Policy &		

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			Performance		
September 2016	**Catford Regeneration Programme Update**	09/11/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
August 2016	**Regionalising Adoption**	09/11/16 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
September 2016	**Restoration and Re-Purposing of Buildings within Beckenham Place Park**	09/11/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Rachel Onikosi, Cabinet Member Public Realm		
August 2016	**Review of National Non Domestic Rates - Discretionary Discount Scheme for Businesses Accredited to Living Wage Foundation**	09/11/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2016	**Carriageway Resurfacing Contract Award**	09/11/16 Mayor and Cabinet (Contracts)	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		

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August 2016	**School Minor Works Programme 2017**	09/11/16 Mayor and Cabinet (Contracts)	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
August 2016	**Deptford High Street (North) Contract Award**	22/11/16 Overview and Scrutiny Business Panel	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
August 2016	**Consultant Appointment 2016 Schools Minor Works Contract**	22/11/16 Overview and Scrutiny Education Business Panel	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
August 2016	**Deptford Parish Council Petition and Community Governance Terms of Reference**	23/11/16 Council	Kath Nicholson, Head of Law and Councillor Kevin Bonavia, Cabinet Member Resources		
May 2016	**Main Grants Programme 2017-18 Appeals Against Proposals**	30/11/16 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Joan Millbank, Cabinet Member Third Sector & Community		
September 2016	**Ashmead Primary School Expansion: Results of**	07/12/16 Mayor and Cabinet	Sara Williams, Executive Director, Children and		

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	Consultation		Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
May 2016	**2017-18 Council Tax Reduction Scheme**	07/12/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2016	**Contract Extensions for Accommodation Based Services and Floating Support Service**	07/12/16 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
August 2016	**Fusion Leisure Contract Variation**	07/12/16 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
May 2016	**Main Grants Programme 2017-18 Allocation of Funding**	07/12/16 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Joan Millbank, Cabinet Member Third Sector & Community		

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May 2016	**Prevention and Inclusion Team Award of Contracts**	07/12/16 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Janet Daby, Cabinet Member Community Safety		
August 2016	**Prevention Inclusion and Public Health Commissioning Contract Award**	07/12/16 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
September 2016	**Lewisham Music Business Plan and Transfer Terms**	11/01/17 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
August 2016	**Community Premises Management Contract Permission to Tender**	11/01/17 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Joan Millbank, Cabinet Member Third Sector & Community		
May 2016	**Council Tax Reduction Scheme 2017-18**	18/01/17 Council	Kevin Sheehan, Executive Director for Customer Services and Councillor Kevin Bonavia, Cabinet Member Resources		

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May 2016	**Council Budget 2017-18**	22/02/17 Council	Kevin Sheehan, Executive Director for Customer Services and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2016	**Community Premises Management Contract Award**	22/03/17 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Joan Millbank, Cabinet Member Third Sector & Community		

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