



HEALTH AND WELLBEING BOARD

Date: THURSDAY, 12 MARCH 2020 at 3.30 pm

Council Chamber, 1st Floor Civic Suite, Catford SE6 4RU

Enquiries to: stewart.weaver-snellgrove@lewisham.gov.uk

Members

Damien Egan (Chair)	Mayor of Lewisham
Cllr Chris Best	Deputy Mayor and Cabinet Member for Health and Adult Social Care
Tom Brown	Executive Director for Community Services, Lewisham Council
Val Davison	Chair, Lewisham and Greenwich NHS Trust
Roz Hardie	Voluntary and Community Sector Representative
Donna Hayward-Sussex	Service Director, South London and Maudsley NHS Foundation Trust
Gwen Kennedy	Interim Director of Nursing South London, NHS England
Michael Kerin	Healthwatch Lewisham
Pauline Maddison	Executive Director for Children & Young People, Lewisham Council
Dr Catherine Mbema	Director of Public Health, Lewisham Council
Dr Simon Parton	Chair, Lewisham Local Medical Committee
Christine Wykes Driver	Acting Chief Executive, Voluntary Action Lewisham



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Members are summoned to attend this meeting

**Kim Wright
Chief Executive
Lewisham Town Hall
Catford
London SE6 4RU**

Date: Wednesday, 4 March 2020



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

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MINUTES OF THE HEALTH AND WELLBEING BOARD

Thursday 14th November 2019 at 3.30pm

ATTENDANCE

PRESENT: Mayor Damien Egan (Chair to the Board); Faruk Majid (Vice Chair to the Board and Chair, Lewisham Clinical Commissioning Group); Cllr Chris Best (Deputy Mayor of Lewisham and Cabinet Member for Health and Adult Social Care); Tom Brown (Executive Director for Community Services, LBL); Donna Hayward-Sussex (Service Director, South London and Maudsley NHS Foundation Trust); Michael Kerin (Healthwatch Lewisham); Dr Catherine Mbema (Director of Public Health, LBL); Chris Wykes Driver (Acting Chief Executive Officer, Voluntary Action Lewisham); and Sara Williams (Executive Director for Children and Young People, LBL)

APOLOGIES: Val Davison (Chair of Lewisham & Greenwich Healthcare NHS Trust); Dr Simon Parton (Chair of Lewisham Local Medical Committee); Roz Hardie (Voluntary and Community Sector Representative); and Gwen Kennedy (NHS England Representative).

IN ATTENDANCE: Brenda Bartlett (Deputy Service Director, CAMHS); Jacqueline Francis (Public Health Information Analyst, LBL); Sharon Gibbs (Programme Officer, Lewisham Clinical Commissioning Group); Barbara Gray (Mayoress of Lewisham, and the Mayor and Council Adviser on BAME health inequalities); Kenny Gregory (Joint Commissioner – Adult Mental Health); Caroline Hirst (Joint Commissioner); Salena Mulhere (SGM Inter-agency, Service Development and Integration, LBL); Sarah Wainer (Programme Lead, Lewisham Clinical Commissioning Group); Stewart Weaver-Snellgrove (Clerk to the Board, LBL); and Martin Wilkinson (Managing Director, Lewisham Clinical Commissioning Group).

Welcome and introductions

The Chair welcomed Chris Wykes Driver (Voluntary Action Lewisham) to their first meeting as a new member of the Health and Wellbeing Board.

Apologies were received from Val Davison and Dr Simon Parton.

1. Minutes of the last meeting

- 1.1 The minutes of the last meeting were agreed as an accurate record with no matters arising.

2. Declarations of interest

- 2.1 There were no declarations of interest.

3.1 Healthier Communities and Children and Young People Select Committees referral

3.1.1 A referral from the joint meeting of Healthier Communities and Children and Young People Select Committees on 17th July 2019, with regards to discussions held on BAME health inequalities, was received by the Board.

3.1.2 Within the referral the two Select Committees recommended:

- i. That HWB investigates the lack of robustness and possible inaccuracies with CAMHS ethnicity data and provides details of how and when this deficiency will be addressed and remedied;
- ii. That HWB considers a dedicated programme, with additional funding and other resources, based within community and third sector partner organisations that already have expertise and the trust of the BAMER communities, on whose cooperation public consultation and co-production will rely.

3.1.3 Action:

- The Board noted the referral and agreed to consider the report at item 3.2 on the agenda as the formal response to the Select Committees' referral.

3.2 BAME health inequalities – response to the referral made by Healthier Communities Select Committee and Children and Young People Select Committee

3.2.1 Caroline Hirst and Brenda Bartlett updated the Board re CAMHS ethnicity data and BAMER health inequalities with regards to children and young people.

3.2.2 Extensive work has been undertaken over the last three months by the Lewisham CAMHS service alongside SLaM data analysts to improve the accuracy and comprehensiveness of ethnicity data for Lewisham CAMHS. Data cleansing has identified that in September 2019, approximately 9% of children and young people against a CAMHS caseload of 1,733 did not provide their ethnicity details.

3.2.3 Alongside this work to improve the Lewisham CAMHS data, commissioners for children and young people have also undertaken analysis of research and ethnicity data across the wider commissioned mental health and emotional wellbeing pathway for children and young people. Early findings have been positive, with BAMER access being around 55-60% for most non-statutory/community based services.

3.2.4. Given the ethnic composition of the Lewisham CYP population, BAMER access to mental health services has been identified as one of nine key priorities within the refreshed CAMHS Transformation Plan 2019.

- 3.2.5 Catherine Mbema, Kenny Gregory and Jacqueline Francis updated the Board re the BAME mental health inequalities programme of work and the BAME Health Inequalities Action Plan.
- 3.2.6 The Provider Alliance Leadership group agreed to allocate the non-committed funding in the 2019/20 programme budget to community engagement and involvement. The Alliance will work with representatives of the BAME network to consider the most effective method of engaging BAME community members and/or representatives in the co-design and co-production within the Provider Alliance development network.
- 3.2.7 An initial service user involvement meeting has taken place to support the identification of service users that are engaged in local service, that are willing to participate in the co-design and co-production of local care pathways that will be delivered by the Provider Alliance.
- 3.2.8 SLaM have established a Lewisham Independent Advisory Group to directly engage BAME community representatives in dialogue that will support the improvement of access, experience and outcomes for BAME service users.
- 3.2.9 An updated version of the BAME Health Inequalities Action Plan was presented to the Board, addressing BAME health inequalities across children and young people and adults. The Action Plan has been extended to cover all three priority areas of BAME health inequality identified by the Board, namely mental health, cancer and obesity.
- 3.2.10 To facilitate the final agreement of a co-produced overarching action plan, it is proposed that a BAME health inequalities working group covering mental health, cancer and obesity consisting of Council officers responsible for the respective priority areas and members of the Lewisham BME network, continue to oversee the development of the plan.
- 3.2.11 This working group will also monitor progress using an agreed indicator framework for the action plan going forward. It is proposed that this working group be co-ordinated by Public Health and present update reports to each meeting of the Health and Wellbeing Board.
- 3.2.12 The following comments and additions were made as part of the discussion by members of the Board and those in attendance:
- It would be beneficial to engage with GP surgeries to better understand potential barriers to specialist CAMHS provision.
 - Most BAME community engagement is happening through the Provider Alliance and there is good BAME involvement through the Service User Involvement forum, which meets again in January 2020.
 - Collaborative lunch sessions have been undertaken on a monthly basis to talk about priorities in the development of the Provider Alliance.
 - It is important to work closely with Lewisham BME Network in the co-production of the BAME Health Inequalities Action Plan, which should be reported back to the Board in March 2020.

- Time to Change hub receive training rather than funding. Struggling with recruitment of champions. Voluntary Action Lewisham to help promote initiative via social media.

3.2.13 Actions:

- The Board noted the content of the report and agreed that it should form the response of the Board to the referral at 3.1 and be provided to the Children and Young People and Healthier Communities Select Committees.

4. Joint Strategic Needs Assessment (JSNA) – refresh of Falls Service JSNA

- 4.1 Catherine Mbema provided an overview of the refreshed Falls JSNA for approval by the Board.
- 4.2 In Lewisham, in 2017, 6% of ambulance service calls were to people over 65 who had fallen and 73% of these cases were taken to hospital. There were 160 hip fractures in 2017-18, costing Lewisham Borough just over £1 million.
- 4.3 This JSNA Topic Assessment was undertaken to provide an overview of the epidemiology of falls in Lewisham and nationally and to identify gaps in current service provision and make recommendations for local planning and strategy formulation.
- 4.4 Since the original Falls JSNA, the Lewisham Falls service has been established.
- 4.5 The following comments and additions were made as part of the discussion by members of the Board and those in attendance:
- Falls-awareness event held in Civic Suite on 8 November 2019 which was supported by the Positive Ageing Council.
- 4.6 Action:
- The Board agreed to sign-off the refreshed Falls JSNA.

5. Better Care Fund – 2019/20 Plan

- 5.1 Sharon Gibbs provided members with an overview of the Better Care Fund (BCF) plan for 2019/20 and asked the Board to formally agree the plan.
- 5.2 The plan was submitted to NHS England on 27 September 2019 but is subject to formal approval by the Health and Wellbeing Board.
- 5.3 As in 2017-19 the BCF plan has been developed by Lewisham Council and Lewisham CCG. Activity supported through the BCF has been developed jointly by commissioners and providers and agreed by the Managing Director of the CCG and the Executive Director for Community Services for the Council.

- 5.4 The BCF Plan 2019/20 covers one financial year and is an evolution of the 2017-19 plan. The 2019/20 plan continues to fund activity in the following areas:
- Prevention and Early Action
 - Community based care and the development of Neighbourhood Care Networks
 - Enhanced Care and Support to reduce avoidable admissions to hospital and to facilitate timely discharge from hospital
 - Estates and IMT
- 5.5 In 2019/20 the financial contribution to the BCF from the CCG is £22.055m. This has increased from £20.915m in 2018/19 in accordance with the published CCG allocations. The IBCF grant to Lewisham Council has been pooled with the BCF and totals £13.134m in 2019/20. The Winter Pressures Grant totalling £1.368m and the Disabled Facilities Grant totalling £1.339m, which are paid to the Council, have also been pooled with the BCF in line with grant conditions. An additional financial contribution from the Council of £774k to support neighbourhood teams is also included in the pooled fund. The total BCF pooled budget for 2019/20 is £38.671m.
- 5.6 Actions:
- The Health and Wellbeing Board agreed to the recommendations to:
- Formally approve the Better Care Fund Plan 2019/20.
 - Delegate future approval of the BCF/IBCF quarterly returns to the S75 Agreement Management Group.
 - Receive the quarterly returns for information at the next available Health and Wellbeing Board following submission.

6. South East London Integrated Care System – Response to the NHS Long Term Plan

- 6.1 Martin Wilkinson provided the Board with an update on the South East London Integrated Care System (SEL ICS) Response to the NHS Long Term Plan.
- 6.2 In responding to the Long Term Plan, the SEL ICS is required to produce and submit a narrative plan for delivery between 2019/20 and 2023/24, supported by technical documents on finance, activity, workforce and performance metrics.
- 6.3 A national framework for implementing the LTP was released in June; the framework confirmed key timelines and importantly identified the areas of the plan that are the ‘core foundations’, the areas that we must have clear plans for delivering on over the next five years.
- 6.4 The framework also outlined a number of areas – ‘prioritised commitments’ – where there is more flexibility for local systems in determining how work is phased over the five year period.

- 6.5 In June 2019, SEL developed a system improvement plan that includes the areas where SEL does not currently meet the standards for a fully mature ICS, sets out a number of actions around performance and finance, and makes a series of commitments to enhance our ICS maturity and system ways of working.
- 6.6 Delivering the commitments of the Long Term Plan can only be achieved through working across the levels within our integrated care system – neighbourhood, place and system.
- 6.7 The following comments and additions were made as part of the discussion by members of the Board and those in attendance:
- The formal response to the NHS LTP by SEL ICS has been agreed by the partners in private and will be submitted on 15 November 2019. A public summary of the document is not currently available due to Pre Election Period restrictions.
 - Healthwatch have surveyed local people about the LTP. The main concern relates to access to services, especially during a time of transition.
 - Workforce and the recruitment and retention of staff is a key element of the LTP.
 - Nursing roles are being reviewed to make these positions more attractive in Lewisham and to consider the opening up of specific elements to VCS providers.
 - There is a significant BAME workforce on the wards which isn't reflected in community settings. Need to rethink how to encourage people to work across broader areas.
 - There should be more opportunities for people in entry-level jobs, who can then progress through the system. Individuals should be working at "the top of their license".
- 6.8 Action:
- The Board noted the contents of the report.

The meeting ended at 16:15 hours

Health and Wellbeing Board		
Title	Declarations of interest	
Contributor	Chief Executive – London Borough of Lewisham	Item 2
Class	Part 1 (open)	12 March 2020

Declaration of interests

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

1 Personal interests

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

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

2 Disclosable pecuniary interests are defined by regulation as:-

- (a) Employment, trade, profession or vocation of a relevant person* for profit or gain
- (b) Sponsorship –payment or provision of any other financial benefit (other than by the Council) within the 12 months prior to giving notice for inclusion in the register in respect of expenses incurred by you in carrying out duties as a member or towards your election expenses (including payment or financial benefit from a Trade Union).
- (c) Undischarged contracts between a relevant person* (or a firm in which they are a partner or a body corporate in which they are a director, or in the securities of which they have a beneficial interest) and the Council for goods, services or works.
- (d) Beneficial interests in land in the borough.
- (e) Licence to occupy land in the borough for one month or more.
- (f) Corporate tenancies – any tenancy, where to the member’s knowledge, the Council is landlord and the tenant is a firm in which the relevant person* is a partner, a body corporate in which they are a director, or in the securities of which they have a beneficial interest.
- (g) Beneficial interest in securities of a body where:-
 - (a) that body to the member’s knowledge has a place of business or land in the borough; and
 - (b) either
 - (i) the total nominal value of the securities exceeds £25,000 or 1/100 of the total issued share capital of that body; or

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

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

(3) Other registerable interests

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

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

(4) Non registerable interests

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

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

- (a) Where a member has any registerable interest in a matter and they are present at a meeting at which that matter is to be discussed, they must declare the nature of the interest at the earliest opportunity and in any event before the matter is considered. The declaration will be recorded in the minutes of the meeting. If the matter is a disclosable pecuniary interest the member must take no part in consideration of the matter and withdraw from the room before it is considered. They must not seek improperly to influence the decision in any way. **Failure to declare such an interest which has not already been entered in the Register of Members' Interests, or participation where such an interest exists, is liable to prosecution and on conviction carries a fine of up to £5000**
- (b) Where a member has a registerable interest which falls short of a disclosable pecuniary interest they must still declare the nature of the interest to the meeting at the earliest opportunity and in any event before the matter is considered, but they may stay in the room, participate in consideration of the matter and vote on it unless paragraph (c) below applies.

- (c) Where a member has a registerable interest which falls short of a disclosable pecuniary interest, the member must consider whether a reasonable member of the public in possession of the facts would think that their interest is so significant that it would be likely to impair the member's judgement of the public interest. If so, the member must withdraw and take no part in consideration of the matter nor seek to influence the outcome improperly.
- (d) If a non-registerable interest arises which affects the wellbeing of a member, their, family, friend or close associate more than it would affect those in the local area generally, then the provisions relating to the declarations of interest and withdrawal apply as if it were a registerable interest.
- (e) Decisions relating to declarations of interests are for the member's personal judgement, though in cases of doubt they may wish to seek the advice of the Monitoring Officer.

(6) Sensitive information

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

(7) Exempt categories

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

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

Agenda Item 3



Health and Wellbeing Board

Black, Asian and Minority Ethnic (BAME) Health Inequalities Progress Update – Children & Young People and Adults

Date: 12th March 2020

Key decision: No

Class: Part 1

Ward(s) affected: All

Contributors: Dr Catherine Mbema, Director of Public Health, London Borough of Lewisham

Outline and recommendations

This report provides an update to the Board on the development of an action plan to address Black, Asian and Minority Ethnic (BAME) health inequalities in Lewisham.

Members of the Health and Wellbeing Board are recommended to:

- Note the contents of this report and action plan
- Approve the planned actions identified for 2020/21 onwards.

Timeline of engagement and decision-making

1. Summary

- 1.1. To provide an update to the Board on the development of an action plan to address Black, Asian and Minority Ethnic (BAME) health inequalities in Lewisham, and to request Board approval for the planned actions for 2020/21 onwards.

2. Recommendations

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

- Note the contents of this report and action plan
- Approve the planned actions identified for 2020/21 onwards.

3. Policy Context

- 3.1. The Health and Social Care Act 2012 required the creation of statutory Health and Wellbeing Boards in every upper tier local authority. By assembling key leaders from the local health and care system, the principle purpose of the Health and Wellbeing Boards is to improve health and wellbeing and reduce health inequalities for local residents.
- 3.2. The activity of the Health and Wellbeing Board (HWB) is focussed on delivering the strategic vision for Lewisham as established in Lewisham's Health and Wellbeing Strategy.
- 3.3. The work of the Board directly contributes to the Council's new Corporate Strategy. Specifically *Priority 5 – Delivering and Defending: Health, Social Care and Support – Ensuring everyone receives the health, mental health, social care and support services they need.*

4. Background

- 4.1. In July 2018 the HWB agreed that the main area of focus for the Board should be tackling health inequalities, with an initial focus on health inequalities for BAME communities in Lewisham.
- 4.2. Following analysis undertaken by a sub group of the Board, three priority areas were identified through which the Board could play a significant role in addressing the widest

gaps in BAME health inequalities. The areas identified were: mental health; obesity; and cancer.

- 4.3. At the November 2018 meeting of the Board it was agreed to frame the ongoing discussion concerning BAME health inequalities around these three themes and to actively engage the Lewisham BME Network in this process.
- 4.4. The Lewisham BME Network is a community development project, managed by the Stephen Charitable Lawrence Trust and funded by the London Borough of Lewisham. The Network is comprised of over 120 BAME stakeholder groups, all working to support Lewisham's BAME community organisations and the communities they serve. The Network includes a BAME Health subgroup which meets monthly.
- 4.5. Progress on actions taken to date have been presented at previous Health and Wellbeing Board meetings, with an initial focus of action on the area of mental health.
- 4.6. A draft action plan covering all three priority areas (cancer, obesity and mental health) was developed in July 2019 in response to a referral made by the Healthier Communities Select Committee.
- 4.7. At the November 2019 Health and Wellbeing Board meeting, Board members agreed to further refine the draft action plan with the BME Network taking a co-production approach.

5. BAME Health Inequalities working group

- 5.1. A BAME health inequalities working group was established in January 2020 to provide a forum to refine and agree the action plan to address BAME health inequalities in Lewisham consisting of commitments from organisations represented at the Board and members of the BME Network.
- 5.2. The working group comprises of representatives of organisations that are members of the Health and Wellbeing Board with influence over health outcomes relating to obesity, cancer and mental health in BAME communities; and members of the BME Network.
- 5.3. The group has met twice since being established and have agreed a refined action plan. This plan can be found in the background papers of this report.

6. BAME Health Inequalities action plan development

- 6.1. The action plan contains 16 key actions that will work to address inequalities for BAME communities across the areas of mental health, cancer and obesity. The progress on each of these actions has been logged in the action plan and a RAG rating system is being applied to help track progress.
- 6.2. A cross cutting section of the action plan for all three priority areas will focus on community capacity building within BAME community groups and organisations. This section has been developed specifically in response to community feedback regarding the ability of BAME community groups to be a key part of addressing health inequalities and being equipped to participate in the commissioning cycle as appropriate. An important action within this section of the plan will be the commissioning of BAME community groups to gather community insights to inform the procurement of public health commissioned obesity services. This exercise will provide valuable learning for any further opportunities to build the capacity of local BAME community organisations to participate in the commissioning cycle.
- 6.3. The refined action plan was presented to a wider BME Network meeting in February 2020, giving Network members an opportunity to comment further on the plan and its

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development. The need for ongoing input and consultation on the plan with members of the Network was highlighted at this meeting and the development of a mechanism to enable this has been included as an action in the plan.

7. Monitoring and evaluation of the action plan

7.1. The progress of the plan in addressing health inequalities in cancer, obesity and mental health in BAME communities in Lewisham will be monitored using the following methods:

- A RAG rating system within the action plan
- Metrics within the existing Health and Wellbeing Board Indicator Dashboard and any monitoring mechanism developed as part of a new Health and Wellbeing strategy

7.2. In addition to this, working group members agreed that it would be beneficial to develop a number of community-generated metrics to gauge community response to the plan. The development of this metrics will be facilitated by members of the working group.

8. Financial implications

8.1. This report seeks approval for planned actions identified for 2021 onwards. The various areas of work within the action plan that are the responsibility of the Council will be met from existing revenue budgets in the Community Services and Children and Young People Directorates.

9. Legal implications

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

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

10. Equalities implications

10.1. This report specifically aims to address health inequalities for particular ethnic groups in Lewisham, with race being one of the nine protected characteristics in the Equality Act (2010).

11. Climate change and environmental implications

11.1. There are no climate change or environmental implications of this report.

12. Crime and disorder implications

12.1. There are no crime and disorder implications of this report.

13. Health and wellbeing implications

13.1. Improving health outcomes and reducing health inequalities is central to the work of the Health and Wellbeing Board. This report directly aligns with these aims by outlining a plan of action to address health inequalities in Lewisham's BAME communities.

14. Background papers

14.1. Black, Asian and Minority Ethnic (BAME) Health Inequalities Action Plan

15. Report author and contact

15.1. Dr Catherine Mbema, Catherine.mbema@lewisham.gov.uk

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Health and Wellbeing Board - Addressing BAME Health Inequalities Action Plan 2019-2022

Ref No.	Action	Owner/Governance	Timescale	Progress	RAG
Mental Health					
Children and Young People (CYP)					
1	Establish mental health participation group with a focus on BAME children and young people	LBL CYP commissioning team / CYP Mental Health and Emotional Wellbeing Board		Jun-19 CAMHS worked with schools to develop a specific school approach in 2019/20 and the CAMHS Participation and Recovery College, Alchemy, continues to facilitate a established BAME group.	
2	Response to recommendations from member-led review and NHS intensive support team review of mental health pathway for CYP in Lewisham	LBL CYP commissioning team / CYP Mental Health and Emotional Wellbeing Board	April 2019 – March 2021	32 recommendations with short, medium and long term actions have been incorporated into an Improvement Plan, which is being overseen by a re-focused, cross sector Governance Structure for CYP Mental Health and Emotional Wellbeing.	
3	Work to develop key performance indicator for BAME referral and attendance within CAMHS services	LBL CYP commissioning team / CYP Mental Health and Emotional Wellbeing Board/Lewisham Public Health		May-21 Work being scoped out with Public Health and CYP commissioning teams. This should be finalised by Q2 2020/21	
Adults					
4	Work to ensure that there is community and service user participation in co-design of local service and care pathways	Adults Mental Health Provider Alliance	Ongoing	In progress. Community Transformation teams have been engaging with various service user/carer and community groups/networks on the work that is taking place. A service user rep is a member of the Transformation Group meeting. Community Insight work brief being put together to gather intelligence in experiences with MH care and support for people from BAME communities.	
5	Implementation of recommendations from the Adults Mental Health JSNA	Adults Mental Health Provider Alliance	Ongoing	In progress. The Community Transformation team have received the recommendations for the JSNA and are building these into the service redesign.	
6	Work to ensure that Lived Experience workers are ethnically representative of the Lewisham population	Adults Mental Health Provider Alliance	Ongoing	External funding was unsuccessful. Now working through local recruitment process to ensure peer support workers are demographically representative of the local population	
7	To co-produce approaches to engagement and on-ongoing dialogue as component of the Alliance Engagement & involvement strategy	Adults Mental Health Provider Alliance	Ongoing	Commenced. The first collaborative lunch took place in January and meet on a monthly basis. Early stages of development is looking at the high level outcomes for the Alliance.	
All Ages					
8	To develop a Lewisham approach to promote the interface between adult and CYP mental health services	CYP Mental Health and Emotional Wellbeing board/Adults Mental Health Provider Alliance	Ongoing		
9	To develop the Time to Change Hub to include a focus on reducing stigma in BAME communities in Lewisham (inclusion)	Lewisham Public Health/Adults Mental Health Commissioning Team/Adults Mental Health Provider Alliance	Ongoing	The Hub has already been established but work to focus on reducing stigma in BAME communities to be developed.	
Obesity					
10	To co-design health promotion materials as part of the Childhood Obesity Trailblazer with BAME communities	Lewisham Childhood Obesity Trailblazer Steering Group	October/November 2019	In progress. The Young Mayors team are facilitating the first poster design with young people	
11	To develop a physical activity strategy that recognises the need to address BAME health inequalities in obesity	Physical Activity Strategy Steering Group		Feb-20 Community insights work is being procured to gain specific insights into BAME community perspectives around physical activity and obesity services	
12	To support further involvement of BAME community groups in the Lewisham Obesity Alliance and Lewisham Whole Systems Approach to Obesity	Lewisham Whole Systems Approach to Obesity Project Board	Ongoing	BAME Health Inequalities action plan an agenda item for the March meeting of the Obesity Alliance.	
Cancer					
13	To deliver cancer awareness workshops to BAME community groups / residents to raise awareness and reduce stigma around main cancer types	Lewisham Cancer Awareness Network/Cancer Research UK/MacMillan		Mar-20 CRUK will be delivering Talk Cancer: Train the Presenter workshop on 26 th March for all community members	
Community Capacity Building					
14	To develop a Health Inequalities Toolkit to circulate to community groups with the Mayor and Cabinet Advisor for BAME Health Inequalities	Cabinet Executive Office/Mayor and Cabinet Advisor for BAME Health Inequalities		Mar-20 In progress - first draft of toolkit completed 16/08/2019	
15	To support the development of BAME community groups to participate in the commissioning cycle as appropriate	Executive Director of Community Services/Director of Public Health/Mayor and Cabinet Advisor for BAME Health Inequalities	Ongoing	Community insights work is being procured to gain specific insights into BAME community perspectives around physical activity and obesity services	
16	To work with the Lewisham BAME Health Network to continue to develop this action plan over the next 2 years through consistent engagement with members of the Network	Executive Director of Community Services/Director of Public Health/Mayor and Cabinet Advisor for BAME Health Inequalities/BME Network Chair		Mar-20 In progress	

Agenda Item 4



Health & Wellbeing Board

Joint Strategic Needs Assessment Update

Date: 12 March 2020

Key decision: No.

Class: Either Part 1

Ward(s) affected: ALL

Contributors: Dr Catherine Mbema, Director of Public Health, London Borough of Lewisham

Outline and recommendations

This report provides details of the recently completed Joint Strategic Needs Assessment (JSNA) Topic Assessments on Mental Health and Adult Asthma and COPD (Chronic Obstructive Pulmonary Disease). It also outlines proposals for a revised JSNA topic selection process for 2020/21 and a review of the impact of recently published JSNA Topic Assessments.

The board is recommended to approve:

- The publication of the completed Joint Strategic Needs Assessment (JSNA) Mental Health and Adult Asthma and COPD Topic Assessments as part of the agreed process at the [July 2017 Health and Wellbeing Board](#).
- The proposals for a revised JSNA topic selection process for 2020/21.
- The proposals to review the impact of recently published JSNA Topic Assessments.

Timeline of engagement and decision-making

This paper is being submitted as part of the revised JSNA process originally agreed by the [Health and Wellbeing Board in 2017](#)

The Health & Wellbeing Board approved the proposal to undertake JSNA Topic Assessments on Mental Health and Adult Asthma and COPD at the meeting on [1/03/18](#)

1. Summary

- 1.1. This update provides an overview of two recently completed JSNA Topic Assessments on Mental Health and Adult Asthma and COPD (Chronic Obstructive Pulmonary Disease). It also outlines proposals to revise the JSNA topic selection process for 202/21 and a proposal to evaluate the impact of recently published JSNAs.

2. Recommendations

- 2.1. The board is recommended to approve:
- 2.2. The publication of the completed Joint Strategic Needs Assessment (JSNA) Mental Health and Adult Asthma and COPD Topic Assessments as part of the agreed process at the July 2017 Health and Wellbeing Board .
- 2.3. The proposals for a revised JSNA topic selection process for 2020/21.
- 2.4. The proposals to review the impact of recently published JSNA Topic Assessments.

3. Policy Context

- 3.1. The production of a JSNA became a statutory duty of PCTs and upper tier local authorities in 2007. The Health and Social Care Act 2012 placed a new statutory obligation on Clinical Commissioning Groups, the Local Authority and NHS England to jointly produce and to commission with regard to the JSNA. The Act placed an additional duty on the Local Authority and CCGs to develop a joint Health and Wellbeing Strategy for meeting the needs identified in the local JSNA.
- 3.2. The objective of a JSNA is to provide access to a profile of Lewisham's population, including demographic, social and environmental information. It also provides access to in-depth needs assessments which address specific gaps in knowledge or identify issues associated with particular populations/services. These in-depth assessments vary in scope from a focus on a condition, geographical area, or a segment of the population, to a combination of these. The overall aim of each needs assessment is to translate robust qualitative and quantitative data analysis into key messages for commissioners, service providers and partners.

- 3.3. The most recent version of the JSNA can be found here: www.lewishamjsna.org.uk.
- 3.4. The priorities of The Health and Wellbeing Strategy 2013-2023 were informed by the JSNA.

4. Background

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

5. JSNA Update

5.1. Completed Mental Health JSNA Topic Assessment

- 5.1.1. The aim of the JSNA is to understand the mental health and wellbeing needs (including dementia) of adults in Lewisham, review how well these needs are met, identify any gaps and make recommendations for improvements in service provision. Some of the key findings include:
 - 5.1.2. Lewisham has significantly higher rates of diagnosed depression than the London average (8.2% compared to 7.1%).
 - 5.1.3. The rate of severe mental illness (SMI) in Lewisham is significantly higher than both the London and England averages (1.3% in Lewisham compared to 1.1% in London and 0.9% in England).
 - 5.1.4. The prevalence of mental ill health is not spread evenly across the population, and there are some population groups that have higher rates of mental ill health in Lewisham, including; BAME communities, the unemployed and those who misuse drugs or alcohol.
 - 5.1.5. The numbers of people with common mental health disorders and severe mental illness in Lewisham are projected to increase in the coming years.
 - 5.1.6. There is a strong link between mental health and physical health. Adults in Lewisham who are in contact with secondary mental health services are more than three times as likely to die as people of the same age in the general Lewisham population

5.2. Completed Adult Asthma and COPD JSNA Topic Assessment

- 5.2.1. This JSNA aims to systematically review information about the adult population in Lewisham living with asthma and COPD. It can be used to support decision making that will ultimately lead to improved health and wellbeing in the local population as well as reduced inequalities. Some of the key findings include:
 - 5.2.2. The rate of premature mortality from respiratory disease in Lewisham is the second highest in London (behind Barking & Dagenham only), at 43.4 per 100,000. Rates are higher in men than women and correlate with increasing levels of deprivation.
 - 5.2.3. In Lewisham, the prevalence of smoking among adults is 15.5%, which equates to 35,780 current smokers. The burden of smoking-related ill health is particularly great in Lewisham as compared to the London and national averages.
 - 5.2.4. Lewisham also has a high level of smoking-attributable mortality, which is statistically significantly higher than the national or London average at 310.7 per 100,000 it is the second highest rate in London.

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5.2.5. According to the GP register, there are 4,308 people in Lewisham with a diagnosis of COPD, which equates to a prevalence of 1.3%. This is lower than the national average. It is widely recognised that COPD is under diagnosed across the UK. A recent estimate by Public Health England suggests that there may be over 3000 patients with undiagnosed COPD living in Lewisham.

5.2.6. According to GP registers there are 17,121 adults with a diagnosis of asthma in Lewisham. This equates to a prevalence of 5.9% in the adult population which is the same as the England average.

5.3. **Proposal for a revised JSNA topic selection process for 2020/21**

5.3.1. The current process for the selection of JSNA Topic Assessments was agreed by the Health and Wellbeing Board in 2017 and is set out [here](#). It is proposed that the process is revised this year, postponing the call for topic suggestions until September 2020 and undertaking a smaller number of topic assessments (1-2) between September 2020 and March 2021. The “Picture of Lewisham” element of the JSNA will also not be updated this year. The rationale for this is as follows:

5.3.2. There are a number of JSNA Topic Assessments still outstanding from 2018/19 and 2019/20. Postponing the agreement of topic assessments for 2020/21 will allow time for these assessments to be completed, approved and published.

5.3.3. It has been proposed that the Health and Wellbeing Board review and refresh the Health and Wellbeing Strategy in 2020/21. It is likely that a Macro Level JSNA will be required to inform this process. Postponing the identification of new JSNA Topic Assessments will provide the analytical capacity to undertake this Macro Level JSNA.

5.3.4. The trends in demographics and population health and wellbeing depicted in the “Picture of Lewisham” do not change significantly from year to year. It often takes at least 3 years of surveillance to identify a change in trend. Extending the period between updates to 2 years should not adversely affect the ability of stakeholders to use the information within the profile to inform their decision-making.

5.4. **Proposal to review the impact of recently published JSNA Topic Assessments**

5.4.1. The overall aim of the JSNA is to translate robust qualitative and quantitative data analysis into key messages for commissioners, service providers and partners. This information should be used to inform short, medium and long-term commissioning decisions and support the development of strategies to improve health, wellbeing and care in Lewisham and tackle inequalities, including the Health and Wellbeing Strategy.

5.4.2. As it is now 3 years since the new process for identifying, producing and publishing the JSNA was agreed by the Health and Wellbeing Board, it is proposed that a brief evaluation should be undertaken of the extent to which, the JSNAs published in this period, have achieved the aims outlined above.

5.4.3. The scope of the evaluation will be determined by the resources available but could involve a mixed methods approach utilising surveys, interviews and desk-based research. The evaluation will cover one or more of the following themes:

- Leadership & Governance
- Engagement and ownership
- Links to strategic planning and commissioning
- Data sharing and collation
- The report itself

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6. Financial implications

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

7. Legal implications

- 7.1. The requirement to produce a JSNA is set out in the Policy Context section.
- 7.2. Members of the Board are reminded that under Section 195 Health and Social Care Act 2012, Health and Wellbeing Boards are under a duty to encourage integrated working between the persons who arrange for health and social care services in their area.

8. Equalities implications

- 8.1. JSNAs are a continuous process of strategic assessment and planning, with a core aim to develop local evidence based priorities for commissioning which will improve health and reduce inequalities. Equalities implications have been highlighted throughout the body of the report and summarised in report section 13.2.

9. Climate change and environmental implications

- 9.1. There are no climate change or environmental implications from this report.

10. Crime and disorder implications

- 10.1. There are no crime and disorder implications from this report.

11. Health and wellbeing implications

- 11.1. The impact of mental wellbeing and poor mental health on the Lewisham population and its sub-groups have been highlighted in the Mental Health Topic Assessment. The report makes a number of recommendations which, if implemented, will have a positive impact on the mental health and wellbeing of Lewisham's residents, these include:
- Improving the physical health of people with severe mental illness
 - Continuation of the work towards reducing BAME mental health inequalities
 - A continued focus on prevention and early intervention
 - More targeted support for protected characteristic groups and groups we know are at higher risk of developing mental health conditions
- 11.2. The impact of asthma and COPD on the adult population in Lewisham and its sub-groups have been highlighted in the Adult Asthma and COPD Topic Assessment. The report makes a number of recommendations which, if implemented, will have a positive impact on the health and wellbeing of Lewisham's residents, these include:
- To continue to invest in stop smoking services and to encourage more Lewisham residents to quit smoking.
 - To identify and diagnose new cases of COPD and asthma in primary care.
 - To ensure that there is adequate access to spirometry in Lewisham to support early diagnosis of COPD.
 - To commission sufficient pulmonary rehabilitation services to meet local need.
 - Clear exacerbation-pathways separate for asthma/COPD to be developed.

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- An integrated community respiratory team would be beneficial in terms of consideration of more holistic care.
- A dedicated home oxygen service could be considered and may work well across boroughs as has been commissioned in other regions.

12. Background papers

- 12.1. Mental Health JSNA Topic Assessment
- 12.2. Adult Asthma and COPD JSNA Topic Assessment

13. Report author and contact

- 13.1. Dr Catherine Mbema, Director of Public Health, catherine.mbema@lewisham.gov.uk

**Adults' Mental Health in Lewisham:
Joint Strategic Needs Assessment**

JOINT STRATEGIC NEEDS ASSESSMENT: ADULTS' MENTAL HEALTH IN LEWISHAM

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1. EXECUTIVE SUMMARY

The aim of this JSNA is to understand the mental health and wellbeing needs (including dementia) of adults in Lewisham, review how well these needs are met, identify any gaps and make recommendations for improvements in service provision.

1.1. NEEDS ANALYSIS: MENTAL HEALTH IN LEWISHAM

Lewisham has lower average wellbeing scores than London or England.

8.2% of adults in Lewisham have a recorded diagnosis of depression. This is significantly higher than in London (7.1%). This is also likely to be an underestimate of actual prevalence, as not everyone who has depression will visit their GP.

1.3% of people in Lewisham have a recorded diagnosis of severe mental illness (SMI). This is significantly higher than in London (1.1%) and in England (0.9%).

4.5% of people in Lewisham aged over 65 have a recorded diagnosis of dementia. The numbers are rising year on year.

The numbers of people with common mental health disorders and severe mental illness in Lewisham are projected to increase in the coming years.

The prevalence of mental ill health is not spread evenly across the population, and there are some population groups that have higher rates of mental ill health in Lewisham, including:

- The Black, Asian and Minority Ethnic population have higher prevalence rates of some mental health conditions, e.g. psychotic disorder, Post-Traumatic Stress Disorder (PTSD), and also experience inequalities in access to services.
- The rate of admission to hospital for mental and behavioural disorders due to alcohol is significantly higher in Lewisham than in London. Approximately a fifth of adults receiving drug misuse treatment and alcohol misuse treatment were also in contact with MH services
- The gap between the employment rate for all people and just those in contact with secondary mental health services is higher in Lewisham than in London or England, and the gap has increased steadily in the last few years
- The proportion of adults in contact with secondary mental health services and known to be living independently (with or without support) is significantly lower in Lewisham than in England and London

There is a strong link between mental health and physical health: Adults in Lewisham who are in contact with secondary mental health services are more than three times as likely to die as people of the same age in the general Lewisham population. There are many causes of this, but the higher smoking prevalence amongst people with SMI is likely to be part of the explanation.

Residents' views on mental health in Lewisham reveal several key issues:

- The continued issue of stigma around mental health conditions, particularly for certain population groups and in the context of employment, and the need for mental health to be recognised as equally important as physical health
- The need for better communication to raise awareness of available mental health services and promote the ways that people can look after their own mental health
- The importance of early intervention, helping people before they reach crisis point.
- The need for services that are shaped to suit populations with specific mental health needs e.g. men, BAME population, or older people. Discussions have highlighted the need for culturally specific services, and the potential benefits of seeing a professional from a similar background as your own.

1.2. CURRENT SERVICE PROVISION

There are a wide range of mental health services on offer for Lewisham residents. These include services delivered by voluntary and community sector organisations (both commissioned and non-commissioned), by primary care, by community mental health teams, and in hospitals.

- There is a broad range of support provided by different voluntary and community sector commissioned services, which are able to reach different populations in Lewisham. However, service outcomes are not universally reported and there is no consistent data set used by services, so a wide range of different outcome measures are reported. There is also a lack of data on longer-term outcomes. For those services who do report them, short-term outcomes are generally positive.
- Whilst the NHS Lewisham CCG average achievement of physical health checks for people with mental health conditions is often similar to the London and England averages, this hides variation between practices.
- There is a lack of data recorded on protected characteristics by many services.
- Whilst improving physical health for people with severe mental illness is a priority for many service areas, there is not a consistent approach across the whole of the mental health pathway.
- There is some evidence of increasing demand for services, for example there has been an upward trend in the number of monthly A&E presentation to the Mental Health Liaison Service by Lewisham residents since 2014/15.
- In general, services are meeting nationally set standards.
- Whilst we have some information on the key inequalities amongst service users, the lack of data recorded (or incomplete data) on protected characteristics, makes analysis indicative rather than definitive. The main inequalities indicated are by ethnicity, by age and by gender:
 - **Ethnicity:** The Lewisham BAME population is underrepresented in the proportion of IAPT (Improving Access to Psychological Therapies) referrals received and are also less likely to move from the referral stage to the finished treatment stage and to the 'moving to recovery' stage than their White counterparts; in comparison to the modelled data on the incidence of psychosis, several community mental health services seem to have a lower than anticipated proportion of Black service users. However, the level of unknown ethnicity in some of the services makes it difficult to come to conclusions about access for BAME service users; there is a very high proportion of Black service users in forensic services and in acute services. This seems to suggest that Black service users are disproportionately found in the Crisis pathway rather than the Common Mental Illness or Severe Mental Illness pathways.
 - **Age:** Data suggests that people aged over 65 are under-represented amongst people who have completed treatment in Lewisham's IAPT services.
 - **Gender:** Service data shows that services are accessed differently by people of different genders. For example, data suggests that men are under-represented amongst people who have completed treatment in Lewisham's IAPT services; however, women are slightly under-represented in other services.

1.3. RECOMMENDATIONS

- More targeted support for protected characteristic groups and groups we know are at higher risk of developing mental health conditions (BAME, refugees and asylum seekers, men, older people, LGBT+ population, homeless people, people with substance/alcohol misuse issues, unemployed people, carers, and people in the criminal justice system)
- We must continue to work towards reducing BAME mental health inequalities
- A continued focus on prevention and early intervention
- Improving the physical health of people with severe mental illness
- Mapping the future demand for services and constantly asking ourselves if they are the right ones
- Employment support that responds to mental health needs
- Better data to give us a better picture of mental health in Lewisham
- Seeking a better understanding of dementia in Lewisham

2. INTRODUCTION

Good mental health and wellbeing are important for all aspects of our lives. However mental health problems affect around one in six people in any given year.¹ They range from common problems, such as depression and anxiety, which cause distress and interfere with normal everyday life, to rarer problems such as schizophrenia and bipolar disorder. Box 1 describes types of common mental health disorder and Box 2 describes types of severe mental illness.

Box 1. Common Mental Health Disorders²

Depression

A mental health problem characterised by persistent low mood and a loss of interest and enjoyment in ordinary things. A range of emotional, physical and behavioural symptoms are likely such as sleep disturbance, change in appetite, loss of energy, poor concentration, low feelings of self-worth and thoughts of suicide. Depressive episodes can range from mild to severe.

Generalised anxiety disorder

An anxiety disorder characterised by excessive worry about many different things and difficulty controlling that worry. This is often accompanied by restlessness, difficulties with concentration, irritability, muscular tension and disturbed sleep.

Social anxiety disorder (social phobia)

A persistent and overwhelming fear of a social situation, such as shopping or speaking on the phone which impacts on a person's ability to function effectively in aspects of their daily life. People with social anxiety will fear doing or saying something that will lead to being judged by others and being embarrassed or humiliated. Feared situations are avoided or endured with intense distress.

Panic disorder

People with panic disorder experience repeated and unexpected attacks of intense anxiety. There is a marked fear of future attacks and this can result in avoidance of situations that may provoke a panic attack. Symptoms include a feeling of overwhelming fear and apprehension often accompanied by physical symptoms such as nausea, sweating, heart palpitations and trembling.

Agoraphobia

Characterised by fear or avoidance of specific situations or activities that the person fears will trigger panic-like symptoms, or be difficult or embarrassing to escape from, or where help may not be available. Specific feared situations can include leaving the house, being in open or crowded places, or using public transport.

Obsessive-compulsive disorder (OCD)

An anxiety condition characterised by the presence of either obsessions (repetitive, intrusive and unwanted thoughts, images or urges) or compulsions (repetitive behaviours or mental acts that a person feels driven to perform), or both.

Specific phobia

¹ 17 percent of adults surveyed in the Adult Psychiatric Morbidity Survey 2014 met the criteria for a common mental health disorder. McManus, S., Bebbington, P., Jenkins, R. and Brugha, T. (2016). Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014.

² Public Health England Mental Health JSNA Toolkit

An overwhelming and debilitating fear of an object, place, situation, feeling or animal. This can include a fear of heights, flying, particular animals, seeing blood or receiving an injection. Phobias can have a significant impact on day to day life and cause significant distress.

Post-traumatic stress disorder (PTSD)

A set of psychological and physical problems that can develop in response to threatening or distressing events, such as physical, sexual or emotional abuse, severe accidents, disasters and military action. Typical features of PTSD include repeated and intrusive distressing memories that can cause a feeling of 'reliving or re-experiencing' the trauma. PTSD is often comorbid with other mental health conditions such as depression.

Health anxiety (hypochondriasis)

A central feature is a persistent preoccupation with the possibility that the person has, or will have, a serious physical health problem. Normal or commonplace physical symptoms are often interpreted as abnormal and distressing, or as indicators of serious illness.

Box 2. Severe Mental Illness

Psychosis

Psychosis (also called a psychotic experience or psychotic episode) is when an individual perceives or interprets reality in a very different way from those around them. The most common types of psychosis are hallucinations and delusions; people might also experience disorganised thinking and speech.

Schizophrenia

Schizophrenia is a severe long-term mental health condition. It causes a range of different psychological symptoms, including: disorganised thinking and speech, difficulty concentrating, delusions (which could include paranoid delusions) – strong beliefs that others don't share, hallucinations, such as hearing voices or seeing things others don't, not wanting to look after yourself, wanting to avoid people or feeling disconnected from your feelings.

Bipolar disorder

Bipolar disorder is a mental health problem that mainly affects your mood. People who have bipolar disorder are likely to have times where they experience: manic or hypomanic episodes (feeling high), depressive episodes (feeling low), and potentially some psychotic symptoms during manic or depressed episodes.

Personality disorders

These are conditions in which an individual differs significantly from an average person in terms of how they think, perceive, feel or relate to others. Experiences of distress or fear during childhood, such as neglect or abuse, are common.

Severe depression

At its most severe, depression can be life-threatening because it can cause people to feel suicidal or simply give up the will to live.

3. DATA

There are many aspects to mental health and therefore many different ways to look at what the needs are for the population. In this report, we categorise need according to different types of mental health and ill health: wellbeing (a positive asset, this can be understood as how people feel and how they function, both on a personal and a social level, and how they evaluate their lives as a whole); common mental health disorders (see Box 1); severe mental illness (see Box 2); suicide; and dementia (a set of symptoms that may include memory loss and difficulties with thinking, problem-solving or language).

There are also many ways to measure the 'need' of the population. These different measures have their own strengths and limitations. For example, many measures of demand, such as admissions to hospital, only capture the need of those people who are accessing services and do not capture the needs of those who are not in contact with services. In addition, data collection is not always complete, and there are often gaps in coverage. Issues of data quality are discussed in Section 14.

This JSNA draws data from a variety of sources, including the Office of National Statistics (ONS), Public Health England (PHE), the Greater London Authority (GLA), NHS Digital, South London and Maudsley (SLaM) NHS Trust and Lewisham Clinical Commissioning Group (CCG).

4. WHAT WE KNOW

4.1. FACTS AND FIGURES

4.1.1. Wellbeing

Each year the Office for National Statistics produces four personal wellbeing estimates for local authorities, based on four questions in the Annual Population Survey. For each of these types of wellbeing, Lewisham was estimated to have lower average wellbeing scores than London and England:

- *Overall, how satisfied are you with your life nowadays?* In 2017/18, the estimated average (mean) life satisfaction in Lewisham was 7.31 out of 10, compared to 7.52 for London and 7.68 for England.
- *Overall, to what extent do you feel the things you do in your life are worthwhile?* For Lewisham in 2017/18 the estimated average rating was 7.62 out of 10, compared to 7.73 for London and 7.88 for England.
- *Overall, how happy did you feel yesterday?* In 2017/18, the estimated average (mean) happiness in Lewisham was 7.40, compared to 7.44 for London and 7.52 for England.
- *Overall, how anxious did you feel yesterday?* For Lewisham in 2017/18 the estimated average (mean) rating was 3.18, compared to 3.13 for London and 2.90 for England.

Although we don't have any data on inequalities in wellbeing levels amongst populations in Lewisham, analysis of national data has shown that there are inequalities in wellbeing according to some personal characteristics. Self-reported health, economic activity, age, marital status, housing tenure and education represent the most prominent differences between those with the poorest personal wellbeing and those who reported higher ratings.³

4.1.2. Common Mental Health Disorders

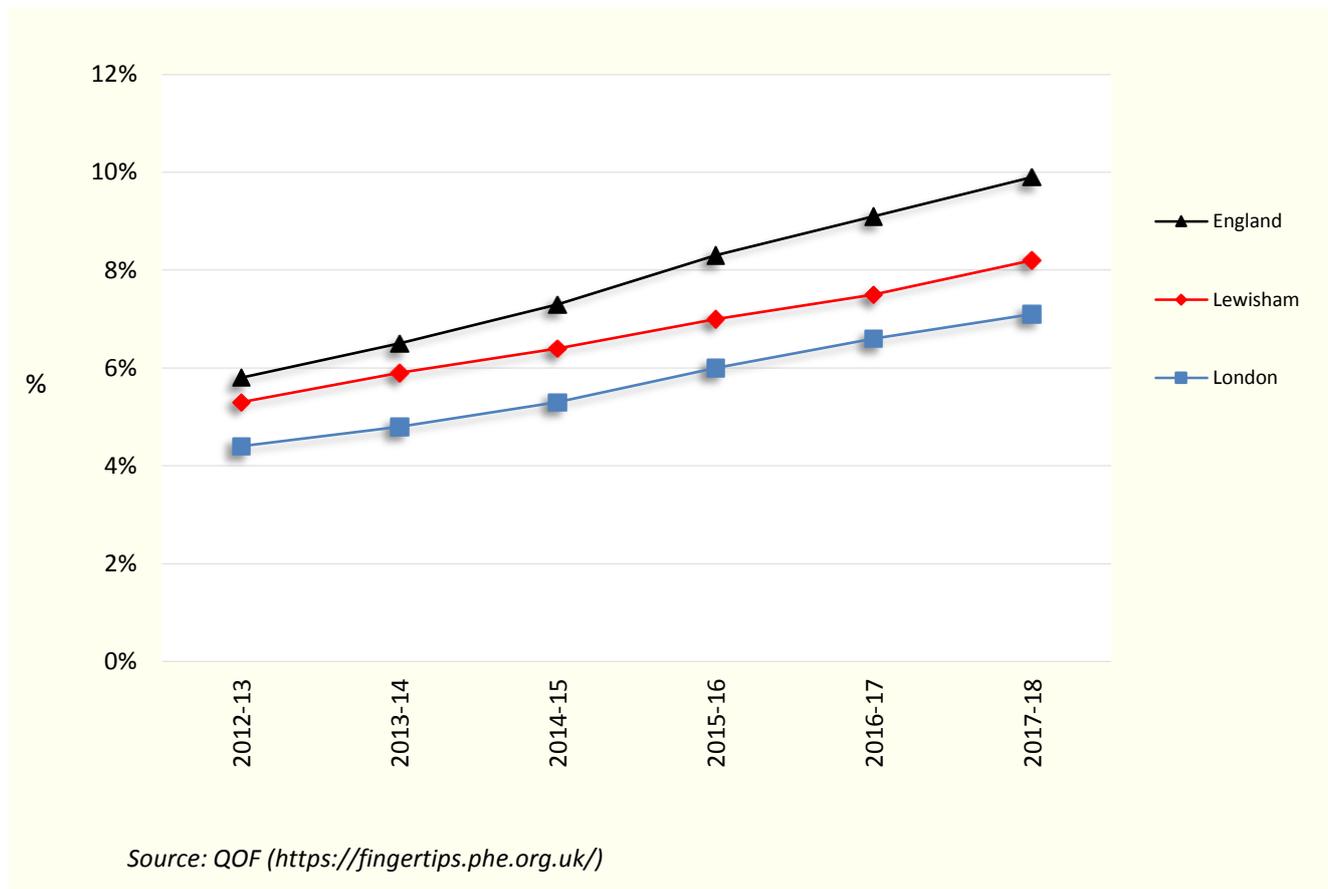
The recorded prevalence of depression amongst patients on GP practice registers aged 18+ in 2017/18 in Lewisham was 8.2% and equates to 21,222 patients).⁴ This is significantly higher than the average prevalence in London (7.1%) but significantly lower than the average prevalence in England (9.9%). However, there are

³ ONS (2018) Understanding well-being inequalities: Who has the poorest personal well-being? Analysis of the characteristics and circumstances associated with the poorest life satisfaction, feeling the things done in life are worthwhile, happiness and anxiety in the UK, from 2014 to 2016.

⁴ NHS Digital. Quality and Outcomes Framework (QOF) 2017/18

various reasons to think that this is likely to be an underestimate: first, not all people with depression may be diagnosed by a GP; and second, diagnoses may not always be recorded consistently. Figure 1 shows that recorded prevalence of depression has increased in Lewisham, London and England since 2012/13. In Lewisham it increased from 5.3% in 2012/13 to 8.2% in 2017/18.

Figure 1. Recorded prevalence of depression (QOF). Percentage of practice register aged 18+. Lewisham compared to London and England. Annual trends.



Other data also supports the hypothesis that the true prevalence may be higher: 32.2% of Lewisham adults who completed the GP Patient Survey in 2017 reported having depression and anxiety⁵ and in 2018 8.2% reported having a long-term mental health condition.⁶

Based on the Adult Psychiatric Morbidity Survey, a representative survey of adults in England, estimates have been produced of the prevalence of common mental health disorders in Lewisham. It is estimated that in 2019, there are 40,047 people aged 18-64 in Lewisham with a common mental health disorder (defined here as comprising different types of depression and anxiety, and including obsessive compulsive disorder).⁷ In addition, it is estimated that there are 2,488 people aged over 65 with depression in 2019.⁸

⁵ Includes patients reporting that they are slightly anxious or depressed, moderately anxious or depressed, severely anxious or depressed, and extremely anxious or depressed. GP Patient Survey 2017 results by CCG (weighted). <https://gp-patient.co.uk/surveysandreports>.

⁶ GP Patient Survey 2018 results by CCG (weighted). <https://gp-patient.co.uk/surveysandreports>

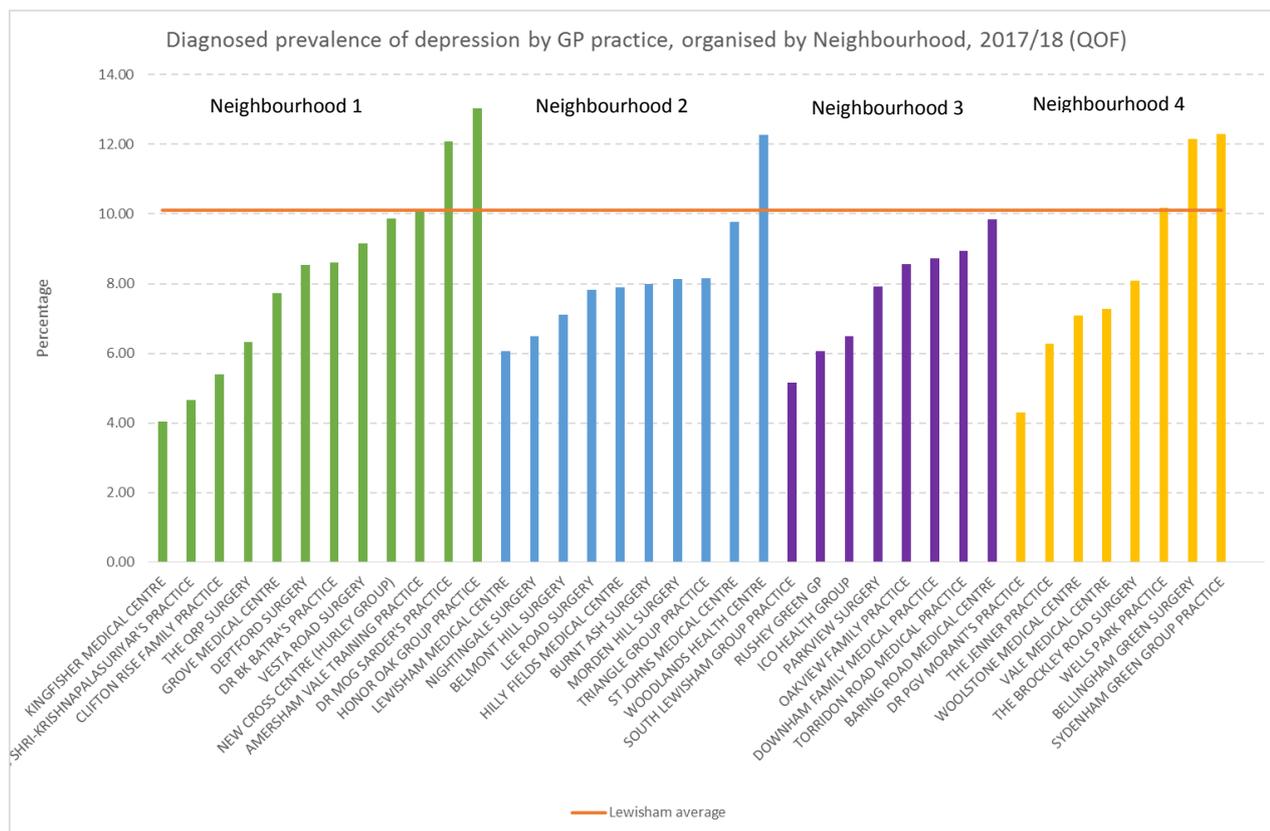
⁷ PANSI (Projecting Adult Needs and Service Information System) – based on the report Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 (2016), NHS Digital

⁸ POPPI – Figures are taken from McDougall et al, Prevalence of depression in older people in England and Wales: the MRC CFA Study in Psychological Medicine, 2007, 37, 1787–1795. The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers predicted to have depression, to 2035

Based on national prevalence estimates, it is expected that approximately 1,019 women (20%) in Lewisham develop a mental health problem in pregnancy or within a year of giving birth.⁹ A recent survey of fathers' mental health in Lewisham revealed that almost a third of new fathers felt 'down, depressed or hopeless' during the pregnancy or in the first year after the birth of their child.¹⁰

Figure 2 shows the variation in recorded prevalence of depression by GP practice. GP practices have been organised into 'neighbourhoods' which correspond to geographical areas of the borough.¹¹ Average neighbourhood prevalence ranges from 7.71% in Neighbourhood 3 to 8.45% in Neighbourhood 4.

Figure 2. Recorded prevalence of depression by GP practice, by Neighbourhood, 2017/18



4.1.3. Severe Mental Illness (SMI)

Based on the Adult Psychiatric Morbidity Survey, estimates have been produced of the prevalence of psychotic disorders in Lewisham. It is estimated that in 2019, there were 1,480 people aged 18-64 in Lewisham with a psychotic disorder.¹² In addition, the incidence rate of new cases of psychosis among people aged 16-64 was estimated in 2011 – in Lewisham this was estimated to be 48.6 per 100,000 resident population aged 16-64, which equates to approximately 94 people.¹³ This rate is significantly higher than the estimated rate for London (40.5) and England (24.2).

⁹ Maternal Mental Health JSNA -

[http://www.lewishamsna.org.uk/sites/default/files/Maternal%20Mental%20Health%20JSNA%20and%20Action%20Plan%20\(24%2004%2018\).pdf](http://www.lewishamsna.org.uk/sites/default/files/Maternal%20Mental%20Health%20JSNA%20and%20Action%20Plan%20(24%2004%2018).pdf)

¹⁰ Father's mental health survey, Lewisham Public Health

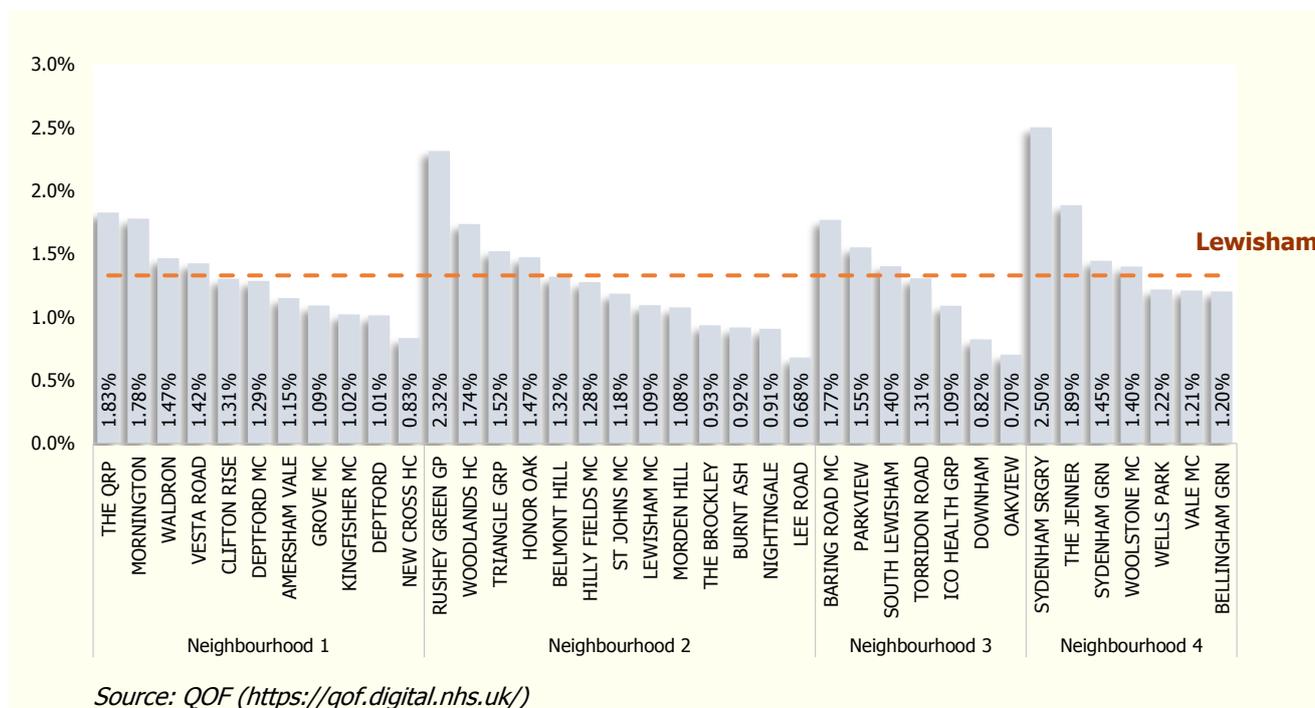
¹¹ Neighbourhood 1 corresponds to North Lewisham, Neighbourhood 2 corresponds to Central Lewisham, Neighbourhood 3 corresponds to South East Lewisham, and Neighbourhood 4 corresponds to South West Lewisham.

¹² PANSI (Projecting Adult Needs and Service Information System) – Based on the report Adult psychiatric morbidity in England, 2007: Results of a household survey, published by the Health and Social Care Information Centre in 2009

¹³ This indicator is an estimate of the number of new, clinically-relevant cases of first episodes of psychosis (FEP). The estimate is based on a modelling approach which used data from large research studies to estimate risk across a range of socio-demographic and socio-environmental factors. These risk estimates were then applied to local population factors

In 2017/18, the recorded prevalence of severe mental illness amongst patients on GP practice registers (all ages) in Lewisham was 1.3% (4,370 patients). This is significantly higher than the average prevalence in London (1.1%) and in England (0.9%). Again, as not all people with severe mental illness are diagnosed by a GP, this is likely to be an underestimate. Figure 3 shows the variation by neighbourhood. This follows the pattern seen for depression, with the highest average prevalence in Neighbourhood 4 (1.55%) and the lowest in Neighbourhood 3 (1.24%).

Figure 3. Recorded SMI prevalence (all ages) by Neighbourhood, 2017/18



In 2017/18, there were 8,825 adults (aged 18 or over) in Lewisham who were in contact with NHS funded secondary mental health, learning disabilities and autism services.¹⁴

The Care Programme Approach (CPA) is the system which coordinates the care of many specialist mental health service patients. CPA requires health and social services to combine their assessments to make sure everybody needing CPA receives properly assessed, planned and coordinated care. It should also ensure that patients get regular contact with a care co-ordinator.

As of December 2018 there were 1550 people in Lewisham on CPA,¹⁵ which is equivalent to a crude rate of 665 people per 100,000 population. This is higher than in Lambeth or Southwark (Figure 4).¹⁶ The crude rate in London at August 2018 (end of quarter snapshot) was 392 people per 100,000 population and in England was 362 people per 100,000 population.¹⁷

Figure 4. Number of patients on Care Programme Approach (CPA) in Lewisham, Lambeth and Southwark, November 2017-December 2018

to estimate the number of new cases in each local authority per year. 2011 is the latest year for which an estimate is available.

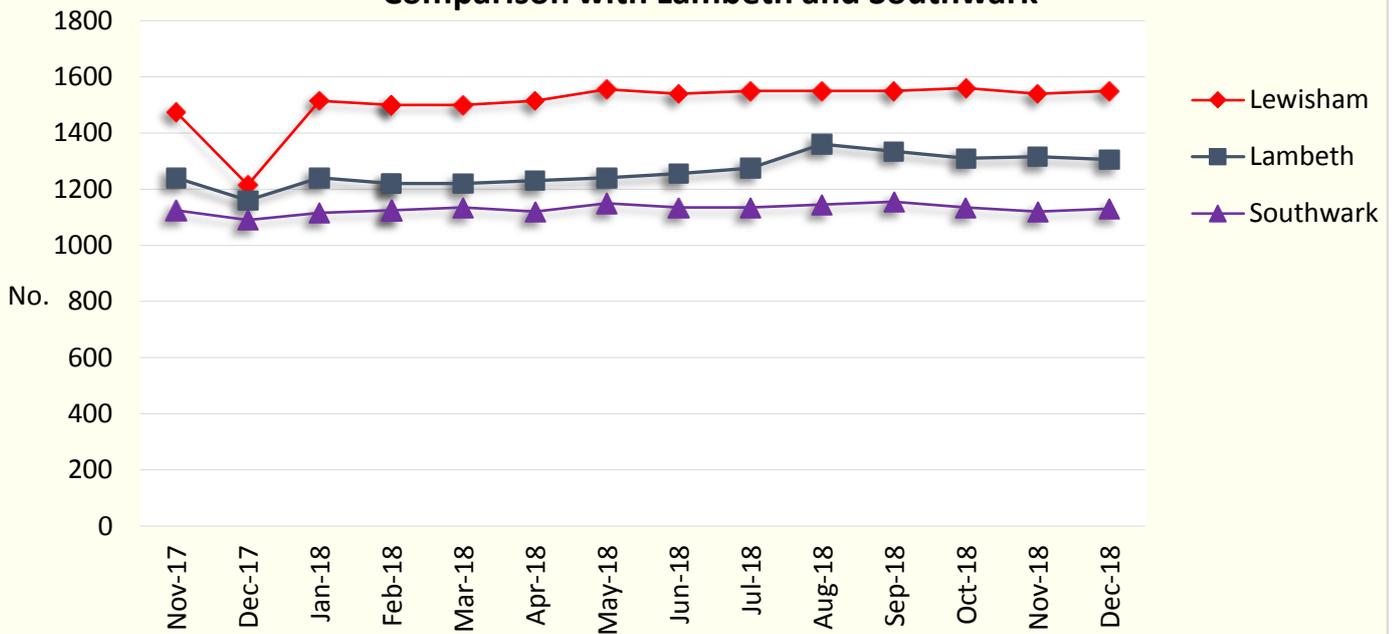
¹⁴ Mental Health Bulletin: 2017-18 Annual report – Reference Tables. The number of people in contact with NHS funded secondary mental health, learning disabilities and autism services does not include people who are being treated for a mental health problem only within primary care settings.

¹⁵ NHS Digital. Mental Health Services Data Set – MHSDS Monthly File December 2018

¹⁶ PHE Fingertips Crisis Care Profile. It should be noted that this rate is a crude rate and therefore does not take into account any differences in the population structure in terms of age or gender.

¹⁷ PHE Fingertips Crisis Care Profile. It should be noted that this rate is a crude rate and therefore does not take into account any differences in the population structure in terms of age or gender.

Number of Lewisham patients on Care Programme Approach (CPA). Comparison with Lambeth and Southwark



Source: <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics>

Box 3. Physical health amongst people with SMI

Mental and physical health are closely related: Poor physical health increases the risk of developing mental health problems, and people with mental health problems, particularly those who do not access treatment early and with more severe conditions, experience poorer physical health and reduced life expectancy.

People with severe mental health conditions die 15-20 years earlier on average than the general population. Two thirds of these deaths are from avoidable physical illnesses, including heart disease and cancer, many caused by smoking.¹⁸

The excess mortality rate is a ratio of observed to expected deaths in adults in contact with secondary mental health services. In 2011/12 in Lewisham, excess mortality in adults aged under 75 was 306.8% i.e. people in contact with secondary mental health services were more than three times more likely to die than people of the same age in the general population. For England, the rate was 337.2% i.e. nearly 3.4 times as likely, and for London the rate was 299.9%.¹⁹

Much of the extra burden of poor physical health among those with mental health problems can be explained by health behaviours such as smoking and alcohol. Smoking prevalence is particularly high among people with mental health conditions.²⁰ It was estimated that approximately 41.5% of people with SMI aged 18+ in Lewisham were smokers in 2014/15,²¹ compared to the estimates of general smoking prevalence of 21.1% amongst adults in Lewisham in 2014.²²

Alongside smoking, there are a number of other links between health behaviours and mental health problems, such as diet and physical activity; and other factors that play a part include barriers to receiving

¹⁸ NHS Five Year Forward View for Mental Health (2016) p.6

¹⁹ PHOF indicator 90553, 2011/12

²⁰ NHS Digital. Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 2016

²¹ PHE Fingertips Tobacco Control Profile. From GP data. Please note that there are concerns with the quality of this data.

²² PHE Fingertips Tobacco Control Profile. From Annual Population Survey estimates based on self-reported survey results. It should be noted that general prevalence of smoking in Lewisham has decreased since 2014, and in 2017 was estimated to be 15.5%.

adequate physical healthcare, for example an assessment of cardiovascular risk for people with schizophrenia in hospital, include a historical lack of clarity over who is responsible for providing primary health care to this group, skills gaps in general practice, and ‘diagnostic overshadowing’ (in which physical symptoms can be overlooked as a result of an existing diagnosis).²³ Data on the provision of physical health checks by GPs for people with SMI are included in Section 12.2 and some data on physical health checks and health promotion interventions for people with SMI in hospital are included in Box 6.

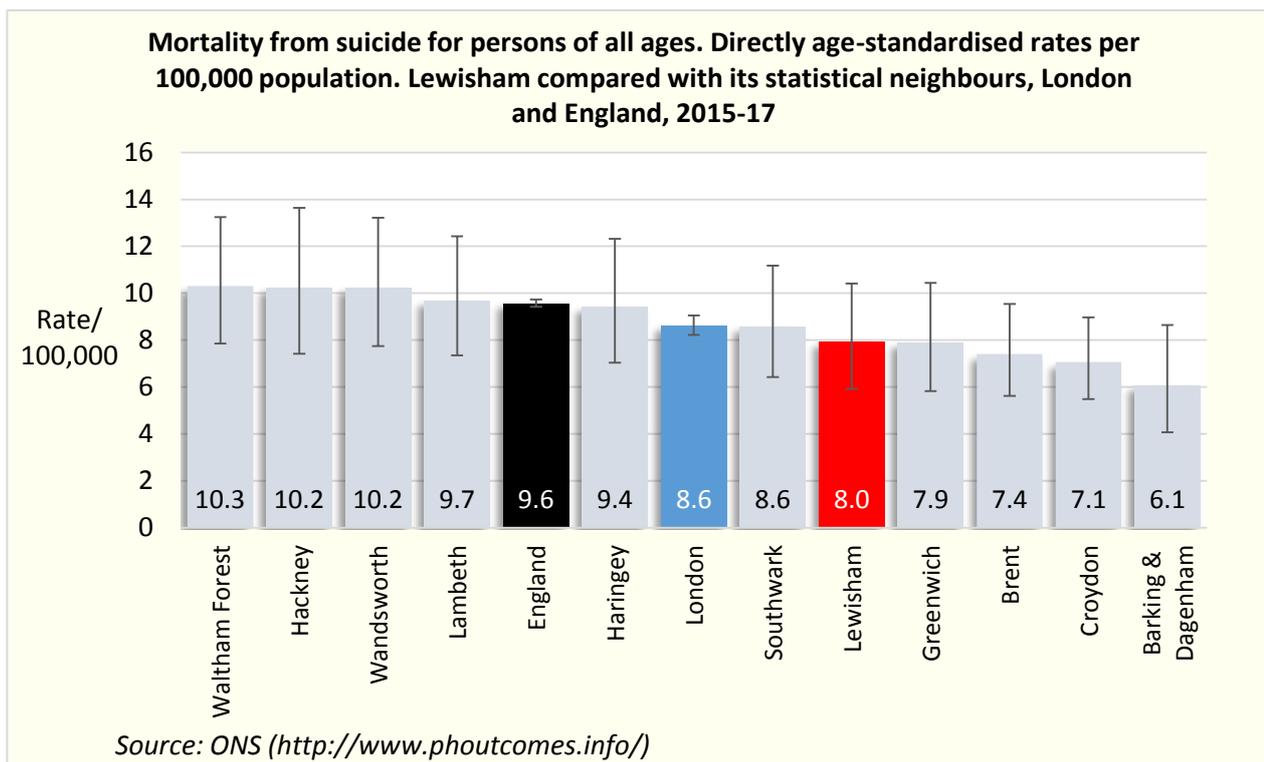
The relationship between mental health and physical health is also strongly underpinned by the underlying social determinants of health, such as deprivation, and barriers to accessing health care may also be further exacerbated by stigma and socioeconomic inequalities.

The Five Year Forward View for Mental Health stated that NHS England should ensure 280,000 more people with SMI have their physical needs met by 2020/2021 by increasing early detection and expanding access to evidence based physical care assessment and intervention each year. Collaboration between public health, primary care and secondary care mental health services is crucial to realising this aim.

4.1.4. Suicide

Between 2015 and 17, Lewisham had a 3-year average suicide rate of 8.0/100,000, which was not significantly different from the London and England averages for that period (Figure 5) or from its statistical neighbours.²⁴

Figure 5. Directly standardised rates of mortality from suicide (all ages) per 100,000 population in Lewisham and its statistical neighbours, London and England, 2015-17



To gain further understanding of local population needs in relation to suicide and to inform the local suicide prevention strategy, the Lewisham Public Health team performed a refreshed suicide audit. The audit examined anonymised data extracted from the Primary Care Mortality Database (PCMD) for the time period

²³ Kings Fund (2016). Bringing together physical and mental health.

²⁴ ‘Statistical neighbours’ are those places that are demographically similar to Lewisham. This can be a better comparator than geographical neighbours and are therefore used to identify realistic opportunities to improve health and healthcare for the population

January 2012 - December 2016.²⁵ This included data on cause of death, age, gender, place of death and country of origin. The main findings concluded from the audit were:

- In Lewisham, the largest number of suicides during the time period examined was among those aged between 24-45 years (53% of all suicides). This differs from what is seen nationally, where those aged between 45 and 55 have the highest suicide rate. However this finding may reflect the relatively younger population in Lewisham compared to England overall since the audit results have not been standardised.
- Three times as many men died as result of suicide in Lewisham in this time period compared to women. This reflects trends seen across the country.
- The most common method of suicide in Lewisham was hanging (66% of all suicides) during this period for both men and women.
- Opiate overdose made up a quarter of all non-violent suicides during this period in Lewisham.

4.1.5. Dementia

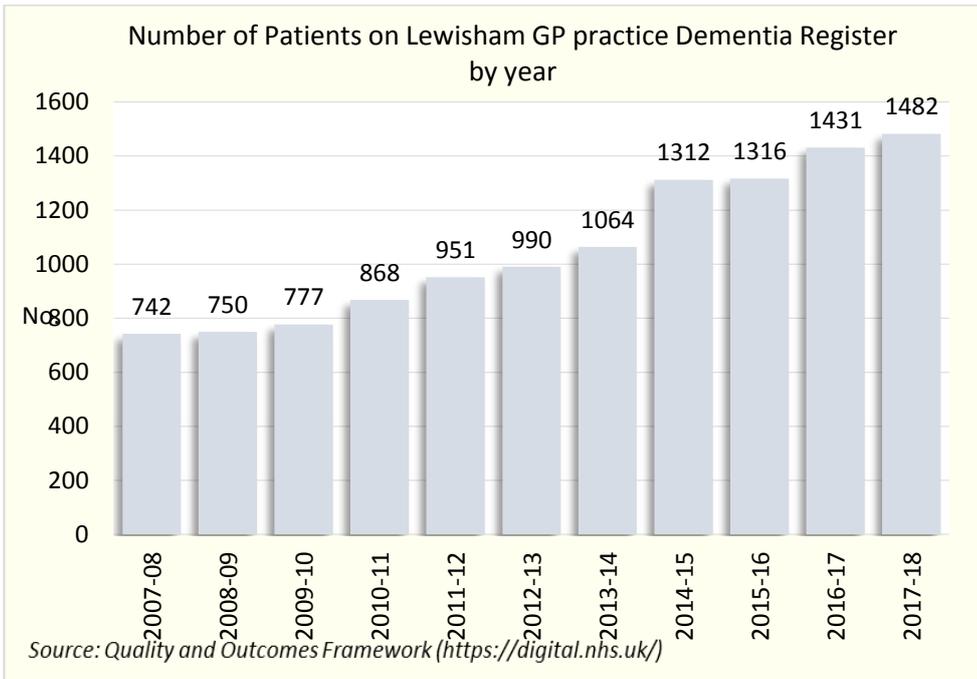
In 2017/18 there were 1482 patients on the Lewisham GP practice dementia register. This represents 0.45% of the total registered patient population in Lewisham. The proportion of the population over 65 diagnosed with dementia in Lewisham as of September 2017 was 4.49%. This is similar to London (4.49%) and England (4.33%). Again, this is likely to be an underestimate of the true prevalence of dementia in Lewisham. Based on the best available evidence of prevalence, estimates have been produced for the number of people predicted to have dementia.²⁶ It is estimated that in Lewisham there were 2,027 people with dementia in 2019.

The number of patients recorded with dementia in Lewisham has risen year on year since 2007/08 (see Figure 6).

Figure 6. Trend in the number of patients on the Lewisham GP practice dementia register, 2007/8 to 2017/18

²⁵ It is important to note that in the UK (and therefore national statistics) suicide is defined as deaths given an underlying cause of intentional self-harm or injury/poisoning of undetermined intent. This means that the Coroner's review does not have to result in a verdict of suicide; open verdicts are still considered suicides. The PCMD is limited in the nature of the data that it can provide around suicide deaths to inform local action. Information concerning ethnicity, socio-economic status, employment, previous mental health diagnoses, previous contact with primary care or mental health services and other contextual factors can only be gained from records held by our local Coroner. We do not currently receive any additional data from the Coroner concerning deaths by suicide. Cross-borough approaches are currently being explored to obtain a minimum Coroner dataset for South East London public health teams concerning suicides and drug/alcohol-related deaths.

²⁶ POPPI (Projecting Older People Population Information System) – Prevalence rates are based on Dementia UK: Update (2014) prepared by King's College London and the London School of Economics for the Alzheimer's Society.



The estimated dementia diagnosis rate for the population aged 65+ in Lewisham was 73.1% in 2018.²⁷ This is not significantly higher or lower than the 66.7% benchmark set nationally. It is also not significantly different from the London or England average diagnosis rates (70.5% and 67.5% respectively).

5. POPULATIONS IN LEWISHAM

Our mental health and wellbeing can be affected by a number of factors, and there are specific groups of people who are at higher risk of developing, or are more likely to have, mental health problems and who may benefit from targeted action for prevention and to ensure their needs are met.

The relationship between inequalities related to socio-economic status and protected characteristics and poor mental health is two-way: experiencing disadvantage and adversity increases the risk of mental health problems and experiencing mental health problems increases the risk of experiencing disadvantage.²⁸ Mental health problems can create a spiral of adversity where related factors such as employment, income and relationships are impacted, and these things in turn are known to compound and entrench mental health problems.

Below are some populations groups whose needs should be considered explicitly when planning and delivering mental health services in the borough. In addition, for some people there is an overlap of protected characteristics (intersectionality), and this will shape their experience of mental health in other ways not captured by the data below.

5.1. LEWISHAM'S BLACK, ASIAN AND MINORITY ETHNIC (BAME) POPULATION

The Annual Psychiatric Morbidity Survey found that the prevalence of some mental health conditions was higher in certain ethnic groups, for example the prevalence of psychotic disorder was much higher amongst Black and Asian men than their White counterparts (see Table 1). Similarly, the proportion of adults who screened positive for PTSD in the past month was higher amongst all non-White compared to White survey respondents, even after standardisation for age.²⁹ The [Mental Health Foundation](#) states that people from BAME groups living in the UK are more likely to be diagnosed with mental health problems; to be diagnosed

²⁷ PHE Fingertips Dementia Profile. Reference rates for expected prevalence are from the Medical Research Council Cognitive Function and Ageing Study II (CFAS II) age 65+ age and sex-specific dementia prevalence rates

²⁸ Mental Health Foundation. Health Inequalities Manifesto 2018.

²⁹ Annual Psychiatric Morbidity 2014 Chapter 4

and admitted to hospital; to experience a poor outcome from treatment; and to disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health.

Table 1. Psychotic disorder in the past year (2007 and 2014 combined), by ethnic group and sex				
<i>All adults</i>	<i>2007 and 2014 combined</i>			
Psychotic disorder	Ethnic group			
	White	Black	Asian	Mixed/other
Men	0.3%	3.2%	1.3%	-
Women	0.7%	-	0.4%	-
All adults	0.5%	1.4%	0.9%	-

Source: Annual Psychiatric Morbidity 2014 Chapter 5

A [2014 report](#) on ethnic inequalities in mental health in the UK found continuing disproportionate representation of Black African and Caribbean men with mental health problems at the ‘hard end’ of services; continuing experience of Black African and Caribbean service users of impoverished or harsh treatment from primary and secondary mental health services; and poor access to adequate mental health services across different BME communities. The report described broad and enduring inequalities in:

- rates of diagnosis (Black African and Caribbean have lower reported rates of common mental illness than other ethnic groups but are more likely to be diagnosed with severe mental illness and are also prescribed higher doses of medication)
- primary care (Black patients are significantly less likely than non-Black patients to have GP involvement in their pathway leading up to a first psychotic episode and rates of referral from GPs and community mental health teams to secondary mental health services are lower than average among some Black and Mixed groups)
- inpatient care (Mental Health Act detention rates are higher for Black groups)
- suicide
- the criminal justice system and mental health
- CAMHS (child and adolescent mental health services)
- older people
- refugees and migrants
- linkage to wider social determinants.

The Greater London Authority (GLA) estimates that 51.6% of the Lewisham population are White, 26.4% are Black, 10.3% are Asian and 11.6% are Mixed or Other ethnic groups.³⁰ Lewisham’s ethnic profile is changing, and from 2028 it is forecast that the BAME population will exceed the White population. Amongst young people, the percentage of 0-19s of BAME heritage has remained at or marginally above 65% since 2011.³¹

In Lewisham, BAME health has been a topic of interest for the Council. In July 2018 a discussion paper on BAME health Inequalities in Lewisham was presented to the Health and Wellbeing Board, and it was agreed that mental health would be the first area of focus. Subsequently, work was carried out to better understand the actions the Board could take to address BAME mental health inequalities based on feedback from the community; and specific areas of action were suggested for the Health and Wellbeing Board to undertake to address BAME mental health inequalities in Lewisham.

Most mental health services collect data on ethnicity, so access to these services according to ethnicity is included below in Section 12.

³⁰ Greater London Authority (GLA) GLA 2016 Ethnicity Projections Central Trend Based

³¹ Picture of Lewisham JSNA – Part A (2018)

Asylum seekers and refugees

Research has shown that asylum seekers and refugees are more likely to experience poor mental health than the local population, including higher rates of depression, PTSD and other anxiety disorders.³² This is linked to both pre-migration experiences (such as war trauma) and post-migration conditions (such as separation from family, difficulties with asylum procedures and poor housing). Data shows that they are less likely to receive support than the general population.³³

Bromley and Lewisham Mind Community Support Service ran a Vulnerable Migrants Project in 2017, working in partnership with migrant organisations and communities in Lewisham. Quantitative and qualitative data and information was collated from 18 survey questionnaires completed during two non-health related activity groups run by Lewisham Refugee and Migrant Network and Afghan and Central Asian Association. The surveys showed that symptoms of diagnosable mental health problems to be very common in migrant and refugee communities: 75% of respondents reported feeling stressed; 69% reported that they couldn't control worrying; 56% reported feeling hopeless; 44% reported they had trouble relaxing; and 38% reported feeling panic.³⁴

5.2. RESIDENTS WHO LIVE IN AREAS OF HIGH DEPRIVATION

Mental health, particularly SMI, is closely related to deprivation. The prevalence of psychotic disorders among the lowest quintile of household income is nine times higher than in the highest. There is a two-fold variation in levels of common mental health problems between the same groups.³⁵

In relative terms, Lewisham remains amongst the most deprived local authority areas in England, and 35.3% of Lewisham residents live in the 20% most deprived areas of England.³⁶ There are concentrations of deprivation in the north and south of the borough (see Figure 7).

Very few mental health services collect data on income levels of service users; any information about access to these services for low income households is included in Section 12.

Figure 7. Map of Indices of Multiple Deprivation (IMD) (2015) in Lewisham

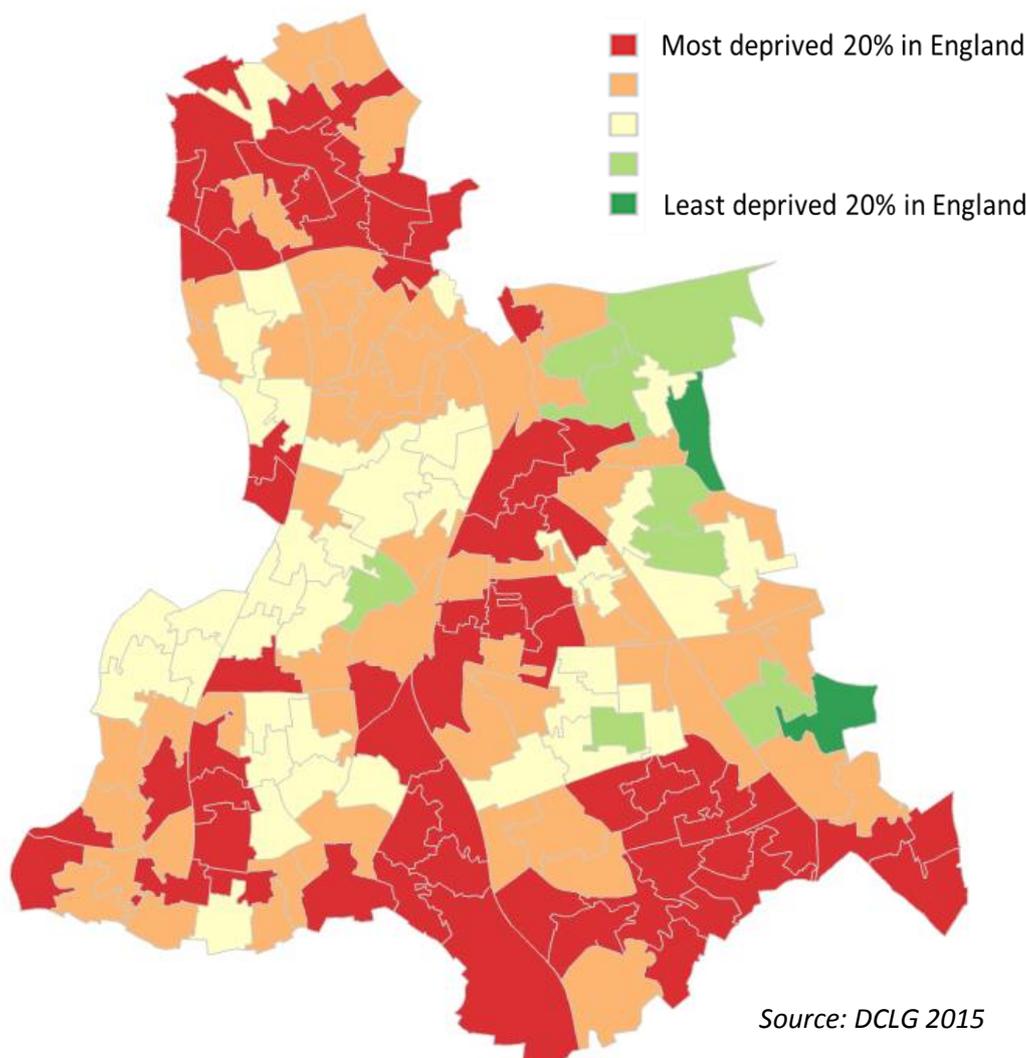
³² <https://www.mentalhealth.org.uk/statistics/mental-health-statistics-refugees-and-asylum-seekers>

³³ Aspinall, P., & Watters, C. (2010). Refugees and asylum seekers: A review from an equality and human rights perspective. Equality and Human Rights Commission Research report 52, University of Kent.

³⁴ Bromley and Lewisham Mind Community Support Service Vulnerable Migrants Project – Review Summary

³⁵ Marmot M. Fair Society, Healthy Lives: A Strategic Review of Inequalities in England (2010) p.54. Data from Bambra C, Joyce K and Maryon-Davis A (2009) Task Group on priority public health conditions, final report. Submission to the Marmot Review

³⁶ PHE Fingertips Mental Health and Wellbeing JSNA Profile. From IMD 2015 (DCLG 2015).



5.3. RESIDENTS WHO MISUSE DRUGS AND ALCOHOL

Misuse of alcohol or drugs often contributes to, or co-exists with, mental health problems and leads to poorer outcomes. People with co-occurring mental health and alcohol/drug use conditions often have multiple needs, with poor physical health as well as issues such as debt, unemployment or housing problems. They are more likely to be admitted to hospital, to self-harm and to die by suicide.³⁷

In Lewisham, the rate of admission to hospital for mental and behavioural disorders due to alcohol (involving a primary diagnosis) in 2017/18 per 100,000 population was 61.5. This is significantly higher than the London rate (51.3 per 100,000 population) but not significantly different from the England rate (69.2 per 100,000).³⁸

In 2016/17, 18.5% of adults in Lewisham receiving drug misuse treatment and 21.4% of adults receiving alcohol misuse treatment were also in contact with mental health services.³⁹

Prevalence data is periodically produced by Public Health England on drug use at local authority level. Lewisham has higher rates of use of opiates and/or crack cocaine than London or England.⁴⁰

³⁷ Royal College of Psychiatrists. Mental Illness, Offending and Substance Misuse (2012)

³⁸ Mental Health and Wellbeing JSNA Profile. Calculated by Public Health England: Risk Factors Intelligence (RFI) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates

³⁹ Mental Health and Wellbeing JSNA Profile. From National Drug Treatment Monitoring System.

⁴⁰ PHE Fingertips Profile: Co-occurring substance misuse and mental health issues

5.4. LEWISHAM'S LGBT+ POPULATION

Evidence from the UK and internationally has shown that there is a higher prevalence of common mental health problems amongst the LGBT+ population.⁴¹

The Annual Population Survey has released experimental statistics on sexual identity at a local authority level, using estimates based on a survey.⁴² It estimated that in Lewisham 2.5% identify themselves as lesbian, gay or bisexual; and 8.5% don't know, refuse to answer or identify themselves as other (i.e. neither heterosexual/straight, lesbian, gay or bisexual).⁴³ This equates to approximately 6,000 residents who identify as lesbian, gay or bisexual.

A few commissioned mental health services collect data on sexual orientation of service users, so information about access to these services by the LGBT+ population is included in Section 12.

5.5. RESIDENTS WHO ARE CARERS

A recent report from the Office for National Statistics found that sandwich carers – those who care for both sick, disabled or older relatives and dependent children – are more likely to report symptoms of mental ill-health, feel less satisfied with life, and struggle financially compared with the general population.⁴⁴

It is estimated that 8.1% of Lewisham residents provide at least some unpaid care each week.⁴⁵

In the 2018 Lewisham Carers Survey, 7.0% of respondents reported that they had a mental health problem or illness; 42.7% reported feeling depressed due to their caring roles in the last 12 months; and 60.4% reported a general feeling of stress due to their caring roles in the last 12 months.⁴⁶

Very few commissioned mental health services collect data on whether service users are carers. Information about access to these services by caring status is included in Section 12.

5.6. RESIDENTS WITH LONG-TERM HEALTH CONDITIONS

There are high rates of mental health problems among people with long-term physical conditions such as cardiovascular, respiratory and liver diseases, cancer and chronic pain. In the UK, 46% of people with a mental health problem have a long-term condition and 30% of people with long-term condition have a mental health problem.⁴⁷ Co-existing mental health problems can lead to increased hospitalisation rates, increased outpatient service use, and less effective self-management.⁴⁸

The 2011 Census asked about long-term health problems and disabilities and found that in Lewisham, 14.4% of the population reported that were living with a long-term health condition that limited their day-to-day activities: 7.1% reported that they were limited a lot and 7.3% reported that they were limited a little.⁴⁹ In the 2018 GP Survey, 43.6% of Lewisham patients who responded reported having any long-term physical or mental health conditions, disabilities or illnesses; and 10.5% reported problems with their physical mobility. Of

⁴¹ For example National Institute for Mental Health in England (2007) Mental disorders, suicide, and deliberate self harm in lesbian, gay and bisexual people: a systematic review; Chakraborty, A., McManus, S., Brugha, T., Bebbington, P., & King, M. (2011). Mental health of the non-heterosexual population of England. *Journal of Psychiatry*, 198, 143–148

⁴² This means they are subject to sampling variability. This is because the sample selected is only one of a large number of possible samples that could have been drawn from the population.

⁴³ Sexual identity by local authority, Croydon and Lewisham, 2013-2015

⁴⁴

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/articles/morethanoneinfoursandwichcarersreportsymptomsofmentallillhealth/2019-01-14>

⁴⁵ Picture of Lewisham JSNA – Part A (2018)

⁴⁶ Lewisham Carers Survey 2018. Please note that the results are accurate to a margin of error of +/- 7%. Results are based on 164 responses.

⁴⁷ Kings Fund (2016) Bringing together physical and mental health

⁴⁸ PHE (2017) Better Mental Health: JSNA Toolkit

⁴⁹ Table KS301UK. 2011 Census: Health and provision of unpaid care, local authorities in the United Kingdom.

those who reported having a long-term condition, the most common were high blood pressure and arthritis or ongoing problem with back or joints.⁵⁰

Several mental health services collect data on disabilities, so access to these services according to disability status is included below in Section 12.

5.7. RESIDENTS WHO ARE HOMELESS OR WHO LIVE IN SUPPORTED HOUSING

Homelessness is associated with severe poverty and is a social determinant of health.⁵¹ In 2017/18 the rate of homeless households in temporary accommodation and awaiting a settled home was more than four times higher on average in Lewisham (14.7 per 1000) than England (3.4 per 1000), although it was not significantly different from the London rate (14.9).⁵² The rate of eligible homeless people not in priority need was 0.6 per 1,000 households, significantly lower than London (1.0) and England (0.8).⁵³ In 2017/18, the rate of statutory homelessness in Lewisham was 4.7 per 1,000 households, significantly higher than England (2.4) and London (4.2).⁵⁴

Maintaining stable and appropriate accommodation and providing social care in this environment promotes personalisation and quality of life, prevents the need to readmit people into hospital or more costly residential care and aids a positive experience of social care. As of August 2018, the proportion of adults (aged 18-69) in contact with secondary mental health services and known to be in settled accommodation (on the Care Programme Approach and recorded as living independently, with or without support) was significantly lower in Lewisham (52.0%) than in England (57.0%) and in London (61.0%).⁵⁵ Figure 8 compares Lewisham with its statistical neighbours.

Figure 8. Percentage of adults aged 18-69 in contact with secondary mental health services who live in stable and appropriate accommodation, Lewisham compared with similar CCGs, London and England, 2017-18

⁵⁰ GP Patient Survey 2018 results by CCG (weighted). <https://gp-patient.co.uk/surveysandreports>

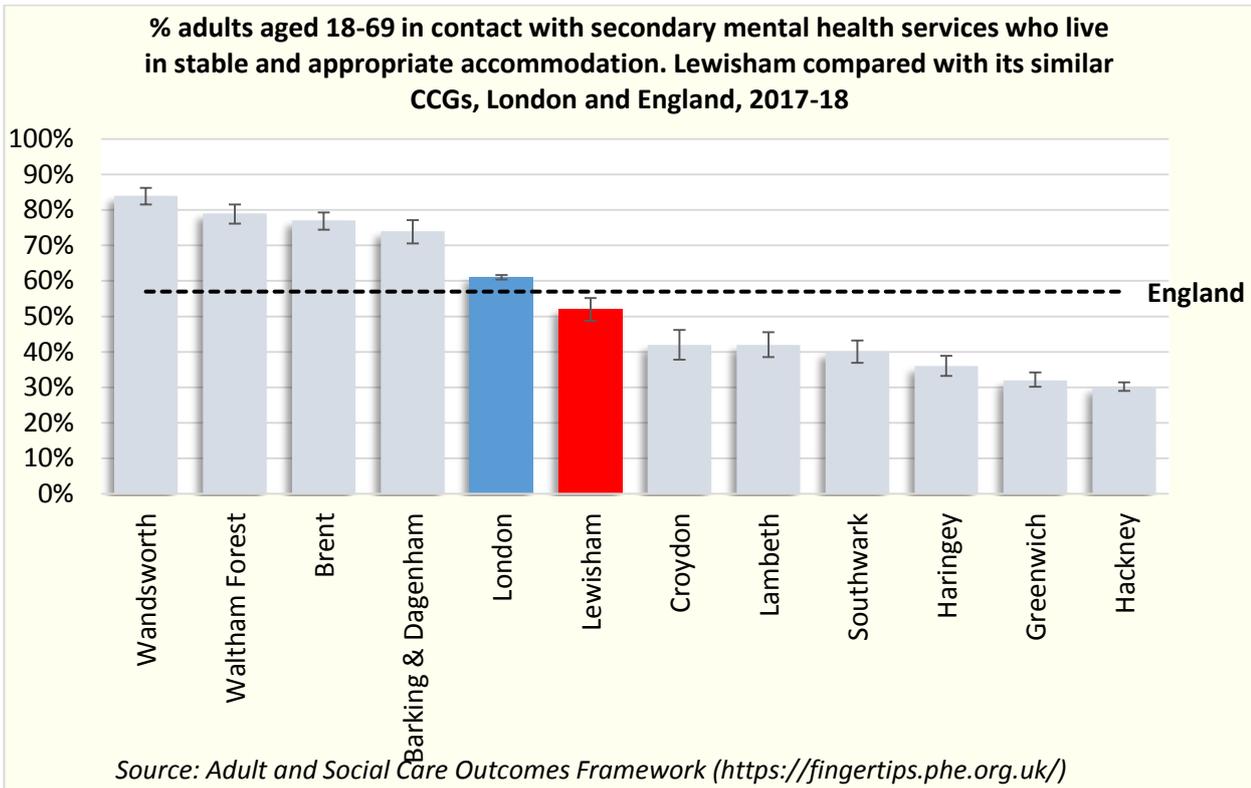
⁵¹ Homeless Link. (2014). The unhealthy state of homelessness: Health audit results 2014.

⁵² PHE Fingertips Mental Health and Wellbeing JSNA Profile.

⁵³ PHE Fingertips Mental Health and Wellbeing JSNA Profile.

⁵⁴ PHE Fingertips Common Mental Health Disorders Profile.

⁵⁵ PHE Fingertips Mental Health and Wellbeing JSNA Profile.



The [Lewisham Council Housing Select Committee report on housing and mental health](#) found that increasing numbers of vulnerable people – people with multiple and complex needs and mental health needs of various levels – are being housed in general needs housing in Lewisham. It also reported that people with mental health problems often have a housing related problem too. The South London and Maudsley NHS Foundation Trust (SLaM), the acute mental health provider for Lewisham, said that the underlying problems for people with mental health issues are almost always related to housing and tenancy or money and debt. Mind Bromley & Lewisham said that 32% of people referred to their Community Support Service last year had a housing-related issue. One of the lead mental-health GPs in the borough also said that the threat of eviction and money problems hanging over people are frequent contributors to mental health problems.

There is a separate JSNA being completed specifically about supported housing in Lewisham.

5.8. RESIDENTS WHO ARE UNEMPLOYED

Unemployment is related to health problems, including poor mental health and higher rates of self-reported ill health, limiting long term illness and prevalence of risky health behaviours including alcohol use and smoking. Links between unemployment and poor mental health have been explained by the psychosocial effects of unemployment: stigma, isolation and loss of self-worth.

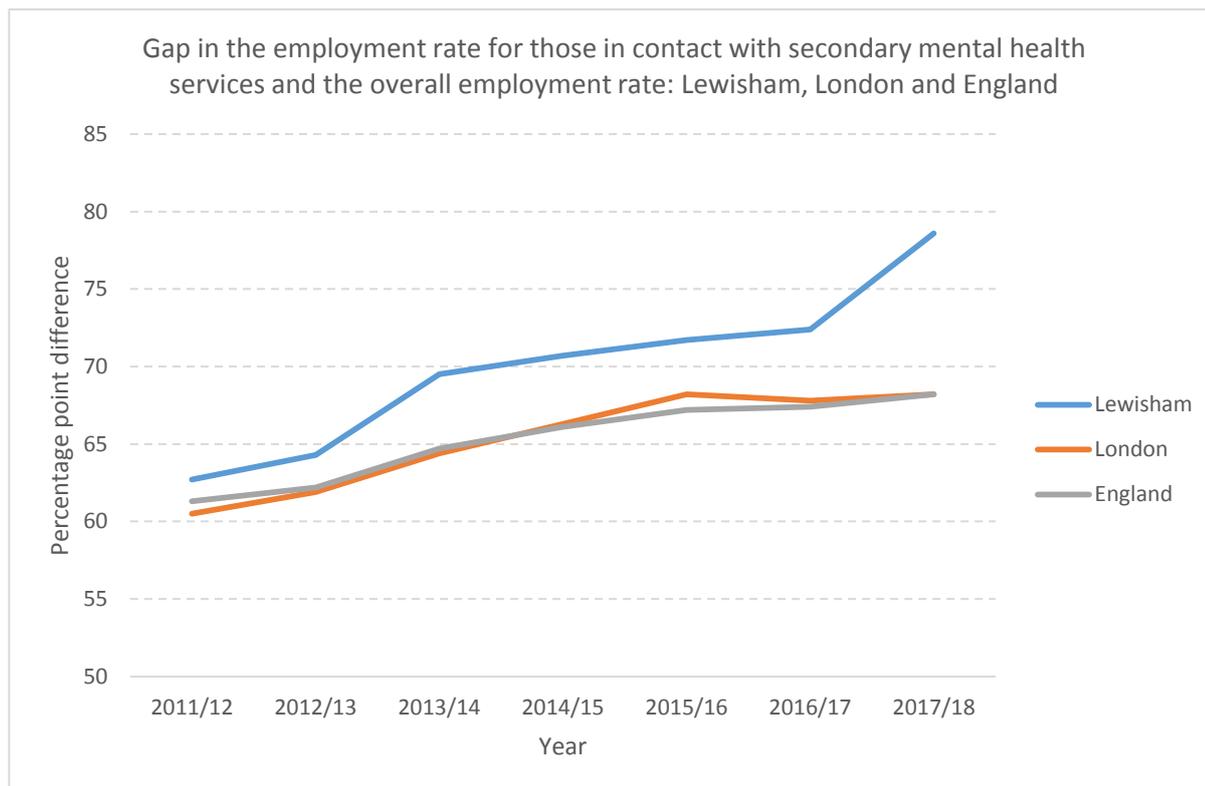
In 2017, the rate of long-term unemployment in Lewisham (people claiming Jobseeker's Allowance (JSA) for >12 months) was per 5.5 per 1,000 population aged 16-64 years. This is significantly higher than both the London and England rates (3.5 and 3.9 per 1,000 population aged 16-64 years respectively).⁵⁶

The gap between the employment rate for all people and just those in contact with secondary mental health services is higher in Lewisham (78.6%) than in London (68.2%) and England (68.2%).⁵⁷ This gap has increased steadily for the last few years (see Figure 9).

⁵⁶ PHE Fingertips Mental Health and Wellbeing JSNA Profile.

⁵⁷ This is defined as the percentage point gap between the employment rate of working age adults who are receiving secondary mental health services and on Care Programme Approach and the employment rate of the overall population. Please note that there are concerns with the quality of this data.

Figure 9: Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate: Lewisham, London and England



Source: PHE Fingertips Mental Health and Wellbeing JSNA Profile.
Please note: There are concerns with data quality for 2016/17 data points

Of people aged 18-69 in contact with mental health services (on the Care Programme Approach) in Lewisham as of August 2018, 5.0% were recorded as being in employment⁵⁸ at the time of their latest assessment or review (the most recent record of whether or not the person is in employment during the financial year is used). This is similar to the London average of 6.1% but significantly lower than the England average of 8.4%.⁵⁹

Very few commissioned mental health services collect data on employment. Access to these services according to employment status is included below in Section 12.

5.9. MEN

As described in Section 4.1.4, the suicide audit revealed that three times the number of men as women died as a result of suicide in Lewisham over the period 2012-2016. As such, young men (those between the ages of 25 and 44 years) are named as one of the high-risk groups in the Lewisham Suicide Prevention Strategy, who will receive targeted interventions and support.

This may be because men are less likely to seek treatment: analysis of the 2014 Annual Psychiatric Morbidity Survey showed that, after controlling for level of need, men are less likely to receive mental health treatment than women.⁶⁰ A recent Healthwatch Lewisham report on men’s health⁶¹ found that the traditional concept of

⁵⁸ Employed refers to those who are either employed for a company or self-employed. It also includes those who are in supported employment (including government supported training and employment programmes), those in permitted work (i.e. those who are in paid work and also receiving Incapacity Benefit) and those who are unpaid family workers (i.e. those who do unpaid work for business they own or for a business a relative owns).

⁵⁹ PHE Fingertips Mental Health JSNA Profile

⁶⁰ McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital.

⁶¹ Healthwatch Lewisham (2018) Men Talk Health

masculinity was a preventing men accessing services early; and that men isolate themselves when experiencing mental health issue. In addition, recent work on dads' mental health found that almost a third of new fathers who were surveyed reported experiencing postnatal depression¹⁰.

5.10. RESIDENTS WITH LEARNING DISABILITIES AND AUTISM

People with learning disabilities demonstrate the complete spectrum of mental health problems, with higher prevalence than found in those without learning disabilities. Between 25-40% of people with learning disabilities also have mental health needs.⁶²

In research conducted by the mental health charity Mind, about people with autism, they found evidence that people with Autistic Spectrum Disorders (ASD) are particularly vulnerable to developing mental health problems, but that existing services tend to treat people either for their ASD or for their mental health problems, failing to recognise the complex dynamic between the two.⁶³

The percentage of patients with learning disabilities, as recorded on practice disease registers, is 0.44% in Lewisham.⁶⁴ This is lower than the national proportion (0.49%) but higher than the London level (0.36%).

There is a separate JSNA chapter specifically about learning disabilities.

5.11. RESIDENTS WHO ARE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM

The prevalence of mental health problems is higher among people on probation and offenders in the community than the general population; and prevalence of psychosis is much higher amongst prisoners (16% of prisoners report symptoms indicative of psychosis) than in the general population.⁶⁵ People in contact with the criminal justice system also have substantially more risk factors for suicide.⁶⁶

In Lewisham in 2017, the rate of first time entrants to the criminal justice system was 242.9 per 100,000 of the population. This is higher than the average rate in London (215.3 per 100,000 population) and in England (166.4 per 100,000 population).⁶⁷

6. PROJECTING FUTURE NEED

It is important to understand demand for mental health services now and in the future to help plan services.

A [Picture of Lewisham JSNA](#) describes the demography and general health of the borough in detail, along with forecasts of how the population is likely to change in the future. In summary, Lewisham has a relatively young population and an estimated population of 301,300 people. This number is set to continue to grow (it is expected to reach 323,000 in 2021 and climb to 357,000 in 2031), with most of the population growth projected to take place in the north of the borough and in Lewisham Central ward.

Figures 10 and 11 display the projected growth by age groups, for males and females in Lewisham. It indicates that from 2017 to 2050, for both males and females, the largest absolute increases are in the 60-69 age group, whilst the largest relative increases are amongst those aged 80+ (for both genders).

⁶² Foundation for People with Learning Disabilities <https://www.mentalhealth.org.uk/learning-disabilities/help-information/learning-disability-statistics-/187699>

⁶³ <https://www.mind.org.uk/about-us/our-policy-work/equality-human-rights/wellbeing-of-people-on-the-autistic-spectrum/>

⁶⁴ QOF Recorded disease prevalence, achievements and exceptions, mental health and neurology group, learning disabilities, 2017-18, CCG level

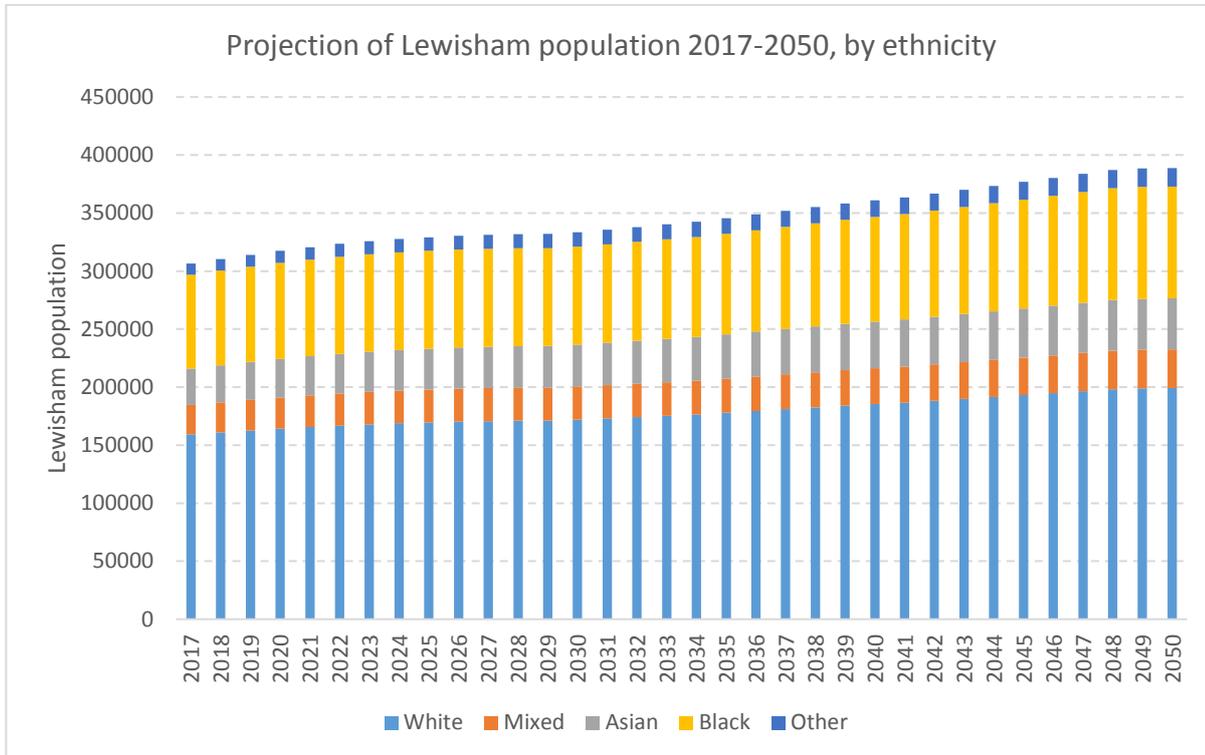
⁶⁵ For the prisoner population, prevalence is defined as reporting symptoms indicative of psychosis. Ministry of Justice (2013). Light M, Grant E, Hopkins K. Gender differences in substance misuse and mental health amongst prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners. Cited from PHE (2017) Better Mental Health: JSNA Toolkit.

⁶⁶ HM Government (2012) Preventing suicide in England: A cross-government outcomes strategy to save lives

⁶⁷ PHE Fingertips Crisis Care Profile.

Lewisham’s ethnic profile is changing, with a relatively and absolutely larger population growth projected for BAME compared to White ethnic groups (see Figure 12). The group with the largest projected relative population growth between 2017 and 2050 is the Other Ethnic group, followed by the Asian group.

Figure 12. Population projection for Lewisham, by ethnicity, 2017 to 2050



Source: GLA 2016-based projections (housing-led)

By applying prevalence rates to simple population projections, it is estimated that the number of residents with common mental health disorders in Lewisham will rise in the future.⁶⁸ For example, between 2020 and 2035, it is estimated that the prevalence of common mental disorders in women aged 18-64 in Lewisham will increase by 7.7% (from 24,902 to 26,819) and in men aged 18-64 will increase by 10.5% (from 15,567 to 17,199).⁶⁹ The number of people aged 65 and over predicted to have depression will increase by 52.6% (from 2,547 in 2020 to 3,887 in 2035).

It is also estimated the number of people aged 18-64 in Lewisham with a psychotic disorder will rise to 1,632 (from 1,480 in 2019) in 2035.⁷⁰

Finally, as the population of Lewisham residents aged 65+ is projected to rise, it is estimated that the number of people predicted to have dementia will increase further, to 2,915 people in 2035.⁷¹

In March 2018 an extensive data match exercise was undertaken between Lewisham CAMHS (Child and Adolescent Mental Health Services) and the Local Authority’s Children with Complex Needs Service. This process collated every child between the ages of 16 – 19 years of age who are currently accessing CAMHS and

⁶⁸ This does not take account of any changes in ethnic breakdown, for example.

⁶⁹ PANSI (Projecting Adult Needs and Service Information System). Prevalence is based on the report Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 (2016), NHS Digital, and applied to ONS population projections for the 18-64 population to give estimated numbers predicted to have a mental health problem.

⁷⁰ PANSI (Projecting Adult Needs and Service Information System)

⁷¹ POPPI (Projecting Older People Population Information System) – Prevalence rates are based on Dementia UK: Update (2014) prepared by King’s College London and the London School of Economics for the Alzheimer’s Society. Rates are applied to ONS population projections of the 65 and over population to give estimated numbers of people predicted to have dementia to 2035

also have an Education and Health Care Plan (EHCP). In addition to the cohort with ‘enduring mental health conditions’ such as psychosis and personality disorder, we can project that colleagues should be working together to support transition planning for approximately 100 young people each year.⁷² This analysis has been used to support transition planning discussions stretching across adult’s and children’s services, across both the CCG and the Local Authority.

7. RESIDENTS’ VIEWS ON MENTAL HEALTH IN LEWISHAM

Over the past few years, Lewisham residents’ views on mental health have been elicited in a range of projects. Some themes that have emerged consistently are:

- The continued issue of stigma around mental health conditions, particularly for certain population groups and in the context of employment, and the need for mental health to be recognised as equally important as physical health
- The need for better communication to raise awareness of available mental health services and promote the ways that people can look after their own mental health
- The importance of early intervention, helping people before they reach crisis point
- The need for services that are shaped to suit populations with specific mental health needs e.g. men, BAME population, or older people. Discussions have highlighted the need for culturally specific services, and the potential benefits of seeing a professional from a similar background as your own.

Men’s mental health (Healthwatch Lewisham)

Healthwatch Lewisham asked local men about their experience of mental health. Key themes included:

- The traditional concept of **masculinity** prevented men accessing services early.
- Men **isolate** themselves when experiencing mental health issues as a coping mechanism. Loss of support networks was a common theme.
- Men feared **disclosing their mental health issues to employers** to avoid appearing ‘weak’ and experiencing negative consequences.
- **Community services** such as counselling and support from charities, as well as **playing sport and being active**, were men’s preferred ways of maintaining and improving mental health and emotional wellbeing
- Men would value services that are **shaped to suit the needs of men** and recognise issues men face. Only 10% of the survey respondents agreed men receive the right support for their mental health.

BAME mental health

A BAME mental health event was held in October 2018. Six overarching priorities emerged:

- **Stigma** – there was a strong feeling that the issue of stigma around mental health still needs to be addressed in BAME communities.
- **Cultural competence of services** – the need for, and benefits of, culturally specific services, and the potential benefits of seeing a professional from a similar background as your own
- **Communication** – improved communication around what is already happening within the community and statutory services is needed
- **Genuine co-production** – there needs to be a clear mechanism for genuine dialogue and co-production with BAME communities for both mental and physical health
- **Early intervention** – the need for earlier intervention with young people, via education and other routes to prevent mental ill health
- **Advocacy** – the need for support from advocates once a mental health diagnosis has been made.

⁷² NHS Lewisham CCG CAMHS Transformation Plan October 2018. <https://www.lewishamccg.nhs.uk/about-us/our-plans/Documents/NHS%20Lewisham%20CCG%20CAMHS%20Transformation%20Plan%202018.pdf>

Stakeholder consultation for public mental health and wellbeing strategy development

At a strategy development workshop in 2016, local stakeholders highlighted key issues:

For working age adults:

- The **stigma** of taking time off for mental health reasons rather than physical health reasons
- More **support for families and carers** of those with mental health patients is needed
- **Underserved and high risk populations** should be identified for help e.g. homeless people, refugees, and young men
- **Awareness** and **communication** of services available should be improved

For older adults:

- For those who do not speak English as a first language there is great **stigma** around mental health
- There is often a focus on dementia in this population, with little done for **anxiety and depression**
- In older men there is a risk of **gambling and alcohol abuse**
- **Isolation and bereavement** can be important issues
- **Transitioning** from adult to older adult can be a big life shift and people can feel lost
- There needs to be a more **positive focus** on ageing well and expanding horizons rather than a negative focus

Lewisham CCG Public Reference Group

Lewisham CCG Public Reference Group has been involved in discussions on CCG commissioning decisions. The group has suggested focusing on **helping those people with developing mental health problems at a time when primary intervention will be effective** and will stop progress to secondary care needs. Practices could try different interventions.

Thrive LDN community conversations

From over 1,000 conversations with Londoners, including with Lewisham residents, recommendations were collated about how to meet Thrive LDN's six aspirations. These included spreading **knowledge, skills and support** so that people can better look after themselves and their neighbours. Londoners said they don't want or need top-down fixes – instead, they **want the tools and networks to do it for themselves**

Lewisham Annual Public Health Report 2017

As part of the Annual Public Health Report in 2017, several Lewisham residents described their experience of mental health. These included post-natal depression; stigma; eating disorders; alcohol and bereavement; and community and trauma.

8. OTHER RELEVANT LOCAL REPORTS

A number of Lewisham JSNAs complement this report, as they address aspects of mental health in adults:

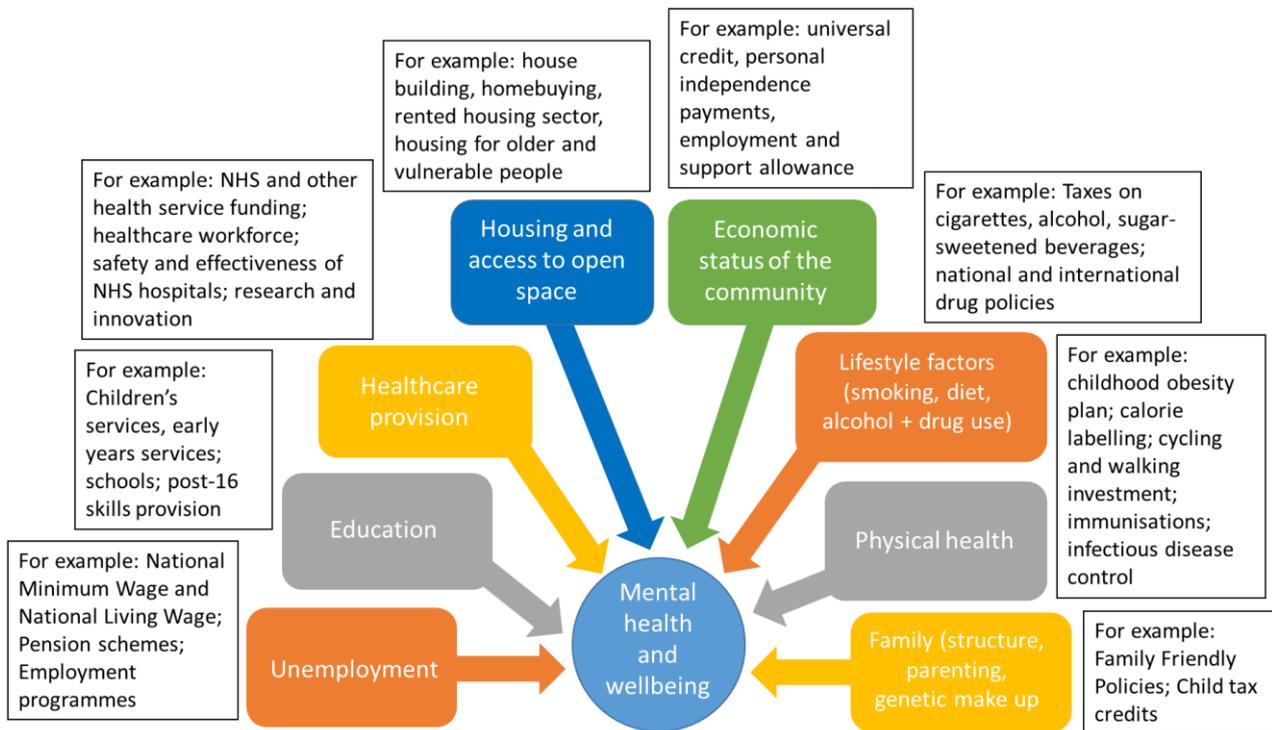
Table 2. Relevant local JSNAs

Title	Content	Date
Supported housing	Assesses the need for, and provision of, supported housing in Lewisham.	<i>To be published soon</i>
Adults with autism	Assesses the needs of adults with autism in Lewisham	<i>To be published soon</i>
Parenting	Assesses impact of parenting on children's life chances in Lewisham, particularly with regards to several risk factors for parents which can result in poor outcomes for children.	Published February 2019
Tobacco Control	Assesses the burden of smoking in Lewisham on mortality and morbidity.	Refreshed October 2018
Maternal mental health	Assesses the mental health and wellbeing needs of women in Lewisham in the 1001 days from the conception of their child until the child is two years old	Published April 2018
Annual Public Health Report 2017	Assesses the mental health and wellbeing needs of Lewisham residents and the ways that good mental health and wellbeing can be supported and maintained throughout the life course	Published December 2017
Mothers and families who have children repeatedly taken into care in Lewisham	Assesses the health and wellbeing needs among cohorts of women and/or families who repeatedly have children taken into care	Published January 2017
Substance Misuse: Adults and Young People	Assesses alcohol and drug related harm in Lewisham	Published April 2016
Mental health	Assesses the common and severe mental illness needs in adults in Lewisham	Published July 2012
Dementia	Assesses the dementia needs in Lewisham residents	Published January 2012

9. NATIONAL AND LOCAL STRATEGIES

Our mental health and wellbeing can be affected by a number of factors, often called risk factors, that can be present at various stages of our lives, such as unemployment, education, housing, economic status, lifestyle factors, physical health and family. This means that a wide range of national, regional and local policies and strategies are likely to influence mental health.

Figure 13. Examples of national policies that may indirectly affect mental health



9.1. WHAT WE KNOW WORKS

A public mental health approach is concerned with promoting mental wellbeing, preventing future mental health problems and with recovery from mental health problems. It advocates adopting a life course approach, place-based interventions and increasing mental health and wellbeing literacy across the whole population. A life-course approach is important because the foundations of mental health are laid down in infancy and in the context of family relationships. A life course approach is complemented by place-based interventions in settings such as schools, workplaces and communities and makes the most of existing opportunities. Increasing mental health and wellbeing literacy across the whole population can help to reduce stigma and discrimination. It should also be noted that whilst policy interventions may not directly target wellbeing, these interventions might still affect wellbeing as an outcome.

The Joint Commissioning Panel for Mental Health⁷³ highlight that the promotion of emotional wellbeing needs to happen at three levels:

- Strengthening individuals – increasing emotional resilience through improving self-esteem, problem solving or coping skills
- Strengthening communities – increasing inclusion and participation, improving environments including safety and bullying
- Reducing structural barriers to emotional wellbeing – promoting access to education and employment, decent housing and increasing the ‘voice’ of marginalised groups

There is now a large body of evidence around promoting mental wellbeing and preventing mental ill health. Important reports include:

- [Better Mental Health for All](#). This report, produced by the Faculty of Public Health and the Mental Health Foundation, outlines a public health approach to mental health improvement.
- [Mental health and prevention: taking local action for better mental health](#). This report, commissioned by Public Health England and written by the Mental Health Foundation, sets out a road map to bring about a prevention revolution in mental health, delivered in every local area.

⁷³ <https://www.jcpmh.info/commissioning-tools/cases-for-change/mild-to-moderate-problems/what-works/>

- [Wellbeing: why it matters to health policy](#). This Department of Health document shows the strong link between people’s health and their wellbeing, giving evidence that increasing people’s wellbeing leads to longer life expectancy; improves recovery from illness; is associated with positive health behaviours in adults; and influences the wellbeing and mental health of partners, children and our social networks. It is also associated with how health care sector staff and providers work; has implications for decisions for patient care practises and services and treatment decisions and costs; affects decisions about local services; and may ultimately reduce the healthcare burden. Wellbeing is also associated with broader positive outcomes, such as employment, education and relationships.
- **Old Problems, New Solutions.** The Independent Commission on Acute Adult Psychiatric Care was set up by the Royal College of Psychiatrists in January 2015 in response to widespread concerns about the provision of acute inpatient psychiatric beds in many parts of England and Northern Ireland, and makes recommendations to address this.

There is also national guidance for the prevention, diagnosis and treatment of mental health conditions:

- **National Institute for Health and Care Excellence (NICE) guidance:** There are several guidance documents published by NICE for adults’ mental health prevention, diagnosis and treatment, including:
 - [Common mental health problems: identification and pathways to care](#) (CG123)
 - [Depression in adults: recognition and management](#) (CG90)
 - [Depression in adults with a chronic physical health problem: recognition and management](#) (CG91)
 - [Psychosis and Schizophrenia in adults: Prevention and management](#) (CG178)
 - [Bipolar assessment and management](#) (CG185)
 - [Older people: independence and mental wellbeing](#) (NG32)
 - [Mental wellbeing at work](#) (PH22)
 - [Post-traumatic stress disorder](#) (NG116)
 - [Mental health problems in people with learning disabilities: prevention, assessment and management](#) (NG54)
 - [Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services](#) (CG136)
- **National Collaborating Centre for Mental Health care pathways:** The [National Collaborating Centre for Mental Health](#) produce care pathways to support the delivery of the Five Year Forward View for Mental Health. Topics include: Early intervention in psychosis, Dementia, Emergency mental health care pathway, Improving Access to Psychological Therapies (IAPT) long-term condition pathway.
- **Public Health England JSNA Toolkit:** In 2017, Public Health England produced [Better Mental Health: JSNA Toolkit](#), guidance to support planners to understand needs within the local population and assess local services.

9.2. PREVENTION

Prevention operates at different levels:⁷⁴

- Primary prevention. Stopping mental health problems from occurring in the first place by using ‘upstream’ approaches.
- Secondary prevention. Identifying the earliest signs that mental health is being undermined and ensuring early intervention is available to minimise progression into a more serious mental health problem.

⁷⁴ Mental Health Foundation. 2015. Prevention Review: Landscape Paper

- Tertiary prevention. Working with people with established mental health problems to ensure the earliest path to sustainable recovery and to reduce the social, economic and health losses often resulting from living with a mental health problem.

In addition, a cross-cutting dimension across the prevention levels allows for a progressive focus on those at highest risk.

- Universal: seeking to influence a whole population or groups within institutions such as workplaces, schools, colleges.
- Selective: seeking to reach individuals or subgroups based on known areas of generally higher risk, including those who may not be showing signs of developing a mental health problem but live in circumstances or with discrimination and stigma known to be corrosive to mental health (BAME communities, people who are homeless, people who have learning disabilities, LGBT+ people).
- Indicated: targeting people at the highest risk of mental health problems and potentially showing early indications such as employees who are displaying signs of workplace stress, children whose parents have a serious mental health problem.

Evidence of what works to reduce mental health stigma and discrimination suggests that successful projects combine a number of approaches including education, social contact and protest. The strongest evidence is that interventions with a high level of appropriate and relevant social contact are able to improve understanding and reduce social distance.⁷⁵ In England, the main anti-stigma campaign is Time to Change.

9.3. TREATMENT AND MANAGEMENT

9.3.1. Common mental health disorders

Table 3 provides information from NICE to guide the overall care for all people with depression. Further information about evidence-based interventions can be found from the Joint Commissioning Panel for Mental Health and in Appendix 1.

Table 3. Overview of the delivery of care for people with depression⁷⁶	
Focus of the intervention	Nature of the intervention
Provide information and support, obtain informed consent	Build a trusting relationship, engaging and open relationship in a non-judgemental manner
Advance decisions and treatments	For people with recurrent severe depression or depression with psychotic symptoms and for those who have been treated under the Mental Health Act, consider developing advance decisions
Support families and carers	Providing written and verbal information on depression and its management, including how families or carers can support the person
Assessment, coordination of care and choosing treatments	Conduct a comprehensive assessment of the person with depression
Effective delivery of interventions of depression	All interventions for depression should be delivered by competent practitioners. Psychological and psychosocial interventions should be based on the relevant treatment manual(s), which should guide the structure and duration of the intervention.

9.3.2. Severe Mental Illness

⁷⁵ cf. Better Mental Health for All: A Public Health Approach to Mental Health Improvement (2016) London: Faculty of Public Health and Mental Health Foundation.

⁷⁶ <https://www.nice.org.uk/guidance/cg90/chapter/Introduction>

NICE quality standards are a concise set of prioritised statements designed to drive measurable quality improvements in a particular area of health or care. The eight quality standards for people with severe mental illness are summarised in Table 4. Further information is found in Appendix 2.

Table 4: NICE Quality Standards of Care for People with Severe Mental Illness	
Quality Statement (1-8)⁷⁷	
Adults with a first episode of psychosis start treatment in early intervention in psychosis services within 2 weeks of referral.	
Adults with psychosis or schizophrenia are offered cognitive behavioural therapy for psychosis (CBTp) .	
Family members of adults with psychosis or schizophrenia are offered family intervention .	
Adults with schizophrenia that have not responded adequately to treatment with at least 2 antipsychotic drugs are offered clozapine .	
Adults with psychosis or schizophrenia who wish to find or return to work are offered supported employment programmes .	
Adults with psychosis or schizophrenia have specific comprehensive physical health assessments .	
Adults with psychosis or schizophrenia are offered combined healthy eating and physical activity programmes, and help to stop smoking .	
Carers of adults with psychosis or schizophrenia are offered carer-focused education and support programmes .	

9.3.3. Dementia

Table 5 provides a framework of interventions which supports the services, and supports patients, carers and practitioners in identifying and accessing the most effective interventions for those with dementia.

Table 5. General care and clinical management for a person with dementia⁷⁸	
General management for a person with dementia	
Intervention	Further detail on the intervention
Involve people living with dementia in decisions about their care	Person centred care; underpins good practice in dementia care. Provide information for the person living with dementia and their family. Advanced care planning.
Initial assessment for suspected diagnosis in non-specialist setting	Use validated cognitive testing scores to identify person at risk (10-CS, 6CIT, mini COG). Refer person to appropriate specialist dementia diagnostic service.
Care coordination	Provide people living with dementia with a single named health or social care professional who is responsible for coordinating their care.
Clinical treatment and management for a person with dementia	
Intervention	Further detail on the intervention
Interventions to promote cognition, independence and well being	Offer a range of activities to promote wellbeing; group cognition stimulation therapy; group reminiscence therapy; cognitive rehabilitation or occupational therapy.
Pharmacological interventions ⁷⁹	Anti-cholinesterase inhibitors (AChE inhibitors), memantine monotherapy.
Specialist care referrals	Psychiatrists, geriatricians and neurologists, other healthcare professionals (such as GPs, nurse consultants and advanced nurse practitioners), if they have specialist expertise in diagnosing and treating Alzheimer's disease.
Managing non-cognitive symptoms	Antipsychotics, psychological treatments and personal multicomponent sleep management approaches where applicable.

⁷⁷ <https://www.nice.org.uk/guidance/qs80/chapter/List-of-quality-statements>

⁷⁸ <https://www.nice.org.uk/guidance/ng97/chapter/About-this-guideline>

⁷⁹ <https://www.nice.org.uk/guidance/ta217/chapter/1-Guidance>

Assessing and managing other longer-term conditions in people with dementia	
Further services available and applicable for patients living with dementia	
Intervention/service	Further detail on intervention
Palliative care ⁸⁰	Flexible needs-based palliative care that takes into account how unpredictable dementia progression can be.
Supporting carers	Psycho-education and skills training intervention to the carers of the person living with dementia.
Transition between different care settings ^{81,82}	Follow the principles in these guidelines for recommended transition of a person with dementia between other settings.
Staff training and education	Care and support providers should provide all staff with training in person-centred and outcome-focused care for people living with dementia. Consider giving carers and/or family members the opportunity to attend.

9.1. COST-EFFECTIVENESS

Better Mental Health for All, the Faculty of Public Health’s report on public mental health, included results of an analysis of returns on investment for different aspects of mental health prevention and promotion.⁸³ The highest total return on investment comes from prevention of conduct disorder through social and emotional learning programmes (returns of £83.73 per £1 expenditure), followed by suicide prevention through bridge safety barriers (returns of £54.45), suicide training courses provided to all GPs (returns of £43.99), school-based interventions to reduce bullying (returns of £14.35), screening for alcohol misuse (returns of £11.75) and early detection of psychosis (returns of £10.27).

9.2. NATIONAL STRATEGIES

In addition to policies that influence mental health via broader risk factors, there are several key national policies that directly shape the provision of mental health services:

<p>NHS Long Term Plan (January 2019). This plan reaffirms a commitment to putting mental health care on a level footing with physical health services. Specifically, it includes a commitment to:</p> <ul style="list-style-type: none"> • spending at least £2.3bn more a year on mental health care • helping 380,000 more people get therapy for depression and anxiety by 2023/24 • delivering community-based physical and mental care for 370,000 people with severe mental illness a year by 2023/24 • making further progress on care for people with dementia
<p>PHE Prevention Concordat for Mental Health (August 2017). A consensus statement that describes the shared commitment of the organisations to work together via the Prevention Concordat for Better Mental Health, through local and national action, to prevent mental health problems and promote good mental health.</p>
<p>Five Year Forward View for Mental Health Implementation Plan (July 2016). Continued to recognise the correlation between good physical and mental health and established a set of objectives that would seek to ensure that access to mental health care became consistent with access to physical health care.</p>
<p>Five Year Forward View for Mental Health (February 2016).</p>

⁸⁰ <https://www.nice.org.uk/guidance/qs13>

⁸¹ <https://www.nice.org.uk/guidance/ng27>

⁸² <https://www.nice.org.uk/guidance/ng53>

⁸³ *Better Mental Health for All: A Public Health Approach to Mental Health Improvement* (2016) London: Faculty of Public Health and Mental Health Foundation. Table 1.

This national strategy, which covers care and support for all ages, was produced by an independent Mental Health Taskforce of health and care leaders, people who use services and experts in the field. It set out a journey for the transformation of mental health services and outcomes in England.

[Future in Mind](#) (March 2015)

NHS England published this strategy as part of a national drive to improve capacity and capability in the delivery of mental health services for children. This report provides a broad set of recommendations across five key themes:

- Promoting resilience, prevention and early intervention
- Improving access to effective support
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

[Mental Health Crisis Care Concordat](#) (February 2014).

The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

[No Health without Mental Health](#) (Feb 2011)

A cross-governmental mental health strategy for people of all ages that established a vision for improving the mental health and wellbeing of the population. The document recognised the correlation between physical and mental health and sought to achieve equal focus on both. Six high level objectives are:

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

10. LOCAL STRATEGIES

There are a number of local strategies and action plans designed to improve the wellbeing and mental health of Lewisham residents:

<p>Lewisham Public Mental Health and Wellbeing Strategy 2016-2019.</p> <p>This strategy took a life course approach, focusing on actions at each life stage. The actions for working age adults included promoting NICE guidance ‘Mental Wellbeing in the Workplace’ with local businesses, workplaces and voluntary (VCS) organisations, encouraging them to become employer ‘Time to Change’ champions and to sign up to the GLA Healthy Workplace Charter; considering the use of the Mental Wellbeing Impact Assessment tool for all major policy and planning projects; working with the local parks and adult education to ensure that residents have good awareness of green spaces and adult education offer available to residents. Actions for older age adults included supporting the work of the Lewisham Positive Ageing Council to make an application for Lewisham to become a</p>	<p>Lewisham Mental Health and Housing Working Group</p> <p>At its meeting in May 2016 the Housing Select Committee agreed to hold an in-depth review into housing and mental health, particularly how social housing tenants with low-level or mild mental health issues (such as anxiety and depression) are supported. The review found that:</p> <ul style="list-style-type: none"> • More people with mental health needs are being housed in general needs housing • People with mental health problems often have a housing related problem too <p>The Lewisham Mental Health and Housing Working Group was established in 2017 to address the recommendations of the review. Comprised of professionals from social</p>	<p>Lewisham Suicide Prevention Strategy 2019-2021</p> <p>The main areas of action of this strategy closely reflect those of the national suicide prevention strategy:</p> <ul style="list-style-type: none"> • reduce the risk of suicide in key high-risk groups: young men (those between the ages of 25 and 44 years); those who misuse drugs and/or alcohol; pregnant women • tailor approaches to improve mental health in specific groups • reduce access to the means of suicide • provide better information and support to those bereaved or affected by suicide • support the media in delivering sensitive approaches to suicide and suicidal behaviour
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<p>WHO Age Friendly Community; raising awareness about ways to protect mental wellbeing and connecting residents in with organisations/initiatives that seek to improve mental wellbeing; supporting Lewisham Dementia Action Alliance to make Lewisham a dementia friendly place to live.</p>	<p>care, mental health and housing from the public and voluntary sectors, the group is working to develop a handbook for practitioners in Lewisham to improve the information and options available to residents and standardise the local approach to early intervention for mental health in a housing context.</p>	<ul style="list-style-type: none"> • support research, data collection and monitoring
<p>Lewisham Health and Wellbeing Strategy: Health and Wellbeing for All by 2023 This ten year strategy was developed by Lewisham’s Health and Wellbeing Board (HWB) and set out the improvements and changes that the Board would focus on. The strategy was refreshed in 2015. Improving mental health and wellbeing is one of the priority areas. Desired achievements for this priority area included:</p> <ul style="list-style-type: none"> • BME representation accessing psychological therapies to be representative of the local population. • Mental wellbeing to be recognised as a key component of good health. • People with mental illness to be physically healthy through better access to screening and by receiving support for behaviour change in relation to smoking, physical activity and healthy weight management. • Suicide rates to be below the national average • An improvement in under 75 mortality for those with mental illness. 	<p>Lewisham Dementia Action Alliance (DAA) The Lewisham Dementia Action Alliance is a vehicle for the local community to improve the area and the offer for local residents living with dementia. The DAA envisages that people living and working in Lewisham are aware of and understand more about dementia through becoming dementia friends; people with dementia and their carers will be encouraged to seek help and support; and people with dementia will feel included in their community, be more independent and have more choice and control over their lives.</p>	<p>The Children and Young People’s Mental Health and Emotional Wellbeing Strategy 2015-2020 The aims of this strategy have a direct link with public mental wellbeing and have a vision to ensure that young people in Lewisham are emotionally resilient and know when and where to seek help if they need it.</p>

In addition to Lewisham strategies, there are several regional strategies that have an influence on adults’ mental health in Lewisham.

- **London Mental Health Transformation Programme:** A single Mental Health Transformation Board for London brings together senior leaders from all sectors to build system-wide mental health capacity and capability as well as strengthen commissioning and contracting.
- **Thrive LDN:** [Thrive LDN](#) is a citywide movement to improve the mental health and wellbeing of all Londoners. It is supported by the Mayor of London and led by the London Health Board partners. Thrive looks to bring together multiple city agencies and providers, as well as voluntary, business and community partners. Areas of focus include: improving the population’s understanding of mental health, employment, children and young people’s mental health, suicide prevention, community resilience and vulnerable people.
- **Healthy London Partnership:** The Healthy London Partnership have produced a range of guides for mental health transformation, including [Closing the Mortality Gap - Opportunities in Sustainability Transformation Planning](#), a guide to help support and inform commissioners to improve the physical health of individuals with severe mental illness.

- **Our Healthier South East London:** Our Healthier South East London (OHSEL) is the NHS Sustainability and Transformation Partnership (STP) for South East London – the ‘umbrella’ plan which brings NHS organisations in the area together with local councils together to establish a place-based leadership and decision-making structure to make plans and decisions that will ensure the sustainability of services into the future. A key component of the plan is prevention and this includes mental health. The vision of OHSEL for mental health can be found on their [website](#).

11. CURRENT ACTIVITIES AND SERVICES

As discussed in Section 9, there are many direct and indirect factors likely to have an impact on mental health. As such, there are a set of statutory mental health services, but also other services that are likely to indirectly or directly contribute to improved mental health in Lewisham, even if this is not the primary purpose of the service. These services may be provided by the community or by statutory organisations, and are described in this report as ‘wellbeing and prevention services’.

Lewisham statutory mental health services operate an integrated approach. Commissioners and providers are seeking to expand on examples of good practice to apply a population based approach and establish personalised service provision that moves beyond responding to a diagnosis and the provision of symptomatic relief. With this aim, and in recognition of the fact that a new integrated model of service delivery is required to make the most effective use of limited resources, a new Lewisham provider alliance launched in April 2019.

The diagrams below (Figures 14-16) depict the three statutory mental health service pathways in Lewisham, for common mental illness (CMI), severe mental illness (SMI) and crisis care. Services are described in further detail in this Section, and service data is analysed in Section 12.

Figure 14: Service Map of Pathways for Common Mental Illness (CMI) in Lewisham

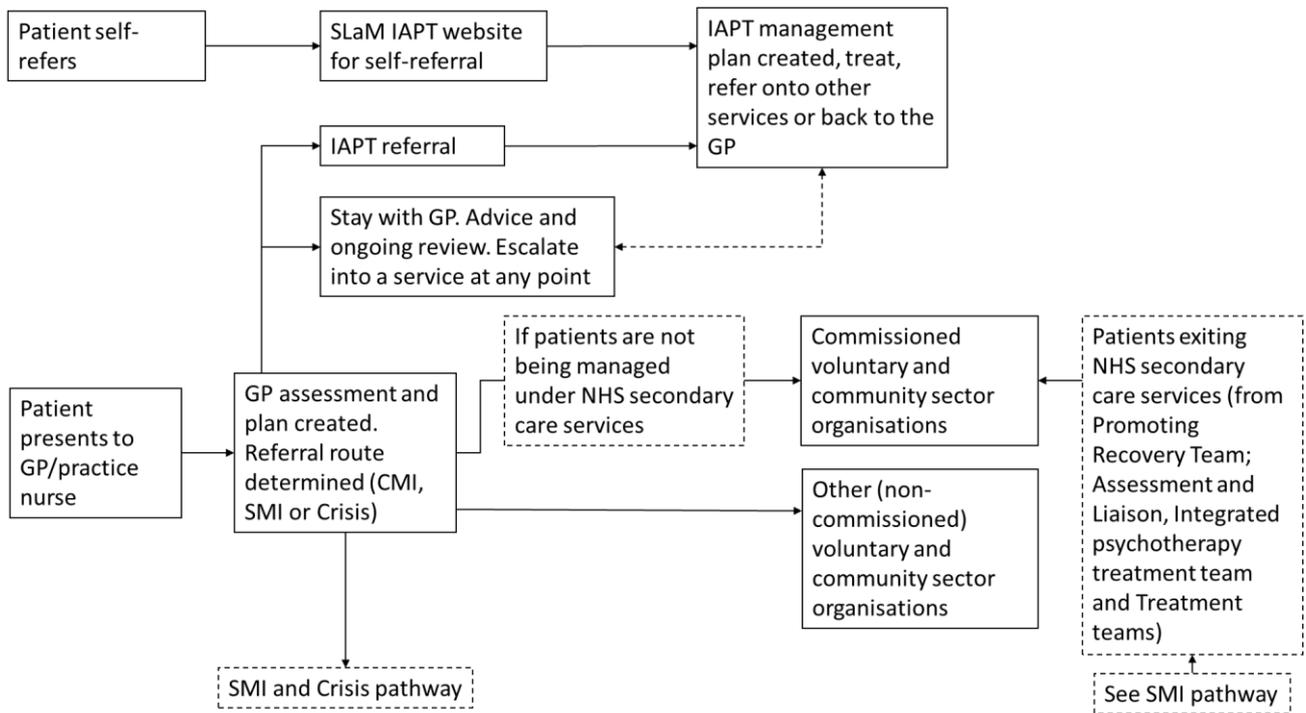


Figure 15: Service Map of Pathways for Severe Mental Illness (SMI) in Lewisham

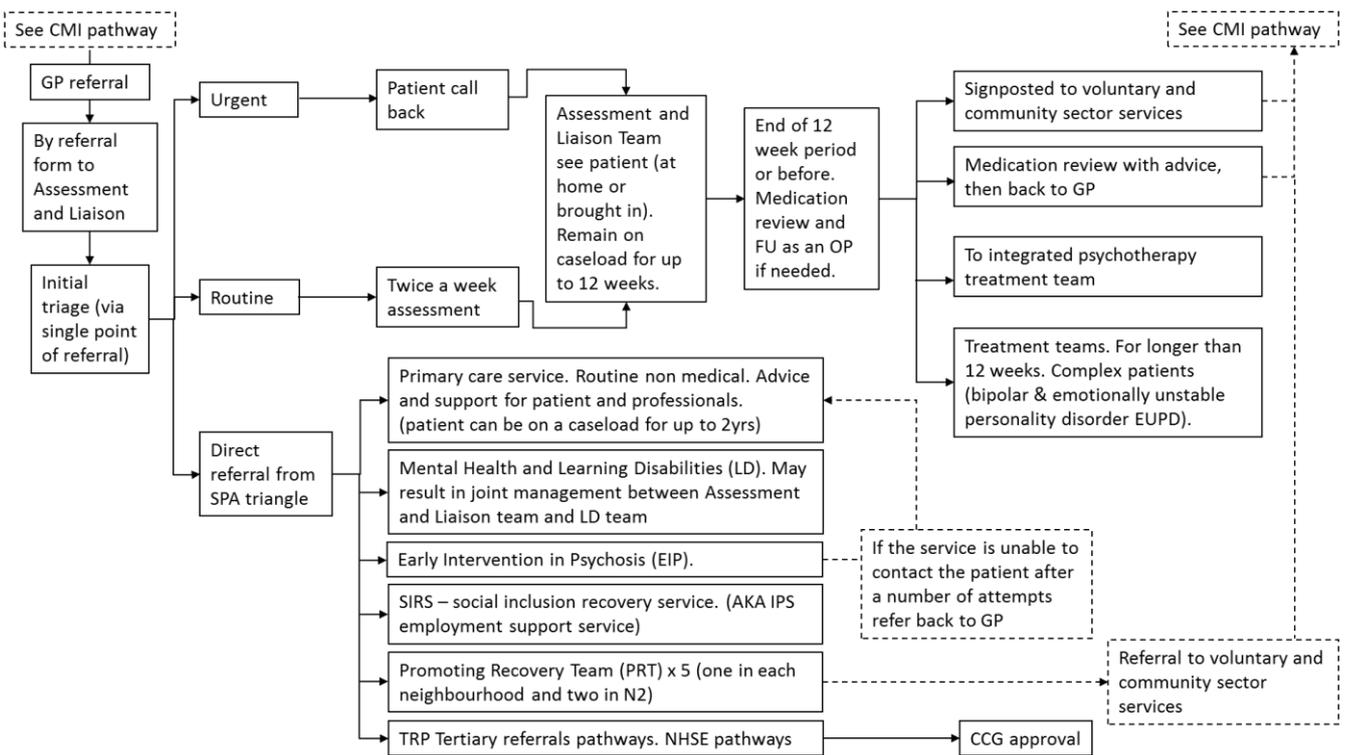
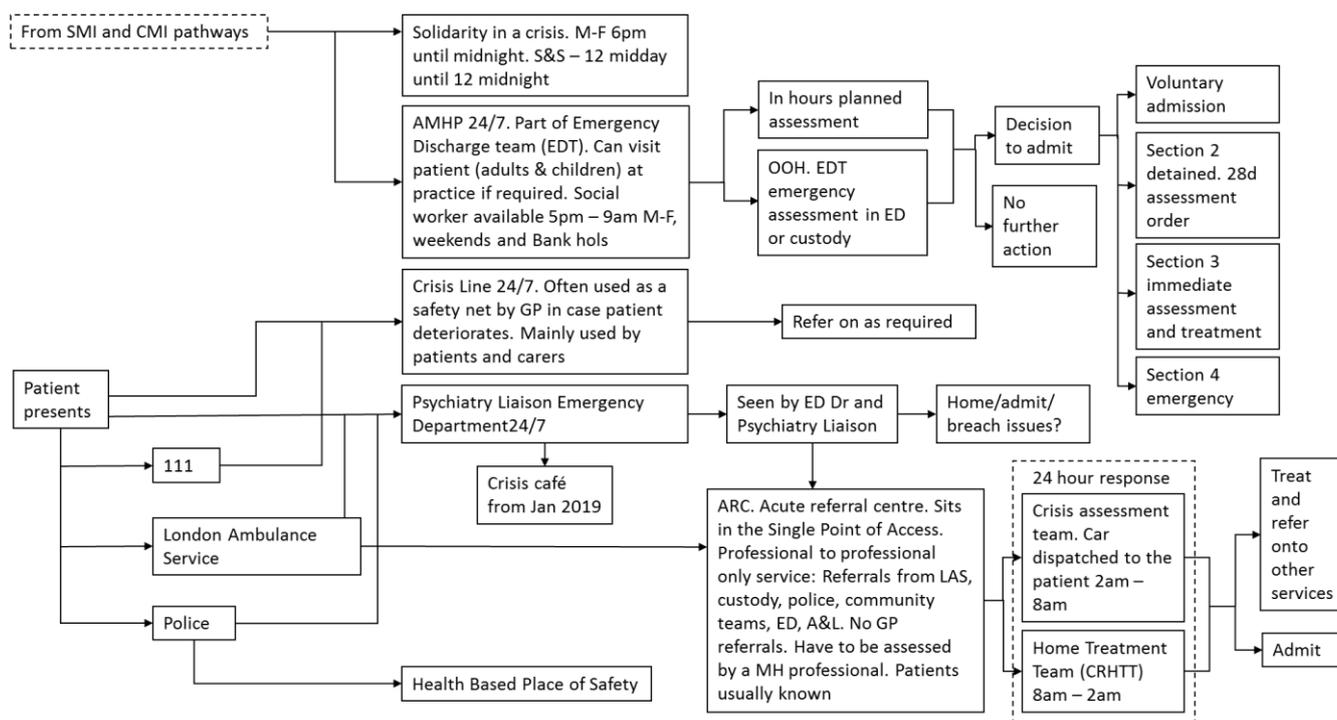


Figure 16: Service Map of Crisis Pathway for Mental Health in Lewisham



11.1. WELLBEING AND PREVENTION SERVICES

11.1.1. Neighbourhood Community Development Partnerships

In February 2017 Lewisham Council developed a Community Development Charter which outlines a partnership approach to community development and builds on current neighbourhood and borough-wide assets and networks with the creation of four Neighbourhood Community Development Partnerships (NCDPs). The partnerships bring together all the relevant voluntary and community sector partners as well as statutory services in each Neighbourhood to identify local health and wellbeing priorities as well as local resources and community assets to address them. Lewisham Public Health has provided funding to support grants to voluntary and community organisations in the four NCDPs, distributed using a community based participatory budgeting process. The grants have supported a variety of projects that promote health and wellbeing for local residents. These include befriending groups, community gardens, a soup kitchen, holiday at home schemes, storytelling and dance workshops, physical activity sessions and a Fit Bus scheme; and many of the projects aim to improve the wellbeing of the local community in some way.

11.1.2. Lewisham Council Main Grants Programme

Lewisham has a diverse voluntary and community sector which ranges from very small organisations with no paid staff through to local organisations affiliated to national charities. As well as being directly involved in delivering services to citizens in the borough, these organisations also provide the essential infrastructure to allow civil society as a whole to develop and to support individual citizens to be able to play an active role within their local communities. Programme themes are: Strong and Cohesive Communities; Communities that Care; Access to Advice; and Widening access to Arts and Sports. These themes all cover projects and organisations that lead to improvements in community wellbeing, whether directly or indirectly, for example Voluntary Services Lewisham, which runs a befriending project, and Deptford Reach, which supports homeless people in the north of the borough.

11.1.3. Parental wellbeing support

In addition to the perinatal mental health support provided by Lewisham and Greenwich Trust and SLAM, as outlined in the [Maternal Mental Health JSNA](#), there are a range of parental wellbeing services provided in the community, for example Mindful Mums, which helps pregnant women and new mums to look after their

wellbeing, and the Parent Champions programme, where parent volunteers give a few hours a week to talk to other parents about the local services available to them. More detail about parental wellbeing services are in Lewisham's [Parenting JSNA](#). Following the Maternal Mental Health JSNA, a review of fathers' mental health in Lewisham was completed. The review revealed that almost a third of new fathers who were surveyed reported experiencing postnatal depression. Whilst there are some services available to support new dads (listed in the report), the review highlighted that more needs to be done.

11.1.4. Employment support

IPS (Individual Placement and Support) supports people with severe mental health difficulties into employment. It involves intensive, individual support, a rapid job search followed by placement in paid employment, and time-unlimited in-work support for both the employee and the employer. There is now overwhelming international evidence that IPS is much more effective than traditional approaches (such as vocational training and sheltered work) in successfully getting people into work.

Lewisham is part of a two-year IPS pilot across South East London STP. In Lewisham there will be an IPS Employment Specialist at SLaM who will be co-located within the Early Intervention in Psychosis service. This means that more Lewisham clients will receive IPS support, with projected increases in the number of clients that enter employment. Previous to this pilot there has been no IPS provision to SLaM patients with severe mental illness in Lewisham.

In SLaM IAPT services, there are vocational/career specialists who support Lewisham service users with a range of vocational needs including supported employment, supported education, and job retention.

Lewisham Job Centre Plus offers employment support for people with mental health needs. They work in partnership with employers to promote employment opportunities for people with mental health conditions, upskill work coaches so they are better able to support people with mental health needs and provide staff with mental health first aid. There's a suicide and self-harm lead in every job centre, alongside safeguarding and referral officers. In addition, the visiting team visit people at home who miss appointments (which is more common amongst people with mental health conditions). However the service is unable to offer specialist support to everyone with mental health needs (there is a threshold for support) and so potentially there are people with mental health needs who are not receiving support with employment. Additionally, stigma from employers around mental health has continually been identified as an issue in research on attitudes to mental health and at stakeholder events in Lewisham.

11.1.5. Adults' substance misuse services

Lewisham's current approach to adult substance misuse treatment was reconfigured in April 2015. The system consists of four main commissioned substance misuse services and a range of associated activity delivered via the council's Prevention, Inclusion and Public Health Commissioning Team, GPs, pharmacists and the providers of detoxification and rehabilitation services. CGL run the main complex needs service in the borough which assesses and triages all those presenting with a substance misuse or alcohol need. Service users receive a systematic assessment for an appropriate pharmacological therapy for opiate dependence and commencement of dose titration within 24 hours of presentation. In addition to this there are a range of specialist elements within the service designed to meet specific needs. Blenheim CDP deliver the primary care recovery service which works in partnership with GPs and provides a range of interventions including advice, information, brief interventions and extended brief interventions to help prevent and minimise problematic alcohol or substance misuse or dependency.

Dual diagnosis continues to be an issue for people with mental health needs. There are two community-based dual diagnosis workers; and referrals can be made between mental health services and substance misuse services when appropriate. There are also interface meetings between mental health services and substance misuse services to facilitate joint working and resolving any differences of opinion regarding which service is

best placed to lead/co-ordinate the care of an individual and/or the appropriate contribution of specific services to care packages.

The National Institute for Health and Care Excellence (NICE) is currently reviewing guidance for people with coexisting severe mental illness and substance misuse, which aims to improve care pathways for this group. It will be important for Lewisham to review these guidelines when they are published in September 2019 in order to provide coordinated services that address the wider health and social care needs as well as other issues such as employment and housing. Mental health and substance misuse commissioners have started to meet to further develop effective pathways for those with dual diagnosis in Lewisham.

11.1.6. Time to Change

Lewisham became a Time to Change Hub in 2018. Local Time to Change Hubs work to reduce mental health stigma and discrimination in local schools, workplaces and communities and improve the quality of life for people living with mental health problems using simple conversations and:

- Putting people with personal experience of mental health problems at the heart of their work
- Embedding anti-stigma and discrimination work locally, whether that be socially, in workplaces, local schools, or other community settings
- Proactively campaigning to improve people's attitudes and behaviours towards mental health.

11.1.7. Health improvement training

Lewisham Council Public Health Department and Lewisham Community Education Provider Network offer health improvement training courses targeted at people working or volunteering in the borough. The programme provides an opportunity for participants to develop and strengthen health improvement skills and competencies. Mental Health First Aid for Adults equips participants with the skills and knowledge to provide initial support to individuals experiencing mental health problems and guide them towards appropriate professional help. Mental Health and Dual Diagnosis training aims to provide participants with a basic awareness of mental health and mental illness and to raise awareness of the issues related to dual diagnosis and improve working with those clients who have a mental health issue/substance misuse. Bromley, Lewisham & Greenwich Mind are also commissioned to provide dementia training in the Borough, particularly targeting people working in health and social care, as part of the Lewisham Dementia Support Hub.

11.1.8. Social prescribing

Social prescribing schemes are beginning to be recognised as vital tools. They have the capacity to assist statutory services as they look to 'do more with less' in the face of a growing, ageing population and restricted funding. Social prescribing schemes have been operating in Lewisham over the last decade. For example, Community Connections is a consortium social prescribing project in Lewisham led by Age UK Lewisham and Southwark that has been running since 2013. It aims to improve integration between services across Health and Social Care and the community sector as well as supporting decreased isolation and improved mental wellbeing for vulnerable adults in Lewisham. This is achieved through the combination of Community Development Work and one-to-one Community Facilitation for vulnerable individuals. An evaluation of the project in 2017/18 showed that 72% of people who were supported reported an improvement in their overall wellbeing after Community Connections' involvement.⁸⁴ Lewisham Safe and Independent Living (SAIL) Connections⁸⁵ is a social prescribing scheme that also operates as a first contact tool, enabling self-referral, early intervention and prevention through use of community-based services across multiple sectors. Evaluation of the pilot showed improved wellbeing and decreased isolation and social prescribing; as a result, Lewisham's social prescribing programme is being taken forward by key partners and will be expanded over

⁸⁴ Age UK Lewisham and Southwark: Community Connections 2017-2018 Impact Report. Available at: <https://www.ageuk.org.uk/lewishamandsouthwark/services/community-connections/>

⁸⁵ Lewisham SAIL Connections: 2016-18 Pilot Evaluation using an adapted Social Return on Investment Methodology. Available at: <https://www.ageuk.org.uk/lewishamandsouthwark/services/sail/>

the coming years. A mental health specific social prescribing service is provided as part of Lewisham Community Wellbeing (see 11.2.1)

11.2. COMMISSIONED VOLUNTARY AND COMMUNITY SECTOR MENTAL HEALTH SERVICES

Voluntary and community sector organisations are commissioned by Lewisham Council and Lewisham CCG Joint Mental Health Commissioners to provide a range of mental health services in Lewisham.

Following a restructuring of commissioned services, from April 2019, partnerships led by Bromley, Lewisham and Greenwich Mind (BLG Mind) are delivering two important new services to meet the needs of local people in their communities: Lewisham Community Wellbeing and the Lewisham Dementia Support Hub (see Section 11.6).

11.2.1. Lewisham Community Wellbeing

Lewisham Community Wellbeing is a new integrated service for people with mental health and wellbeing problems, which is delivered by BLG Mind, Lewisham Refugee and Migrant Network (LRMN), Sydenham Garden and METRO, working closely with South London & Maudsley NHS Foundation Trust (SLaM).

The service supports people to manage their mental health and wellbeing problems, stay well, recover, achieve their personal goals and connect with their local community. It includes:

- A single point of access to the range of support available
- Individual person-centred support and recovery planning
- Workshops, courses and groups
- Peer Support, through activity-based groups
- Culturally specific provision for people from BAME communities
- Community engagement and mental health awareness raising
- Service user involvement

Lewisham Community Wellbeing replaces some services previously provided by BLG Mind, services provided by Family Health ISIS and aspects of Sydenham Garden's provision. Staff and clients from Family Health ISIS transferred into the new service in February 2019.

11.2.2. Sydenham Garden

Sydenham Garden is a wellbeing centre that uses its gardens, nature reserve and activity rooms to help people in their recovery from mental and physical ill-health in Lewisham. They are commissioned to run several projects, along with many supplementary activities and clubs. Three projects are focused on adult mental health and include gardening, art and craft, cooking, and opportunities to achieve recognised qualifications. Sydenham Garden also run a project focused on dementia.

11.2.3. METRO

METRO are commissioned to provide counselling, group therapy and family therapy for LGBTQ young people aged 11-25 and a mental health drop-in, which runs every Thursday from 12:30pm to 3:30pm in Woolwich. It's a safe space to socialise with others in a comfortable, non-judgemental, relaxed atmosphere.

11.2.4. Lewisham Bereavement Counselling

Lewisham Bereavement Counselling provides counselling and advice services for bereaved people in Lewisham.

11.2.5. The Vietnamese Mental Health Service

The Vietnamese Mental Health Service provides services to people from Vietnam living in Lewisham with mental health difficulties with a medium to high support need. Services include outreach and counselling services and drop-in day centres

11.2.6. The Cassel Centre

Previous to April 2019, the Cassel Centre provided counselling, psychotherapy, cognitive behavioural therapy (CBT) and therapeutic social work to Lewisham patients. The Cassel Centre is a community of around sixty professionals across South East London who offer time for people to talk about practical and emotional difficulties in times of personal or family vulnerability. The Cassel Centre is no longer commissioned to provide these services.

11.3. PRIMARY CARE

11.3.1. General practice

The vast majority of people receiving treatment for mental health problems are seen within primary care.⁸⁶ Nationally, 81% of people first come into contact with mental health services via their GP and continue to receive support from their GP throughout the period they are in contact with secondary care services; 90% of people receive treatment and care for their mental health problem solely in primary care settings; and it is estimated that a third of GP appointments involve a mental health component.⁸⁷ In recognition of the relationship between mental and physical health, an important part of the role of general practice for people with mental ill health, especially severe mental illness, is to provide regular physical health checks.

11.3.2. Primary Care Mental Health Service

This service is a partnership between SLaM and BLG Mind to provide support for people with long-term mental health problems in a primary care, community-based setting. The service includes SLaM staff, including nurses, social workers and occupational therapists, working alongside BLG Mind staff, to provide both low level clinical support and practical and peer support. Referrals to the service are accepted via SLaM's Assessment and Liaison Team.

11.3.3. Improving Access to Psychological Therapies (IAPT) Service

IAPT Lewisham is a primary care service that provides advice and brief treatment, including self-help therapy for people, aged over 18, with depression or anxiety. Referrals are received from GPs and self-referrals.

11.4. COMMUNITY MENTAL HEALTH SERVICES FOR ADULTS WITH SEVERE MENTAL ILLNESS

The South London and Maudsley (SLaM) NHS Trust provide community mental health services for adults with severe mental illness in Lewisham.

11.4.1. Assessment and Liaison Service

The Assessment and Liaison Service works with primary care and adult social care to support people aged 18-65, with mental health problems, where possible, without the need for a secondary mental health service. The team gets referrals from GPs and other health and social care workers.

11.4.2. The Treatment Service

The Treatment Service combines the Assessment and Liaison Service with targeted therapeutic interventions. Referrals come from the Assessment and Liaison Service.

11.4.3. Psychosis Promoting Recovery Community Service

The Psychosis Promoting Recovery Community Service has teams in the four Lewisham 'neighbourhoods',⁸⁸ providing care for adults who have a psychotic illness. This involves distorted perceptions of reality – thinking,

⁸⁶ NHS England (2017) RightCare Mental health conditions pack for Lewisham CCG

⁸⁷ NHS England (2017) RightCare Mental health conditions pack for Lewisham CCG

⁸⁸ Lewisham has been organised into four 'neighbourhoods' which correspond to geographical areas of the borough.

feeling, hearing and seeing – often with symptoms of hallucinations and delusions. Vocational and a Primary Care Enhanced Mental Health services are also provided.

11.4.4. Early Intervention in Psychosis

SLaM's Early Intervention Service (Lewisham) provides support to people aged 16-64 who are suspected to be at risk or who are having a first episode of psychosis before they reach 'crisis point'. Referrals come from a range of sources including GPs and schools.

11.4.5. OASIS

OASIS is a health service for young people aged 14-35 who are experiencing psychological distress. Referrals come from a range of sources and the team accepts self-referrals.

11.4.6. Lewisham Enhanced Recovery Team

The Enhanced Recovery Team provide intensive community-based rehabilitation, care and support for adults with severe and long-term mental illness who live in Lewisham.

11.5. CRISIS AND ACUTE MENTAL HEALTH SERVICES FOR ADULTS WITH SEVERE MENTAL ILLNESS

SLaM NHS Trust provide crisis and acute mental health services for Lewisham residents.

11.5.1. Lewisham Integrated Psychological Therapy Team

The Integrated Psychological Therapy Team (Lewisham) is a specialist psychological therapy service (secondary care) that provides assessment, treatment and care for people, aged 18-65, who have severe mental illness. The service receives referrals from IAPT and the Assessment and Liaison team.

11.5.2. Acute wards

The Trust has a number of wards that support people in Lewisham, aged 18 to 65 years old, who need inpatient crisis or acute mental health care. These include Clare Ward; Johnson Psychiatric Intensive Care Unit; Lewisham Triage; Powell Ward and Wharton Ward. To ensure people get the help they need when most unwell, referrals to these wards can be received from anywhere across the Trust not just Lewisham. The Trust uses the Care Programme Approach (CPA) to assess, plan, co-ordinate and review care for service users with mental health problems and complex issues. In addition, there is a health promotion and wellbeing service that aims to reduce smoking, increase physical activity levels and improve diet amongst inpatients (see Box 4).

11.5.3. Mental health liaison service

This services aims to provide psychiatric assessment and treatment to patients aged 18 and over who may be experiencing distress whilst at University Hospital Lewisham. They provide a valuable interface between mental and physical health. The service assesses people to determine if they need mental health care and treatment.

11.5.4. Inpatient and community forensic services

The Trust provides a range of medium, low secure and specialist inpatient forensic services, in state of the art modern facilities at River House. The Community Forensic Service (Lewisham) provides community-based assessment, treatment and care for people, aged 18-65, who have severe mental health problems and who may be a risk to themselves and others.

Box 4. Physical health and health promotion services in hospitals

Health promotion

To address the physical health inequalities in people with SMI, there are a variety of health promotion activities that take place within crisis and acute mental health services for adults with severe mental illness.

Some of this activity has been driven by the 2017-19 CQUIN (Commissioning for Quality and Innovation), an incentive scheme). However, in the case of alcohol and smoking, this only covers inpatients and so community services are not included. Health promotion in community services and follow up after discharge is not funded by the CQUIN.

A large component of the health improvement has involved staff training. For example, there is a 5-day training on dual diagnosis, training on services and referrals for alcohol, and training for staff on how to have conversations with patients about evidence-based treatments for tobacco dependence.

The SLaM Physical Healthcare Policy⁸⁹ requires that written information is accessible for service users detailing the range of local physical health care services, referral criteria and access arrangements to these services. Information should include support to stop smoking, healthy eating, sleeping well, being more active, and access to specialist services such as sexual health clinics and drug and alcohol services (including information on self-help and mutual aid organisations such as Alcoholics Anonymous and Narcotics Anonymous).

In addition, inpatient areas directly provide healthy living programmes which should include healthy eating, support to stop smoking, alcohol and drug awareness and of being more active.

Physical health checks

All patients entering SLaM Addictions Operational Directorate/Borough services receive a triage assessment. At that assessment the following physical health assessments take place:

- Disability issues that may affect engagement e.g. mobility problems, eyesight problems, hearing loss
- Engagement with GP/registration with GP
- Physical health history, including any current illnesses, long term conditions and disabilities. Weight and waist circumference may be measured (however levels of recording are low)
- Risks to health from current and past substance use will be assessed e.g. overdose, withdrawal, Blood Borne Viruses (BBVs), injecting related problems
- Smoking, including Brief Intervention
- Pregnancy

Tests/investigations (if relevant):

- Urine or oral drug testing
- Breathalyser
- AUDIT (Alcohol Use Disorders Identification Test)/SADQ (Severity of Alcohol Dependence Questionnaire)

Additional issues that may be relevant include:

- Contraception/fertility
- Sexual health risks
- Dental and oral health problems

11.6. DEMENTIA SERVICES AND MENTAL HEALTH SERVICES FOR OLDER PEOPLE

11.6.1. Lewisham Dementia Support Hub

Lewisham Dementia Support Hub is a partnership between BLG Mind, Sydenham Garden, Carers Lewisham and SLaM. It delivers integrated, high quality support to help Lewisham residents diagnosed with dementia,

⁸⁹ South London and Maudsley NHS Trust Physical Healthcare Policy. Ratified June 2018.
https://www.slam.nhs.uk/media/24407/physical_healthcare_policy_v3_-_june_2018.pdf

and their carers, to live well with dementia. The Lewisham Dementia Support Hub also takes the lead on the Lewisham Dementia Action Alliance, working with businesses and organisations in Lewisham to take action on dementia and make Lewisham a more dementia friendly community. The Hub replaces Lewisham MindCare Dementia Support, which has been delivering dementia support services to residents Lewisham for many years.

11.6.2. Sydenham Garden Sow and Grow (now part of the Lewisham Dementia Support Hub)

Sow and Grow is a course that runs on weekly basis and lasts for six months. It aims to support people to cope with early stages dementia, using gardening, cooking and craft activities, as well as providing plenty of opportunities for reminiscence, social interaction, reflection and discussion. Referrals come from GPs, Lewisham Dementia Support Hub, Adult Social Care Advice and Information team and residents can also self-refer.

11.6.3. Memory Service

SLaM has a Memory Service team for Lewisham who provide early assessment, treatment and care for people over 18 who have memory problems that may be associated with dementia. Referrals are received from GPs. The team is made up of psychologists, nurses, occupational therapists and doctors. Anyone who is referred to the memory service is seen either at home or in a local clinic. Using the latest diagnostic tools to detect very early dementia, staff carry out an initial assessment and follow up with a talk about the results. It's at this stage that a diagnosis can be made with a referral for appropriate treatment as required.

11.6.4. Community Mental Health Team for Older Adults

SLaM's Community Mental Health Team for Older Adults in Lewisham North and Lewisham South provide community-based assessment, treatment and care for people aged over 65 who have mental health problems and younger people with a diagnosis of dementia.

11.6.5. Home Treatment for Older Adults Service

The Home Treatment for Older Adults team care for people aged 65 and over with severe mental illness who would benefit from assessment and treatment at home as an alternative to hospital. Referrals come from GPs, social services or other secondary care services.

12. SERVICE DATA ON OUTCOMES AND INEQUALITIES

To understand who is accessing services and what the outcomes of any treatment are, data from commissioned services can be analysed. This analysis also reveals whether there are inequalities in either access or outcomes across the population. Service data from providers can also be combined with publicly available data on, for example, rates of diagnosis or hospital admissions.

It should be noted, of course, that service data only takes into account people who present to services, so are unlikely to reflect the true picture of need in Lewisham. In addition, there may be issues with data quality such as recording/coding inconsistencies or missing data, which make it difficult to comprehend the full picture of mental health need in Lewisham. Issues with data quality are discussed fully in Section 14.

12.1. COMMISSIONED VOLUNTARY AND COMMUNITY SECTOR PROVIDERS

12.1.1. BLG Mind Community Support Service

Bromley, Lewisham and Greenwich Mind are commissioned to provide a community support service for Lewisham residents (now Lewisham Community Wellbeing). In 2017/18 they received 421 enquiries to their helpline and 469 referrals. Of these referrals, 265 (56.5%) were accepted onto their caseload, with many others receiving guidance and signposting. All referral responses were made within three days of the initial referral. Almost a third of referrals (29%) came from the Lewisham Assessment and Liaison Team; 20% were self-referrals; 20% came from GPs; and a further 18% came from the IAPT service.

In 2017/18, for those clients for whom there is data recorded:

- 44.0% were female; 55.5% were male; 0.5% were transgender
- The largest age group was 46-55 (28.0%), followed by 26-35 (19.9%), 36-45 (19.7%) and 56-65 (19.1%)
- 59.0% were White; 24.4% were Black; 7.0% were Mixed; and 5.6% were Asian
- 89.7% were heterosexual; 3.6% were gay/lesbian; 1.7% were bisexual; and 5.0% identified as other
- 63.6% reported that they had a mental health condition; 14.2% reported that they had a long term condition

Access to this service in 2017/18 was therefore broadly in line with the Lewisham general population, though women and people from Asian backgrounds are slightly underrepresented amongst service users.

The most popular areas of provision cited as a reason for accessing the service in 2017/18 were 'mental health' and 'meaningful use of time'. Following these were 'motivation and confidence' and 'develop skills'. Information and advice was most commonly reported as what people would like to get out of the service (194 people said this), followed by one-to-one contact (144) and the peer support project (120).

Of the 372 active cases in 2017/18, 45% were seen within 10 days of referral. Of those clients who were discharged over the period (312), 84.0% had a planned discharge from the service.

12.1.2. Sydenham Garden

Sydenham Garden run a service called the Garden Project. In 2017/18, 221 people were referred to this service, of which 41 started the programme. Of these, 18 completed the programme. The three biggest source of referrals were GPs (19.9%), the voluntary sector (16.7%) and CMHT (14.5%). The evaluation of their Transitions pilot project showed that it significantly improved participants' wellbeing during their last 3 months in the Garden project.

12.1.1. Metro

Data for this service is only available for Q1 and Q2 2017/18, so there is no accurate record of who accessed the service over the whole year. The available data shows that 52 Lewisham residents accessed Metro counselling services in Q1 and Q2 2017/18. There is no data available on other services provided by Metro, or on the characteristics (age, ethnicity, etc.) of those Lewisham residents who did access services.

12.1.2. Lewisham Bereavement Counselling

Data for this service is only available for Q1-Q3 2017/18, so there is no accurate record of who accessed the service over the whole year. The available data shows that 157 Lewisham residents contacted the service and were sent bereavement guides in these three quarters; 41 people were assessed; and 40 people started counselling. Of those people that contacted the service, 74.2% were female and the most common age group was 65 and over.

12.1.3. Vietnamese Mental Health Service

The service is for Vietnamese and Chinese people with a medium to high mental health support need. The service delivers across Lewisham, Lambeth and Southwark, offering 80 places for the three boroughs each quarter. Lewisham residents made up 39.7% of these places in 2017/18.

In 2017/18, the Lewisham clients accessing this service:

- 63.8% were male
- The majority (56.7%) had a diagnosis of schizophrenia. 9.4% had a diagnosis of depression, 9.4% had a diagnosis of depression, and 8.7% had a diagnosis of dementia/Alzheimer's
- 26.0% were aged 46-55; 25.2% were aged 56-65
- 70.9% were Vietnamese and the rest were Chinese
- 90.6% were heterosexual, and the rest preferred not to say

The most common activity was telephone support. At the last review of the recovery star (in Q3 2017/18), 100% of service users reported positive improvement in every domain (Managing mental health; Self-Care; Living Skills; Social Network; Work; Relationships; Addictive Behaviour; Responsibility; Identity & Self-esteem; Trust & Hope).

12.1.1. VoiceAbility

VoiceAbility were until 2019 commissioned to provide Lewisham residents with Independent Mental Health Advocacy (IMHA), Care Act advocacy, and have also been taking part in a University Hospital Lewisham (UHL) advocacy pilot project.

In 2017/18, there were 287 total referrals open for IMHA and 241 new referrals. Approximately 70% of referrals came from professionals; 27% were self-referrals; and 3% were from family/friends or internal referrals. The most common type of issue was discharge and aftercare, followed by education, and leave. For eight of the nine outcomes that were surveyed (Involved in decisions about my life; Understand my rights and entitlements; Can speak up for myself more; Have better support (quality); Understand support options available; Have more choice; Understand how to keep myself safe; More confident to keep myself safe; Know who to tell if some-one was hurting me), at least 85% of people reported that things got better or got a lot better (the rest reported no change)⁹⁰ after support from VoiceAbility.

In 2017/18, there were 107 total referrals open for Care Act advocacy and 66 new referrals. The majority of new referrals were from Neighbourhood Teams (of which Neighbourhood 4 made the most referrals). The most common type of issue was safeguarding support, followed by assessment, and support planning.

In 2017/18, there were 51 total referrals open for the UHL advocacy pilot and 39 new referrals. For all but two of the nine outcomes, at least 60% of people reported that things got better or got a lot better.⁹¹

⁹⁰ 65% of respondents reported things got better or got a lot better for 'live more independently'

⁹¹ The two exceptions were 'more confident to keep myself safe' (54.3%) and 'know who to tell if some-one was hurting me' (48.6%)

12.1.2. The Cassel Centre

The data below shows the demographic breakdown of service users for the Cassel Centre. The Cassel Centre is no longer commissioned to provide these services from April 2019.

In 2017/18, 275 adults received psychological therapy (counselling and psychotherapy) from the Cassel Centre. Of these:

- 29.5% were aged 31-40; 25.5% were aged 21-30; 21.8% were aged 41-50
- 65.8% were female
- 40.0% were self-referrals and 42.2% were referrals from a health authority
- 6.2% had a disability
- 5.8% identified as LGBT+
- 29.8% were from a low income household
- 70.9% were White; 14.5% were Black; 8% were Mixed Ethnicity; and 4% were Asian

In 2017/18, 74 adults received CBT (cognitive behavioural therapy) from the Cassel Centre. Of these:

- 33.8% were aged 21-30; 29.7% were aged 31-40; 20.3% were aged 41-50
- 62.2% were female
- 32.4% were self-referrals and 44.6% were referrals from a health authority
- 4.1% had a disability
- 2.7% identified as LGBT+
- 35.1% were from a low income household
- 74.3% were White; 10.8% were Black; 8.1% were Mixed Ethnicity; and 1.4% were Asian

In 2017/18, 37 adults received therapeutic social work from the Cassel Centre. Of these:

- 35.1% were aged 21-30; 18.9% were aged 51-60; 18.9% were aged over 60
- 70.3% were female
- 35.1% were self-referrals
- 35.1% had a disability
- No-one identified as LGBT+
- 67.6% were from a low income household
- 54.1% were White; 35.1% were Black; 8.1% were Mixed Ethnicity; and no-one was Asian

In addition, in 2017/18, 7 adults received art psychotherapy from the Cassel Centre.

This data from all three services indicates that, compared to the general Lewisham population, men (for all services) and people from BAME backgrounds (particularly for CBT and psychological therapy) were underrepresented amongst Cassel Centre users in 2017/18.

12.2. PRIMARY CARE

12.2.1. General practice

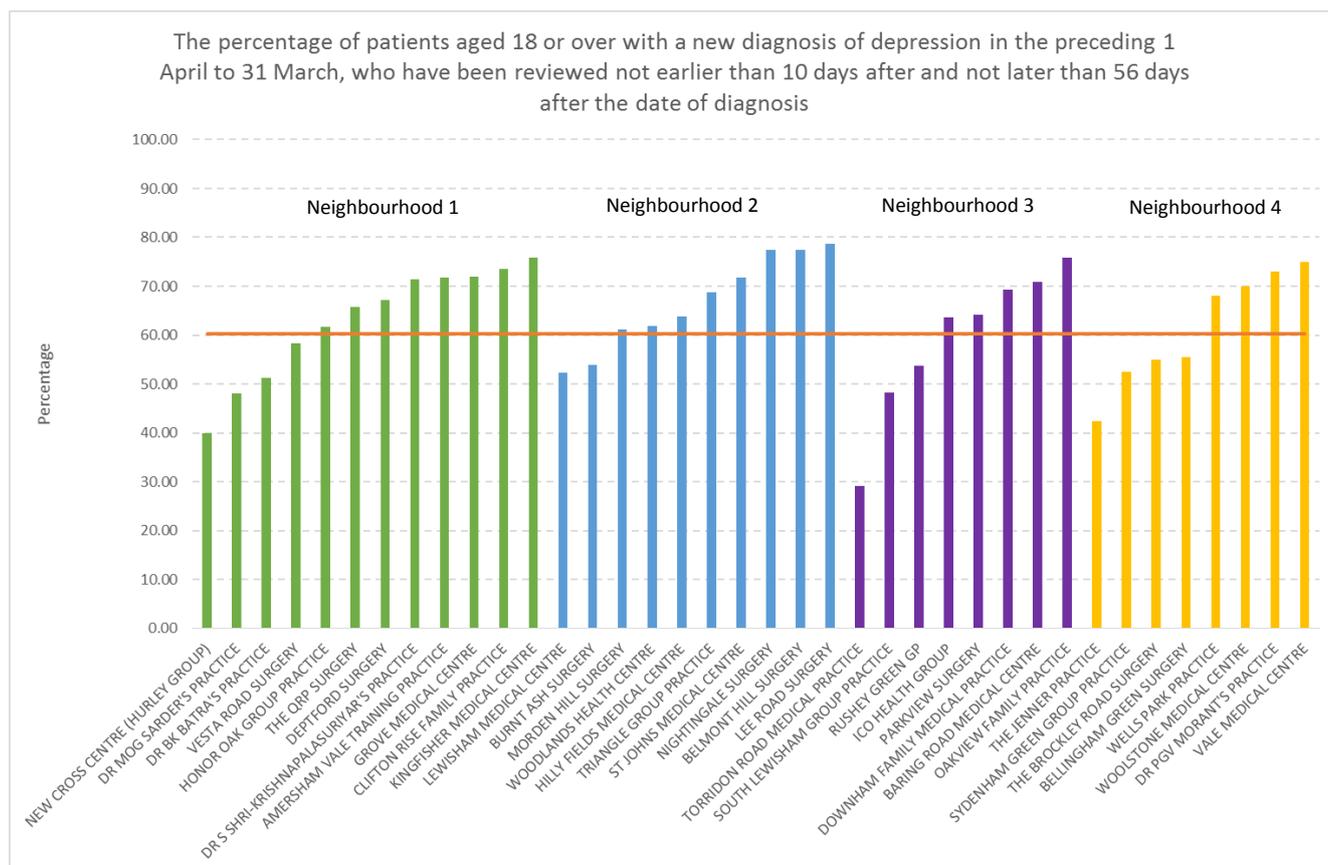
The Quality and Outcomes Framework includes various measures of GP achievement related to mental health. These mostly relate to GPs conducting timely checks and reviews for their patients who have been diagnosed with a mental health condition. Physical health checks are especially important because of the evidence that people with poor mental health (especially those with severe mental illness) are also more likely to experience poor physical health (see Box 3). When considering how GPs perform, we can look at both the overall average for all GP practices in the borough, as well as the variation between practices (and grouped by neighbourhood).

Common mental health disorders

Across all GP practices in Lewisham, 60.2% of patients aged 18 or over with a new diagnosis of depression in 2017/18, were reviewed between 10 and 56 days after the date of diagnosis.⁹² This is significantly lower than both the London average (63.2%) and the England average (64.2%).

Within Lewisham, the achievement of this by individual practices ranged from 29.2% to 78.8%. Figure 17 considers the variation at practice level in this achievement by neighbourhood, in 2017/18. The largest variation is found amongst GP practices in Neighbourhood 3.

Figure 17. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis



Severe mental illness

In 2017/18, 80.8% of patients in Lewisham with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate. This is significantly lower than the London average (83.3%) but significantly higher than the England average (78.2%). Within Lewisham, the achievement of this by individual practices ranged from 62.9% to 96.2%.

In 2017/18, 82.3% of patients in Lewisham with schizophrenia, bipolar affective disorder and other psychoses had a record of blood pressure in the preceding 12 months. This is significantly lower than the London average (84.0%) and similar to the England average (81.5%). Within Lewisham, the achievement of this by individual practices ranged from 65.8% to 98.0%.

⁹² Some patients with a new diagnosis, however, had exceptional reasons why they could or should not be reviewed ('exceptions'). If these are taken into account, 82.1% of Lewisham patients aged 18 or over with a new diagnosis of depression in 2017/18, were reviewed between 10 and 56 days after the date of diagnosis. This is compared with 81.6% London average and 82.8% England average.

In 2017/18, 82.9% of patients in Lewisham with schizophrenia, bipolar affective disorder and other psychoses had a record of alcohol consumption in the preceding 12 months. This is significantly lower than the London average (85.2%) and significantly higher than the England average (80.6%). Within Lewisham, the achievement of this by individual practices ranged from 61.6% to 100%.

In 2017/18, 70.4% of Lewisham women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses have notes that record that a cervical screening test has been performed in the preceding 5 years. This is not significantly different from the London average (68.4%) or the England average (69.7%). Within Lewisham, the achievement of this by individual practices ranged from 52.5% to 86.7%.

In 2017/18, 90.1% of patients in Lewisham on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months. This is similar to the London average and (92.7%) and significantly lower than the England average (94.2%). Within Lewisham, the achievement of this by individual practices ranged from 50.0% to 100.0%. The numbers of patients in each practice on lithium therapy ranged from zero to 16, and the low numbers of patients on lithium therapy in many practices (only three practices had more than 10 patients) may explain the large range of achievement.

In 2017/18, 71.6% of patients in Lewisham on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months. This is similar to the London average (76.7%) and significantly lower than the England average (82.5%). Within Lewisham, the achievement of this by individual practices ranged from 0.0% to 100.0%. As above, the low numbers of patients on lithium therapy in most practices may explain this large range of achievement.

Box 5. Improving physical health checks in primary care

One Health Lewisham (Lewisham's GP federation) included SMI Health Checks as part of its Population Health Scheme (a Quality Improvement programme to improve the clinical outcomes for the population of Lewisham) in an attempt to improve the annual health checks completed for patients with Serious Mental Illness.

GPs were asked to focus on completing the annual physical health check through various strategies unique to each practice. A summary of the key ones include:

- Recall systems that include letters, calls and text messages
- Alerts on the system to opportunistically capture patients if they attend the practice
- Dedicated Mental Health Clinics
- Home visits (owing to difficulties of calling these patients)
- Trawling through data to ensure coding is correct
- Going through results such as blood tests to make sure these are coded/attached to notes.

Between October 2018 and March 2019, analysis showed that the proportion of patients on the mental health register who were recorded as having an annual physical health examination completed increased from 8% to 68%. It should be noted, however, that there is a discrepancy between local reporting and national reporting: national reporting indicates that over the same period, 34.5% of patients on the mental health register had a record all six physical health checks described by the Quality and Outcomes Framework (QOF) (BMI/waist circumference; blood pressure; cholesterol or QRISK; blood glucose or HbA1c; alcohol consumption; smoking status). The discrepancy is likely to have arisen because of recording inconsistencies, but also because of the treatment of data on 'exceptions' (those patients who are exempt from receiving a check because of various reasons).

The focus on physical health checks also contributed to improved understanding of some of the challenges faced by practices in completing health checks for a high proportion of their patients on the mental health register:

- The high proportion of people who do not attend appointments (DNAs)

- The difficulty of covering all elements of the physical health check in the time available
- The challenges of engaging with patients in this cohort
- Some patients refusal to have bloods taken
- Non-cooperation with checks such as blood/cholesterol/weight/blood pressure
- Patients not turning up for blood tests if done outside of practice

Inequalities

To understand the key inequalities in physical health checks for patients with SMI, data was extracted for the patients with SMI who received all six physical health checks in 2018/19 and disaggregated by several characteristics. It shows that 53.6% were male and the majority were aged 40-69. Unfortunately, there were low levels of recording of ethnicity (6.8% of records), marital status (25.1% of records), sexual orientation (0.4% of records) and religion or belief (5.3% of records) for people who have received all six physical health checks, so it is not possible to see whether there are inequalities according to these characteristics.

12.2.2. IAPT

The annual objective for the IAPT access rate set out in the Five Year Forward View Implementation plan for 2017/18 is that 16.8% of people who have depression and/or anxiety disorders should enter NHS funded treatment with IAPT services, which translates to 4.2% for each quarter. Assessment is based on a quarterly 'run rate' requirement, with the expectation that each CCG will achieve a rate of at least 4.2% of local prevalence entering services in quarter 4 of 2017/18 and 4.75% in quarter 4 of 2018/19. The measurement of whether IAPT access ambitions have been met is made in the last quarter of the year giving time for expansion to take place; Table 6 shows that Lewisham was on track at the end of 2017/18, but that access rates need to rise in 2018/19 if the CCG is to meet the 4.75% target for Q4 2018/19.

Table 6. The proportion of people who have depression and/or anxiety disorders that enter NHS funded treatment with IAPT Services in the reporting period, NHS Lewisham CCG

	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19
IAPT access rate: proportion of people with depression/anxiety entering NHS funded treatment during reporting period	4.70%	4.40%	4.36%	4.34%

Source: Mental Health Five Year Forward View Dashboard

In 2017/18, there were 9400 referrals to the IAPT service. Of these, 6390 received their first treatment (68.0% of total referrals) and 2960 finished their treatment course (defined as the referrals with an end date in the year that had at least two attended treatment appointments (excluding follow up), which is 31.5% of total referrals. In terms of referral sources, the highest number of drop-outs in 2018/19 were from online self-referral, followed by GP.⁹³

Inequalities

A breakdown of referrals, first treatments and finished course of treatment by ethnicity is in Table 7, with the ethnic breakdown of Lewisham as a whole, for reference. The table shows that not only is the Lewisham BAME population underrepresented in the proportion of IAPT referrals received, they are also less successful at moving from the referral stage to the finished treatment stage than their White counterparts.⁹⁴ This could suggest there are issues with how culturally appropriate the IAPT service is, in addition to issues with lower referral rates from the BAME population.

⁹³ IAPT 2018/19 data analysis

⁹⁴ Defined as end date in the year and at least two attended treatment appointments excluding follow up

Table 7. IAPT referrals, first treatments and finished course of treatment by ethnicity, NHS Lewisham CCG, 2017/18

Ethnicity	Percentage of IAPT referrals received in 2017/18	Percentage of IAPT first treatment in 2017/18	Percentage of finished course of IAPT treatment in 2017/18	Percentage of Lewisham population, 2017 (GLA)
White	58.9%	61.6%	66.6%	51.6%
Black or Black British	20.8%	20.4%	17.9%	26.2%
Asian or Asian British	5.5%	5.2%	4.6%	10.1%
Mixed	7.5%	7.2%	6.4%	8.2%
Other Ethnic Groups	2.6%	2.5%	2.5%	3.1%
Not stated/Not known/Invalid code	4.7%	3.1%	2.0%	

Source: Psychological Therapies: Annual Report on the Use of IAPT services 2017/18 (NHS Digital); GLA 2016-based ethnic group projections (housing-led)

Of those people that finished a course of treatment (end date in the year and at least two attended treatment appointments excluding follow up):

- 69% were female
- 55% were aged 18-35; 42% were aged 36-64; and 3% were aged 65 and over
- 88% identified as heterosexual; 4% as gay/lesbian; and 3% as bisexual (5% did not state a sexual orientation)
- 17% had a disability recorded (83% had no code recorded but this may be an issue of data quality, rather than a true indication of disability status)
- 26% had a long term condition

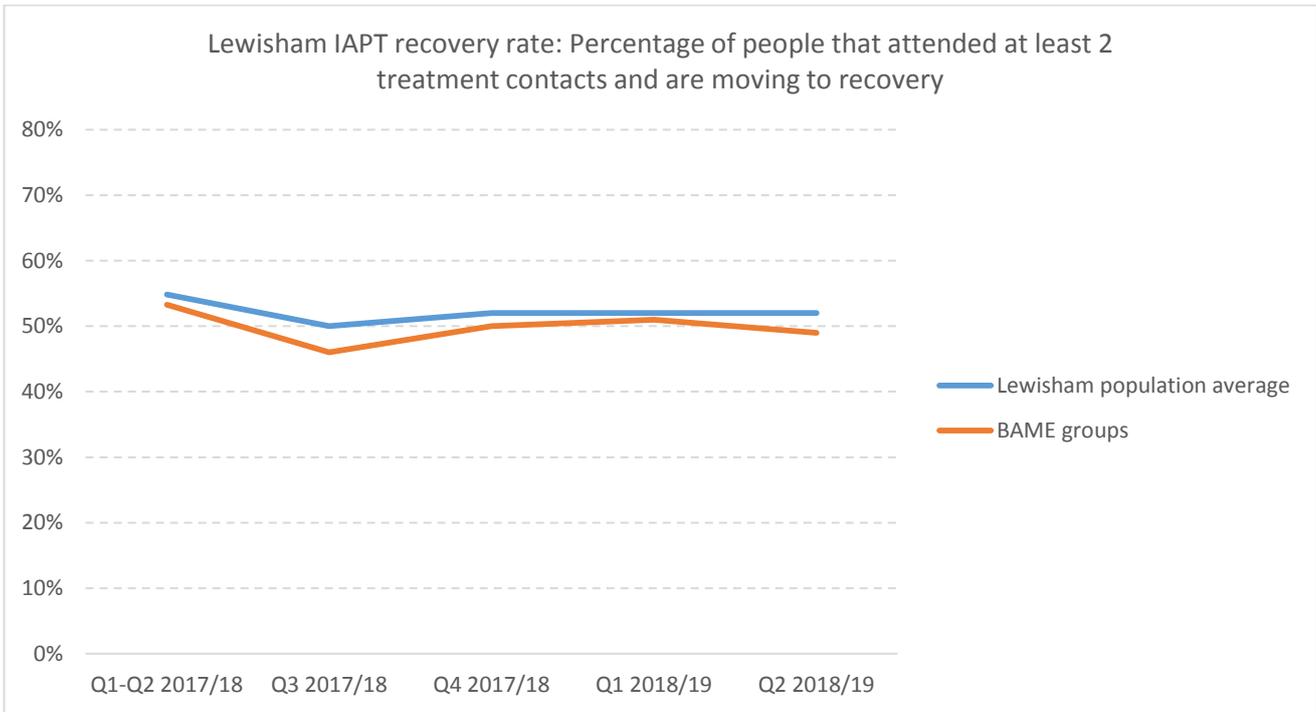
This data suggests that age and gender are other key inequalities (alongside ethnicity) in outcomes for Lewisham’s IAPT services.

4180 of the 6390 people who received their first treatment (65.4%) waited 6 weeks or less for their first treatment, and SLaM equalities analysis of service use between September 2017 and June 2018 showed that waiting times to enter IAPT treatment are broadly similar for different ethnic groups, with a higher proportion of people from Other Ethnic Groups entering first treatment within 6 weeks.

Figure 18 shows that there is a gap between the proportion of people from BAME groups and the general Lewisham population in terms of those people who are moving to recovery.⁹⁵

Figure 18. Lewisham IAPT recovery rate: Percentage of people that attended at least 2 treatment contacts and are moving to recovery

⁹⁵ Defined as end date in the year and at least two attended treatment appointments excluding follow up



Source: *Psychological Therapies: Annual Report on the Use of IAPT services 2017/18 (NHS Digital)*

Lewisham IAPT have undertaken a number of outreach activities to increase access to the service by BAME groups. They have found that these outreach activities can lead to ‘spikes’ in referral but have not led to sustained change. IAPT have analysed their data on BAME engagement and this was presented to a service meeting to look at how the whole staff team can help make improvements and identify training needs. The service is aware of the variability in recovery rates for all ethnicities. The service has had some success in raising the recovery rate of Asian/Asian British. This improvement was welcomed as this ethnic group showed lower recovery rates both in the Lewisham and in national data.⁹⁶

Lewisham IAPT is also working to develop a new group for young BAME men.⁹⁷ This will be run by two male BAME staff who will aim to recruit young men via local gyms and clubs. There will be an emphasis on delivering brief psycho-education information slots and giving opportunities for men to then sign up for online or face to face therapies where needed. They are also trying to work with a physical health, exercise and wellbeing approach as they anticipate that this may be more appealing to men than talking treatments alone.

12.3. COMMUNITY MENTAL HEALTH SERVICES FOR ADULTS WITH SEVERE MENTAL ILLNESS

As of December 2018, there were 6455 Lewisham patients in contact with adult mental health services and 7980 open referrals.⁹⁸

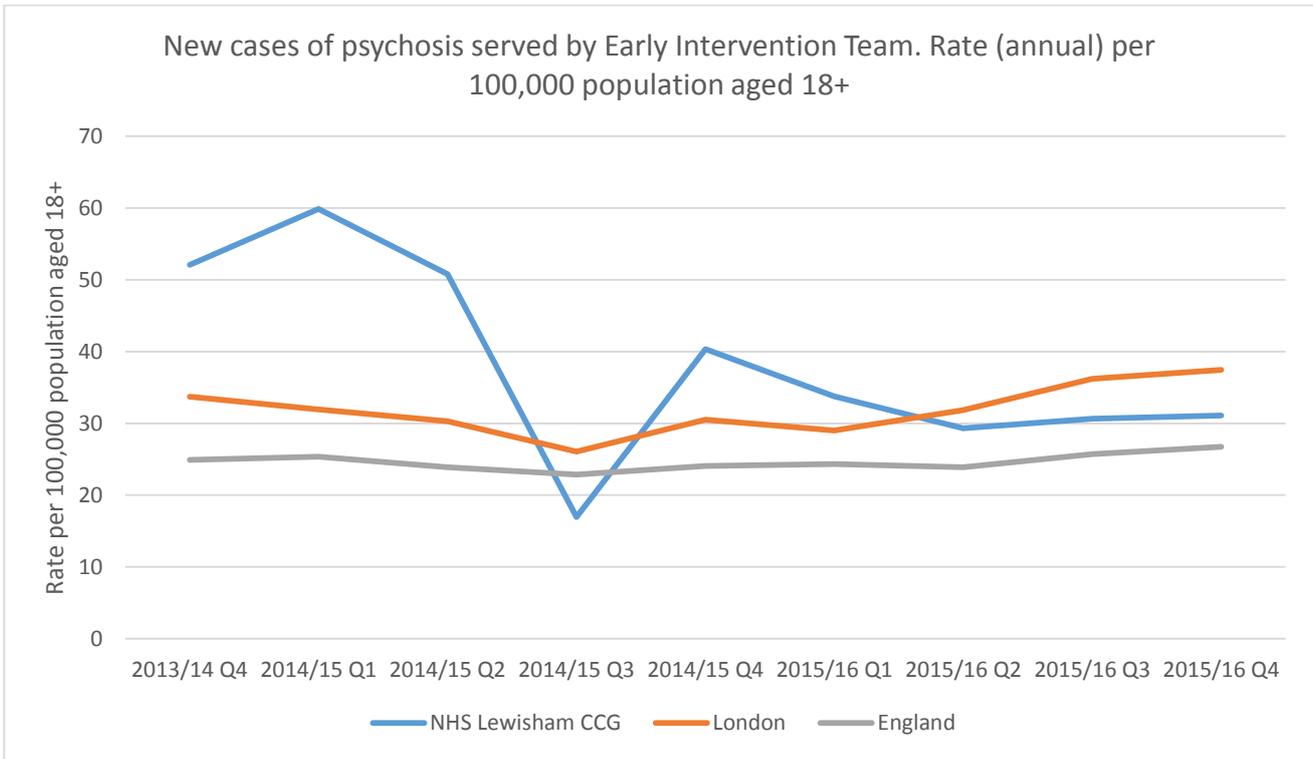
Figure 19 shows the cases of First Episode Psychosis which have been taken on by Early Intervention Teams for treatment and support expressed as a rate per 100,000 resident population aged 18 years and over. The last quarter for which data is published was Q4 2015/16. At this point, the rate of new cases of psychosis served by Lewisham’s Early Intervention Team (per 100,000 population 18+) was not significantly different from the England rate.

Figure 19. New cases of psychosis served by the Early Intervention Team. Rate (annual) per 100,000 population aged 18+, Lewisham, London and England

⁹⁶ SLAM Equalities Report 2018

⁹⁷ SLaM equalities report 2018

⁹⁸ NHS Digital. Mental Health Services Data Set – MHSDS Monthly File December 2018



Source: PHE Fingertips Severe Mental Illness Profile.

The EIP (Early Intervention in Psychosis) access and waiting time standard requires that a majority of patients experiencing First Episode Psychosis (FEP) are treated with a NICE-recommended package of care within two weeks of referral. The standard increases from 50% in 2017/18 to 60% in 2020/21, and is 53% in 2018/19. Table 8 shows the percentage of people in Lewisham who meet the recommended waiting standards. It shows that Lewisham met the standard for 2017/18 and is on track to meet the standard for 2018/19.

Table 8. Proportion of people in Lewisham who started treatment within 2 weeks of referral (All ages)				
Q1-Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19
60.98%	83.33%	63.16%	75.00%	66.67%
<i>Source: Mental Health Five Year Forward View Dashboard</i>				

The Care Programme Approach (CPA) requires health and social services to combine their assessments to make sure everybody needing CPA receives properly assessed, planned and coordinated care. It should also ensure that patients get regular contact with a care co-ordinator. As of August 2018, 91.8% of people in Lewisham on CPA for more than 12 months had a review. This is similar to the London average (93.0%) and significantly higher than the England average (76.6%).⁹⁹

As seen in Table 9, the proportion of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care in Lewisham has decreased slightly from 99.1% in Q1 2017/18 to 89.0% in Q3 2018/19 (the latest data available).

Table 9. Proportion of patients on Care Programme Approach discharged from hospital and followed up within 7 days							
	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19
Lewisham	99.14%	99.02%	99.07%	91.45%	94.12%	89.25%	89.98%
England	96.65%	96.74%	95.40%	95.50%	95.76%	95.73%	95.52%

⁹⁹ PHE Fingertips Crisis Care Profile

Inequalities

SLaM conducts analyses to see whether there are inequalities in its services for Lewisham patients in terms of ethnicity. It is not possible to draw conclusions about access to community mental health services by comparing it to the ethnic breakdown of the Lewisham population as a whole (e.g. by comparing it to Census data). Other factors need to be considered such as the uneven incidence of psychosis across different ethnic groups and referrals to the service coming via other services, not directly from the community. The Psymaptic model is a national tool that predicts cases of first episode psychosis in each borough for people of different ethnicities and offers a more appropriate for access to these services. Table 10 provides a breakdown of Lewisham community mental health service users by ethnicity, and compares these to predicted cases of psychosis.

Table 10. The ethnicity of service users in Lewisham community mental health services between September 2017 and August 2018 in comparison with the ethnicity of 18-65 year olds in Lewisham and the percentage of predicted cases of psychosis for 16-64

	Asian	Black	Mixed	Other Ethnic Group	White	Unknown
18-65 year olds in Lewisham (Census 2011)	7.5%	25.4%	5.2%	5.4%	56.6%	0.0%
Predicted cases of psychosis for 16-64 year olds in Lewisham	1.0%	50.5%	7.1%	0.0%	18.7%	22.7%
OASIS Outreach and Support caseload between Sep 17 and Aug 18 (ePJS) (All 4 boroughs)	7.9%	24.5%	6.4%	5.4%	33.0%	22.8%
Assessment and Liaison Service caseload between Sep 17 and Aug 18 (ePJS)	5.1%	18.2%	4.2%	4.3%	48.7%	19.6%
Early Intervention team caseload between Sep 17 and Aug 18 (ePJS)	4.4%	51.0%	3.4%	4.9%	33.5%	2.8%
Psychosis Community Service caseload between Sep 17 and Aug 18 (ePJS)	5.0%	52.6%	2.7%	4.5%	34.9%	0.4%
Psychosis Low Intensity Treatment caseload between Sep 17 and Aug 18 (ePJS)	5.1%	37.7%	2.8%	6.0%	43.7%	4.7%
Social Inclusion and Recovery Occupational Therapy Service caseload between Sep 17 and Aug 18 (ePJS)	5.9%	30.8%	6.4%	2.6%	50.8%	3.5%
Social Inclusion and Recovery Vocational/Self Directed Support Service caseload between Sep 17 and Aug 18 (ePJS)	5.2%	40.5%	6.0%	4.1%	37.9%	6.2%
Enhanced Recovery service caseload between Sep 17 and Aug 18 (ePJS)	2.5%	37.9%	2.8%	2.1%	54.7%	0.0%

Source: SLaM equalities report for Lewisham 2018

In comparison to the psymaptic data on the incidence of psychosis, OASIS Outreach and Support, the Assessment and Liaison and Social Inclusion and Recovery Occupational Therapy service seems to have a lower than anticipated proportion of Black service users. Comparison of psymaptic data with the ethnicity profiles of Early Intervention and Psychosis Community Service caseloads suggests that there is proportionate access to these services for Black service users. In comparison to psymaptic data, there is a higher than anticipated proportion of White service users in all Lewisham community mental health services.

However, the level of unknown ethnicity in some of the services, for example the Assessment and Liaison service and OASIS Outreach and Support, makes it difficult to come to conclusions about access for ethnic

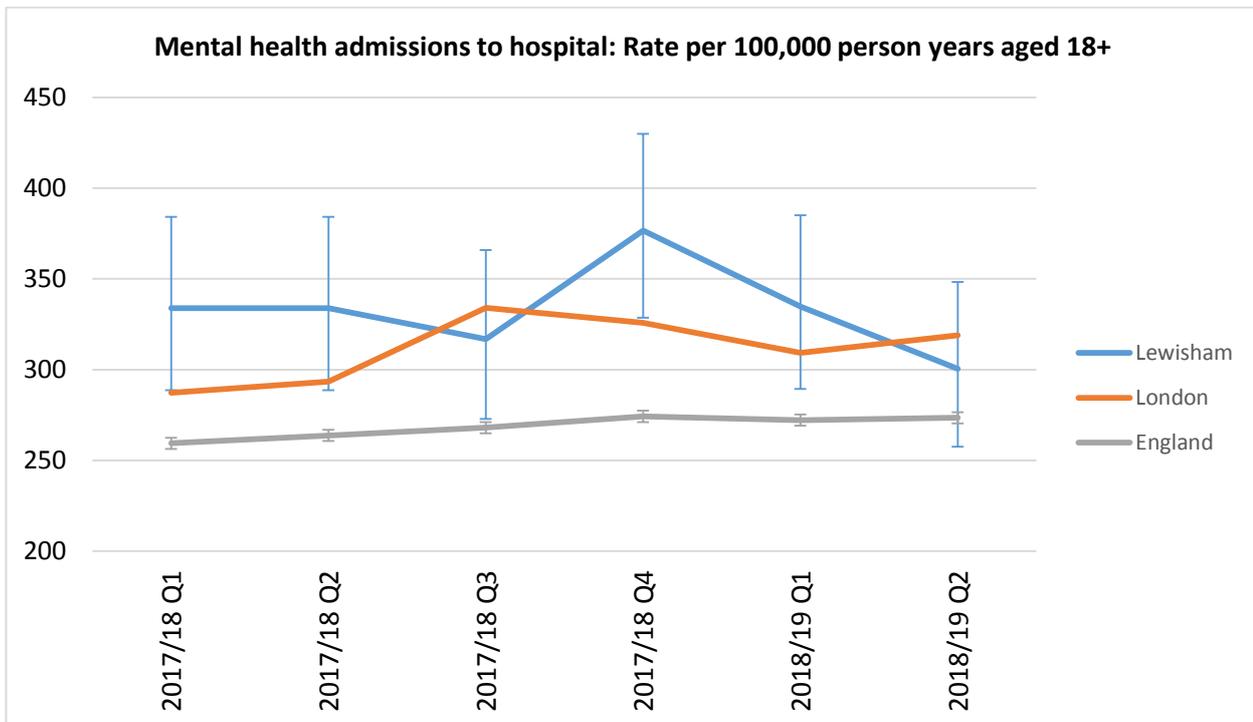
minority service users. It is important that this service considers what they can do to improve recording to produce the data needed to analyse and understand potential access issues.

12.4. CRISIS AND ACUTE MENTAL HEALTH SERVICES FOR ADULTS WITH SEVERE MENTAL HEALTH

In 2017/18, there were 745 admissions of Lewisham residents to NHS funded secondary mental health, learning disabilities and autism inpatient services and 730 discharges. The average (mean) occupied bed days were 175.¹⁰⁰

Figure 20 shows the number of hospital provider spells in secondary mental health services starting during the quarter expressed as a rate per 100,000 person years.¹⁰¹ For most of the period from 2017/18 Q1 to 2018/19 Q2, the rate of mental health hospital admissions in Lewisham has not been significantly different from London, but at several points has been significantly higher than the national rate. In addition to acting as a measure of admissions to hospital, it also can act as measure of bed capacity in an area. Admission rate could be at maximum capacity and many people may be redirected in to other areas in the system. A recent report by NHS mental health providers states clear concern about the level of demand. Admission levels may therefore be one of the key measure to examine demand in an area.

Figure 20. Mental health admissions to hospital: Rate per 100,000 person years aged 18+, Lewisham, London and England, 2017/18 Q1 to 2018/19 Q2



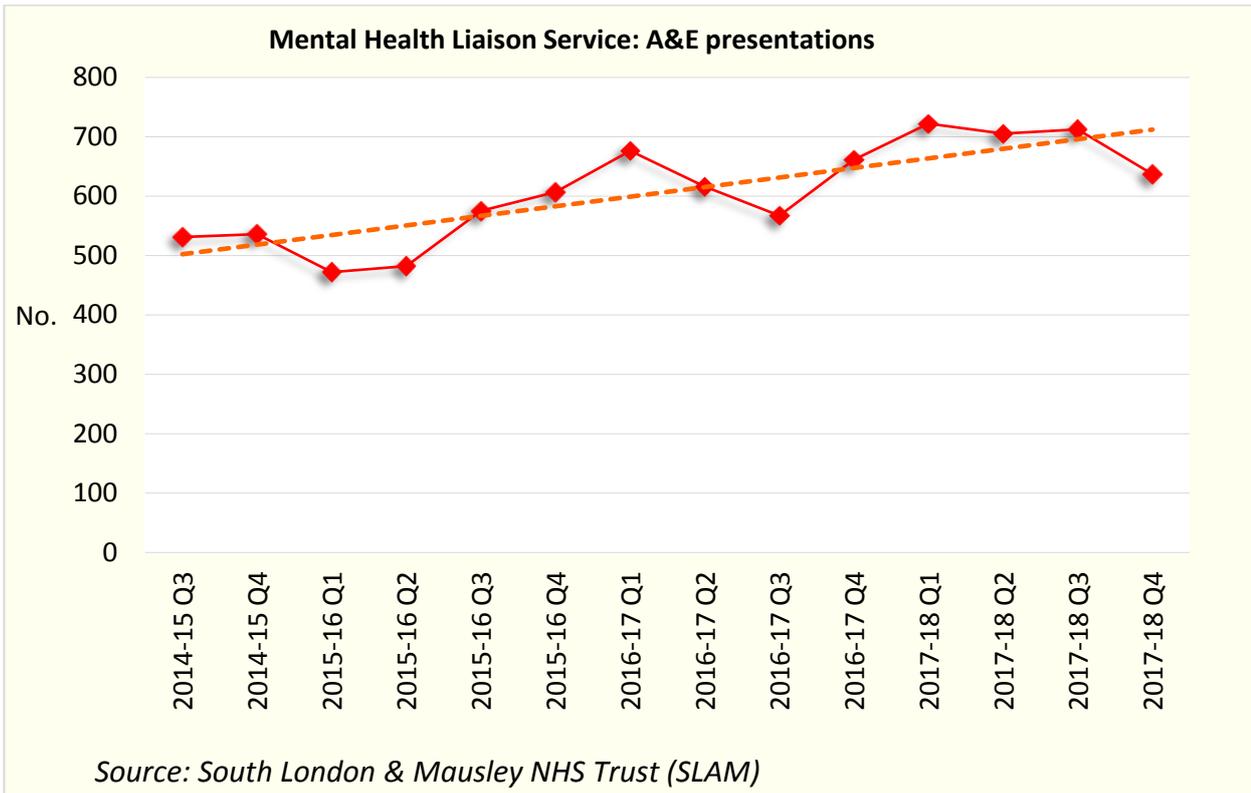
Source: Mental Health Services Data Set (<https://fingertips.phe.org.uk/>)

Figure 21 shows that there has been an upward trend in the number of monthly A&E presentations to the Mental Health Liaison Service by Lewisham residents since 2014/15.

Figure 21. A&E presentations to the Mental Health Liaison Service in Lewisham, 2014/15 Q3 to 2017/18 Q4

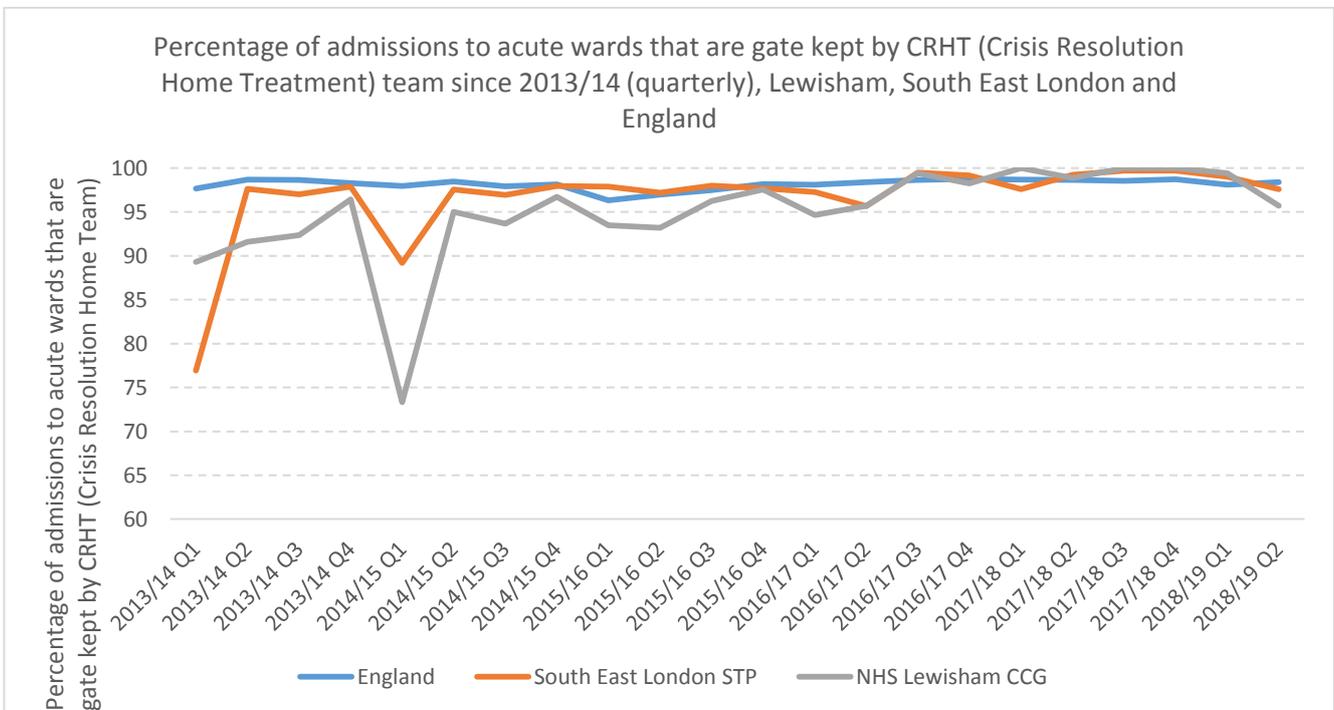
¹⁰⁰ Mental Health Bulletin: 2017-18 Annual report – Reference Table.

¹⁰¹ It is expressed as a rate per 100,000 person years because...



The percentage of admissions to acute wards that are gate kept by the CRHT (Crisis Resolution Home Treatment) team¹⁰² was 95.7% in Lewisham in 2018/19 Q2. This proportion has not dropped below 90% since 2014/15 Q1 (see Figure 22).

Figure 22. Percentage of admissions to acute wards that are gate kept by the Crisis Resolution Home Treatment Team, Lewisham, London and England, 2013/14 Q1 to 2018/19 Q2.



Source: PHE Fingertips Severe Mental Illness Profile

¹⁰² An admission is 'gate kept' if the service user was assessed before admission and if they were involved in the decision-making process, which resulted in admission.

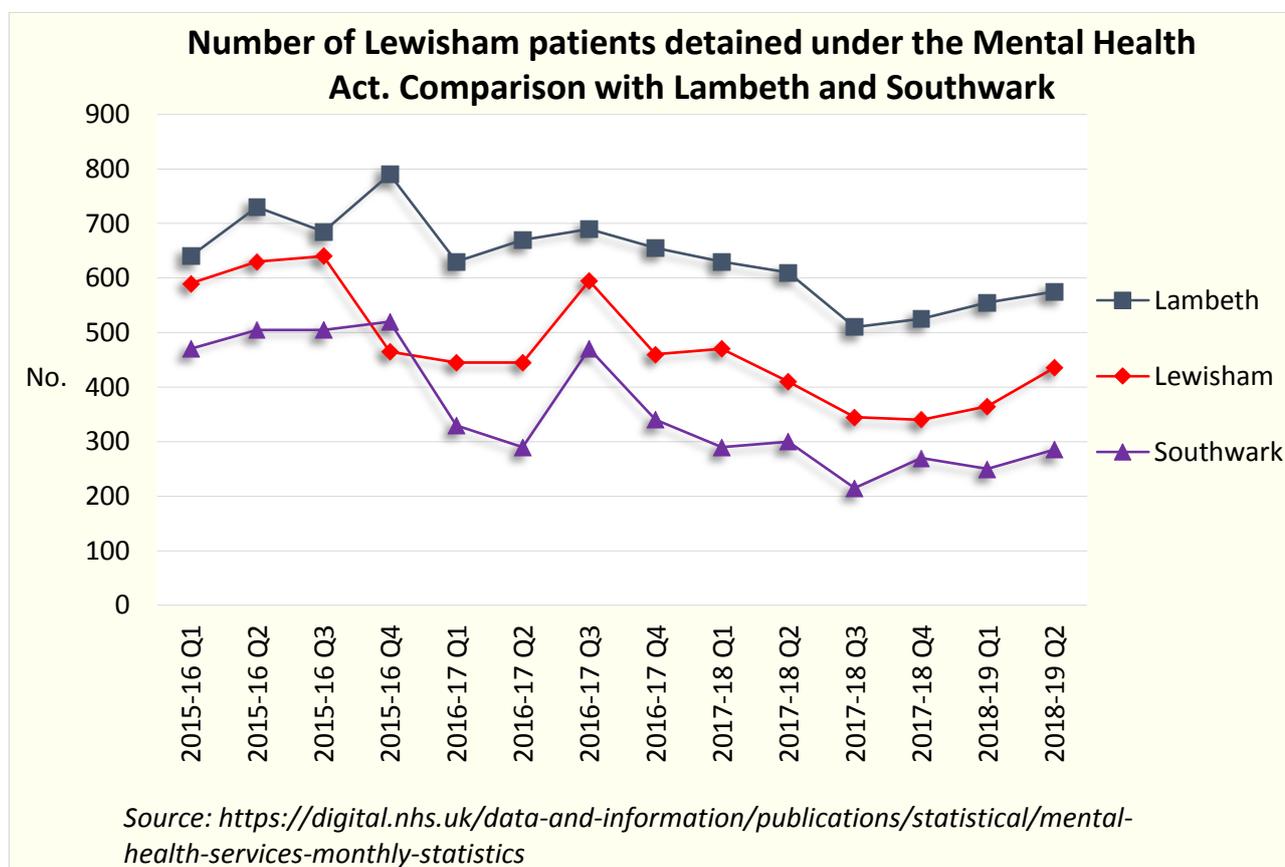
	Q1-Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19
NHS Lewisham CCG	34.4	18.9	18.3	26.5	17.9
London	35.2	14.5	14.0	16.9	16.9
England	80.2	34.0	32.8	41.0	42.7

Source: Mental Health Five Year Forward View Dashboard

Although self-harm is not the same as suicide, self-harm can escalate into suicidal behaviours; and previous episodes of self-harm have been identified as the strongest predictor of suicide.¹⁰³ In Lewisham, the (age-standardised) rate of emergency hospital admissions due to intentional self-harm is lower than the England average (Table 11), and has seen a declining trend since 2013. However, local data on presentations/attendances at emergency services for episodes of self-harm is not routinely reported.

In most cases, when people are treated in hospital or another mental health facility, they have agreed or volunteered to be there. However, there are cases when a person can be detained (also known as sectioned) under the Mental Health Act (1983) and treated without their agreement. The Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others. Figure 23 shows the number of Lewisham patients detained under the Mental Health Act since 2015/16. This number has ranged from 340 to 640 in quarter snapshots.

Figure 23. Number of patients detained under the Mental Health Act, Lewisham, Lambeth and Southwark, 2015/16 Q1 to 2018/19 Q2



¹⁰³ Public Health England (2016). Local suicide prevention planning: a practice resource

Police may detain members of the public under Section 136 of the Mental Health Act if they appear to have a disorder of the mind, are in a public place and present a risk to themselves or others. Police will take these detained people to a place of safety which could be an A&E department or a designated Section 136 suite in a hospital for assessment and further management. In 2017/18, 179 Lewisham patients were admitted to a 136 suite.¹⁰⁴

As of December 2018, there were 150 open ward stays in adult mental health services; 70 open ward stays in adult acute mental health care; and 20 open ward stays in specialised adult mental health services for Lewisham residents.¹⁰⁵

Box 6. Physical health checks and interventions for people with Severe Mental Illness in hospital

Smoking¹⁰⁶

Over the course of 2017/18, on average 18.4% of the Adult Mental Health (AMH) caseload and 8.1% of the Mental Health of Older Adults (MHOA) caseload had their smoking status recorded.

Of those AMH patients who smoke, 29.7% were referred to smoking cessation services. The equivalent proportion in the MHOA caseload was 24.3%.

Alcohol:

In Q4 2018/19, alcohol screening was attempted on 83% of eligible Lewisham service users. The percentage of people on whom alcohol screening was attempted has continued to increase over the course of the CQUIN. In Q4 2018/19, interventions were recorded as having been delivered to 21% of people that were eligible.¹⁰⁷

Issues with dual diagnosis present a constant challenge: there is a lack of robust outreach for people with co-existing mental health and drugs and alcohol issues, including homeless people; and although there are commissioned drugs and alcohol services in Lewisham, these are not always suitable for people with severe mental illness (for example offering group work rather than individual support, which may present particular challenges for people with SMI).

In addition, there is a lack of data on inequalities in accessing physical health support, for example by age, gender or ethnicity.

Physical health checks:

In 2017/18, on average 79.8% of AMH inpatients and 79.0% of MHOA inpatients who had been in SLaM hospital/long-term health care for more than one year had a physical health check in the last 12 months.

Sexual health:

In 2017/18, 43.9% of new patients with the ability to consent that were admitted to AMH inpatient services were offered an HIV test.

Inequalities

In comparison to the psymaptic data on the incidence of psychosis, services such as mental health liaison and home treatment, seem to have a lower than anticipated proportion of Black service users and a higher than anticipated proportion of White service users (Table 12).

¹⁰⁴ Lewisham Activity Schedule 6 Part C M12

¹⁰⁵ MHSDS Monthly File December 2018

¹⁰⁶ SLaM monitoring report March 2018

¹⁰⁷ Analysis of the free text indicates that in some cases interventions have been delivered but not recorded.

The high proportion of Black service users in the Forensic Offender Health Pathway caseload means it vital that forensic services are culturally-appropriate and meet the needs of Black service users.

Table 12. The ethnicity profile of Lewisham crisis and acute mental health services caseloads between September 2017 and August 2018 compared to the ethnicity profile of 18-65 year olds in Lewisham, the percentage of predicted cases of psychosis for 16-64

	Asian	Black	Mixed	Other Ethnic Group	White	Unknown
18-65 year olds in Lewisham (Census 2011)	7.5%	25.4%	5.2%	5.4%	56.6%	0.0%
Predicted cases of psychosis for 16-64 year olds in Lewisham (Psymaptic)	1.0%	50.5%	7.1%	0.0%	18.7%	22.7%
Home Treatment Team caseload between Sep 17 and Aug 18 (ePJS)	5.7%	35.2%	4.2%	5.5%	42.8%	6.6%
Lewisham Hospital Mental Health Liaison caseload between Sep 17 and Aug 18 (ePJS)	4.3%	21.4%	2.9%	7.1%	53.9%	10.4%
Acute wards caseload between Sep 17 and Aug 18 (ePJS)	4.0%	49.1%	2.7%	3.8%	36.3%	4.2%
Lewisham CCG Forensic Offender Health Pathway caseload between Sep 17 and Aug 18 (ePJS)	1.1%	59.8%	3.3%	4.1%	30.6%	1.2%

Source: SLaM equalities report for Lewisham 2018

12.5. DEMENTIA SERVICES

12.5.1. Commissioned voluntary and community sector dementia services

Bromley, Lewisham and Greenwich Mind were commissioned to provide Lewisham MindCare, a dementia information and support service, to Lewisham residents. Since 11 February 2019, MindCare has been replaced by the Dementia Support Hub (see Section 11.6), but MindCare service data remain the most up-to-date source of information on who is accessing the service in Lewisham.

In 2017/18, MindCare received 177 new referrals. Of these, 81% were accepted onto their caseload; 15% required information, advice and signposting only; and the remaining were declined. All referral responses were made within three days of receiving the referral.

Of new referrals to MindCare in 2017/18:

- 63% were female; 37% were male
- 94% were aged over 65 (the two largest age groups were 71-80 (38%) and 81-90 (45%))
- There was no ethnicity recorded for 12%. Of the remaining, 68% were white; 27% were black; 2% were mixed; and 2% were Asian
- There was no sexual orientation recorded for 15%. Of the remaining, 96% were heterosexual and 4% were other/prefer not to say
- Almost half (47%) reported that they had a long term condition; only 15% reported that they didn't have a disability

In 2017/18, 77 reviews took place and 80.0% of support plan goals were achieved at review. The most common focus for support plan goals was 'Activity to improve physical health / mental wellbeing', followed by 'Improved choice in care and support', 'Improved or maintained independent living skills' and 'New employment or daytime activity'.

12.5.2. Primary care

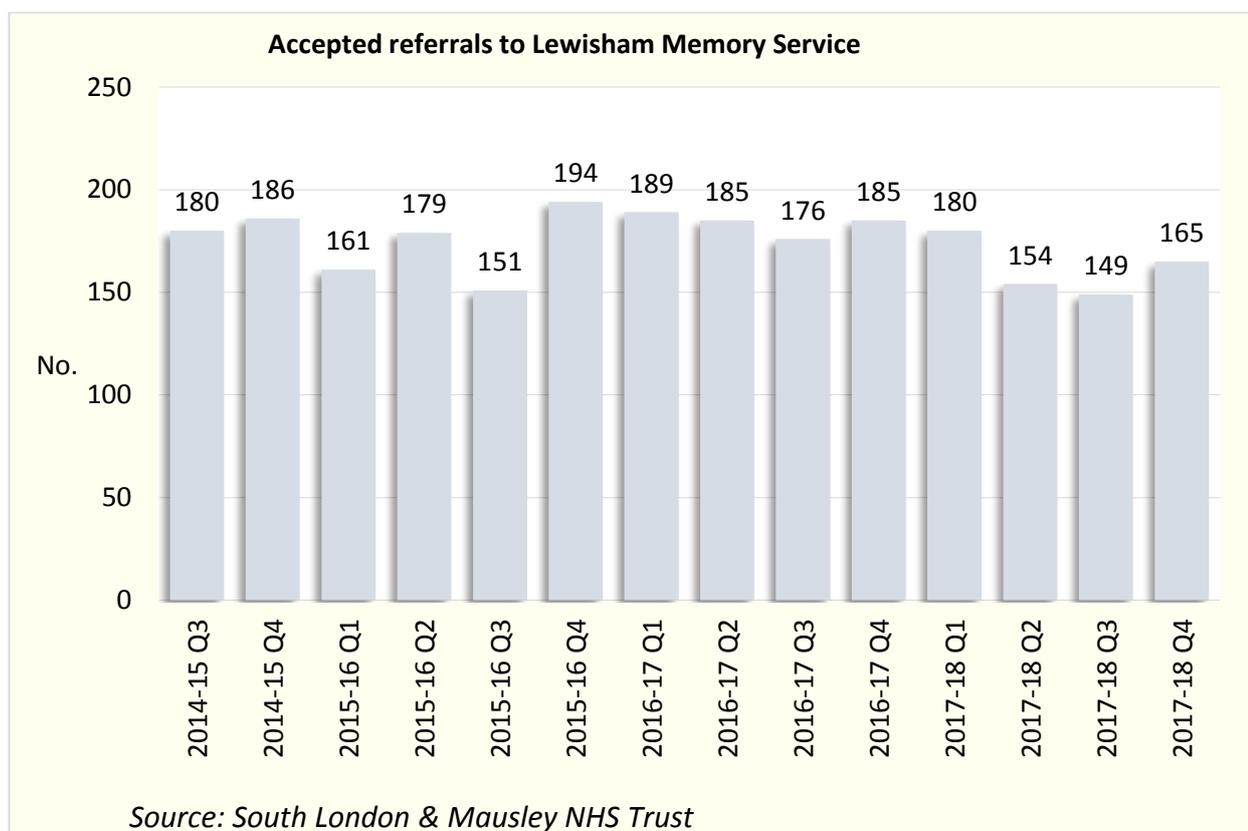
In 2017/18, 82.79% of patients in Lewisham diagnosed with dementia had a face-to-face review of their care plan in the preceding 12 months. This is significantly higher than the London average (79.69%) and England average (77.50%).

In 2017/18, 64.38% of patients in Lewisham with a new diagnosis of dementia recorded in the preceding 1 April to 31 March had a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels (recorded between 12 months before or 6 months after entering on to the register). This is similar to the London average (62.88%) and the England average of (68.01%).

12.5.3. Lewisham Memory Service

Figure 24 shows the number of accepted referrals to Lewisham Memory Service from 2014/15 Q3 to 2017/18 Q4. The quarterly number has ranged from 194 to 149 but there is no clear trend over this period.

Figure 24. Accepted referrals to Lewisham Memory Service, 2014/15 Q3 to 2017/18 Q4



12.5.4. Secondary care

In 2017/18, 57.2% of people with a recorded diagnosis of dementia on the primary care register were admitted to hospital with a mention of dementia in the diagnosis code. This is similar to London (6.07%) and England (56.5%).¹⁰⁸ This provides an indication of the use of inpatient general hospital services for people diagnosed with dementia. The indicator illustrates the variation across England, identifying areas where the percentages are both higher and lower than the national average. Areas identified of both types might warrant further investigation to try to establish the underlying causes for higher or lower percentages and to gain an understanding of where improvements might be required.

The age standardised rate of emergency inpatient hospital admissions of people (aged 65+) with a mention of dementia per 100,000 population similarly indicates variation in the rates of emergency admissions for dementia across England. In 2016/17 in Lewisham the rate was 3,403 per 100,000 population. This is

¹⁰⁸ PHE Fingertips Dementia Profile

significantly lower than London (4,052 per 100,000 population) but similar to England (3,482 per 100,000 population).

Table 13. The ethnicity profile of Lewisham older adult service caseloads between Sep 2017 and Aug 2018 compared to the ethnicity profile of over 65 year olds in Lewisham

	Asian	Black	Mixed	Other Ethnic Group	White	Unknown
Over 65 year olds in Lewisham (Census 2011)	3.6%	18.0%	1.9%	1.9%	74.6%	0.0%
Memory Service (SLIMS) caseload between Sep 17 and Aug 18 (ePJS)	4.3%	23.2%	1.7%	1.1%	64.1%	5.5%
Older Adult Community Mental Health Team caseload between Sep 17 and Aug 18 (ePJS)	4.0%	22.6%	0.5%	1.2%	69.4%	2.2%
Older Adult Home Treatment team caseload between Sep 17 and Aug 18 (ePJS)	2.3%	13.8%	1.5%	0.0%	79.9%	2.4%

Source: SLaM equalities report 2018

In comparison with Census data, the caseloads of dementia and older adult mental health services appear broadly reflective of the ethnicity of older people in Lewisham (Table 13). Other borough memory services have identified the need to encourage earlier access to memory services for older Black African and Caribbean service users.¹⁰⁹ Interpreting data suggests that Lewisham dementia and older adult mental health services use fewer interpreters than older adult services in other boroughs.¹¹⁰

In 2016, the Directly Age Standardised Rate of Mortality in persons (aged 65+) with a recorded mention of dementia per 100,000 population was 654. This is significantly lower than London (775) and England (868). However, it should also be noted that this may be because of recording inconsistencies rather than a true difference in mortality rate.

In 2016, 52.7% of deaths with a recorded mention of dementia in Lewisham were in the usual place of residence (as opposed to a secondary care setting). This is similar to London (55.8%) but significantly lower than England (67.9%).

12.6. USERS' VIEWS ON SERVICES

In their project on men's mental health, Healthwatch Lewisham asked participants to rate mental health services in Lewisham that they have used (SLaM mental health teams; IAPT talking therapies (SLaM); other counselling e.g. Metro, Cassell, Bereavement; BLG Mind; Samaritans; Family Health Isis; Other (Oxleas, St Christopher's, Keyworker, Community Connections, Today project, Friends at Stephen Lawrence Centre and CAMHS)).¹¹¹ They found that Samaritans received the highest (100%) satisfaction rate with 67% respondents scoring the services as excellent and 33% as good. BLG Mind services also received high satisfaction levels with 50% of respondents saying the service is excellent and a further 28% rating it as good; 40% scored the SLaM mental health service as excellent and 30% as good; and 60% of the IAPT service users scored it as good or excellent. Other services received mixed reviews, however there was a low number of respondents providing their feedback to achieve a balanced view.

The Care Quality Commission publish a survey of people who use community mental health services. In 2018, the survey results of people who had accessed the SLaM NHS Foundation Trust community mental health services (which includes but is not limited to Lewisham residents) was published.¹¹² Results for SLaM were

¹⁰⁹ SLaM equalities report 2018

¹¹⁰ Interpreter data, Lewisham

¹¹¹ Healthwatch Lewisham (2018) Men Talk Health.

¹¹² Care Quality Commission (2018) Survey of people who use community mental health services: South London and Maudsley NHS Foundation Trust. http://www.nhssurveys.org/Filestore/MH18/MH18_RV5.pdf

similar to most other trusts in terms of most measures (in the expected range of performance). However, SLaM service users reported worse scores than other trusts for the following questions: 'How well does this person organise the care and services you need?' (Organising care) and 'Were you involved as much as you wanted to be in agreeing what care you will receive?' (Planning care). They reported better scores for the question 'What impact has this had on the care you receive?' (Change in who people see). Overall, SLaM service users rated their experience as just under 7 out of 10 (with 0 being a very poor experience and 10 being a very good experience).

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. SLaM conducted the FFT with Lewisham residents who used its Assessment and Liaison service, Integrated Psychological Therapy service, adult mental health community services, adult mental health acute services, and community dementia or older adult mental health services. The results, disaggregated by ethnicity, are in Tables 14-17 below. They show that there are no discernible patterns in how likely patients were to recommend the services by ethnicity, although patients of Mixed ethnicity reported slightly lower levels of positive responses in 2017/18 for Assessment and Liaison and Integrated Psychological Therapy services and for Crisis and Acute Mental Health services; and patients of Other ethnicity reported lower levels of positive responses for Crisis and Acute Mental Health services in 2017/18.

It is difficult to assess how representative the ethnicity profile of FFT respondents are because a high proportion of respondents did not disclose their ethnicity. Comparing this partial profile to acute ward caseloads suggests that service users who are Black or from other ethnic groups could be under-represented. Increasing survey responses from these ethnic minority service users and carers will make experience data more representative and therefore more useful.

Table 14. How likely are you to recommend Lewisham Assessment and Liaison and Integrated Psychological Therapy services to friends and family if they needed similar care or treatment?

Ethnicity	Number of responses in 16/17	Positive responses in 16/17	Number of responses in 17/18	Positive responses in 17/18	No. of responses so far in 18/19	Positive responses so far in 18/19
Asian	14	92.9%	30	90.0%	22	95.5%
Black	45	82.2%	69	91.3%	50	80.0%
Mixed	27	92.6%	31	83.9%	21	76.2%
Other ethnic group	5	100.0%	2	100.0%	6	66.7%
White	178	89.3%	222	87.4%	186	82.8%
Overall	304	89.1%	388	87.4%	322	81.7%

Source: SLaM equalities report 2018

Table 15. How likely are you to recommend Lewisham adult mental health community services to friends and family if they needed similar care or treatment?

Ethnicity	Number of responses in 16/17	Positive responses in 16/17	Number of responses in 17/18	Positive responses in 17/18	No. of responses so far in 18/19	Positive responses so far in 18/19
Asian	25	84.0%	33	93.9%	17	100.0%
Black	183	86.9%	202	91.1%	97	93.8%
Mixed	28	96.4%	29	100.0%	13	69.2%

Other ethnic group	9	88.9%	6	100.0%	1	100.0%
White	180	86.7%	209	93.3%	96	95.8%
Overall	467	86.9%	520	92.5%	250	93.2%

Source: SLaM equalities report 2018

Table 16. How likely are you to recommend Lewisham crisis and acute mental health services to friends and family if they needed similar care or treatment?

Ethnicity	Number of responses in 16/17	Positive responses in 16/17	Number of responses in 17/18	Positive responses in 17/18	No. of responses so far in 18/19	Positive responses so far in 18/19
Asian	24	79.2%	36	86.1%	19	68.4%
Black	156	71.8%	273	81.3%	145	66.2%
Mixed	53	69.8%	79	73.4%	47	80.9%
Other ethnic group	11	63.6%	14	64.3%	12	58.3%
White	193	68.9%	406	75.4%	166	80.7%
Overall	497	69.0%	894	75.8%	457	73.3%

Source: SLaM equalities report 2018

Table 17. How likely are you to recommend Lewisham community dementia or older adult mental health services to friends and family if they needed similar care or treatment?

Ethnicity	Number of responses in 16/17	Positive responses in 16/17	Number of responses in 17/18	Positive responses in 17/18	No. of responses so far in 18/19	Positive responses so far in 18/19
Asian	2	100.0%	9	88.9%	6	100.0%
Black	19	94.7%	34	91.2%	12	83.3%
Mixed	0	N/A	3	100.0%	2	100.0%
Other ethnic group	3	100.0%	3	100.0%	0	N/A
White	76	94.7%	141	91.5%	78	89.7%
Overall	147	93.2%	228	91.2%	109	90.8%

Source: SLaM equalities report 2018

12.7. PRESCRIPTION DATA

The available data suggests that prescribing rates of antidepressants and hypnotics in Lewisham is lower than nationally. In Lewisham in 2017/18, the average daily quantities (ADQs) for prescribing antidepressants (BNF 4.3 sub-set) per STAR-PU (weighted for age and sex), was 0.9. In England, the ADQs were 1.5.¹¹³ The ADQs of hypnotics prescribing were 0.44 per STAR-PU in Lewisham in 2017/18. In England the ADQs were 0.84.¹¹⁴

¹¹³ PHE Fingertips Common Mental Health Disorders Profile

¹¹⁴ PHE Fingertips Common Mental Health Disorders Profile

In addition, the number of drug items for psychoses and related disorders (BNF 4.2) in each quarter (expressed as a rate per registered population) has been significantly lower in NHS Lewisham CCG than in England since the start of 2014/15.¹¹⁵

It should be noted that indicators on prescribing within primary care should always be considered in the context of other data on mental ill health prevalence, activity and outcomes.¹¹⁶

12.8. FINANCIAL DATA

Table 18. Planned and actual NHS Lewisham CCG spend on mental health services		
	2017/18	2018/19 planned spend
Early Intervention in Psychosis	£1,810,000	£1,791,378
A&E and Ward Liaison mental health services	£957,000	£1,109,539
Crisis resolution home treatment teams	£1,852,000	£3,283,160
IAPT	£3,376,000	£3,677,800

Source: Mental Health Five Year Forward View Dashboard

13. WHAT IS THIS TELLING US?

13.1. OVERVIEW

- There is a broad range of support provided by different voluntary and community sector commissioned services, which are able to reach different populations in Lewisham. However, service outcomes are not universally reported and there is no consistent data set used by different services, so a wide range of different outcome measures are reported. There is also a lack of data on longer-term outcomes. For those services who do report them, short-term outcomes are generally positive.
- Whilst the Lewisham CCG average achievement of physical health checks for people with mental health conditions is often similar to the London and England averages, this can hide variation between practices. Some of this variation is likely to be due to differences in population needs associated with different areas in Lewisham, for example because of varying levels of deprivation. Other variation may be due to differences in approaches by GP practices, or because of the cultural competence of certain services that was raised as an issue during the BAME health inequality insight work. Some of the variation may be warranted whilst some may not and should be addressed in order to reduce inequalities.
- There is a lack of data recorded on protected characteristics by many services. For example, for those patients with SMI receiving health checks in primary care, there is relatively little data recorded on ethnicity, sexual orientation or religion/belief.
- Whilst improving physical health for people with severe mental illness is a priority for many service areas, there is not a consistent approach across the whole of the mental health pathway. For example, whilst health promotion activities such as smoking cessation are offered to inpatients, this is less actively pursued for outpatients and once inpatients have been discharged. Efforts have been made to improve the proportion of physical health checks offered to primary care patients, which has translated into some local data, but national data shows that there is still a long way to go to improve rates and reduce variation across practices.
- There is some evidence of increasing demand for services, for example there has been an upward trend in the number of monthly A&E presentation to the Mental Health Liaison Service by Lewisham residents since 2014/15.

¹¹⁵ This indicator is not weighted to take account of differences in populations that may affect levels of prescribing (e.g. age). The numerator is only for primary care prescribing and thus misses prescriptions in other settings, such as hospitals. Source: PHE Fingertips Severe Mental Illness Profile.

¹¹⁶ RightCare Mental Health CCG pack

- In general, services are meeting nationally set standards. Lewisham’s IAPT service is on track to achieve the national annual objective in terms of access rates; and the Early Intervention in Psychosis service is on track to meet the access and waiting time standards for First Episode of Psychosis.

13.2. WHAT ARE THE KEY INEQUALITIES?

Whilst we have some information on the key inequalities amongst service users, the lack of data recorded (or incomplete data) on protected characteristics, makes analysis indicative rather than definitive.

Ethnicity

The Lewisham BAME population is underrepresented in the proportion of IAPT referrals received and are also less successful at moving from the referral stage to the finished treatment stage and to the ‘moving to recovery’ stage than their White counterparts.

In comparison to the psymaptic data on the incidence of psychosis, OASIS Outreach and Support, the Assessment and Liaison and Social Inclusion, Recovery Occupational Therapy, Mental Health Liaison and Home Treatment services seem to have a lower than anticipated proportion of Black service users. However, the level of unknown ethnicity in some of the services makes it difficult to come to conclusions about access for BAME service users.

There is also a very high proportion of Black people in forensic services and in crisis and acute services. This seems to suggest that Black service users are disproportionately found in the Crisis pathway rather than the CMI and SMI pathways. The reasons for this warrants more in-depth investigation.

Age

Data suggests that people aged over 65 are under-represented amongst people who have completed treatment in Lewisham’s IAPT services.

Gender

Service data shows that services are accessed differently by people of different genders. For example, data suggests that men are under-represented amongst people who have completed treatment in Lewisham’s IAPT services; however, women are slightly under-represented in other services.

14. DATA QUALITY

Drawing conclusions about the mental health needs of adults in Lewisham from the data available is limited in some cases by the quality of the data. The main source of error and bias in mental health statistics is incompleteness, for example of the MHSDS monthly statistics. In addition, recording of some key information relating to a person’s accommodation and employment status, ethnicity and diagnosis is often not complete.¹¹⁷ Table 19 shows data recording completeness for diagnosis, ethnicity, accommodation status and employment status in Lewisham. For other information, there is likely to be variation in recording standards, such as information related to whether a person has a crisis plan in place or is on the Care Programme Approach.¹¹⁸ There is now a significant national drive to improve the quality of mental health data and CCGs should work with providers to improve data quality in order to better inform service improvements.

Percentage of people in contact with mental health services with a diagnosis recorded (end of quarter snapshot)	2015/16 Q2	44.8%
Percentage of cases where the ethnicity of the patient has been recorded	2014/15	96.3%

¹¹⁷ RightCare Mental Health CCG pack

¹¹⁸ RightCare Mental Health CCG pack

Percentage of people in contact with mental health services with their accommodation status recorded (end of quarter snapshot)	2015/16 Q2	48.1%
Percentage of people in contact with mental health services with their employment status recorded (end of quarter snapshot)	2015/16 Q2	49.5%
<i>Source: NHS RightCare Mental Health Conditions pack – NHS Lewisham CCG</i>		

Much mental health data is currently not collected in a consistent way, particularly from commissioned services delivered by voluntary and community sector organisations.

15. GAPS IN KNOWLEDGE AND DATA

There are a number of gaps in our understanding of local health need that have been identified throughout this project:

1. Although there is data on access to services and on caseload, there has been little data thus far on mental health ‘outcomes’ in the truest sense of the word. In many cases we do not know how effective services are in improving users’ mental health and wellbeing. Service data reporting requirements as part of the new Lewisham Community Wellbeing Service been amended to address this gap in understanding and in the future monitoring of VCS contracts will include standardised outcomes. This consistent approach to measurement will improve our understanding of the effectiveness of different services, and for different populations.
2. We need to better understand why Lewisham has lower estimated wellbeing scores than London and England.
3. We do not know enough about the characteristics of those with a common mental health diagnosis or severe mental illness, including people with a low socioeconomic status, those who misuse drugs and/or alcohol, those with long-term health conditions.
4. There are other high risk population groups have been identified nationally that we have a poor understanding of locally. These include: some ethnic minority groups, homeless people and those with poor living conditions, migrants and refugees, and people in contact with the criminal justice system
5. We need to better understand the characteristics of those currently accessing many of our services. Services need to be able to actively monitor experience and outcomes for protected characteristic service users.

16. WHAT SHOULD WE BE DOING NEXT?

There are several areas of recommendation that have emerged from this JSNA. These high-level recommendations need to be developed into an action plan that commissioners and providers can use to shape the provision of services in Lewisham, for example through the newly created Mental Health Provider Alliance.

16.1. **More targeted support for protected characteristic groups and groups we know are at higher risk of developing mental health conditions (BAME, refugees and asylum seekers, men, older people, LGBT+ population, homeless people, people with substance/alcohol misuse issues, unemployed people, carers, and people in the criminal justice system)**

- A co-production approach should be taken for all future service developments impacting on the mental health of protected characteristic groups, beginning with BAME. This could potentially be in collaboration with Healthwatch Lewisham, or other stakeholders, who may be best placed to do further work with specific groups to inform future service developments.
- Current local activity should be explored for these groups to identify what enhancements and reasonable adjustments could be made to services and/or the feasibility of targeted approaches.
- Good practice models should be identified for how mental health staff consider how their service is providing the best possible care to users from protected characteristic groups. This

- could include further developing the cultural competency of staff and service or identifying quality improvement activity that can deliver positive changes for these service users.
- Increased efforts should be made to target upstream prevention activities to high risk population groups.
- The suicide prevention strategy identifies three population groups that have been identified as being at higher risk of suicide than the overall Lewisham population and for whom specific action and interventions should be targeted: young men (aged between 24-45 years); those who misuse drugs and/or alcohol; and pregnant women. Interventions include suicide prevention training, public mental health awareness, and continuing the development of effective pathways for dual diagnosis.

16.2. We must continue to work towards reducing BAME mental health inequalities

- Mental health services need to consider how they are providing the best possible care to BAME users. This could include further developing the cultural competency of staff or identifying quality improvement activity that can deliver positive changes for these service users.
- We should respond to the request from the BAME community that mental health services should be delivered by ‘people who look like me’.
 - Copying the workforce analysis completed by SLaM, the extent that the full mental health workforce is representative of its users should be evaluated and any response to its findings should take a co-produced approach.
 - We should help peer support services to recruit BAME members. This could involve supporting a pilot peer support project for the BAME population.
- Further work must be done with the BAME population to explore how IAPT can achieve sustained change in access rates and improved outcomes. Part of this exploration should involve a critique of the appropriateness of services for particular groups, and scope for cultural competency developments.
- The Lewisham Community Wellbeing Service, which is provided by a consortium that includes Lewisham Refugee and Migrant Network will be responding to the emerging mental health needs of refugees in Lewisham. As service data is built up on the type and level of support required by the refugee population in Lewisham, findings should be fed into future commissioning intentions.

16.3. A continued focus on prevention and early intervention

- Given the importance of the wider determinants (such as employment, housing, education, economic status, lifestyle factors) as risk factors for both mental and physical health, we recommend that the Council explores how it might introduce a wellbeing approach to policy evaluation, putting residents’ wellbeing at the heart of its decision-making.
- Following on from the Lewisham Public Mental Health and Wellbeing Strategy 2016-2019, good workplace mental health should continue to be a priority area. This includes promoting NICE guidance ‘Mental Wellbeing in the Workplace’ with local businesses, workplaces and VCS organisations, encouraging them to become employer ‘Time to Change’ champions and to sign up to the GLA Healthy Workplace Charter. Members of the Lewisham Health and Wellbeing Board should also be encouraged to sign up to workplace mental health initiatives..
- The social determinants of health and reducing inequalities should continue to be a priority for the public health team, and addressing these through commissioned services, including ‘wellbeing services’ and community development, should continue to be an explicit aim. This includes continuing to report data on the social determinants of health and health inequalities in all publications.

- Social prescribing has been shown to be effective in improving wellbeing outcomes and reducing social isolation. The role of social prescribing in preventing adults' mental ill health at a population level should be therefore continue to be explored and expanded in Lewisham.
- A co-ordinated Lewisham-wide campaign linking GPs, pharmacists, primary care, schools, early years' settings and workplace, and signposting to early intervention support should be organised, as a means to improve mental health literacy, reduce stigma and improve referral pathways. This may be best delivered through the newly formed Mental Health Provider Alliance and could be linked to existing campaigns, such as Time to Change.
- Mental health prevention work must be embedded within Lewisham's Early Help approach, which is currently being reviewed by Lewisham Council and partners. In particular, it must respond to the need to take a more joined-up approach that recognises that all people – whether adults or children – are part of a network of families and communities, and do not exist in isolation. This requires a more holistic and integrated approach to service provision and the offer of support. The Lewisham Early Help approach should use co-production to develop the best ways to work with parents and families experiencing mental health issues, with clear pathways to support this.
- Maternal mental health should continue to be a high priority, including support for those mothers at the lower and middle end of the spectrum of mental health needs and for prevention services such as Mindful Mums. In addition, as our understanding of the prevalence of postnatal depression amongst new dads grows, we should explore how best to support and promote good paternal mental health, taking a co-production approach and putting in place governance structures to ensure accountability.

16.4. Improving the physical health of people with severe mental illness

- Quality improvement efforts should continue to be made in order to increase the level of Lewisham patients with SMI who receive physical health checks in primary care. In response to specific challenges raised, more – or different – support should be offered to people to help them attend physical health checks, for example peer supporters. Alternative local incentives may also be considered to ensure that primary care is responding to the most prominent issues for Lewisham residents and contributing to reducing health inequalities.
- Health promotion and prevention services:
 - Smoking and alcohol: the provision of smoking cessation and alcohol support after discharge from SLaM should be supported where needed to extend this support from inpatient to community mental health (outpatient) services.
 - The opportunities to provide targeted physical health support to people with SMI via Public Health commissioned services should be reviewed e.g. sexual health and substance misuse services.
 - Improve referrals of people with mental health conditions into prevention services by GPs, for example smoking cessation, or other lifestyle services where appropriate.
- We need to understand whether there are inequalities in the physical health of people with SMI according to protected characteristics. This requires better (more complete) data on the provision of health checks by primary care, and analysis of these data.

16.5. Mapping the future demand for services and constantly asking ourselves if they are the right ones

- Modelling should be carried out to project future service use and inform service planning. This can be done by applying nationally- and regionally- produced Lewisham population projections by age and ethnicity to prevalence of different mental health conditions, in conjunction with more detailed service analysis. A specific piece of modelling may be required to plan for the

transition between childhood and adulthood; another piece of modelling may be needed to inform dementia service planning.

16.6. Employment support that responds to mental health needs

- Closer ways of working need to be developed with Job Centre Plus to ensure that those who are eligible for employment support receive it in a timely way, for example in an appropriate period following discharge from mental health services.
- Work with Job Centre Plus and others needs to be undertaken to boost employment support for people with mental needs (especially those who 'slip through the net' because they don't reach the eligibility threshold for support).
- Lewisham must continue to address employer stigma via the Job Centre Plus partnerships work and also via continuing the actions in the Lewisham Public Mental Health and Wellbeing Strategy 2016-2019 e.g. by promoting NICE guidance 'Mental Wellbeing in the Workplace' with local businesses, workplaces and VCS organisations, encouraging them to become employer 'Time to Change' champions and to sign up to the GLA Healthy Workplace Charter.

16.7. Better data to give us a better picture of mental health in Lewisham

- Commissioned services delivered by voluntary and community sector organisations have moved towards measuring improvements in mental health and wellbeing in terms of outcomes, to supplement the service activity data. These outcomes should be used inform commissioning decisions in an explicit way and should be reviewed on a regular basis.
- As part of the adoption of a Population Management System in Lewisham, mental health indicators should be agreed and integrated to support whole systems approach to improving mental health outcomes and reducing health inequalities. This should also help to address barriers to data sharing for analytical purposes that currently arise from incompatible IT systems.
- Concerted efforts should be made to improve data completeness, for example increasing the recording of protected characteristics, to improve our understanding of who is accessing services. This could be achieved by training the mental health workforce to understand the importance – and purpose – of data collection, and also be standardising some of the ways that data is reported, for example the way that information that is included in letters from psychiatrists to GPs so that practices know what to upload to GP patient records.
- The Suicide Prevention Strategy identified the need for better data collection, for example clear and standardised data on self-harm presentations to emergency services in Lewisham. In addition, the strategy recommended that a local South East London suicide audit should be completed on an annual basis.

16.8. Seeking a better understanding of dementia in Lewisham

- A workshop with providers and commissioners should take place about what further developments to dementia services may not be reflected in the quantitative data but may be needed, for example community-based activities for dementia, dementia day care, cognitive stimulation therapy.
- Trends in dementia prevalence in terms of age and demographics should be continually monitored so that projections for future need can be built into service planning.

17. APPENDIX 1: GUIDANCE ON THE PROVISION OF SERVICES FOR PATIENTS WITH DEPRESSION

Stepped-care model framework for the provision of services for patients with depression depending on the presentation and severity of symptoms¹¹⁹	
Focus of the intervention depending on the presentation and severity of symptoms	Nature of the intervention
STEP 1: All known and suspected presentations of depression	Assessment, support (see Table 4), psycho-education (see Table 4 high), active monitoring and referral for further assessment and interventions (secondary care services e.g. psychiatry).
STEP 2: Persistent subthreshold depressive symptoms; mild to moderate depression	Low-intensity psychosocial interventions (Table 5), medication (Table 5) and referral for further assessment and interventions.
STEP 3: Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression	Medication, high-intensity psychological interventions, combined treatments, collaborative care and referral for further assessment and interventions.
STEP 4: Severe and complex depression; risk to life; severe self-neglect	Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multi-professional and inpatient care.

Providing support for people with depression¹²⁰	
Person/People the support is focused on	Nature of the support
The person with depression, their families	Build a trusting relationship in non-judgemental manner; explore treatment options; be aware of stigma and discrimination associated with a diagnosis of depression; ensure discussions take place in settings of confidentiality, privacy and dignity.
The person with depression, their families, their carers	Provide information appropriate to the level of understanding about the nature of depression and the range of treatments available; ensure that comprehensive written information is available; provide and work proficiently with independent interpreters.
The person with depression	Inform people with depression about self-help groups, support groups and other local and national resources.
The person with depression	Ensure that consent to treatment is based on the provision of clear information about the intervention.

Further detail on evidence-based interventions for people with depression¹²¹	
Intervention	Further detail on intervention
General Measures ¹²²	Sleep hygiene; active monitoring
Cognitive Behavioural Therapy (CBT)	Individual CBT; Group CBT; Computerised CBT (CCBT)
Pharmacological Treatment	Selective Serotonin Re-uptake Inhibitors (SSRIs) e.g. citalopram; Selective and Norepinephrine Reuptake Inhibitors (SNRIs) e.g. venlafaxine; Tricyclic

¹¹⁹ <https://www.nice.org.uk/guidance/cg90/chapter/Introduction>

¹²⁰ <https://www.nice.org.uk/guidance/cg90/chapter/1-Guidance> (Section 1.1.1.1 – 1.1.1.5)

¹²¹ <https://www.nice.org.uk/guidance/cg90/ifp/chapter/Treatments-for-mild-to-moderate-depression>

¹²² <https://www.nice.org.uk/guidance/cg90/chapter/1-Guidance>

	antidepressants (TCAs) e.g. amitriptyline; Monoamine Oxidase Inhibitors (MOAIs) e.g. hydrazine
Low-intensity psychosocial interventions	Individual guided self-help programmes on the principles of CBT; CCBT; physical activity programmes (structured group exercise classes)
High-intensity psychosocial interventions	CBT; IPT (inter-personal therapy); counselling, short-term psychodynamic therapy; behavioural activation, behavioural couples therapy
Inpatient care, crisis resolution, home treatments ¹²³	
Electroconvulsive Therapy (ECT) ¹²⁴	Used for depression associated with psychosis. Always given in hospital under general anaesthetic and works by passing an electric current through the brain

¹²³ <https://www.nice.org.uk/guidance/cg90/chapter/Introduction>

¹²⁴ <https://www.nice.org.uk/guidance/cg90/ifp/chapter/Treatments-for-moderate-or-severe-depression>

18. APPENDIX 2: GUIDANCE ON THE PROVISION OF SERVICES FOR PEOPLE WITH SEVERE MENTAL ILLNESS

NICE Quality Standards of Care for People with Severe Mental Illness	
Quality Statement (1-8)¹²⁵	Further Information on Statement
Adults with a first episode of psychosis start treatment in early intervention in psychosis services within 2 weeks of referral.	Early intervention in psychosis services can improve clinical outcomes, such as admission rates, symptoms and relapse, for people with a first episode of psychosis. They should ensure that culturally appropriate psychological and psychosocial treatment is provided to people from diverse ethnic and cultural backgrounds.
Adults with psychosis or schizophrenia are offered cognitive behavioural therapy for psychosis (CBTp) .	CBTp in conjunction with antipsychotic medication, or on its own if medication is declined, can improve outcomes such as psychotic symptoms.
Family members of adults with psychosis or schizophrenia are offered family intervention .	Family intervention can improve coping skills and relapse rates of adults with psychosis and schizophrenia.
Adults with schizophrenia that have not responded adequately to treatment with at least 2 antipsychotic drugs are offered clozapine .	Clozapine is the only drug with established efficacy in reducing symptoms and the risk of relapse for adults with treatment-resistant schizophrenia. It is licensed only for use in service users whose schizophrenia has not responded to, or who are intolerant of, conventional antipsychotic drugs.
Adults with psychosis or schizophrenia who wish to find or return to work are offered supported employment programmes .	These can increase employment rates in adults with psychosis or schizophrenia. It is estimated that just 5–15% of people with schizophrenia are in employment, and people with severe mental illness (including psychosis and schizophrenia) are 6 to 7 times more likely to be unemployed than the general population. Unemployment can have a negative effect on the mental and physical health of adults with psychosis or schizophrenia.
Adults with psychosis or schizophrenia have specific comprehensive physical health assessments .	Life expectancy for adults with psychosis or schizophrenia is between 15 and 20 years less than for people in the general population. Physical health problems, including cardiovascular and metabolic disorders, such as type 2 diabetes, can be exacerbated by the use of antipsychotics.
Adults with psychosis or schizophrenia are offered combined healthy eating and physical activity programmes, and help to stop smoking .	Rates of obesity and type 2 diabetes in adults with psychosis or schizophrenia are higher than those for the general population. Rates of tobacco smoking are also high in people with psychosis or schizophrenia. These factors contribute to premature mortality. Offering combined healthy eating and physical activity programmes and help to stop smoking can reduce these rates and improve physical and mental health.
Carers of adults with psychosis or schizophrenia are offered carer-focused education and support programmes .	Reduces carer burden and psychological distress, and may improve the carer's quality of life.

¹²⁵ <https://www.nice.org.uk/guidance/qs80/chapter/List-of-quality-statements>

Patient-centred care for people with severe mental illness¹²⁶	
Intervention	Further details
Preventing psychosis	
Cognitive Behavioural Therapy (CBT)	Offer individual CBT with or without family intervention
Address anxiety disorders, depression, emerging personality disorder or substance misuse	Offer interventions recommended in NICE guidance for people with any of the anxiety disorders, depression, emerging personality disorder or substance misuse
First episode psychosis	
Early intervention in psychosis services	
Assess for post-traumatic stress disorder	
Antipsychotic Medication	The choice of antipsychotic medication should be made by the service user and healthcare professional together
Subsequent acute episodes of psychosis or schizophrenia and referral in crisis	
CBT	This can be started either during the acute phase or later, including in inpatient settings
Family Intervention	Offer family intervention to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user
Promoting recovery and possible future care	
Responsibility of care / shared care / transfer of care	GPs and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is transferred from secondary care, and then at least annually
Medication	Offer clozapine to people with schizophrenia whose illness has not responded adequately to treatment despite the sequential use of adequate doses of at least 2 different antipsychotic drugs. At least 1 of the drugs should be a non-clozapine second-generation antipsychotic.
Supported employment programmes	Offer to those who wish to return to work. Consider other occupational or educational activities, including pre-vocational training, for people who are unable to work or unsuccessful in finding employment.

¹²⁶ <https://www.nice.org.uk/guidance/cg178/chapter/Key-priorities-for-implementation>



**Joint Strategic
Needs Assessment:**

***Adult asthma and chronic obstructive
pulmonary disease (COPD)***

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1. Introduction

This joint strategic needs assessment focuses on two chronic respiratory diseases in adults – chronic obstructive pulmonary disease (COPD) and asthma.

Chronic obstructive pulmonary disease (COPD) at a glance

COPD is a progressive lung disease characterised by a persistent reduction of airflow, resulting in breathlessness and predisposing to exacerbations and serious illness.¹ Most cases of COPD in the UK (~90%) are caused by tobacco smoke (including passive exposure) and are preventable by avoidance or early cessation of smoking.² Although COPD is not curable, early detection and treatment can relieve symptoms, improve quality of life, prevent exacerbations (and hospital admissions) and reduce the risk of premature death. There are an estimated 1.2 million people living with a diagnosis of COPD in the UK, however it is known to be severely under-diagnosed and there is the opportunity to diagnose up to three times as many people.³ COPD is the fifth most common cause of death in the UK, responsible for almost 30,000 deaths per year.⁴ Premature mortality (that is, deaths occurring under the age of 75) from COPD in the UK is almost twice as high as the European average (EU-15).⁵ Furthermore COPD is the second leading cause of emergency hospital admission in the UK – in fact, COPD accounts for more than one million ‘bed days’ each year in UK hospitals.⁶

Asthma at a glance

Asthma is a chronic lung disease characterised by recurrent attacks of breathlessness and wheezing, which vary in severity from person to person.⁷ Unlike COPD, asthma is reversible (that is, the characteristic airflow obstruction diminishes with medications such as salbutamol) and there is no single ‘cause’ – rather individuals with a combination of genetic predisposition and environmental exposures are at risk, both throughout childhood and adult life. Exacerbations are often triggered by indoor and outdoor allergens, tobacco smoke, chemical irritants and air pollution. The National Asthma Campaign reports that there are 5.4 million people in the UK currently receiving treatment for asthma.*¹⁸ Premature mortality from asthma in the UK is much higher than the European average⁵ and, although deaths from asthma have plateaued in recent years (to around 1,300 deaths per year),⁴ it is estimated that at least two thirds of these deaths are preventable.¹¹

It is also important to note that a small group of patients have risk factors for, and clinical features of, both asthma and COPD and so an ‘overlap’ syndrome also exists. These patients often experience frequent exacerbations, have worse quality of life, a more rapid decline in lung function and higher mortality.^{12,13}

This Joint Strategic Needs Assessment (JSNA) at a glance

Respiratory disease is an important topic warranting this needs assessment, partially because crude indicators would suggest Lewisham is performing poorly compared to comparable London boroughs. For example, there is a higher than expected premature mortality from respiratory disease in the borough and excess deaths are occurring in the acute hospital setting. However, there are also many opportunities for improvement – for example in supporting residents with long-term conditions, reducing health inequalities and achieving efficiencies in the local health and care economy.

This JSNA aims to systematically review information about the adult population in Lewisham living with asthma and COPD. The JSNA is focussed on adult asthma and COPD specifically

* 5.4 million people in the UK are currently receiving treatment for asthma: 1.1 million children (1 in 11) and 4.3 million adults (1 in 12).

because:

- Asthma and COPD can reasonably be considered together as they share some physiological commonalities (both are chronic, obstructive airways diseases, and characterised by exacerbations) and share some risk factors (most importantly smoking)
- Asthma and COPD were highlighted early in the development of this needs assessment as priority areas (from clinical and commissioning leads in the borough)
- It was felt that combining childhood asthma with adult asthma would result in a less in-depth and meaningful needs assessment (as adult and paediatric asthma are quite distinct in terms of population needs, as well as service provision and design)

How to use this JSNA

This JSNA aims to paint a comprehensive picture of adult asthma and COPD in Lewisham and can be used to support decision making that will ultimately lead to improved health and wellbeing in the local population as well as reduced inequalities. This JSNA may be useful:

- To inform funding proposals, business cases and strategies
- To aid planning, commissioning, and delivering services for residents
- As an evidence base to make decisions about service provision
- For forecasting future demand for specific services.

Although the JSNA has been developed to be considered in its entirety, readers may find it helpful to navigate to particular chapters for specific references. [Chapter 2](#) outlines the general profile and broad determinants of respiratory disease in Lewisham. Important data is summarised with regards to asthma and COPD outcomes (including historical trends and benchmarking with comparable boroughs) and key inequalities are highlighted. Readers can locate important national and local strategies in [Chapter 3](#) and evidence about what works in terms of treatments for asthma and COPD in [Chapter 4](#). [Chapter 5](#) presents the current activities and services on offer for people living with asthma and COPD in Lewisham and assesses their access, performance and outcomes in relation to the needs identified in this JSNA. Changes on the horizon which are relevant to asthma and COPD are detailed in [Chapter 6](#), followed by a brief outline of local views gathered from consultation with service-users in [Chapter 7](#). Key gaps, in terms of both knowledge and services for asthma and COPD, are presented in [Chapter 8](#) – with corresponding recommendations on how to address them outlined in [Chapter 9](#)'s JSNA action plan.

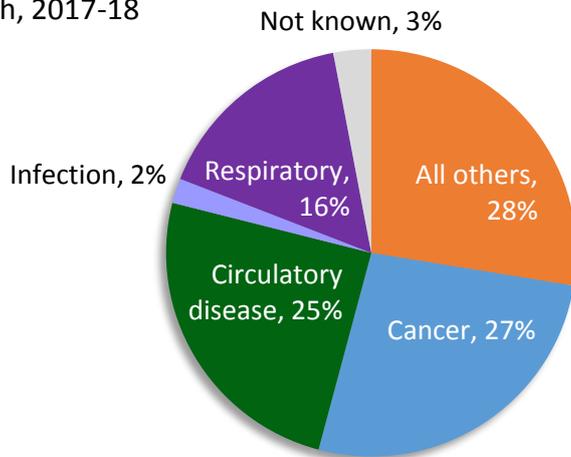
2. Respiratory disease in Lewisham

This chapter outlines the respiratory profile of Lewisham – first, in broad consideration of mortality from and risk factors for respiratory disease in the borough, and then the specific profiles of asthma and COPD.

2.1. Respiratory mortality

Respiratory diseases are the third leading causing of death in Lewisham (behind cancer and cardiovascular disease, as shown in **Figure 1**) and claimed the lives of 1,979 people in 2017-18.¹⁰

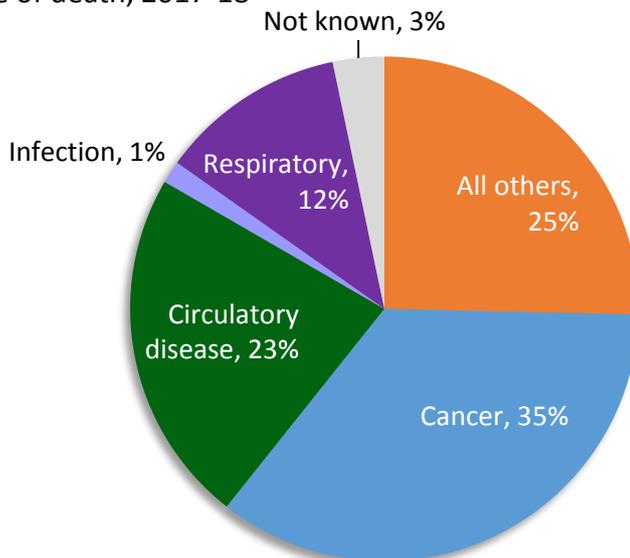
Figure 1. All age mortality in Lewisham by broad cause of death, 2017-18



Source: Primary Care Mortality Database (local analysis)

Respiratory diseases are also the third leading cause of premature mortality (**Figure 2**) in Lewisham and claimed the lives of 765 people under the age of 75 in 2017-18.

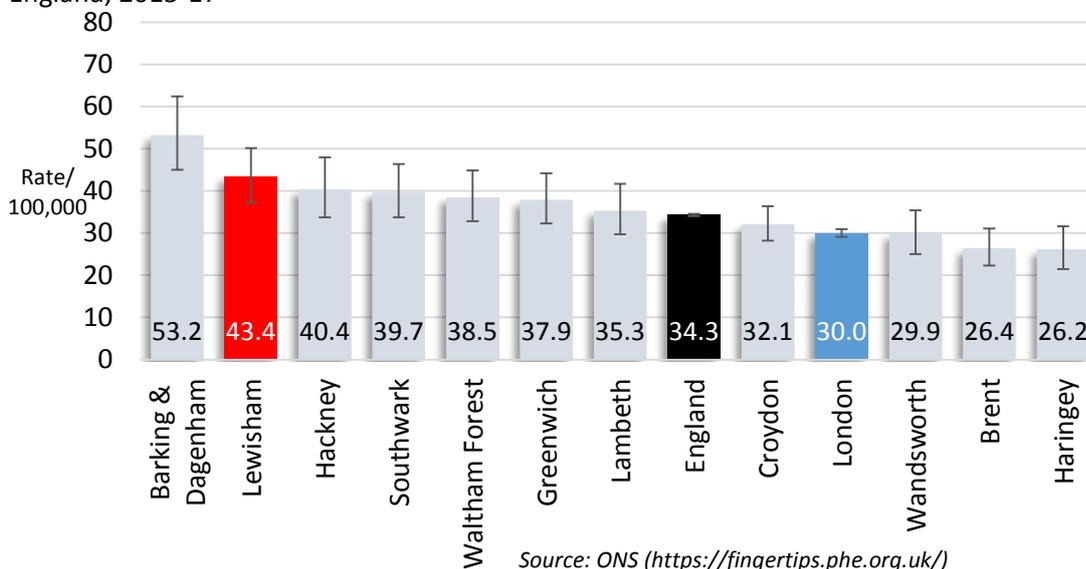
Figure 2. Premature mortality in Lewisham by broad cause of death, 2017-18



Source: Primary Care Mortality Database (local analysis)

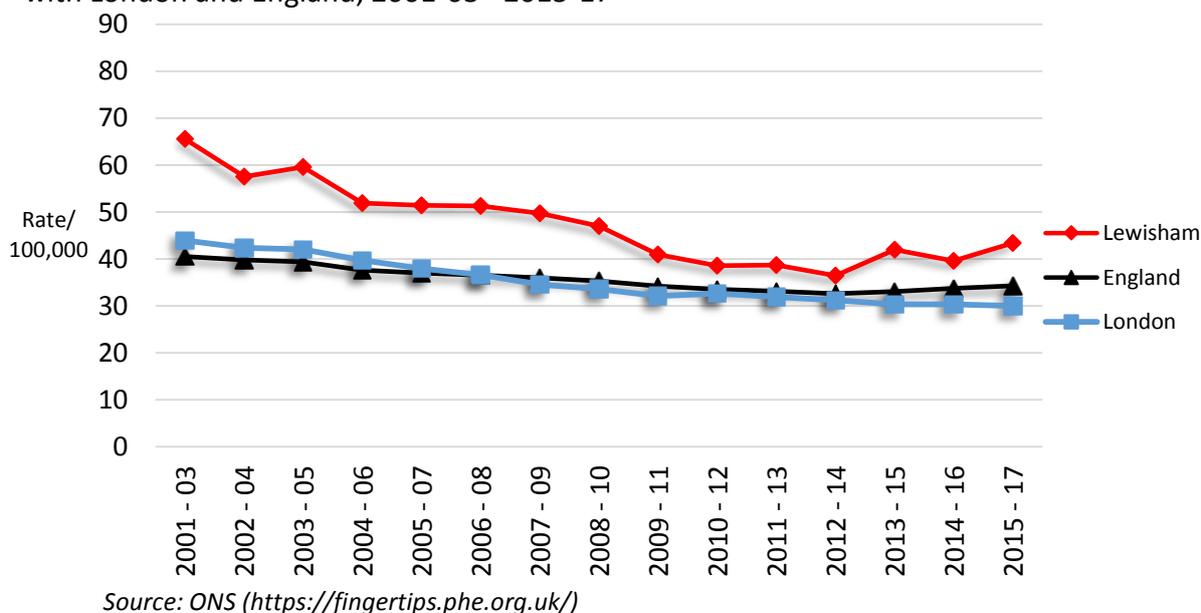
The rate of premature mortality from respiratory disease in Lewisham is the second highest in London (behind Barking & Dagenham only), at 43.4 per 100,000 (**Figure 3**).¹¹

Figure 3. Under 75 mortality from respiratory disease. Directly age-standardised 3 year average rates/100,000 persons with 95% confidence Intervals. Lewisham compared with its statistical neighbours, London and England, 2015-17



As shown in **Figure 4**, premature mortality from respiratory disease was in decline from 2001 until 2012-14 but has since plateaued and, more worryingly, may even be increasing – going against the trend witnessed in England and other London boroughs.

Figure 4. Under 75 mortality from respiratory disease. Directly age-standardised 3 year average rates/100,000 persons. Lewisham compared with London and England, 2001-03 - 2015-17



It should be noted that the data referred to in figures 1-4 refer to all-respiratory mortality and therefore encompass a heterogeneous group of diseases, which may or may not be preventable. Public Health England also provide mortality estimates by borough for

respiratory diseases that are considered preventable, and it would appear that preventable premature mortality in Lewisham is increasing in men but not in women. Further information about inequalities in respiratory outcomes by sex can be found [here](#) in the JSNA.

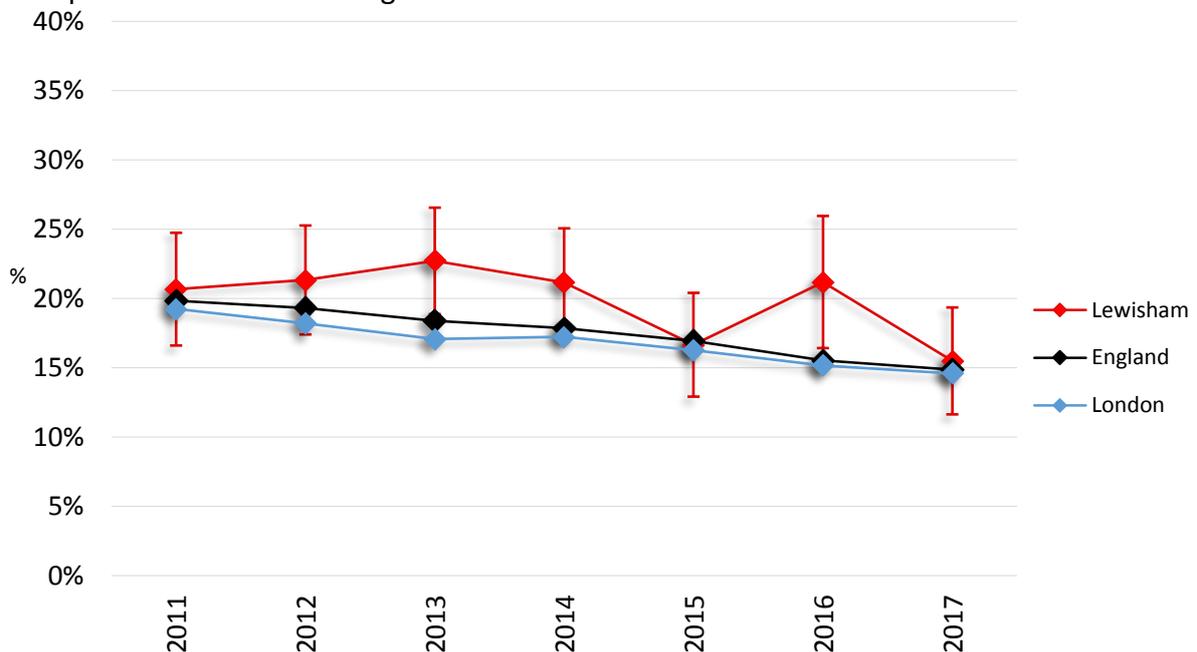
2.2. Risk factors for respiratory disease

2.2.1. Smoking

Smoking, as the cause of around 90% of COPD cases and a leading cause of asthma exacerbations in the UK, is the single most important risk factor for respiratory diseases. Further, tobacco use is the biggest single contributor to the gap in healthy life expectancy between Lewisham and England. In Lewisham, the prevalence of smoking among adults is 15.5%, which equates to 35,780 current smokers (**Figure 5**).

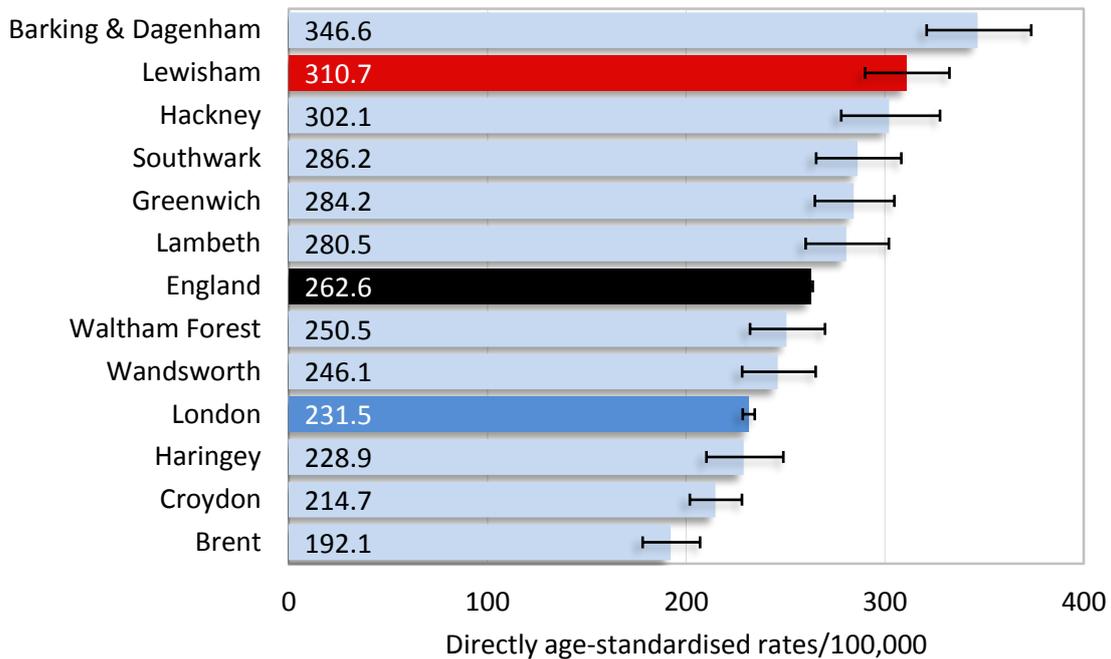
The burden of smoking-related ill health is particularly great in Lewisham, as indicated by many of the commonly cited measures of public health impact (such as hospital admissions and cause-specific mortality) which show a relatively greater impact of smoking in our borough as compared to the London and national averages. For example, in 2017-18, there were an estimated 1,750 per 100,000 hospital admissions attributable to smoking in Lewisham – a much higher proportion than in our neighbouring boroughs of Lambeth and Southwark or London as a whole. The high burden of smoking in Lewisham is also demonstrated by the high level of smoking-attributable mortality, which is statistically significantly higher than the national or London average at 310.7 per 100,000 (and the second highest in London, **Figure 6**).

Figure 5. Smoking prevalence aged 18+: current smokers. Lewisham compared to London and England. Annual trends



Source: Annual Population Survey (<http://www.tobaccoprofiles.info>)

Figure 6. Smoking attributable mortality. Directly aged-standardised rates/100,000. Lewisham compared to London and England, 2015-17



Source: ONS (<http://www.tobaccoprofiles.info>)

Further information about smoking in Lewisham can be accessed [here](#), in a recent JSNA on tobacco control.

2.2.2. Air quality

Poor air quality is a significant public health issue and people with chronic respiratory diseases such as COPD and asthma are especially vulnerable to the detrimental effects of air pollutants. Air pollution can induce the acute exacerbation of COPD and onset of asthma, as well as increase morbidity and mortality more generally. The health effects of air pollution depend on the components and sources of pollutants, which vary by geography, time and season.

Short-term health impacts of air pollution on respiratory disease:

- Short-term exposure to air pollution can worsen respiratory symptoms in those with pre-existing lung disease and asthma in particular.¹⁴
- Gaseous pollutants (such as NO₂, SO₂, O₃), particulate matter (PM_{2.5} and PM₁₀) and traffic-related air pollution have all been implicated in increased respiratory morbidity and mortality.
- How these pollutants result in increased morbidity and mortality of people with asthma and COPD is multi-factorial, including via immunological pathways increasing susceptibility to respiratory infection.^{15,16}
- Use of health services often spikes during and after periods of strong air pollution. For example, Public Health England's Real Time Surveillance System Team found an increase in GP consultations for respiratory problems immediately following an episode of worsened air pollution in 2014.¹⁷

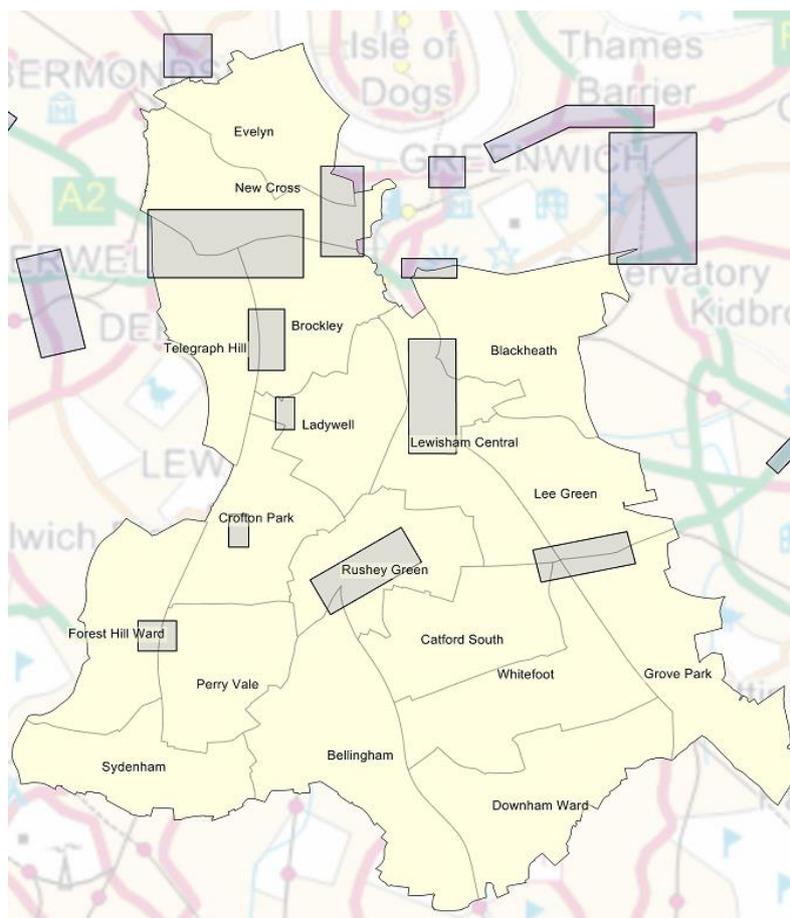
Long-term health impacts of air pollution on respiratory disease:

- Air pollution has been demonstrated to reduce normal lung function development in children;¹⁸
- In adults, there is emerging evidence that air pollution accelerates decline in lung function.^{19,20}
- The evidence-base for air quality's contribution to COPD onset is inconclusive,^{21,22} however studies have shown that exposure to air pollution increases risk of progression to “asthma-COPD overlap syndrome” three-fold.²³
- A recent meta-analysis reviewing the effect of traffic-related air pollution on asthma in children concluded that increased exposure to NO₂ was associated with a higher prevalence and incidence of childhood asthma.²⁴

In 2011 the Greater London Authority (GLA) identified Air Quality Focus Areas within in Lewisham, these which are depicted in **Figure 7** (by the shaded areas of the map). Air quality focus areas have been selected by the GLA as areas where there is the most potential for improvements in air quality within London, and should therefore act as strategic priorities for action on air pollution in the borough. These areas have been selected through an analysis of the following factors:

- Baseline air quality for NO₂ and PM₁₀ by 20m grid resolution
- Locations where air pollution limit values have been exceeded
- Level of human exposure
- Local geography and topography
- Local sources of air pollution
- Traffic patterns
- Future predicted air quality trends

Figure 7. Lewisham Air Quality Focus Areas

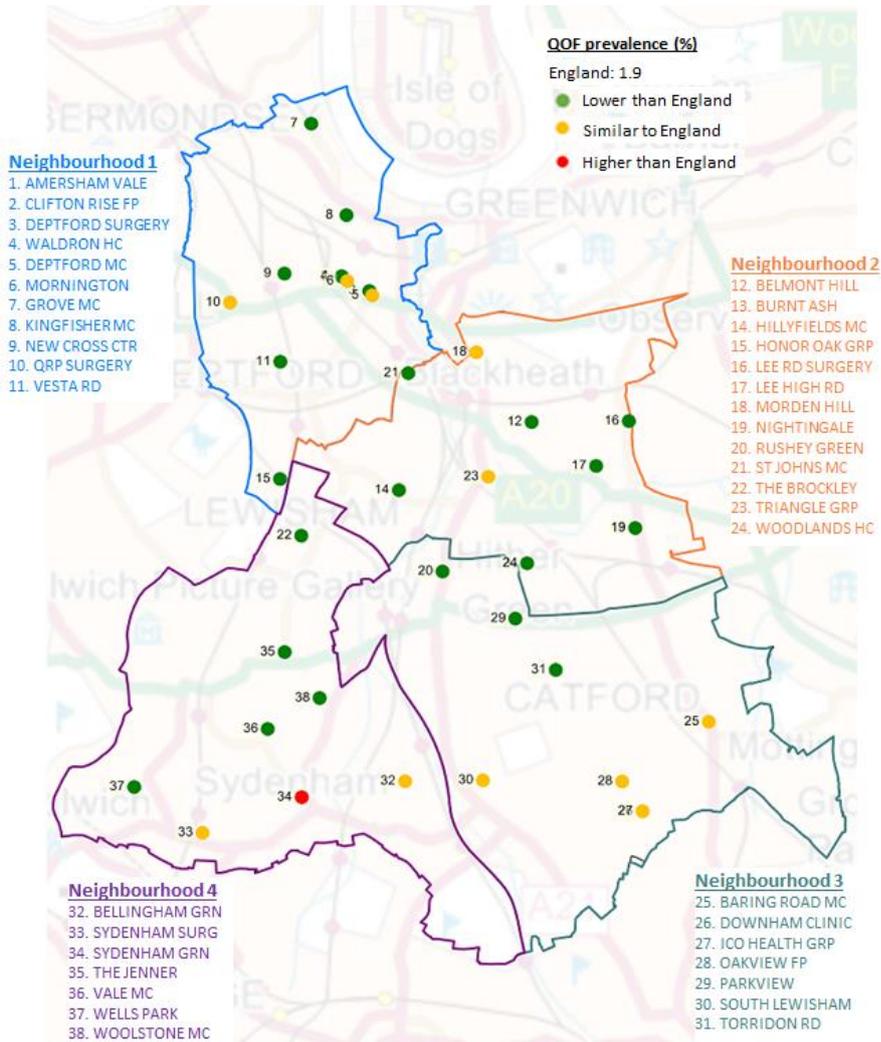


Air quality in Lewisham was the topic of a recent JSNA, and further information can be accessed [here](#).

2.3. Chronic obstructive pulmonary disease in Lewisham

According to the GP register, there are 4,308 people in Lewisham with a diagnosis of COPD, which equates to a prevalence of 1.3%. **Figure 8** depicts the prevalence of diagnosed COPD by GP practice, and shows that the majority of practices diagnose less COPD than the national average.

Figure 8. COPD (QOF) prevalence in patients of all ages by Lewisham GP practice and neighbourhood, 2017-18



Source: QOF

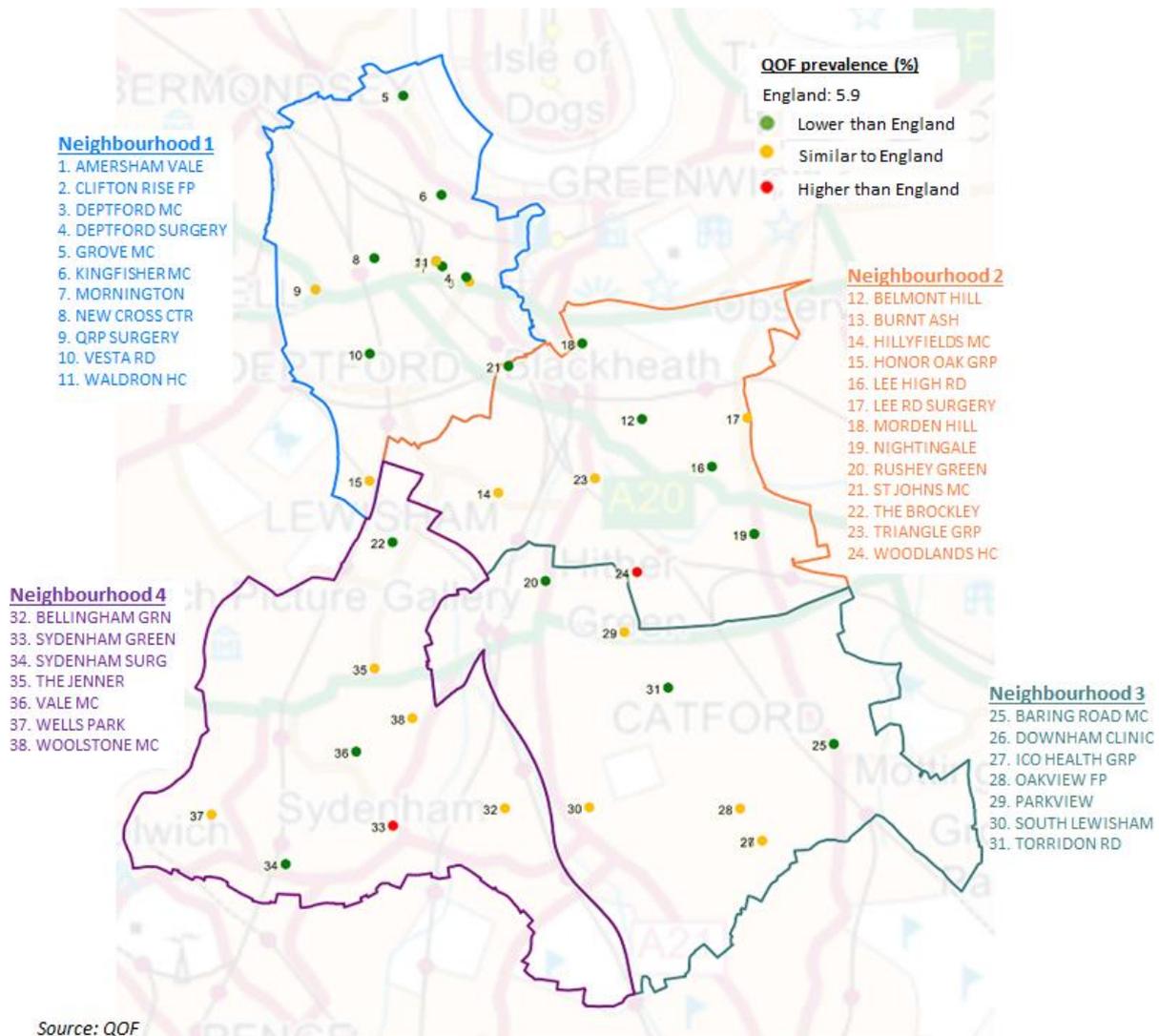
It is well-established that COPD is underdiagnosed in the UK, as it is worldwide,²⁵⁻²⁸ and is partially due to people dismissing their early symptoms of COPD as a ‘smoker’s cough’ and therefore not seeking medical care. Many patients with COPD remain undiagnosed in the community and are only identified at the point of hospital admission. This is such an important problem as early detection of COPD is necessary to initiate effective ‘treatments’ (namely smoking cessation, pulmonary rehabilitation and inhaled medications) which can slow decline in lung function and lengthen the period of time in which someone can enjoy an active life. Additionally, early diagnosis can achieve efficiencies in the local health and care economy – through prevention of emergency hospital admissions and enhanced productivity of persons with COPD.

Public Health England modelled the expected prevalence of COPD in 2011 and estimated that there were 8,088 people in Lewisham living with COPD (including those undiagnosed).²⁹ This estimate should be interpreted with caution, as it is based on incomplete and now outdated data, however it does provide some insight into how under-diagnosed COPD may be in the borough. According to this PHE estimate, there are 3,780 undiagnosed people in Lewisham with COPD.

2.4. Asthma in Lewisham

According to the GP register, there are 17,121 people (children and adults) in Lewisham with a diagnosis of asthma (that have been prescribed asthma-related medications in the preceding 12 months). **Figure 9** depicts the prevalence of diagnosed asthma in Lewisham (overall 5.9%), broken down by GP practice. It shows that the majority of practices in Lewisham diagnose asthma at a rate less than or similar to the national average.

Figure 9. Asthma (QOF) prevalence in patients of all ages by Lewisham GP practice and neighbourhood, 2017-18



It is important to note some challenges in interpreting the variations in number of diagnosed asthma and COPD patients per GP practice, namely:

- It is difficult to establish how much of this variation is attributable to the true burden of chronic disease and how much is related to GP diagnosis patterns.
- Drawing any meaningful conclusions on any effect of air quality on diagnosis or presence of disease is challenging.

It should be noted that most prevalence estimates of asthma exclude people that haven't been prescribed asthma-related medications as is the case in **figure 9** (on the assumption

that they are well in the community), however this may be missing people that are unwell with asthma but not seeking medical care (or at least not in the community). The total number of adults (i.e. 18+) with a diagnosis of asthma (including those not prescribed any medications) in Lewisham was 25,702.

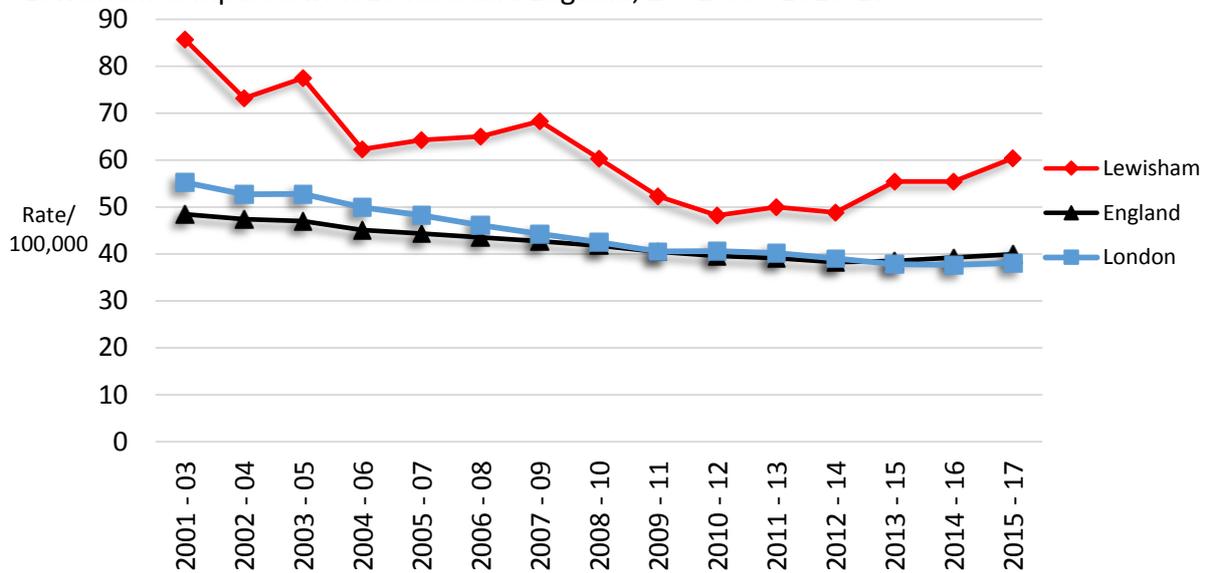
2.5. Key inequalities

Sex

In Lewisham, respiratory mortality (**figures 10 & 11**), and especially premature mortality considered preventable (**figures 12 & 13**), is higher in men than women. As was previously discussed in chapter 1, there was a general declining trend in respiratory mortality in Lewisham up until around 2012, at which point it started to plateau in women and increase in men.

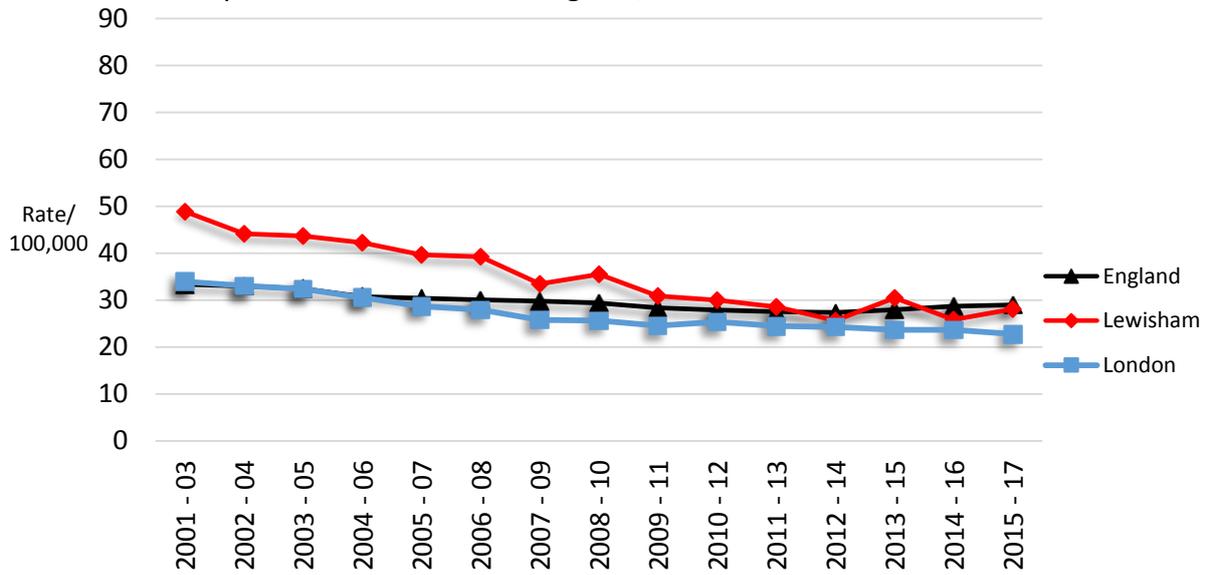
Figure 10. Under 75 (premature) mortality from respiratory disease. Directly age-standardised 3 year average rates/100,000 **males**.

Lewisham compared with London and England, 2001-03 - 2015-17



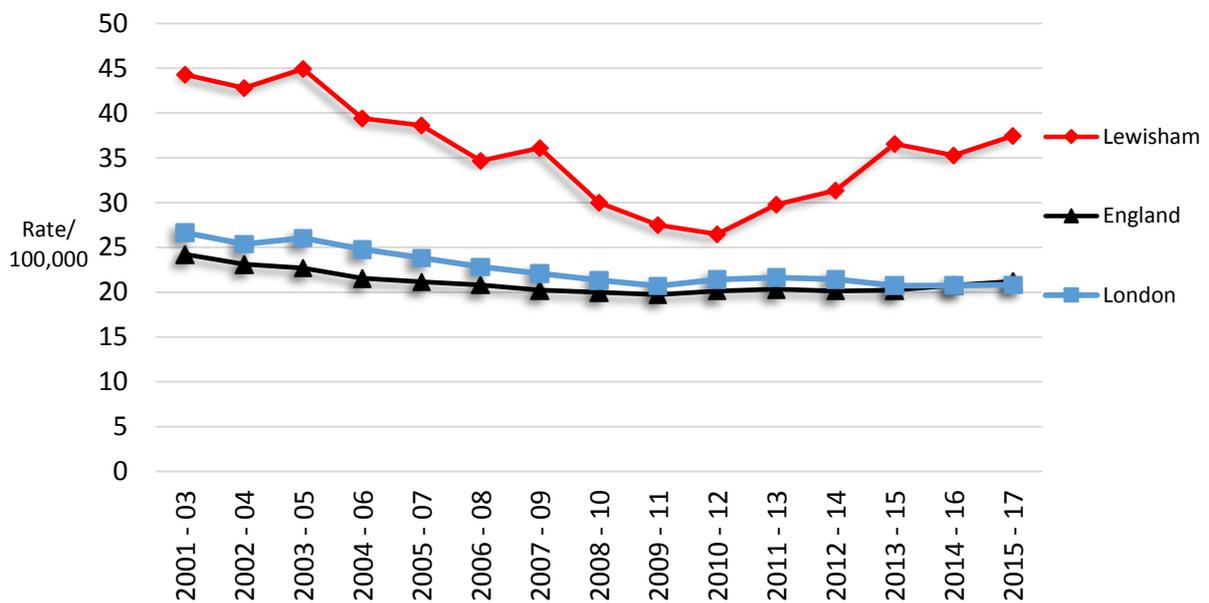
Source: ONS (<https://fingertips.phe.org.uk/>)

Figure 11. Under 75 (premature mortality) from respiratory disease. Directly age-standardised 3 year average rates/100,000 **females**. Lewisham compared with London and England, 2001-03 - 2015-17



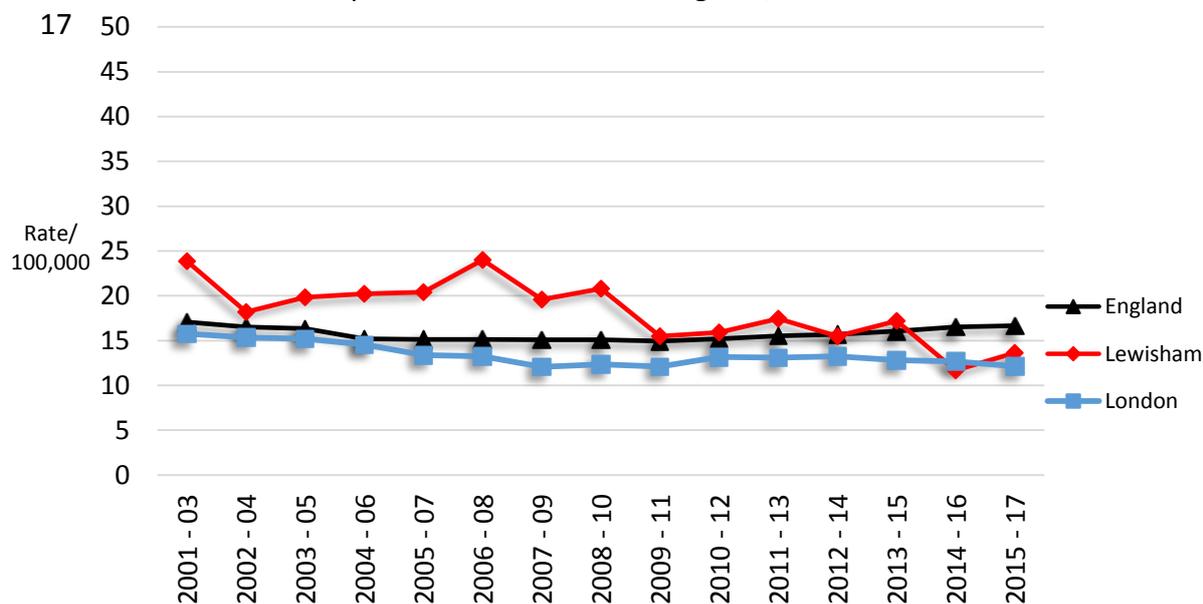
Source: ONS (<https://fingertips.phe.org.uk/>)

Figure 12. Under 75 mortality from respiratory disease considered preventable. Directly age-standardised 3 year average rates/100,000 **males**. Lewisham compared with London and England, 2001-03 2015-17



Source: ONS (<https://fingertips.phe.org.uk/>)

Figure 13. Under 75 mortality from respiratory disease considered preventable. Directly age-standardised 3 year average rates/100,000 females. Lewisham compared with London and England, 2001-03-2015-17



Source: ONS (<https://fingertips.phe.org.uk/>)

Some, but not all, of the difference in respiratory mortality in Lewisham between men and women can be explained by differences in smoking habits (namely the lag in health impacts from men previously smoking in greater quantity than women). However the inequality in respiratory mortality by sex may also be due to other factors such as:

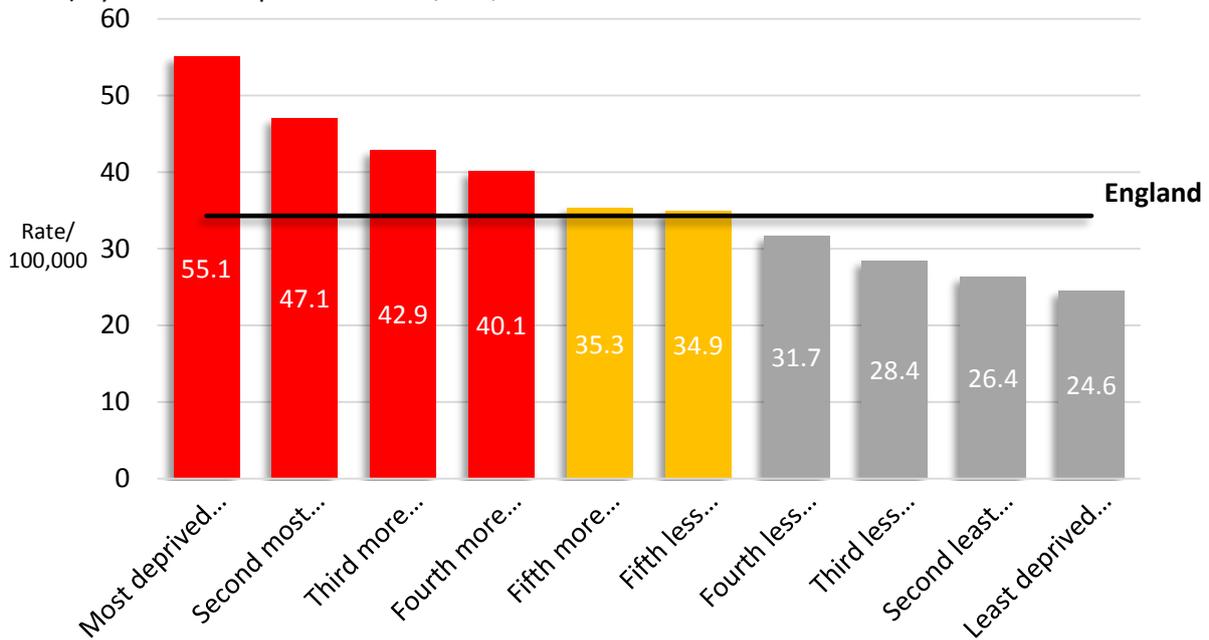
- Differences in the way men and women access care (both for diagnosis and ongoing management)
- Healthcare-professional bias, for example some studies show that men are more likely to be diagnosed with COPD and therefore their deaths coded as due to respiratory disease
- Differences in smoking cessation rates among men and women once diagnosed with a respiratory disease
- Differences in access and compliance with interventions such as medications and pulmonary rehabilitation

Deprivation

Premature mortality from respiratory disease is almost perfectly correlated with deprivation. As shown in **figure 14** (which depicts mortality by decile of deprivation), the premature mortality rate of the most deprived in England is over double that of the least deprived. Smoking is responsible for more than half of the difference in premature death rates between people on high incomes and those on low incomes. The following smoking-behavioural patterns which are associated with deprivation all increase the risk of respiratory disease as a whole, as well as disease progression, frequency and severity of exacerbations and overall mortality:

- Smoking prevalence is higher in lower socio-economic groups (e.g. people on low incomes are twice as likely to smoke than the more affluent)³⁰
- People in deprived circumstances are more likely to start smoking younger
- The number of cigarettes smoked per day is higher in lower socio-economic groups
- People in deprived circumstances are less likely to quit smoking

Figure 14. Premature mortality from respiratory disease in England (2015-2017) by decile of deprivation. Rate/100,000



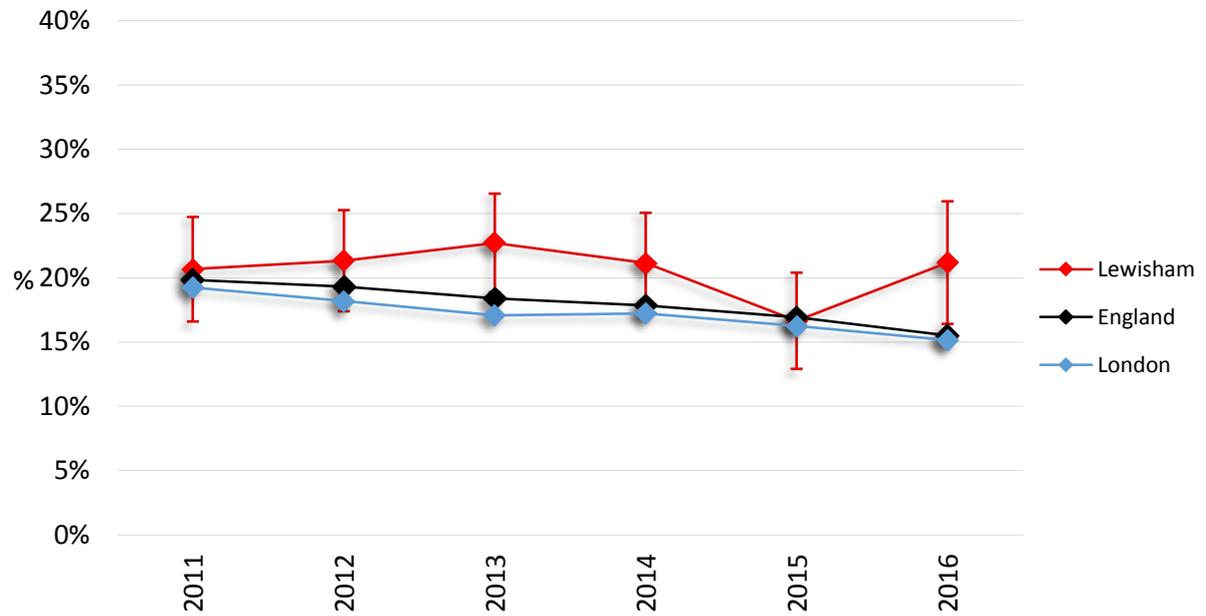
Source: ONS (<https://fingertips.phe.org.uk/>)

Other smoking-related inequalities

The majority of the inequalities seen in respiratory mortality are attributable to smoking (and we have previously presented how smoking is an important mediator for the difference in outcomes by sex and deprivation). Other ways in which smoking-related respiratory consequences widen existing inequalities are:

- People in routine and manual occupations are more likely to smoke than others in society (see **figure 15**). Cigarette smoking is higher among households classified as routine and manual (26%) than those classified as professional and managerial (15%)³¹
- Smoking rates amongst people with a mental health condition are significantly higher than in the general population³²
 - Over 70% of psychiatric inpatients smoke
 - 76% of people with first episode of psychosis smoke
- Smoking rates also differ significantly by ethnicity, with people of Mixed and White ethnicity most likely to smoke (at 20.5% and 15.4% respectively)³³

Figure 15. Smoking Prevalence (%) aged 18-64 in routine and manual jobs: current smokers (APS). Lewisham compared to London and England. Annual trends



Source: Annual Population Survey (<http://www.tobaccoprofiles.info>)

3. National and local strategies

The following national and local strategies relevant to adult asthma and COPD were identified. Please follow the links for further information. A summary of the relevant strategies from the NHS long-term plan has been provided as an example (box A) and the two local guidelines are included in the appendix (A and B).

National

- [NHS long-term plan](#)
- [Department of Health: An Outcomes Strategy for Chronic Obstructive Pulmonary Disease and Asthma in England](#)
- [COPD prevention and Early Identification toolkit, NHS Improvement](#)
- [NHS Commissioning Toolkit for COPD pathway](#)
- [Good practice guide for adults with asthma, Primary Care Commissioning](#)
- [NICE guidance and quality standards on asthma](#)
- [NICE guidance and quality standards on COPD](#)
- [British guideline on management of Asthma – British Thoracic Society](#)
- [Pulmonary rehabilitation - IMPRESS](#)
- [Pulmonary rehabilitation following exacerbations of chronic obstructive pulmonary disease, Cochrane Collaboration](#)

Local

- [South East London Integrated Guideline for the Management of COPD \(appendix A\)](#)
- [South East London Integrated Guideline for the Management of Adult Asthma \(appendix B\)](#)

Box A. Respiratory disease priority areas from the NHS long-term plan

- **Earlier detection and diagnosis** of respiratory disease
- Expand **access to pulmonary rehabilitation**
- Support those with respiratory disease to receive and use the **right medication**
- Enable people with **heart and lung disease** to complete a programme of **education and exercise** based rehabilitation

4. What works locally and elsewhere?

COPD

Table 1. Evidence that supports the management of Stable COPD

Intervention	Further details on Intervention	Reference
Smoking Cessation	Smoking cessation counselling plus either nicotine replacement therapy or an antidepressant are effective ways to help patients to stop smoking.	Link A: https://www.nice.org.uk/guidance/ng115/evidence/evidence-update-pdf-134515693
Inhaled Therapy	Link highlights evidence on the various inhaled therapies which are beneficial for COPD management. Long-acting beta-agonists plus inhaled corticosteroids (ICS) reduce moderate exacerbations. ICS alone may be associated with a risk of pneumonia. See Link A for further information.	Link A Link C https://www.nice.org.uk/guidance/gs10/chapter/Quality-statement-2-Inhaler-technique
Oral therapy	Options available with supporting evidence includes corticosteroids, prophylactic antibiotics, mucolytics, theophylline.	Link H https://pathways.nice.org.uk/pathways/chronic-obstructive-pulmonary-disease/managing-copd#content=view-index&path=view%3A/pathways/chronic-obstructive-pulmonary-disease/stable-copd-oral-therapy.xml
Oxygen therapy	Long term oxygen therapy is beneficial, NOT short term burst therapy in breathless people with COPD or ambulatory therapy.	Link I https://pathways.nice.org.uk/pathways/chronic-obstructive-pulmonary-disease/managing-copd#content=view-index&path=view%3A/pathways/chronic-obstructive-pulmonary-disease/stable-copd-oxygen-therapy.xml See Table 3 (below) for further evidence and details.
Lung volume therapy	Bullectomy, lung volume reduction procedures, lung transplantation.	Link J https://pathways.nice.org.uk/pathways/chronic-obstructive-pulmonary-disease/managing-copd#content=view-node%3Anodes-lung-volume-reduction-procedures&path=view%3A/pathways/chronic-obstructive-pulmonary-disease/stable-copd-lung-volume-reduction.xml

Pulmonary Rehabilitation	<p>Pulmonary rehabilitation offers potential benefits even in patients with the most severe COPD.</p> <p>Current evidence seems unable to define an optimal programme length</p>	<p>Link A Link B https://www.nice.org.uk/guidance/gs10/chapter/Quality-statement-4-Pulmonary-rehabilitation-for-stable-COPD-and-exercise-limitation See Table 4 (below) for overview of pulmonary rehabilitation in the management of COPD.</p>
Chest physiotherapy	<p>If patients have excessive sputum, they should be taught:</p> <ul style="list-style-type: none"> - How to use positive expiratory pressure devices. - Active cycle of breathing techniques. 	<p>Link K https://pathways.nice.org.uk/pathways/chronic-obstructive-pulmonary-disease/managing-copd#content=view-node%3Anodes-chest-physiotherapy</p>
Vaccination and anti-viral therapy	<p>Recent evidence appears to suggest that pneumococcal vaccination in patients with COPD may not reduce the risk of pneumonia, exacerbations or mortality. Large, well-designed trials of newer polyvalent vaccines are needed.</p>	<p>Link A</p>
Multidisciplinary management	<p>Complex patient education programmes may be more effective than simpler interventions particularly in patients with more severe COPD. Further investigation of long-term outcomes in wider patient groups may be useful.</p>	<p>Link A</p>
Anxiety and depression	<p>Be alert for anxiety and depression in people with COPD. Consider whether people have anxiety or depression if they: have severe breathlessness, are hypoxic or have been seen at or admitted to a hospital with an exacerbation of COPD. See link for appropriate management.</p>	<p>Link L https://pathways.nice.org.uk/pathways/chronic-obstructive-pulmonary-disease/managing-copd#content=view-node%3Anodes-anxiety-and-depression</p>

Table 2. Evidence that supports the management of Exacerbations of COPD

Intervention	Further details on Intervention	Reference
Oral therapy	Antibiotic therapy. Steroid therapy.	<p>Link M https://pathways.nice.org.uk/pathways/chronic-obstructive-pulmonary-disease/exacerbations-of-copd#content=view-index&path=view%3A/pathways/chronic-obstructive-pulmonary-disease/antibiotics-for-treating-exacerbations-of-copd.xml</p> <p>Link P https://pathways.nice.org.uk/pathways/chronic-obstructive-pulmonary-disease/exacerbations-of-copd#content=view-node%3Anodes-corticosteroids</p>
Oxygen therapy	Titration of oxygen therapy to an appropriate target is associated with better outcomes than administering high flow oxygen.	<p>Link A Link C https://www.nice.org.uk/guidance/qs10/chapter/Quality-statement-3-Assessment-for-longterm-oxygen-therapy</p> <p>Link N https://pathways.nice.org.uk/pathways/chronic-obstructive-pulmonary-disease/exacerbations-of-copd#content=view-node%3Anodes-oxygen-therapy See Table 3 (below) for further evidence and details.</p>
Physiotherapy	Consider physiotherapy using positive expiratory pressure devices for selected people with exacerbations of COPD, to help with clearing sputum.	<p>Link O https://pathways.nice.org.uk/pathways/chronic-obstructive-pulmonary-disease/exacerbations-of-copd#content=view-node%3Anodes-physiotherapy</p>
Pulmonary Rehabilitation	For those patients who have recently experienced an exacerbation, this may reduce hospital admissions and possibly mortality.	<p>Link A Link B Link D https://www.nice.org.uk/guidance/qs10/chapter/Quality-statement-5-Pulmonary-rehabilitation-after-an-acute-exacerbation</p> <p>Link E https://www.nice.org.uk/guidance/qs10/chapter/Quality-statement-6-Emergency-oxygen-during-an-exacerbation</p>

		<p>Link R</p> <p>https://pathways.nice.org.uk/pathways/chronic-obstructive-pulmonary-disease/managing-copd#content=view-node:nodes-pulmonary-rehabilitation</p> <p>See Table 4 (below) for overview of pulmonary rehabilitation in the management of COPD.</p>
Non-Invasive Ventilation	For people with an acute exacerbation of COPD and persistent acidotic hypercapnic ventilatory failure that is not improving after 1 hour of optimal medical therapy, evidence advises non-invasive ventilation has a role.	<p>Link F</p> <p>https://www.nice.org.uk/guidance/gs10/chapter/Quality-statement-7-Noninvasive-ventilation</p> <p>Link Q</p> <p>https://pathways.nice.org.uk/pathways/chronic-obstructive-pulmonary-disease/exacerbations-of-copd-treatments-only-delivered-in-hospital#content=view-node%3Anodes-non-invasive-ventilation-and-doxapram</p>
Hospital discharge care bundle	There is currently a lack of evidence-based guidance about the details that should be included in these care bundles.	<p>Link G</p> <p>https://www.nice.org.uk/guidance/gs10/chapter/Quality-statement-8-placeholder-Hospital-discharge-care-bundle</p>

Table 3. Long-term Oxygen Therapy in the management of COPD

Intervention	Further details on intervention	Reference
Long term oxygen therapy	Who to assess the need for oxygen therapy, how to assess the need, who to consider issuing long-term oxygen therapy.	Link Y https://www.nice.org.uk/guidance/ng115/chapter/Recommendations#oxygen Please refer to section 1.2.51 – 1.2.69 in the above link. See Link I, which gives further evidence for management of stable COPD. See link A, C and N, which gives further evidence for management in acute exacerbation COPD.
Ambulatory oxygen therapy	Consider ambulatory oxygen in people with COPD who have exercise desaturation and are shown to have an improvement in exercise capacity with oxygen, and have the motivation to use oxygen.	Link Y Section 1.2.63 to 1.2.68
Short term oxygen therapy	Do not offer short-burst oxygen therapy to manage breathlessness in people with COPD who have mild or no hypoxaemia at rest.	Link Y Section 1.2.69

Table 4: Pulmonary Rehabilitation in the management of COPD

Intervention	Further details on intervention	Reference
Pulmonary Rehabilitation	This is a multidisciplinary programme of care for people with chronic respiratory impairment. It is individually tailored and designed to optimise each person's physical and social performance and autonomy.	Link Y https://www.nice.org.uk/guidance/ng115/chapter/Recommendations#oxygen Section 1.2.77 – 1.2.81

Asthma

Table 5. Evidence that supports the management of Asthma

Intervention	Further details on intervention	Reference
Pharmacological therapy	Inhaled therapy and oral therapy	<p>Link S https://www.nice.org.uk/guidance/ng80/evidence/full-guideline-chronic-asthma-management-pdf-4656179345</p> <p>Link T https://www.nice.org.uk/guidance/ng80/Chapter/Recommendations#principles-of-pharmacological-treatment</p> <p>Link U https://pathways.nice.org.uk/pathways/asthma#path=view%3A/pathways/asthma/managing-asthma.xml&content=view-node%3Anodes-person-aged-17-or-over</p> <p>Link V https://pathways.nice.org.uk/pathways/asthma/managing-asthma#content=view-node%3Anodes-difficult-and-severe-asthma</p> <p>Link W https://www.sign.ac.uk/assets/sign153.pdf</p>
Asthma self-management plan	Evidence for personal asthma action plans and what to include.	<p>Link S. page 270</p> <p>Link X https://pathways.nice.org.uk/pathways/asthma#path=view%3A/pathways/asthma/managing-asthma.xml&content=view-node%3Anodes-self-management</p>
Breathing exercises	Dysfunctional breathing is common in people with asthma. Information on clinical and cost effectiveness of breathing exercises is discussed in Link s, pg 317.	Link S. page 317
Monitoring asthma control		Link T

Table 6. Evidence that supports the management of Acute Asthma Exacerbations

Intervention	Further details on intervention	Reference
Oxygen therapy	Supplementary oxygen should be given urgently to hypoxaemic patients, using a face mask, Venturi mask or nasal cannulae with flow rates adjusted as necessary to maintain SpO ₂ of 94–98%, ⁵⁷¹ taking care to avoid over oxygenation which may be detrimental.	Link W https://www.sign.ac.uk/assets/sign153.pdf
Oral therapy	Antibiotics, corticosteroids and further pharmaceuticals.	Link W
Pharmacological inhaled therapy (not including oxygen therapy – see above)		Link W
Non-invasive ventilation		Link W
Asthma care bundle at discharge		Link W
Dysfunctional breathing	It remains unclear what is the best mechanism of identifying and managing this problem.	Link W

An example of good practice of our neighbours: Lambeth and Southwark Community Integrated Respiratory Team

Lambeth and Southwark community integrated respiratory team (IRT) provide all community elements of respiratory care across Lambeth and Southwark. The integration enables close communication between primary care and secondary care. The overlap into secondary care is enabled by Dr Irem Patel who is the Consultant Chest Physician at Kings College Hospital and Guys and StThomas'. There are also several other chest physicians who lead from their respective base hospitals (see Table 7 for link to key contacts). The team is multi-disciplinary and includes, in addition to chest physicians, GPs, nurses, physiotherapists and other allied health professionals.

The team currently offer the following referral services (see table below) for patients within their catchment that have respiratory pathology.

After choosing the appropriate service to refer the patient to, the referral is made via the “choose and book service” or by using the single point referral email. The referral is assessed within 48 hours and contact made with the referrer within this time to advise of the most appropriate next step in patient management pathway.

The locations where patients can be seen for the services are: Kings College Hospital, Guy's Hospital, St Thomas' Hospital, St George's Hospital / Wandsworth community team (home oxygen service only), Mayday Hospital / Croydon community team (home oxygen service only).

The aim is to provide patients with a better patient journey through the NHS from primary through to secondary care. The IRT believe that most chronic respiratory care can be managed optimally at the primary care level, with the aim to reduce hospital admissions and outpatient referrals.

Table 7. The referral services offered by the Community Integrated Respiratory Team (IRT)

Service	Description of Service	Reference
Smoking cessation for sick smokers (Tier 3)	This is a specialist stop smoking service for people with any long term condition. The service will provide intensive clinic and home based support in combination with appropriate pharmacotherapy.	Link Z https://www.kch.nhs.uk/Doc/RF%20-%20094.1
Spirometry and Lung Function Service (advanced lung function service where diagnosis is not conclusive in primary care)	This service can provide diagnostic standard spirometry where practice case finding has suggested a diagnosis of COPD or asthma. They can also help with difficult spirometry and can review patients where past spirometry results do not fit with the suspected clinical diagnosis or results sit outside usual diagnostic parameters.	Link Z.1 guysstthomashospital.newsweaver.co.uk/Connect/1jjzvr1i8gi?a=1&p...t...
Pulmonary Rehabilitation	Any patient with COPD and MRC3 breathlessness or more should be offered referral to pulmonary rehabilitation. The service will also accept people with MRC 2 scores and accepts breathless people with any respiratory disease as long as any cardiac disease is stable.	
HOSAR – Home oxygen assessment and review	Any patient requiring long term oxygen therapy needs to be seen by a specialist in oxygen therapy. This service will see any new patient who the referrer feels may benefit from oxygen and would also like to see patients currently on oxygen who haven't had a review in the last year. When referring it is useful to provide at least one pulse oximetry reading.	
Respiratory Specialist opinion (chest clinic referrals)	The referral pathway will forward the patient to the most appropriate respiratory specialist and venue. The service does not handle 2WW and TB referrals. Virtual clinics have been delivered to practice since April 2013.	
Link to refer to the IRT (integrated respiratory team)		http://nww.southwarkehealth.nhs.uk/local_referral_pathways/referral_forms
Link to Key IRT Lambeth and Southwark contacts		http://www.gstvtvs.co.uk/website/IGP545/files/Lambeth%20and%20Southwark%20Integrated%20Respiratory%20Service%20GP%20VTS%20attachment.pdf

5. Current activities and services in relation to need

Services and activities on offer for adults with asthma and COPD in Lewisham

Table 1 provides a high-level overview of the current services and activities that are available to adult patients with asthma and COPD and has been presented approximately in order of the natural history of respiratory disease – from prevention through to diagnosis, community management and finally escalation to specialist hospital services.

Table 1. Services and activities for adults with asthma and COPD in Lewisham		
Community	Outpatient	Inpatient
Smoking cessation services		
GP diagnosis & management		
Spirometry		
Prescribing		
Pulmonary rehabilitation		
Peer-support group		
Respiratory nursing team		
Assessments, spirometry interpretation, clinic/ward/home reviews & home oxygen		
	Respiratory consultant	
	Clinic	Ward review

* In addition to the above, some Lewisham residents with complex asthma/COPD will be referred for specialist services outside the borough (e.g. COPD patients with non-invasive ventilation at home, patients for consideration of surgical management of COPD, and those with 'brittle' (severe) asthma).

Each of the broad service/activity areas outlined in **table 1** will be reviewed in relation to:

- The local needs of the population as outlined in [chapter 2](#)
- The priority areas of the national and local strategies referenced in [chapter 3](#)
- The evidence of what works (locally and elsewhere) in [chapter 4](#)

This review comprises data from multiple sources (e.g. service data, performance data, targets and hospital admission data) which are often incomplete and not collected for the purpose of a needs assessment. Although the data presented gives some insight into how services are accessed in relation to need, readers should exercise caution in interpretation for the aforementioned data quality issues.

Smoking cessation/tobacco control activities

Smoking cessation is the single-most effective prevention against the development of COPD and asthma exacerbations. There are a number of different tobacco control measures in Lewisham, which are fully outlined in a recent tobacco control JSNA, accessed [here](#). The tobacco control measures can be summarised as follows:

- Stopping the inflow of young people recruited as smokers through trading standard's inspections of tobacco trading premises
- Lewisham's Stop Smoking Service provided at GP practices, pharmacies, University Hospital Lewisham, community centres, maternity services and digital services
- Supporting trading standards to ensure compliance with the restrictions on tobacco advertising at the point of retail sale
- Taking action on illicit tobacco / counterfeit tobacco seizures

Spirometry

Spirometry, alongside a careful clinical history and physical examination, is the main diagnostic test for both asthma and COPD. There is currently a Quality and Outcomes Framework (QOF) around spirometry performance soon before or after a COPD diagnosis is made. As shown in table 2, 87% of patients with COPD in Lewisham have their diagnosis confirmed by post-bronchodilator spirometry between 3 months before and 12 months after entering onto the register.

Table 2. Percentage of COPD patients in Lewisham in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering the register	
Year	Percentage of patients (%)
2016	89.4
2017	88.5
2018	87.1

There is one full-time spirometry technician who performs spirometry at UHL and supports the performance of spirometry in primary care. In the 2017/18 reporting period, a total of 125 visits were made to primary care to support the competence and confidence in spirometry in the community.

Primary care

Table 3. Lewisham QOF COPD outcomes by year	2016	2017	2018
1. Percentage of COPD patients* in whom the diagnosis has been confirm by post bronchodilator spirometry between 3 months before and 12 months after entering onto the register	89.4	88.5	87.1
2. Percentage of COPD patients who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea scale in the preceding 12 months	90.4	88.8	91.4
3. Percentage of COPD patients with a record of FEV1 in the preceding 12 months	83.6	82.8	85.2
4. Percentage of patients with COPD and MRC dyspnoea score ≥ 3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 12 months	95.3	95.7	95.6

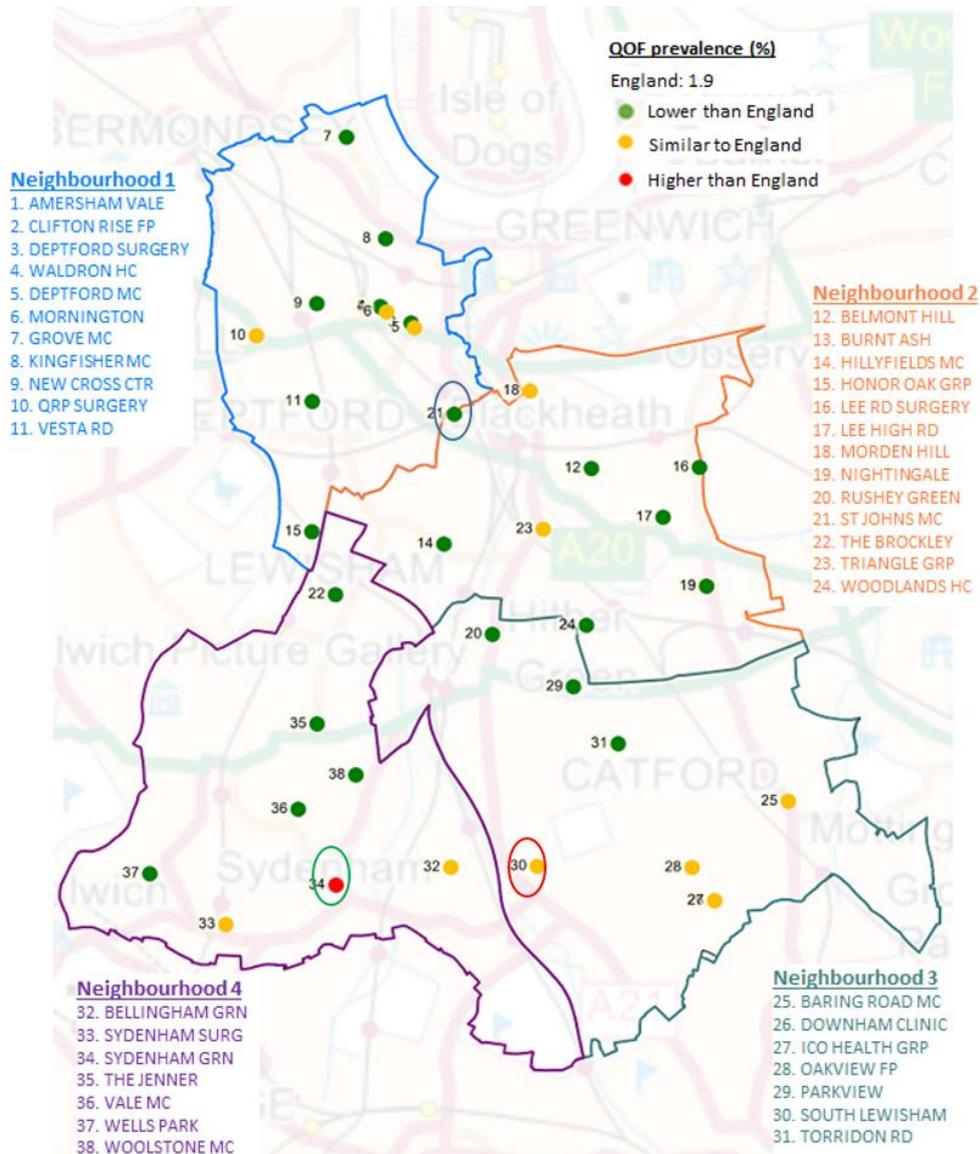
5. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 Aug to 31 March	95.3	95.0	96.4
*diagnosed on or after 1 st April 2011			

Table 4. Lewisham QOF asthma outcomes by year	2016	2017	2018
The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before and any time after diagnosis	88.4	88.8	89.3
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions	75.8	74.6	74.8
The percentage of patients with asthma, aged 14-19, on the register, in whom there is a record of smoking status in the preceding 12 months	88.3	86.5	89.4

Pulmonary rehabilitation

A pulmonary rehabilitation programme is offered to all patients with respiratory disease (of all severity) in Lewisham, called the Lung Exercise and Education Programme (LEEP). It is a six week (12 session) programme, delivered on a rolling basis at 3 locations in the borough, which are depicted in **figure 16**. Further information about LEEP can be accessed [here](#).

Figure 16. Locations (circled) where Lung Exercise and Education programme (LEEP) is available in Lewisham



Source: QOF

Referrals

In 2017/18, 587 people were referred to LEEP:

- 24 (4%) of these referrals were deemed 'inappropriate'
- 266 (45%) of these people had an initial assessment/first appointment
- 189 (32%) of the people referred started LEEP, of whom 124 (66%) completed the course
- All of the people that completed LEEP and responded to the feedback request (n=73) would recommend the service

A more in-depth analysis of referral patterns over a 3-month period (Oct-Dec '18) showed that almost 70% of referrals came from GP practices, with the remainder from inpatient

hospital stays. Of all of the people sent an invitation letter, only 42% responded. It was anecdotally noted by the service provider that many GPs in Lewisham have never referred to the service.

Outcomes

Patients that attend LEEP are accessed pre- and post- the rehabilitation programme on the following outcomes:

- Incremental shuttle walking test (ISWT) – the patients that completed LEEP in 2017-18 improved by 20.6%
- Hospital anxiety and depression score (HAD) – patients reported a mixture of increased and decreased anxiety and depression post-rehabilitation with the overall average % change (in absolute HAD score) of -0.2%, suggesting a very mild improvement on average
- Community assessment tool (CAT) improved by 5.3% on average

Respiratory nursing team

The respiratory nursing team in Lewisham comprises one respiratory nurse consultant and two respiratory specialist nurses who perform a vast range of clinical duties both in the community and the hospital, including:

- **Providing advice to clinicians**
 - In 2017/18, 1,252 requests for email/telephone advice were received
- **Home reviews**
 - In 2017/18, 70 patients with acute exacerbations of COPD were treated at home by the respiratory nursing team (each avoiding hospital admission)
- **Clinic reviews (currently 2 sessions/week)**
 - In 2017/18, 736 clinic appointments with the respiratory nursing team were available (332 for new patients and 404 for follow-up patients)
 - 20% of patients did not attend their appointments (28% for new patients, 14% for follow-up)
- **Home oxygen reviews**
 - The respiratory nursing team review all patients starting on home oxygen from UHL and are responsible for ongoing review of all patients in the borough on home oxygen (even those started on oxygen outside of Lewisham, for example in other London hospitals)
 - There are 262 adult patients on home oxygen in Lewisham in total, of whom 135 have an underlying diagnosis of COPD. Many patients receive home oxygen for non-respiratory purposes (e.g. palliative care/cluster headaches)
 - 181 appointments were available for home oxygen reviews in 2017-18 (and only 1 patient did not attend)
 - 135 domiciliary visits were made in 2017-18 that were related to home oxygen

The respiratory nursing team additionally made 98 referrals to stop smoking services in 2017-18. Of the 995 patients that responded to a request for feedback, 92% would recommend the respiratory nursing team in Lewisham.

Respiratory consultant-led outpatient clinics

There is one respiratory consultant based at University Hospital Lewisham who is the lead specialist on asthma and COPD. Although the clinic sessions held in the chest clinic are

mixed (for all respiratory conditions), the approximate capacity for asthma and COPD patients is two clinics per week. In 2017/18, in these two clinic sessions there were 1,122 clinic appointments available.

- 939 clinic appointments were attended (32% with new patients and 68% with follow-up patients)
- 16% of patients did not attend their clinic appointments (26% for new patient appointments and 10% for follow-up)

A breakdown of new patients attending outpatient appointments at Lewisham’s chest clinic (in 2017-18) by sex and ethnicity is shown in **table 5**, which gives us an idea about how different groups are accessing specialist cares. We can see that:

- Men are slightly under-represented (45% of new patients seen in clinic are male, compared the 50% male Lewisham’s population as a whole).
- Black, Asian and minority ethnic (BAME) groups are slightly under-represented. 41% of the new patients seen in the chest clinic were BAME, compared to 48% of the Lewisham population

There are a few important limitations/quality issues to the data presented in table 5:

- Outpatient data is not coded by diagnosis (unlike inpatient data) and so the data refer to all adult respiratory patients, not only asthma and COPD
- The data refer only to new appointments, not follow-up appointments
- The characteristics (e.g. sex and ethnicity) are only collected for patients that attend their appointments. We do not know the profile of the ~26% of new patients that did not attend their appointment in 2017-18.

Table 5. New patients seen in the Lewisham chest clinic by sex and ethnicity, 2017-18			
	Male	Female	Total
White British	471	534	1005
White Irish	18	15	33
White other	75	110	185
Mixed, white & black Caribbean	9	9	18
Mixed, white & black African	5	6	11
Mixed, white & Asian	1	3	4
Mixed, any other background	8	17	25
Indian	28	25	53
Pakistani	5	5	10
Bangladeshi	7	4	11
Any other Asian	61	50	111
Black, Caribbean	67	120	187
Black, African	92	119	211
Black, any other	29	60	89
Chinese	15	13	28
Any other ethnic group	37	40	77
Not stated	73	86	159
Total	1001	1216	2217

Hospital admissions

Asthma

The number of hospital admissions for asthma has been increasing in the last three years, from 328 admissions in 2015-16 to 403 in 2017-18 (**table 6**) – nb. Referring to admissions in people aged 15+ (due to way data is grouped).

	2015-16	2016-17	2017-18
	328	377	403

Reviewing the hospital admissions for asthma from 2015-2018, we can see that:

- 71% of these hospital admissions were for female patients
- 51% of patients were white (any), 49% BAME
- For females only, 55% patients were white (any), 45% BAME
- For males only, 42% patients were white (any), 58% BAME

	Male	Female	Total
White British	93	350	443
White Irish	2	7	9
White other	18	40	58
Mixed, white & black Caribbean	7	15	22
Mixed, white & black African	2	5	7
Mixed, white & Asian	1	0	1
Mixed, any other background	13	19	32
Indian	1	15	16
Pakistani	2	2	4
Any other Asian	21	24	45
Black, Caribbean	32	115	147
Black, African	26	60	86
Black, any other	21	34	55
Chinese	4	4	8
Any other ethnic group	27	35	62
Not stated	49	64	113
Total	319	789	1108

COPD

There were 910 hospital admissions for COPD in 2017-18 (up 72% from 2015-16 when there were 532 admissions). It is possible that some of this increase may be due to coding inconsistencies, however coding alone is unlikely to explain the whole increase.

Table 8. Hospital admissions for COPD in Lewisham by sex and ethnicity, 2017-18			
	Male	Female	Total
White British	249	376	625
White Irish	12	24	36
White other	27	11	38
Mixed, white & black Caribbean	1	8	9
Mixed, white & black African	0	0	0
Mixed, white & Asian	0	3	3
Mixed, any other background	0	7	7
Indian	7	0	7
Pakistani	2	0	2
Any other Asian	5	2	7
Black, Caribbean	21	43	64
Black, African	4	0	4
Black, any other	5	2	7
Chinese	4	0	4
Any other ethnic group	10	40	50
Not stated	14	33	47
Total	361	549	910

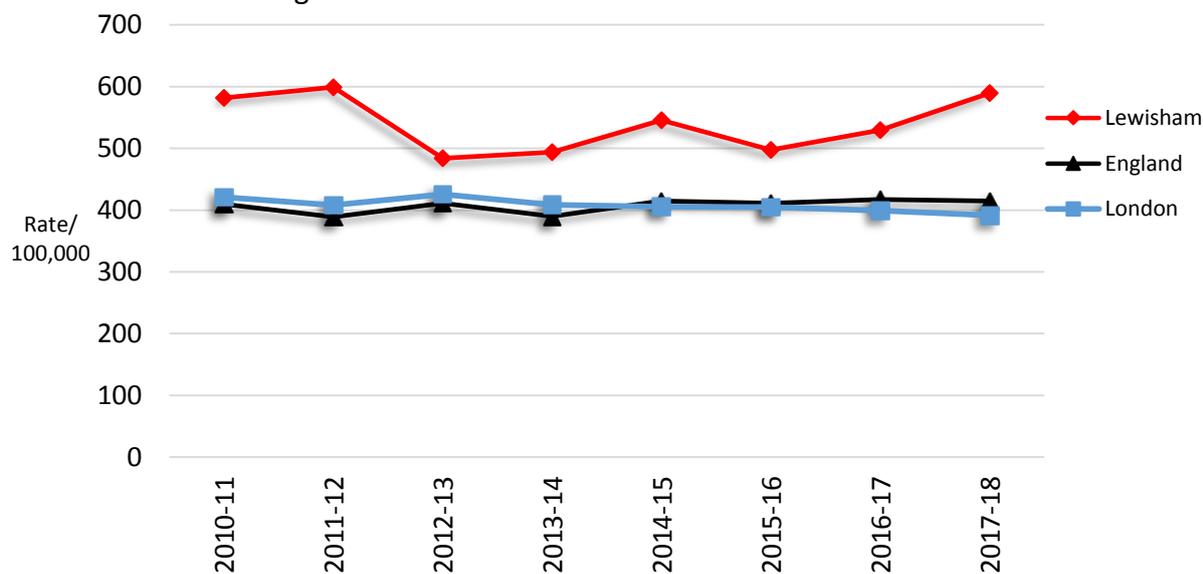
The breakdown of hospital admissions for COPD (in 2017-18) by sex and ethnicity is shown in table 8. We can see that:

- 60% of hospital admissions were for female patients
- 81% of COPD-related hospital admissions were for white (any) patients, 19% BAME
- For males only, 83% of COPD-related hospital admissions were for white (any) patients, 17% BAME
- For females only, 80% of COPD-related hospital admissions were for white (any) patients, 20% BAME

Figures 17 and 18 show the trends in emergency hospital admissions for COPD in Lewisham compared to England, London and other London boroughs. Emergency hospital admissions for COPD in Lewisham have been:

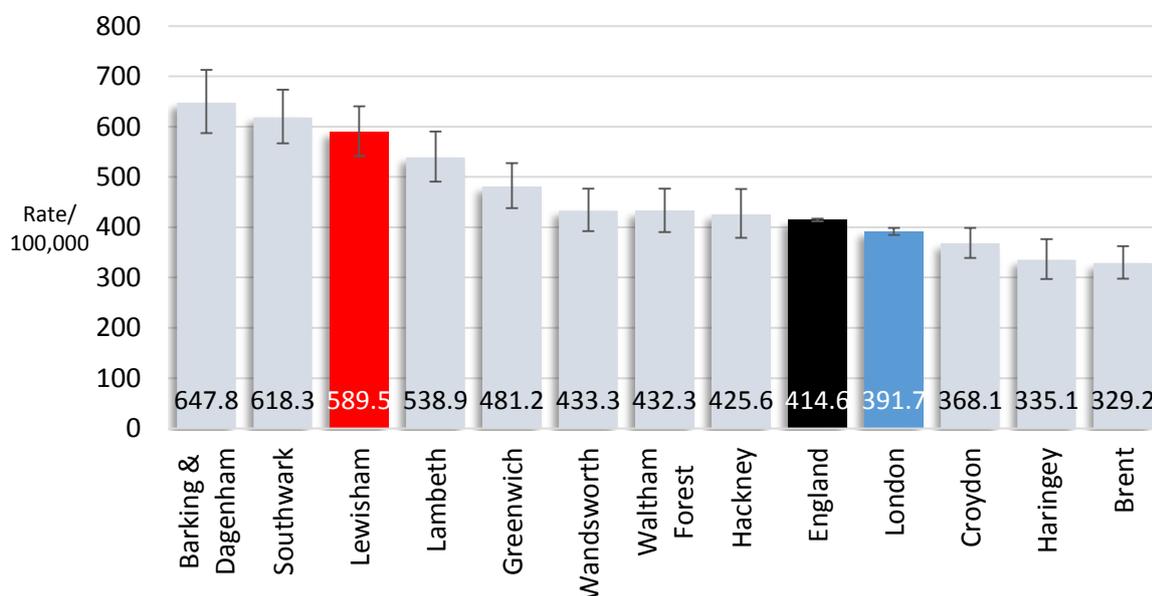
- Fluctuating between ~500 and ~600 per 100,000 population over the past decade, but increasing since 2015
- Higher than the London and England average
- The third highest in London, although similar to neighbouring boroughs Southwark and Lambeth

Figure 17. Emergency hospital admissions for COPD. Directly age-standardised rates/100,000 population aged 35+. Lewisham compared with London and England. Annual trends



Source: HES (<https://fingertips.phe.org.uk/>)

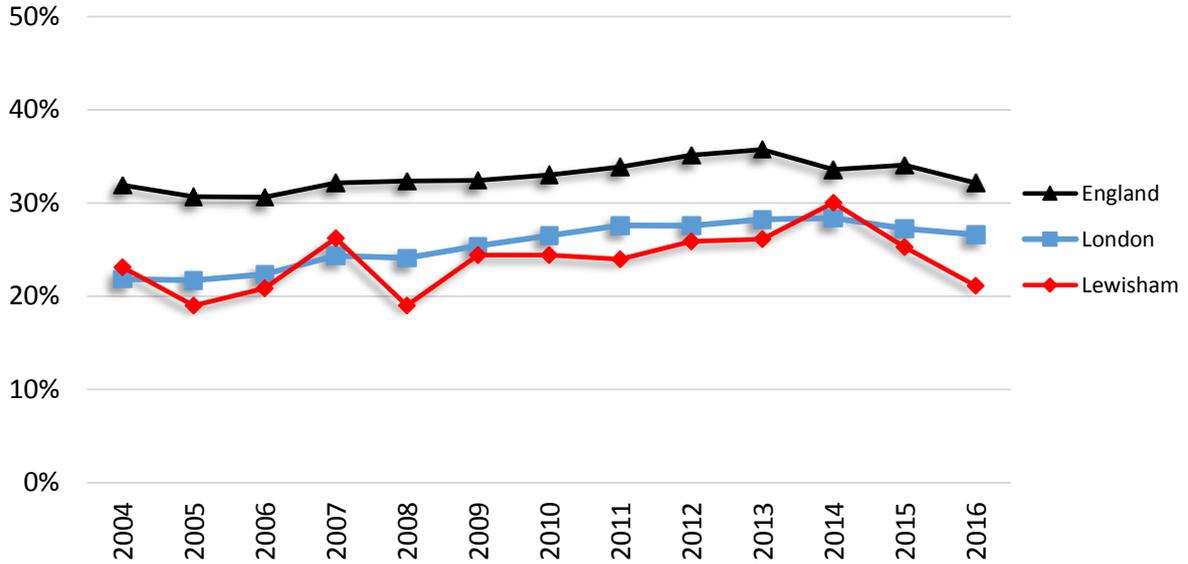
Figure 18. Emergency hospital admissions for COPD in persons aged 35+. Directly age-standardised rates/100,000 with 95% confidence Intervals. Lewisham compared with its statistical neighbours, London and England, 2017-18



Source: HES (<https://fingertips.phe.org.uk/>)

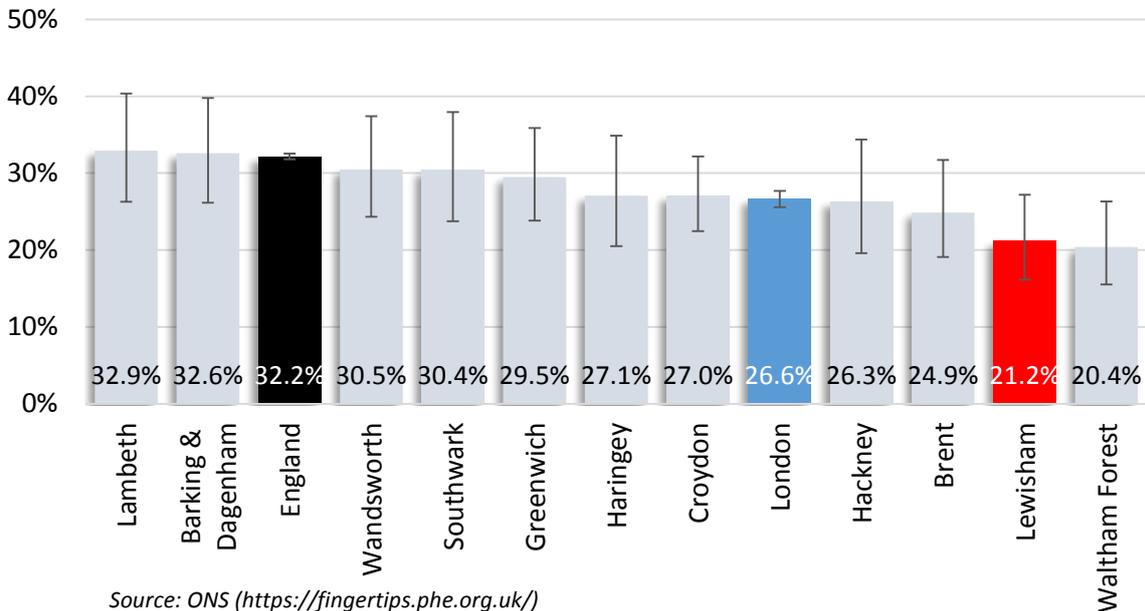
21% of Lewisham’s respiratory deaths in 2016 occurred at individuals’ usual place of residence – lower than the London or England average, as well as neighbouring boroughs Lambeth and Southwark.

Figure 19. Percentage of deaths with underlying cause of respiratory disease that occur in usual place of residence for persons of all ages. Lewisham compared with London and England. Annual trends



Source: ONS (<https://fingertips.phe.org.uk/>)

Figure 20. Percentage (with 95% confidence intervals) of deaths with underlying cause of respiratory disease that occurred in usual place of residence for persons of all ages. Lewisham compared with its statistical neighbours, London and England, 2016



Source: ONS (<https://fingertips.phe.org.uk/>)

6. Changes on the horizon

New guidelines on spirometry performance, interpretation and reporting (ARTP, 2021)

On the 12th September 2016 there was the launch of a competency assessment framework 'Quality Assured Spirometry', and this document sets the minimum competency standards for healthcare practitioners performing spirometry. The ARTP spirometry qualifications are now the recognised competency assessment qualifications for all practitioners performing spirometry. The ARTP are now also responsible for holding the national register of spirometry accredited practitioners at all levels. The document can be accessed via [this link](#). The framework will be phased in commencing 1st April 2017 with full implementation by 31st March 2021.

- Essentially, the change means that by March 2021, anyone performing or reporting on spirometry will need to complete an assessment – around 3 months' online training and 3,000 word assessment.
- Further information available at: <http://www.artp.org.uk/en/spirometry/>

New community respiratory clinic (including spirometry)

At the time of writing this JSNA, the CCG were considering commissioning a new community respiratory clinic which would include spirometry.

New South East London integrated asthma and COPD guidelines expected Q4/Q1. Colour/flag system.

- For asthma, this will combine BTS and NICE guidelines which currently differ with regards to leukotriene receptor antagonists (recommended by NICE but not BTS)
- For COPD, the guidelines will be more 'phenotypic' i.e. separate management pathways for patients with and without exacerbations and patients with asthma-crossover

Reduction in smoking cessation services

- A reduced smoking cessation service has been commissioned through the local authority for a 3 further years.
- At the time of writing this JSNA, a digital smoking cessation platform was being promoted by the smoking cessation service.

Pneumonia pilot starting soon

- A pilot programme of management of pneumonia was being planned at the time of writing this JSNA.
- The pilot programme will involve trialling the use of 4 portable ultrasound units in primary care for the diagnosis of pneumonia in order to better triage patients requiring secondary care input. Three of ultrasound units will be in three practices in the borough, with one in the GP assessment unit. .
- The pilot also involves training ~12 clinicians (10 GPs, 2 nurses) in ultrasonography.

Changes to QOF

- An additional QOF measure will include offering pulmonary rehabilitation to all patients with COPD.

7. Local views

It is important to consider how local residents and communities view the issues raised about adult asthma and COPD in Lewisham. A consultation was held with the attendees of 'Breathe-Easy', Lewisham's peer support group for people with chronic respiratory disease.

Consultation with Breathe-Easy (Lewisham peer-support group), March 2019

The following themes and concerns were identified:

- Lack of information about diagnosis, spirometry, inhalers, end-of-life care
 - Discussion with practice nurse or respiratory nurse preferred for information
- Difficulty accessing GP appointments
- LEEP very well-regarded
 - although most people asked to be referred themselves or were referred from hospital (none proactively from GP)
- Aware of services/activities available in other boroughs
 - Community respiratory teams, COPD choir in Dulwich

National Outcomes Strategy for respiratory disease (DOH), 2011

A consultation was held with the public, people with COPD and asthma, their carers and clinicians on what they want from services.

The general public concluded that their needs are for:

- Information and advice on how to reduce their risk of respiratory disease;
- Timely access to services which can help them reduce their risk of respiratory disease or of making it worse;
- Information on the symptoms and signs of respiratory disease to help them seek help early;
- The reassurance that if they or their relatives develop respiratory disease they have rapid access to high quality services that can meet their immediate healthcare need.

People with COPD and asthma and their carers want:

- Timely access to comprehensive quality assured assessment and diagnostic services;
- Information related to their condition and how it is managed to be available to all practitioners involved in their care irrespective of the setting;
- Access to reliable information about their condition which sets out all the options so that they can make choices which are appropriate for them;
- Easy access to comprehensive information about the services available to them and the outcomes achieved by these services;
- To be empowered to make choices about their care where these are clinically appropriate and to be supported in decision making to the extent that they wish;
- To know that they will receive the support they need whilst living with their condition and to be supported to remain in work and play an active role in society and local communities;
- To be treated as a whole person, often with a range of other conditions;
- To know that everyone involved in their care has the necessary skills, training and expertise and be reassured that everyone involved in their care will work effectively

together, so that their care will feel seamless even when delivered in different locations;

- To be able to access specialist services without delay should they need to do so; and to be assisted where necessary to remain at home;
- To know that if they are approaching the end of life their preferences for care will be discussed with them and every effort will be made to meet their needs and their preferences;
- To be treated as a whole to enable them to fully undertake activities of daily living and for the care providers to act as one team.

Health and social care professionals want:

- The training, support and information they need to deliver high quality care and deliver good outcomes;
- To work in a service which is well managed, so that their time is used effectively and so that care is streamlined for people with COPD and Asthma;
- To be able to compare the outcomes they achieve with those achieved elsewhere in this country and in other countries;
- To be free to make the choices which they feel will benefit their patients the most
- To be recognised for the specialist skills and knowledge that they possess and for this to be fully utilised to deliver better outcomes for people;
- To be able to work across traditional boundaries of care and to be supported to be innovative and to deliver care differently;
- To have information about the people they care for, that is shared and easily accessible across the whole health system;
- To be supported in creating the evidence on which models of care needs to be based.

8. Key gaps in knowledge and services

Key gaps in knowledge and services have been discussed in previously chapters, but can be summarised as follows:

Gaps in knowledge and data

- Throughout this JSNA, we have highlighted the limited availability of data about protected characteristics, especially in terms of access to services.
- There is specifically a lack of data specific to prevention, including whether smoking cessation advice has been offered to patients throughout the respiratory pathway.
- In the development of this JSNA, some coding inconsistencies were mentioned from the hospital (e.g. issues with hospital admission coding and lack of outpatient coding by diagnosis).
- A gap in this JSNA itself was that it did not cover paediatric asthma services (and the transition to adult services).

Prevention

- Smoking cessation services shrinking.
- No local asthma/COPD exacerbation guidelines, which may be helpful in preventing hospital admissions/re-admissions.

Under-diagnosis of COPD

- Spirometry access patchy across the borough.
- No active case-finding for COPD.

No dedicated community respiratory team

- A lack of Integration between community and chest clinic services was identified.
- An integrated community team would be able to consider the more holistic role of care e.g. including:
 - Dietician
 - Palliative/end-of-life care
 - Psychologist
 - Social advice, re. work/housing etc.
 - Smoking cessation
 - Social prescribing
- No integration with drug & alcohol services.
- Individual with severe asthma or COPD are often seen by a specialist outside the borough.

Pulmonary rehabilitation (LEEP)

- Referrals low across the borough and some GPs not referring to LEEP at all.
- Accessibility in all parts of borough (and no information on protected characteristics)
- Inequalities in accessing care and support - by sex and ethnicity, and limited information about accessing care for house-bound patients who may be better served by an integrated community team.

9. JSNA action plan

The following recommendations are based on:

- *Addressing gaps identified*
- *Impact on equalities*
- *Opportunities for savings*
- *Commissioning priorities*

Prevention

Smoking cessation services/very brief advice

- To continue to invest in stop smoking services and to encourage more Lewisham residents to quit smoking.

Early and accurate diagnosis

- To identify and diagnose new cases of COPD and asthma in primary care.
- To ensure there is active case finding that is effective in closing the gap between recorded and expected prevalence.
- Active case-finding measures could involve population health management systems, opportunities at health checks and walk-in/drop-in clinics.
- To ensure that there is adequate access to spirometry in Lewisham to support early diagnosis of COPD.

Pulmonary rehabilitation

- To commission sufficient pulmonary rehabilitation services to meet local need.
- To promote the LEEP service and increase referrals into the service from all GPs across the borough.

Managing exacerbations

- Clear exacerbation-pathways separate for asthma/COPD to be developed.
- The use of virtual/digital services or group consultations could be considered in the management of exacerbations.
- Higher visibility respiratory leadership in primary care networks may be beneficial.
- Promotion of self-management

Integrated/community respiratory team

An integrated community respiratory team would be beneficial in terms of consideration of more holistic care. For example, respiratory patients may benefit from the following types of input:

- Dietician
- Palliative/end-of-life care
- Psychologist
- CAB – work/housing advice
- Smoking cessation
- Social prescribing
- Drug & alcohol services

Chronically unwell

- A further needs assessment on house-bound patients/end-of-life patients would provide much needed information on this population.

Home oxygen service

- A dedicated home oxygen service could be considered and may work well across boroughs as has been commissioned in other regions.

Opportunities for savings

The current pattern of service utilisation, featuring as it does high spend for non–elective treatment, is not the most cost effective and there are opportunities to improve outcomes for patients whilst reducing costs, these include;

- Ensuring a more systematic evidence based approach to care management in primary care in line with NICE guidance and identified local areas of need
- Further developing accessible community based respiratory services;
- Establishing alternative assessment and treatment services which are able to offer alternatives to emergency hospital admission for this group of patients.
- Smoking cessation services / tobacco control initiatives

Potential further needs assessments

- Paediatric asthma / transitioning from paediatric to adult services for chronic diseases
- House-bound patients / nursing home residents / end-of-life care.

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Health & Wellbeing Board

Annual Public Health Report 2020

Date: 12 March 2020

Key decision: No.

Class: Part 1

Ward(s) affected: ALL

Contributors: Dr Catherine Mbema, Director of Public Health, London Borough of Lewisham

Outline and recommendations

This report introduces the 2020 Annual Public Health Report (APHR) by the Director of Public Health.

This year's report focuses on the Health in All Policies approach, providing case studies of how it has been implemented across Lewisham Council and with wider partners. It also contains a set of recommendations as to how the approach can be further embedded by working across the system to increase understanding and build capacity to implement a health in all policy approach when developing ideas.

The board is recommended to note the contents of the report and consider how it can support the implementation of the recommendations, particularly with regard to the development of the new Health and Wellbeing Strategy for Lewisham.

Timeline of engagement and decision-making

This paper is being submitted for consideration by the Health and Wellbeing Board.

It will also be presented to the Healthier Communities Select Committee on 18th March 2020.

1. Summary

- 1.1. This report introduces the 2020 Annual Public Health Report by the Director of Public Health. This year's report focuses on the Health in All Policies approach, providing case studies of how it has been implemented across Lewisham Council and with wider partners. It also contains a set of recommendations as to how the approach can be further embedded by working across the system to increase understanding and build capacity to implement a health in all policy approach when developing ideas.

2. Recommendations

- 2.1. The board is recommended to note the contents of the report and consider how it can support the implementation of the recommendations, particularly with regard to the development of the new Health and Wellbeing Strategy for Lewisham.

3. Policy Context

- 3.1. The Health and Social Care Act 2012 stated that the production of an APHR is a statutory duty of the Director of Public Health, which the local authority is responsible for publishing.
- 3.2. The APHR will be presented to the Healthier Communities Select Committee at its meeting on 18th March 2020.

4. Background

- 4.1. The evidence behind the benefits of implementing a Health in All Policies approach and the impact it has on population health and health inequalities, has been growing over the last decade both nationally and internationally. In recent years both Public Health England (PHE) and the Local Government Association (LGA) have published guidance for local areas to implement a Health in All Policies Approach, acknowledging their consensus on the effectiveness of this approach on improving the social determinants of health and reducing health inequalities in a local context (PHE, 2016 and LGA, 2016).
- 4.2. In Lewisham, Councillors recently came together to participate in a Health in All Policies workshop, facilitated by the Local Government Association, focussing on the fundamentals of the approach, local progress to date and the next steps in implementing this approach across the Council. To maintain focus and momentum on this aspect of council policy development, the Director of Public Health chose to focus her Annual Public Health report for 2020 on this topic.

5. Annual Public Health Report 2020

- 5.1. The report highlights the variety of influences on health and wellbeing and how the vast majority of these influences fall outside the remit of health service provision.

The first chapter provides an overview of the Health in All Policies approach and outlines the ways in which it can be used.

The main body of the report presents examples of where a 'Health in All Policies' approach is already being successfully adopted in the work of teams within Lewisham Council and partner organisations. These examples include:

- A collaboration with Adult Learning Lewisham to measure health and wellbeing outcomes in adult learners.
- Working with the Transport Team to develop Lee Green as Healthy Neighbourhood.
- Support to the Early Years Education Team to engage Lewisham early years settings in the Healthy Early Years London programme.

The report concludes with a set of recommendations about how we can work positively to influence health and wellbeing for all in Lewisham. The recommendations include:

- Continuing to work with stakeholders across the council and wider system to increase understanding and build capacity to implement a health in all policies

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approach when developing ideas.

- Developing a framework to enable the ongoing and robust assessment of the impact of policy decisions on health and health inequalities within the Lewisham population.

6. Financial implications

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

7. Legal implications

7.1. The requirement to produce an APHR is set out in the Policy Context section.

8. Equalities implications

8.1. This report has no specific implications for equalities however it highlights how taking a Health in All Policies approach to strategy development and service planning is a key method of tackling inequalities in population health and how people experience the social determinants of health.

9. Climate change and environmental implications

9.1. There are no direct climate change or environmental implications from this report. However the report highlights the opportunities for a Health in All Policies approach to support joint working between Public Health, Environmental Health and Transport Teams to achieve further improvements in environmental health and actions to mitigate and reduce the impacts of climate change for the residents of Lewisham.

10. Crime and disorder implications

10.1. There are no direct crime and disorder implications from this report. However the report highlights the opportunities for a Health in All Policies approach to build on the work already being undertaken by the Council's Public Health and Community Safety Teams, the Metropolitan Police and local communities to improve community safety and reduce the prevalence and impact of violence across Lewisham.

11. Health and wellbeing implications

11.1. The report highlights the benefits of taking a Health in All Policies approach to improving population health and wellbeing, positively influencing the wider determinants of health and tackling health inequalities. The report concludes with a number of recommendations which, if implemented, will support further improvements in the health and wellbeing of the Lewisham population and positively impact on the wider determinants of their health.

12. Background papers

12.1. Health In All Policies. The Annual Public Health Report of the Director of Public Health for Lewisham. 2020

13. Report author and contact

13.1. Dr Catherine Mbema, Director of Public Health, catherine.mbema@lewisham.gov.uk

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Annual Public Health Report

Health in All Policies

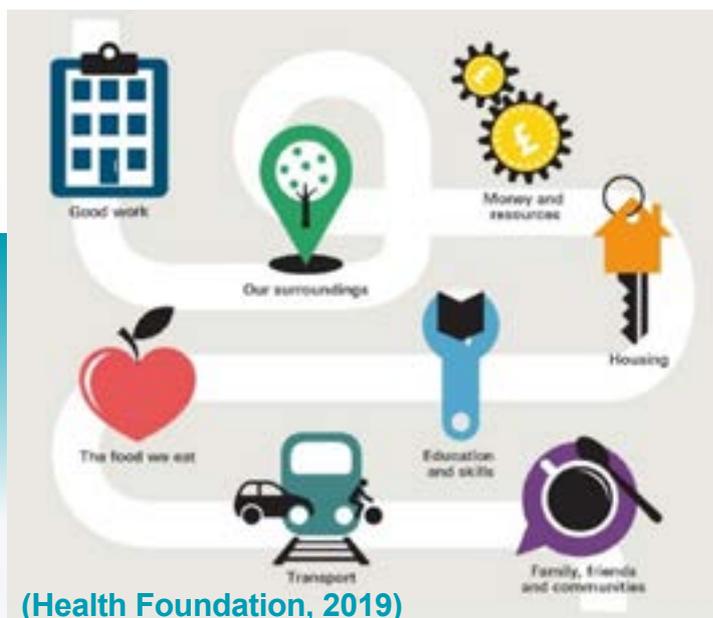
Dr Catherine Mbema
Director of Public Health
December 2019

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Dr Catherine Mbema,
Director of Public Health



It is now well recognised that our health and wellbeing as individuals, families and communities is influenced by a whole range of things that span beyond access to good healthcare. Some of these ‘health influencers’ include the homes that we live in, the work that we do, the money and resources that we have access to and the food that we eat.

Colleagues at the Health Foundation have depicted these factors in the helpful infographic above right. Most of these ‘health influencers’ fall outside of the typical remit of those involved in providing healthcare services. This means that most of us, particularly those in the local authority and local community, will have some role to play in improving health and wellbeing locally whether we run a local community group in the borough, maintain our local parks and open spaces or run a local food business.

I’m therefore very pleased to be starting my role as Director of Public Health with this report on how we can all recognise our role in influencing health and wellbeing by embracing a ‘Health in All Policies’ approach. This approach quite simply provides a means for us to all recognise and embed health and wellbeing into the work that we do. The first chapter of the report will provide an overview of the approach and outline the ways in which

“This approach quite simply provides a means for us to all recognise and embed health and wellbeing into the work that we do.”

a ‘Health in All Policies’ approach can be used. The main body of the report presents examples of where a ‘Health in All Policies’ approach is already being successfully adopted in the work of teams within Lewisham Council and partner organisations, for example with transport teams, community partnerships and adult education colleagues.

The report will conclude with a firm set of recommendations about how we can work together to adopt this approach to positively influence health and wellbeing for all in Lewisham. I look forward to seeing further examples of ‘Health in All Policies’ work in the coming year.

Dr Catherine Mbema
Director of Public Health
February 2020



Councillor Chris Best,
Deputy Mayor and Cabinet Member for Health and Social Care

We all have a role to play in ensuring all of Lewisham's residents have a high quality of health and wellbeing. I am pleased that this year's annual public health report focusses on how the council, partners and community are working together to realise this and hope that this will inspire more collaborative work around taking a 'Health in All Policies' approach.

From being one of the first councils in the country to be selected for the Childhood Obesity Trailblazer Programme, to our work to evaluate and tackle BAME health and mental health inequalities, there is much to be proud of in our partnership work. I encourage all colleagues to consider how they can work across teams to improve residents' health and wellbeing.

Councillor Chris Best
Deputy Mayor and Cabinet Member for
Health and Adult Social Care
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“I am pleased that this year's annual public health report focusses on how the council, partners and community are working together to realise this”

Report contributors

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Background to Health in All Policies

Health is much more than not being ill or needing access to healthcare. Many of the current major health challenges faced in England such as poor mental health, obesity and diabetes affect certain sectors of the population more than others. Evidence shows that these inequalities in people’s health are largely determined by the social, economic and environmental conditions they live in, (referred to as ‘the wider determinants of health’ fig.1).

Local authorities have a duty to improve health and reduce health inequalities of their local communities and to do this effectively this issue needs to be part of everyone’s business. The wider determinants of health have a much greater impact than medical care on how long and well people live. This is clearly shown in the difference seen in life expectancy between the most and least deprived LA’s in England, for males this is a difference of 9.3 years. This is also seen in Lewisham where life expectancy is 7.2 years lower for men and 6.1 years lower for women in the most deprived areas of Lewisham than in the least deprived areas.

Estimates of the contribution of different factors to people’s health have suggested that health behaviours (such as smoking and diet) and

Since 1948 the World Health Organisation definition of health is ‘health is much more than healthcare but a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity’

socio-economic factors (such as education and employment) are the biggest contributors to health, but that health services (clinical care) is still important and significant (fig.2).

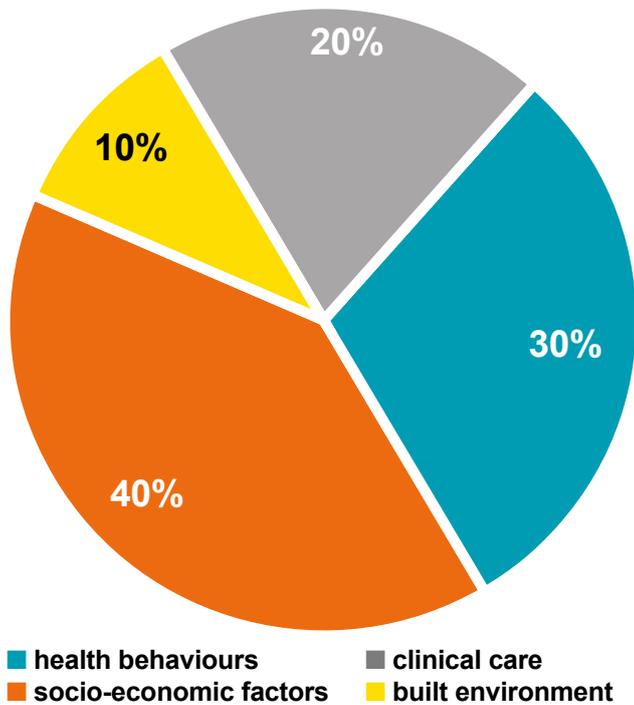
Because of the many factors involved in shaping the social determinants of health and the complexity of the issues in each layer it is unlikely that one sector can successfully impact on health on its own. However, these factors can be influenced and changed if sectors work together to improve health. This will also deliver additional co-benefits, as actions that improve health will also have other benefits such as educational attainment.

Figure 1.
Social determinants for health model (source LGA)



Health in all policies (HiAP) is an established approach to improving health and health equity through a whole systems approach with collaboration between local government, organisations and communities working together on the wider determinants of health.

Figure 2.
Relative contributions to health (source LGA)



Health behaviours

- Smoking
- Diet/exercise
- Alcohol
- Poor sexual health

Socio-economic factors

- Education
- Employment
- Income
- Family/social support
- Community safety

Definition

Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. It improves accountability of policymakers for health impacts at all levels of policy-making. It includes an emphasis on the consequences of public policies on health systems, determinants of health and wellbeing.

The Helsinki Statement on Health in All Policies 2014.

HiAP is based on the concept that the environment that people are born, live, study, work, relax and grow old shape their health

outcomes. Individual choices affects health but are always made in the context of the wider determinants (economic, social and physical environment) that can affect every decision. This concept should be regularly communicated through the process, as for many the first option when asked to address poor health is through better access to healthcare and lifestyle choices. There is no ‘right way’ to incorporate HiAP but general principles apply:

- **Promote health, equity and sustainability** – incorporate into policies and programmes and embed into decision making
- **Support intersectoral collaboration** – build partnerships recognising links between health and other policy areas
- **Benefit multiple partners** – ‘win-win’ approach, all partners have something to gain from HiAP
- **Evidence that partnerships work** – clear focus on outcomes
- **Engage stakeholders** – essential that work is responsive to community needs
- **Create structural or procedural change to embed HiAP** – policy decisions to be seen through health and equity lens
- **Develop common monitoring & evaluation tools** – agreement between partners on what constitutes success for a HiAP approach HiAP can be used across the whole organisation, partnership or sector and can also be applied to specific policies, programmes and strategies.

There are many ways that that HiAP can be implemented, these include:

- **Focus on a specific public health issue** such as obesity or air quality where a multi partnership and cross sector commitments can lead to major change.
- **Focus on a key policy area** such as housing or transport that have significant health impacts.
- **Focus on a window of opportunity** that provide opportunities to engage in collaboration for health.
- **Focus on changing structures or practice** to establish and/or use a mechanism or process to embed policy.

Case studies from across the Council



Neighbourhood Community Development Partnerships (NCDPs)

AIM

Neighbourhood Community Development Partnerships (NCDPs) are made up of local voluntary and community sector organisations (VCSOs) and statutory agencies based in all four Neighbourhoods in Lewisham. Each of the four partnerships is led by local community development workers employed by Age Concern, who support members to identify community-level health and wellbeing priorities and to develop local solutions to address them. Using an asset-based approach NCDPs are encouraging VCSOs and other key stakeholders to share skills and resources in order to strengthen community networks.

Relationship with Public Health

To help with the development of each NCDP, grants have been made available from Lewisham's Public Health team for community projects which focus on locally identified health and wellbeing priorities. Using a combination of available health and wellbeing data and evidence highlighting the key health and wellbeing issues across the borough and local community knowledge, grants are encouraged from innovative partnership approaches that seek to address the key areas of concern.

Partnership

The development of NCDPs has formed out of a partnership approach between Age Concern and Lewisham Council. Council Officers from the Public Health team and Culture and Communities team have supported the development and the ongoing administration of the partnerships. The Public Health team have supported the prioritisation work of the NCDPs by providing local health and wellbeing data and other available evidence as well as assisting with the shortlisting and distribution of the small grants.

Outline of the work

There are four NCDPs located in each of the Lewisham Neighbourhoods who meet on a quarterly basis. The partnerships focus on the following overarching aims:

- Reduced social isolation and loneliness
- Increased access to routes to improve health and wellbeing
- Structures in place to ensure local community development activity is coordinated at a neighbourhood level
- Communities identify local health and wellbeing priorities that matter to them and develop solutions
- Develop existing local assets to build networks leading to greater community cohesion and control
- Recruit and train local volunteers

Engagement

Each of the Partnerships also develop their own local health and wellbeing priorities at a workshop event every year. Partnership meetings provide opportunities for networking and information sharing for all key stakeholders supported by the Community Development worker leads.

The Public Health grants application process is launched each summer to allow time for community groups to work together to develop project ideas for their local area. 30 community projects have been funded between 2017-2019. The funded projects are wide-ranging and innovative. They range from increasing social opportunities for older people, IT training programmes, gardening projects, young film makers and cookery classes.

What difference was made

Over 170 different VCISOs have attended the NCDPs since their formation. The partnerships have resulted in a greater collaboration between community organisations. This has resulted in the creation of a number of innovative local collaborative projects. Many projects are intergenerational with participants aged under 18 to over 85. Some projects are

ethnic minority cultural celebrations attracting 48% of participants from BAME groups. Other projects address men's mental health but overall participants' gender is roughly equal; 57% women and 43% men.

The work of the NCDPs was recognised nationally as they were shortlisted in the community involvement category at the national Local Government Chronicle awards in 2019.

Challenges

One of the main challenges has been to ensure that all VSCO stakeholders have an equal voice and are supported to develop project plans. Smaller organisations do not necessarily have the capacity or skills and require greater input from the community development workers. There is also more work to be done to ensure that the work of the NCDPs is communicated to wider stakeholders.

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NCDPs have shown that partnership working can result in increased community connectedness and cohesion.



Measuring Health and Wellbeing Outcomes in Adult Education

AIM

Adult Learning Lewisham (ALL) is Lewisham Council's adult education service. ALL have developed an Outcomes Framework in order to capture the main outcomes and benefits of adult learning. Six types of outcomes have been identified (through a literature review, participant research and first principles) including Health & Wellbeing Outcomes. The project, over the past year, has been to identify and measure the health and wellbeing outcomes of adult education. This was partly through direct surveys (SF-8 short survey) and partly through a universal question that all learners have been asked as part of their individual learning plan.

Relationship with Public Health

ALL have been working on monitoring health outcomes since 2015, and have been working on specific projects with the Public Health since 2016. This includes work with the Director(s) of Public Health as well as specifically contributing to the following initiatives over the past few years: ALL's contribution to the Public Health and Wellbeing Strategy; ALL's support for public health initiatives such as Sugar Smart; ALL's contribution to the development of Lewisham's Social Prescribing Framework; and the SF-8 health outcomes pilot.

Partnership

Initial meetings were held with key officers in 2015, followed by an invitation to the Public Health team meeting in which an extensive range of joint initiatives were discussed. The successful initiatives were those that were congruent with the aims and priorities of ALL and Public Health, and to which resources were already being committed. These are listed above.

Outline of the work

For the health outcomes pilot there were two separate strands. The first strand was the development of a simple survey question that ALL learners could be asked at the beginning and at the end of their course as part of their Individual Learning Plan (ILP), to give a simple measure of the health (and wellbeing) outcomes of particular courses. These results were collated at the end of each year, to give an overview of the health impact of ALL. The second strand was in partnership with the Learning & Work Institute to pilot 'social metrics' which we hoped would give a valid and reliable measure of health outcomes – using the SF-8 short form survey.

Engagement

Project leaders worked with heads of department and tutors to identify the most appropriate courses and groups of learners for the pilots. For the SF-8 survey we concentrated on classes aimed at those with mental health issues, for the ILP version we asked for volunteer tutors. Very basic instructions were issued to tutors who then administered the surveys as part of their ILP planning and review process. Aside from the evidence that these surveys provide, they provide the data for the tutor to deliver personalised and targeted support for the learner.

What difference was made?

At a recent Local Education Authorities' Forum for the Education of Adults (LEAFA) Executive Board meeting we presented our research, and agreement was reached to run a national pilot of our latest learning plan/ outcomes survey. This will provide a large amount of data which will better inform future curriculum, health, and social prescription decisions. It will also provide a framework for tutors and curriculum leaders to help learners develop in areas beyond course objectives and certification.

Challenges

The SF-8 survey presented challenges because it is a commercial product and would be expensive to use on a large scale. The results

were also inconclusive, and this highlighted how this was a clinical tool, and probably not suited to the interventions we provide. We have used these pilots to address the challenges that the ILP survey presented, such as the depth and number of questions that tutors and learners felt most appropriate and how to let learners have control of the outcomes they were aiming for, the result being a usable survey for a national pilot. We still face challenges around the best way to gather the information (paper based, online, an app) and if or how to measure distance travelled. We hope to address these in the next phase of pilots.

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Time spent on pilot projects is time well spent.



Encouraging Good Air Quality in Lewisham

AIM

Improve Air Quality through engagement with local stakeholders (healthcare providers, schools, businesses & community groups).

Relationship with Public Health

Public Health's remit includes responsibilities around air quality and work closely with Environmental Protection who have traditionally led on air quality work. The Director of Public Health (DPH) is responsible for sign off of Lewisham's Annual Status Report for Air Quality and Air Quality Action Plans.

Partnership

Public Health was instrumental in establishing liaison with University Hospital Lewisham with the aim to engage to reduce their impact on local air quality through local solutions to reduce congestion on roads.

Outline of the work

In 2018/19 the council secured funding for a Clean Air DEFRA Grant, which funds The Clean Air Villages project. This is delivered by Cross River Partnership (CRP) for Lewisham in partnership with; the London Boroughs of Camden, Hammersmith and Fulham, Lambeth, Wandsworth, the Royal Borough of Kensington and Chelsea and Westminster City Council, Cadogan Estates (landowners), and Euston Town BID. The programme aims to reduce emissions in 13 hotspots of poor air quality across 7 London boroughs. Within these hotspot villages, working with businesses and communities to make deliveries and servicing more

efficient, using both individual and collective action. Businesses and communities are engaged through workshops, seminars and 1-to-1s. The areas identified are within the GLA defined Air Quality Focus Areas and for Lewisham, Deptford High Street area and Lewisham Town Centre are the two designated villages.

Engagement

Cleaner Air Village is a behaviour change project, which works with businesses focussing on the dual benefits of improving air quality whilst also saving them time and money through more efficient operations. CRP works with businesses in these villages to offer 1 to 1 support to help businesses reduce emissions from business-related deliveries and services. There is also a tailored solution for each village. The CRP will enable the sharing of best-practice and learning across villages.

What difference?

Outcomes will be as a result of actions taken by businesses in the 13 villages which will reduce demand for delivery and servicing trips, and increase the number of trips undertaken by ultra-low emission vehicles.

Challenges

Clean Air Village is promoting air quality-related behaviour change from a wider community perspective (including residential and commercial transport and travel), there has been some limitation on the business engagement around Lewisham.

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University Hospital Lewisham is a key partner to engage in air quality improvement work



Lewisham and Lee Green Healthy Neighbourhood

AIM

Healthy neighbourhoods is a programme that will change our streets to encourage people to walk and cycle rather than drive, improving local people's health through encouraging physical activity and improving local air quality.

Interventions include:

- Traffic management measures including banned turns and modal filter installations that stop vehicles passing but allow pedestrians and cyclists through.
- Road closures outside schools during pick-up and drop-off times to address congestion and parking, encourage more active travel to school and improve air quality.

Complementary measures such as:

- contra-flow cycling (cycling both ways along one-way streets)
- improved pedestrian crossing points
- secure cycle parking
- street trees
- benches
- electric vehicle charging points

Relationship with Public Health

Over recent years the aims and objectives of both Public Health and Transport Policy have become increasingly aligned with priorities around getting the general population more active through encouraging the use of sustainable travel opportunities an obvious crossover in both services. The drive for essential car use to be through cleaner fuelled electric vehicles also has knock on improvements in air quality and health.

Partnership

As well as the Healthy Neighbourhood programme, partnership working between Public Health and Transport includes aligning polices and Public Health's Schools Super Zones programme.

Outline of the Work

Proposing the introduction of a series of model filters to specified locations, restricting motorised through traffic to access only, thus reducing traffic flows and creating favourable walking and cycling conditions. Also delivering supporting measures in the form of School Streets (timed closures outside school entrances at drop off and pick up times) as well as cycle parking and electric vehicle charging points.

Engagement

Using Sustains (walking and cycling charity) we have delivered a programme of in depth and engaging public consultation understanding the local issues and inviting suggestions for solutions. The engagement took the form of both online and face to face methods with, issue identification and co-design elements being delivered. The result has been a concept design which has been designed in conjunction with the local community resulting in an easier to deliver final design with full community buy in.

What difference was made?

We are looking to deliver the interventions in early 2020, however the community engagement has already created an appetite for change in the area, reducing the dominance of the motor vehicle and embracing the new road conditions this will create.

Challenges

With any scheme of this size looking to severely constrain motorised traffic, there are issues around displacement of traffic on other roads. This had required added traffic modelling commitments not fully realised at the conception of the programme.

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Bringing the community with you from the start gives you a strong mandate to deliver schemes that look to radically change attitudes to ingrained norms.



Mental Health First Aid in Schools

AIM

Youth Mental Health First Aid (YMHFA) is an internationally recognised training approach in Mental Health First Aid (MHFA). The programme is designed to teach people how to identify the signs and symptoms of mental ill health in children and young people and offers guidance regarding onward support. Courses are tailored for professionals who teach, work and care for school-aged children and young people. Learners will also gain an understanding of how stigma and discrimination about mental health affect children and young people's mental health and emotional well-being, with an expectation on the individual to challenge negative attitudes in the workplace to support the creation of a mental health friendly environment.

The key outcomes intended for this training programme are:

- Improved mental health and wellbeing for children and young people in Lewisham
- Improved engagement in education and reaching full potential in academic and social milestones by children and young people identified
- Improved relationships with other children and adults, as well as family relationships

Relationship with Public Health

The YMHFA training courses were introduced through the Lewisham Public Health Improvement Training Programme in 2013-14. Offering MHFA training across the workforce is an opportunity to provide consistent knowledge and information. The training also helps to support work on transition between children and adult services by providing consistent information to professionals in both child, adolescent and adult services.

As part of the wider drivers for the CAMHS Transformation Plan, agreement was given by Joint Commissioners for the delivery of a YMHFA Programme for schools in Lewisham. This was building on positive outcomes in improving attitudes, skills and confidence around mental health.

Partnership

In line with national and local intentions, the Lewisham Children and Young People's Partnership, including NHS Lewisham CCG, committed to providing programme of MHFA training courses to schools across Lewisham during 2019. This MHFA England training programme is available to professionals working in all Lewisham schools.

Outline of the Work

Course delegates gain an understanding of how stigma and discrimination around mental health affects children and young people's mental health and emotional well-being, with an expectation on the individual to challenge negative attitudes in the workplace to support the creation of a mental health friendly environment. This support to strengthen school's approach to mental health and emotional wellbeing is set in line with the Transforming Children and Young People's Mental Health Green Paper, 2017.

Youth Mental Health First Aid training complements a wider mental health and emotional wellbeing offer to Lewisham Schools. Specifically, the training has enabled practitioners to explore mental health literature, understand how to combat stigma, and promote early intervention.

Engagement

The YMHFA training offer is delivered during term time only and is tailored to meet the needs of schools to maximise take up. In order to make this training appealing to schools, options are available for a 1 or 2 day course. Promotion for the training has been undertaken by meeting with school leads, via the Mental Health and Emotional Wellbeing Programme Board and schools' mailing bulletin. This Way

Up Wellbeing deliver YMHFA Training with a strong focus on prevention and de-escalation of mental and emotional distress in children and young people. As well as teaching resilience and strategies to improve the emotional and mental well-being of CYP and promote positive mental health and wellbeing.

What difference was made?

There have been significant developments in strengthening the mental health and emotional wellbeing offer within Lewisham, in which YMHFA Training has been a key component. The training has already reached 48% of Lewisham schools with representatives from 41 educational settings (71 participants) with the concluding course in the autumn term. In the coming year, commissioners will continue to promote early intervention and prevention of children and young people's mental health difficulties, with a particular focus on delivery in schools. As part of this work YMHFA training will continue to be offered to schools.

Challenges

Take up from secondary schools has been lower than primary schools, measures are being taken to understand and respond to this. Some schools required more than the initial 2 places maximum offered – this was to ensure an even spread of training across the borough. This has since been relaxed due to schools identifying the need for additional places. Dates for delivery can be challenging against all schools calendars. Not all schools as aware of the training offer despite ongoing promotion.

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Ensure buy in from school strategic leads and significant lead in time for promotion.



Daily Mile Initiative

AIM

The Daily Mile initiative encourages children to run outdoors for 15 minutes per day, for a minimum of three days per week, during school hours. The Daily Mile aims to improve the ‘physical, mental, emotional, and social health and wellbeing’ of children and importantly, increase and embed physical activity in daily habits.

Relationship with Public Health

Lewisham has been implementing a Whole Systems Approach to Obesity (WSAO) since 2016 and was selected as one of four national pilot WSAO sites in the country. Implementing a WSAO was a direct response to Lewisham’s ongoing challenges around childhood obesity.

It was acknowledged, that to accelerate progress, two main cross cutting actions were required to create healthier environments.

These were:

- 1 The Daily Mile
- 2 Lewisham Sugar Smart Campaign

Partnership

A diverse range of over 100 stakeholders were brought together to form the Lewisham Obesity Alliance (LOA), which meets on a regular basis to share best practice and identify opportunities to align actions. Stakeholders, including elected members, champion the whole systems approach to obesity, including the Daily Mile.

Outline of the Work

The success of the Daily Mile rests on building and maintaining relationships with stakeholders, especially schools. The importance of the initiative for child health, concentration, learning and behaviour is highlighted to schools. Reiterating that the Daily Mile is simple, inclusive (children with special needs/disabilities can take part) is also helpful.

As part of the Childhood Obesity Trailblazer programme, unsold out of home advertising estate (billboards) will be utilised to promote locally co-produced public health campaigns including the Daily Mile. We hope that by doing this, the initiative will be taken up by more primary schools in the borough.

Working in partnership with the Daily Mile strategic lead for London and Lewisham's Healthy Schools Officer has provided further opportunities to encourage schools to adopt the Daily Mile and provide support to those schools that are already doing the initiative.

Engagement

Engagement with schools has been conducted through a variety of direct and indirect measures, including: presentations given to schools; organising or participating at school conferences; surveys; information in the Governor's pack; information in the feedback letters to schools as part of the National Child Measurement Programme and communication via the schools mailing. Face to face meetings with school leads or PSHE staff have been arranged by public health directly liaising with school staff. Schools doing the Daily Mile have been encouraged by public health to host open days for other school staff to observe the Daily Mile in action.

What difference was made?

To date, 45 schools (44 primary and 1 secondary) are running the Daily Mile, ranging from one year group, to a whole school of nearly 600 children. In total, 12,890 pupils in Lewisham are running the Daily Mile. When speaking to schools, there seems to be more awareness of the Daily Mile.

Challenges

Maintaining contact with schools and keeping 'on top' of changes-for example: key member of staff leaving, number of children participating and encouraging schools that have not adopted the Daily Mile to take part has been challenging.

Aligning actions, sharing information with the London strategic Daily Mile lead and Lewisham Healthy Schools Officer will help to overcome these challenges.

Children taking part in the Daily Mile at Turnham Primary School

More information

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Embed the Daily Mile within a wider piece of work that has local political support in order for it to gain significance and recognition from stakeholders and schools.



School Superzones Pilot

AIM

Lewisham has signed up to the London Devolution (Public Health England) School Superzones pilot project. The aim of the project is to create a healthier and safer environment for children to live, learn and play. Superzones are a 400m radius around schools in which actions are taken to protect children’s health and encourage healthy behaviours through interventions that target: unhealthy food and drink sales; advertisements; alcohol; smoking; gambling; air quality; physical inactivity; and crime.

Relationship with Public Health

Officers and Councillors were invited to an initial workshop facilitated by Public Health to start the process of developing a School Superzones action plan for Lewisham. The project has become established through development of a joint action plan, regular meetings and workshops and attending regional workshops.

Partnership

The project is a collaboration between different teams in the Council, elected members, school staff, pupils and parents, local residents, community organisations and other local stakeholders. It brings together existing, planned and new actions and focuses them in the Superzone area, ensuring that they align with other actions across the themes.

Outline of the work

- Mapped activities that focused on; adverts, alcohol, unhealthy food and drink, air quality, gambling, smoking, physical inactivity that were already happening, as well as upcoming initiatives; crime was identified as an eighth category for inclusion.
- Haseltine Primary School in Bellingham ward was identified as a pilot school, based on looking at levels of need in the area and also at the level of school engagement. Concurrently, asset mapping of the physical environment and infrastructure around the school was done.
- A detailed map of the superzone area was developed to help identify the assets, harms and opportunities in the area.
- Two workshops held at Haseltine Primary School discussed local issues and challenges which included: air quality and traffic, children and parents getting to school, fast food takeaway premises, crime, and other challenges. This helped prioritise actions and an action plan has been developed and is updated on a quarterly basis.

Engagement

We have held a number of meetings at the school, this has helped gain engagement from a wide range of stakeholders in the area. The insight gained helped to prioritise actions and develop a joint action plan. Also, links between different teams in the council has been a key success factor. This has made relationships stronger and will also benefit other areas of collaborative work in the future. It also has enabled the profile of some public health issues to be raised, for example bringing physical activity and the food environment into discussions about air quality.

What difference was made?

Benefits include:

- The Superzone was included as a criteria to prioritise areas for the creation of Healthy Neighbourhood Zones. The area was selected for the first year of the programme and there will be measures put in place to improve air quality, and to make the neighbourhood more walkable and bikeable.

- As part of the Air Quality audit a green screen for the school received matched funding through Section 106
- The Superzone will be included in the Council's new licensing policy.

Challenges

The main challenges has been to match expectations of the local community to the superzones concept. It was important to clearly identify that there was no funding attached to this project so that we did not raise false expectations. Many of the benefits would not be immediate or beyond the scope of the pilot period, because of this, the decision was made to extend the pilot for a further year so that actions can be progressed and learning shared.

More information

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Aligning actions across diverse work streams takes time, it is important to factor this into your timeline.

This created a shared understanding of how complex obesity is and that all sectors of society have a role to play in its reduction. This helped to gain commitment and engagement from the diverse stakeholders.

Following a series of meetings on the food environment and the use of parks and open spaces, members of the Alliance identified 3 key actions to focus on for each theme, working together to align actions to maximise outcomes.

Increase access to healthier food	Increase use of parks and open spaces
Public/private sector organisations to buy in to a workplace charter that outlines provision on healthy eating guidelines at events	Give people reasons to go to parks-range of activities/hydration stations or coffee bars in parks
Up-skill people; including schools and youth services, looked after children and residential care homes	Support schools, workplaces to use parks
Support services, children’s centres, early years providers in developing updated food and nutrition policies	Maximise walking and cycling e.g. by increasing uptake amongst specific groups and identify key set of messages on benefits of physical activity

Engagement

We engage with partners in several ways. Firstly, the quarterly meetings are held with a different external speaker or local stakeholder sharing examples of best practice each time. These relate to the 6 key actions the Alliance is working towards. Sharing learning with additional insight from external speakers helps inspire and motivate Alliance members to reflect on their individual areas of work and also how they can align actions. Secondly, partners provide updates on how they are contributing to this agenda in a quarterly Public Health Obesity Alliance e-newsletter. All partners are able to use this as a means to evaluate how engaged stakeholders are and the work they are doing.

What difference was made?

A key success is that the Lewisham Obesity Alliance is continuing to grow and is now made up of a diverse range of over 100 stakeholders who champion the obesity agenda and whole systems approach. This has helped the Alliance gain support and recognition from elected members, and has created partnerships

between organisations that would not have formed without a whole systems approach to obesity.

Challenges

The main challenges are competing priorities for stakeholders and gaining commitment in the early stages from other Council directorates who had not previously been fully engaged with the obesity agenda. Being a national pilot and having senior leadership buy-in helped overcome some of these. We will continue to engage a wider partnership to join the Alliance and encourage stakeholders to embed the WSAO into their policies and actions plans to ensure sustainability of the work.

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2016 Lewisham Annual Public Health Report on Obesity

Involving stakeholders in all the earlier phases of the whole systems approach led to sustained engagement and contribution to the agenda



Healthy Early Years London Scheme (HEYL)

AIM

To support and accredit Early Years settings with First Steps, Bronze, Silver and Gold awards for developing a focus on health and wellbeing through the 12 themes of HEYL. To increase awareness of child health and wellbeing to children, parents and the staff that work with them.

Relationship with Public Health

The HEYL scheme brought together Public Health and the Early Years Education Team and one officer from each team began to plan and work together.

Partnership

Lakhvinder Matharu (Public Health Officer - Nutrition) and Mary Gobey (Early Years Advisor) plus a working group made up from both teams to become the Quality Assurance Team (QUAGS) to ensure a breadth of knowledge and skill is shared and cascaded.

Outline of the work

We introduced the scheme to all early years settings at all regular network meetings and forums and encouraged all to take up the scheme. We visited settings to support and monitor progress.

We have delivered training/presentations from people representing the 12 themes of HEYL. We have marked, assessed and accredited audits for awards. Planning celebration events and are continuing to reach out to more settings.

Engagement

The first year we introduced the scheme to all settings. This year we are targeting more hard to reach settings, settings that Require Improvement and those in areas of deprivation. On going strong communication and regular contact, visits and support will continue across the borough.

What difference was made?

81 settings engaged,

46 First Steps achieved,

7 Bronze Awards.

Through this scheme the healthy curriculum is highlighted and recognised by Ofsted. Good knowledge about healthy lifestyles is cascaded and more early intervention/support is put into place.

There is more awareness about the 12 themes of HEYL – healthy eating, infection control, home safety, social and emotional wellbeing, oral health, home learning, speech, language and communication, physical activity, supporting children with chronic illness/SEN, early cognitive development and parent/staff mental health and sustainability.

Challenges

The time invested in this work comes from the commitment to improve Early Years and the belief that every child deserves a good start in life. This now depends on the goodwill of the early years provision management and its members. We continue to promote the scheme and plan in small incentives and an end of year celebration event.



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Active promotion of health and education working together to make a difference to the lives of young children and their parents and the teams that work with them.



Joint Strategic Needs Assessments (JSNA)

AIM

To profile Lewisham's population, including demographic, social and health information. The JSNA also provides access to in-depth needs assessments which address specific gaps in knowledge or identify issues associated with particular populations/services. These in-depth assessments vary in scope from a focus on a condition, or a segment of the population. The overall aim of each needs assessment is to translate robust qualitative and quantitative data analysis into key messages for commissioners, service providers and partners.

Relationship with Public Health

The JSNA is a core part of Public Health's work and is a statutory obligation through the 2012 Health & Social Care Act. The work allows the team to establish and build relationships with teams and colleagues across the council and the partnership, through shared working and collaboration. A JSNA Steering Group was established in 2017, chaired by the Director of Public Health, which is responsible for development of the JSNA and has representation from across all Lewisham health sectors.

Partnership

In recent years work has taken place with the Children's Joint Commissioning Team for the Parenting JSNA, Environmental Health and Transport for the Air Quality JSNA, Youth Offending Team for the Young People in Contact with the Criminal Justice System JSNA and Social Care for Repeated Removals of Children into Social Care JSNA.

Outline of the work

A revised process for undertaking the JSNA was agreed at the Health and Wellbeing Board in July 2017. The purpose of this was to:

- 1 Achieve wider stakeholder engagement;**
- 2 Provide a more strategic overview of needs;**
- 3 Take account of and help determine local priorities;**
- 4 Be more transparent and accountable to the Health & Wellbeing Board;**
- 5 Provide effective monitoring and efficient management of available JSNA resources.**

The implementation of the newly agreed process means that there is now a systematic approach to prioritising topic assessments and has meant that the 'Picture of Lewisham' document, providing an overview of key health and socio-demographic information is updated each year. There is also a direct sign-off process with the Health & Wellbeing Board ensuring the JSNA keeps a political and public profile. This has better embedded the JSNA within council work.

Engagement

Public Health has engaged with commissioners and other relevant stakeholders by attending team meetings, Directorate Management meetings, voluntary sector events etc. to promote the JSNA and ensure engagement and awareness is as wide as possible. Presentations at the Neighbourhood Community Development Partnership neighbourhood meetings has also meant that the resource has reached a wider audience. This activity has meant that awareness has improved, therefore more informed decisions can be made. A broader range of topics for the in-depth needs assessments is now put forward rather than the traditional 'medical' health focus.

What difference was made?

The aim of any JSNA process is to provide accurate and timely information so that better decisions can be made, whether this be commissioning/decommissioning of a service, ensuring residents/service users are more aware of an issue, or that inequalities between groups are better understood. Feedback on both the Picture of Lewisham and the new JSNA process has been positive, the hope is this will continue to improve as the JSNA becomes part of the soon to be launched 'Lewisham Observatory', so the JSNA information is seen in conjunction with other relevant local data and information.

Challenges

Challenges have included data quality and availability. The aim is to understand if there are specific health inequalities within the borough and between population groups. Often there is a lack of borough specific information, especially getting equalities monitoring data.

In other cases commissioned services are not providing data which is robust enough to draw conclusions from. Both challenges frequently appear as recommendations within individual needs assessments.

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Plan ahead, ensure colleagues know what is going to be asked of them and that findings can be publicly shared.



Making Every Contact Count

AIM

Making Every Contact Count (MECC) training provides staff with the competence and confidence to deliver a brief intervention to an individual to bring about a lifestyle behaviour change. This can focus on a range of behaviours that may impact on health including alcohol, smoking, nutrition and physical activity. The training is aligned to the NHS Prevention and Lifestyle Behaviour Change: A Competence Framework. It also reflects Drugs and Alcohol National Occupational Standards (DANOS) supporting brief interventions around alcohol use, as well as NICE guidance on individual behaviour change (PH49).

Relationship with Public Health

In Lewisham, the Health and Wellbeing Board have made it a strategic priority to ensure that all staff working across health, social care and voluntary organisations are equipped with the necessary knowledge and skills to promote health and wellbeing to bring about a behaviour change. Members of the Board made a commitment to prioritise the training of their staff to deliver brief interventions on healthy lifestyles, in line with NICE guidance, on account of the strength of evidence, in alignment with the Health Education England mandate.

Partnership

The MECC training programme has been rolled out across the borough in a variety of settings and a range of organisations; some in-house for particular professional groups, others in multi-professional settings. We have worked closely with partners from the local CCG and strategic training networks.

A tier of manager's briefings was also built into the programme. This training for managers and service leads aimed to increase understanding of MECC delivery, support staff in implementation

and allow for discussion in supervision and performance evaluation sessions.

Outline of the work

The Health Improvement training programme is a fundamental component in the implementation of Lewisham Health and Wellbeing strategy and the integration of Health and Social care. The training programme provides a range of quality assured training to equip the workforce with the skills and knowledge to identify opportunities for health promotion and facilitate key health messages within their work practice and community settings.

A MECC training course has been developed as part of this programme to enable participants to gain the knowledge and develop the skills to equip them to improve their practice, based on a sound evidence base. The training has a clear aims, objectives and includes post training evaluation, over 1500 staff and volunteers have been trained. The knowledge and skills acquired on the course will enable participants to promote health in various settings through effective practice.

Engagement

We engaged with our target audience by presenting proposals for the delivery of a systematic approach to brief intervention to the board. This supported in identifying how each member organisation could contribute, through identifying the numbers and areas of their workforce who would receive MECC training. The MECC training programme has since been rolled out across a variety of settings, involving a range of organisations; some in-house for particular professional groups, others in multi-professional settings. We have worked closely with partners from the local CCG and strategic training networks. Public Health also developed a local MECC resource (handout) for participants to support the sustainability of the knowledge and skills gained and signposting to local services.

What difference was made?

- Over 1500 staff and volunteers from the workforce have been trained
- An increase in health outcomes of the local population
- A culture whereby all health and social care professionals and volunteers can, as a minimum, deliver a lifestyle intervention
- An increase in referrals to Lewisham lifestyle services
- MECC can be delivered as face to face 0.5 day sessions or within Protected learning time/team meetings where ever possible. There is also online training if a capacity issue is identified
- Senior leadership will support MECC and staff will be released to attend training

Challenges

- The need to consider how best to meet the training needs of the workforce including targeting the wider workforce who have not previously accessed MECC training
- Focus on providing targeted training which is easily accessible to staff is key, taking training to staff teams is seen as an incentive in attendance.
- Fostering a culture where releasing staff for training is seen as an investment in learning rather than a cost pressure. Taking into account, there is no direct cost to providing brief interventions by existing staff, it will present a small pressure on staff time.
- The need to ensure that delivery is embedded in practice following the training. Support and opportunities for staff to report on how the training has been utilised in working practice is also a factor which should also be considered
- The inclusion of mental health and wellbeing and cancer awareness as topics of focus to support health improvement activity within local communities

More information

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The investment of funding for continuation of the programme particularly in Making Every Contact Count (MECC) training is vital. MECC has been recognised across London as a priority, underpinned by NICE 2014 guidance (PH 49). The continuation of MECC to prevention requires sustainable resourcing.

Case studies from our partners



Maternity Stop Smoking Brief Intervention and Carbon Monoxide Monitor Provision

AIM

- Carbon Monoxide (CO) monitoring of every pregnant woman at booking and at 36 weeks of pregnancy
- Increase in the take up of referrals by women to the Stop Smoking Service
- Reduction of smoking in pregnancy and post-birth

Relationship with Public Health

The Public Health Consultant Midwife and local joint Children's Commissioners provided a case to use public health funding to finance the above approach in view of the significant impact of maternal smoking on family health and wellbeing.

Partnership

Work took place with Lewisham and Greenwich Trust, Children's Centres, Greenwich and Bexley colleagues, the Smoke Free Delivery group and an outside provider to plan the above approach.

Outline of the work

- Met with stakeholders to ensure that everyone was committed to aims and implementation of the programme
- Investigated evidence base of preferred trainer including contact with organisations that had used her and the training approach
- Provision of evidence-based, brief intervention training to over 340 staff including midwives, health visitors, admin staff, obstetricians, support workers and all of the Stop Smoking advisors in 2018
- Provision of specialist stop smoking intervention called 'Risk Perception' for delivery by a small number of staff to the most addicted smokers (2019)
- Provision of CO monitors to every community midwife
- Inclusion of % of women offered CO monitoring on the maternity commissioning scorecard so that LGT report on this on a quarterly basis
- Monitoring of pregnant smokers referred and quits in the Smoke Free Delivery group

Engagement

- Inclusion of all key stakeholders from the beginning
- Use of evidence-based approaches
- Ensuring that monitoring of outcomes is measured in both the Smoke Free Delivery group and the Maternity Commissioning group. This ensures that the investment put into the staff training does not disappear as a priority once the training is completed

What difference was made?

- 90.2% of pregnant women were offered CO monitoring (Nov 2019) as opposed to 12.2% in December 2016
- Smoking at time of delivery at UHL and for Lewisham borough is significantly lower than the national average
- We have not seen an increase in take up of stop smoking services by pregnant women offered by LGT
- We have not so far seen an increase in quits by pregnant women using the stop smoking service

- It is hoped that quits by the most addicted pregnant smokers and their partners will increase when the Risk Perception approach begins at UHL

Challenges

- Training fatigue by staff, attempts to mitigate this by using an evidence-based approach
- The sheer logistics of trying to train such a large number of clinical staff across two sites and backfill challenges. Found that leadership is essential and senior leaders putting 'can-do' people in charge of the organising training element
- Staff capacity to spend time on this subject when there are so many competing areas for discussion. To combat this the trainer tailored her approach to be used in the context of busy staff with a few minutes to get maximise effectiveness of the intervention.

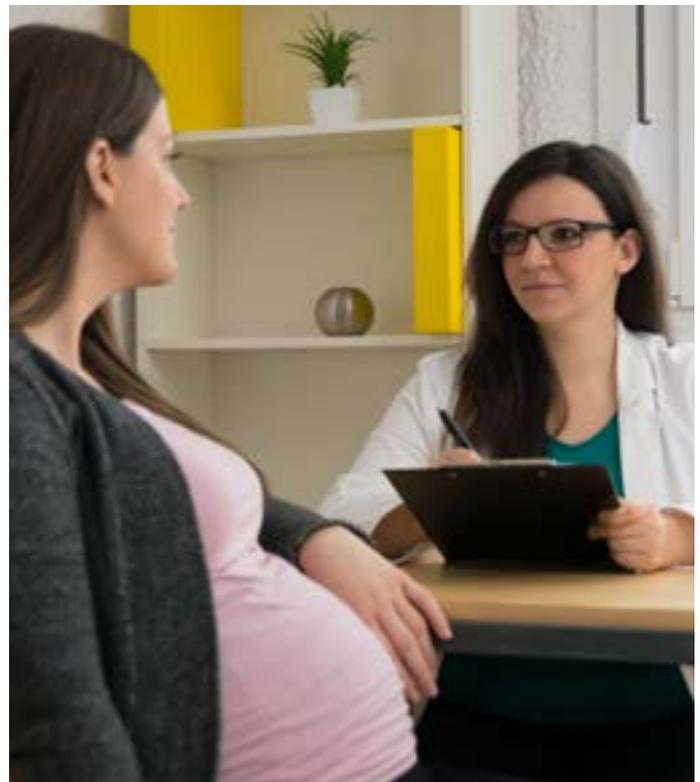
More information

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Involve senior leaders from the beginning in the proposed initiative including showing them the evidence, as well as agreeing how the desired outcome will be measured following the initiative



Cancer Awareness Training for Pharmacy Teams and Community Members

AIM

To support the Health and Wellbeing Strategy Priority to increase the number of people who survive bowel, breast and cervical cancer.

Relationship with Public Health

As part of implementing the Health and Wellbeing Strategy priority, a number of actions have been undertaken including the following:

- Public Health has commissioned Cancer Research UK (CRUK) 'Talk Cancer' training to pharmacists and a bursary-funded CRUK workshop was delivered to 15 community group members in December 2018. A total of 34 pharmacists were trained over three sessions.

- Several cancer learning events for healthcare professionals have now taken place in Lewisham specifically around bowel and lung cancer.

Partnership

Public Health worked closely with partners from the local CCG, Pharmaceutical Committee, Cancer Research UK and Medicines Management to explore how a model of Cancer Awareness training could be developed and implemented within Lewisham Community

Pharmacies. The model involved training staff from each pharmacy to conduct brief conversations with customers about cancer. The Pharmacies would also undertake health promotion displays using approved material. Members of this group also led initial discussion on developing cancer awareness training for community members.

Outline of the work

Lewisham Public Health have supported the coordination of Cancer Awareness training for Lewisham Pharmacy Teams. This training was delivered by facilitators with a nursing background from Cancer Research UK. Talk Cancer workshops equip and empower community members to raise awareness of cancer and support early diagnosis in the community. The training provides participants with better knowledge around cancer prevention, screening and early prevention. It also provides participants with the tools and confidence to encourage people to make lifestyle choices, use local services and go to the GP with their concerns. We want to foster a culture in Lewisham, where residents are more aware of signs and symptoms of key cancer types and feel comfortable to visit primary care settings with their concerns, thus increasing the proportion of cancers diagnosed earlier.

Engagement

Public Health worked closely with strategic partners and Health Engagement facilitators from Cancer Research UK to develop promotion approaches to the target audience. Members of this group then actively engaged with pharmacies and community members by presenting proposals for the delivery of the training. This in turn encouraged potential participants to identify, if they had a special interest in raising awareness amongst local communities with a health focus. This was to support the role of primary care in improving cancer outcomes, by having conversations with the public.

What difference was made?

- Supporting members of the wider workforce to gain skills, confidence and knowledge about practical interventions to be able to respond to people experiencing poor health and wellbeing through delivery of targeted and tailored training.
- Increasing awareness of the signs and symptoms of cancer and improve the knowledge of the main cancer screening programmes (bowel, breast and cervical) among members of the wider workforce tailored to the needs of different population groups in Lewisham.
- Contributing towards the reduction in stigma around cancer in the borough.
- Working towards achieving long-term local and South East London STP outcomes to improve uptake of breast and bowel cancer screening, cancer survival and improve overall health and wellbeing in Lewisham and South East London

Challenges

Although we have seen particular success with the Awareness training for Lewisham Pharmacy Teams, the challenge has been to ensure that under represented areas of the workforce have access to training. We now want to build on this work with those who have received this training to ensure they continue to have the confidence and capacity to deliver on the scale required.

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Ensure opportunities to facilitate the sustainability of this work, since those receiving training could then become a useful resource for the borough in terms of knowledge and skills around cancer.

Recommendations

Continue to work with stakeholders across the council and wider system to increase understanding and build capacity to implement a health in all policies approach when developing ideas.

Build on existing work to formalise a health in all policies approach at all stages of service development and strategy and policy-making.

Continue to champion the health in all policies approach at a strategic level by highlighting the links between improvements in population health and the achievement of corporate and other strategic priorities

Develop a framework to enable the ongoing and robust assessment of the impact of policy decisions on health and health inequalities within the Lewisham population



References/Further Information

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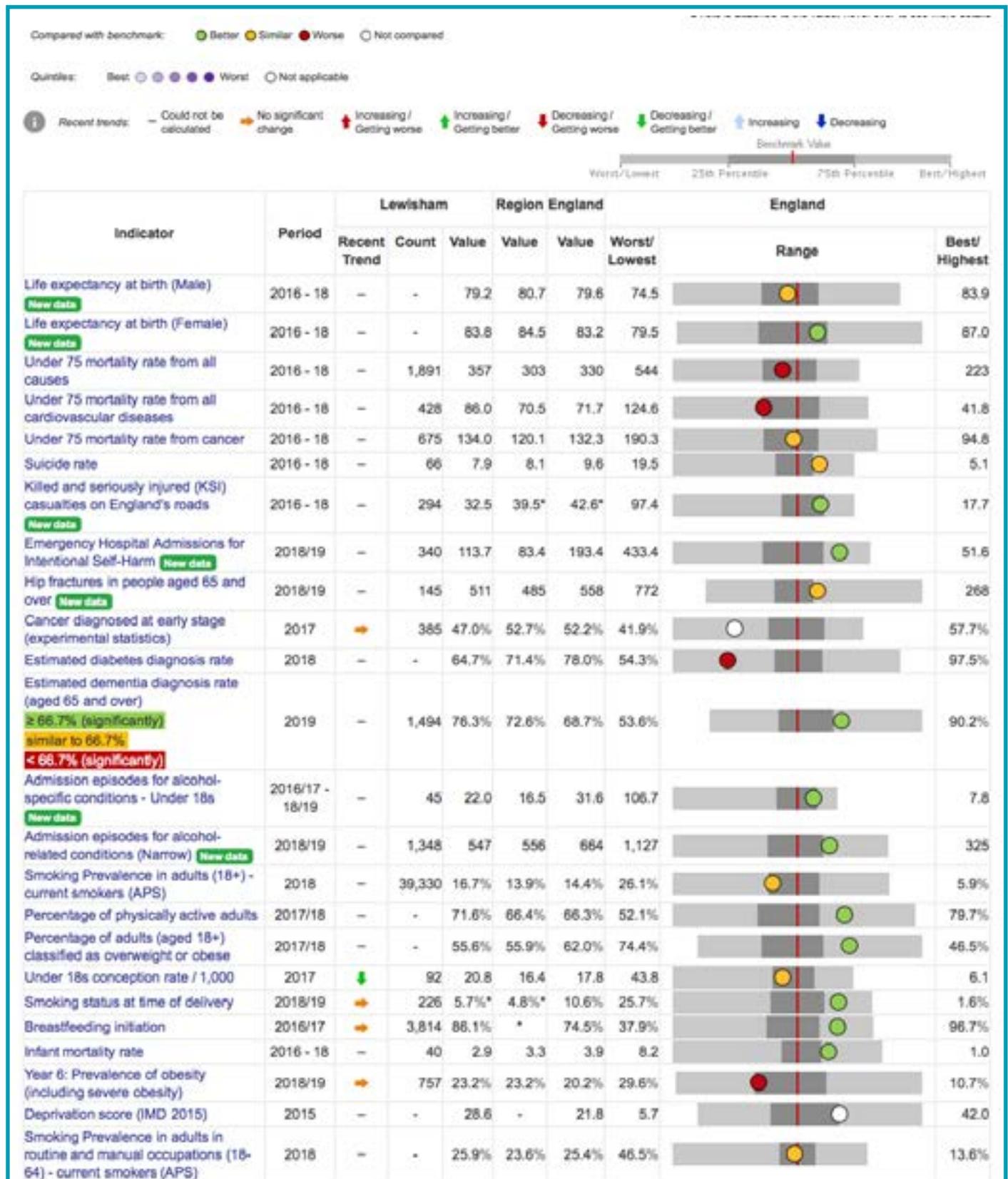
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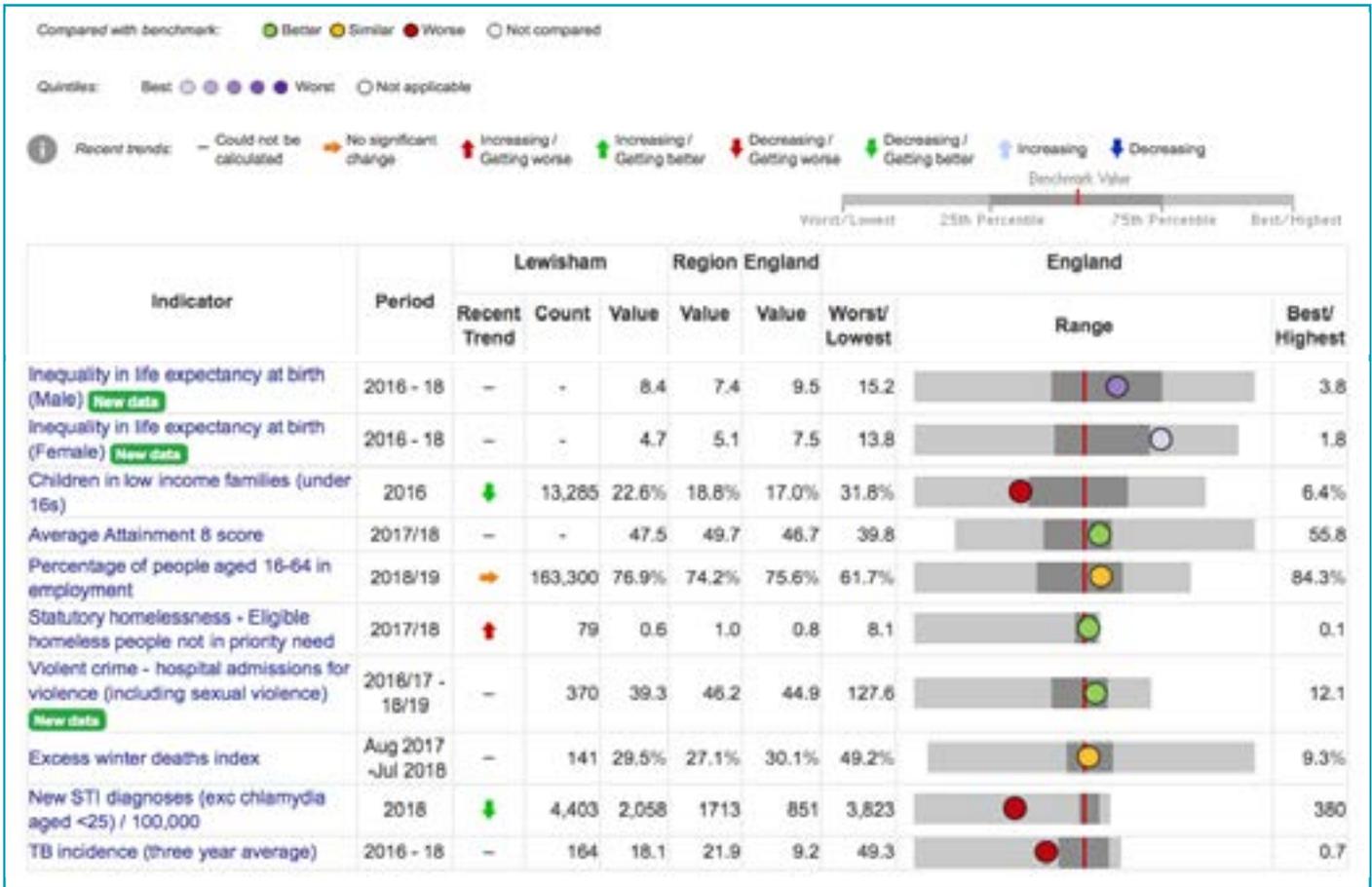
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Appendices: Health & Wellbeing Profile for Lewisham

The chart below provides an overview of the key indicators of health and wellbeing for the population of Lewisham as of February 2020.





This chart has been taken from the Public Health England Fingertips website. This site provides a wide range of data and analysis of indicators of health and wellbeing for areas across England.

The data for each profile is summarised in a Spine Chart. In this spine chart the value for Lewisham for each indicator is shown as a circle. The chart provides a comparison between the health of people in Lewisham and the average for the rest of England.

The England average is indicated by the red line at the centre of the chart. The range of values for all boroughs in England is indicated by the light grey horizontal bar. A red circle means that Lewisham is significantly worse than the England average for that indicator. A green circle indicates that Lewisham is significantly better than the England average for that indicator.

Link to profile:

<https://fingertips.phe.org.uk/profile/health-profiles/data#page/1/gid/1938132701/pat/6/par/E12000007/ati/202/are/E09000023>

For a list of all the profiles available for Lewisham please visit:

<https://fingertips.phe.org.uk/>

If you would like further information about a particular indicator on this profile or have any other query relating to data on the health of the Lewisham Population please contact the Public Health Intelligence Team:

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Agenda Item 6



Health & Wellbeing Board

Developing a new Joint Health and Wellbeing Strategy 2021-26

Date: 12 March 2020

Key decision: No.

Class: Either Part 1

Ward(s) affected: ALL

Contributors: Dr Catherine Mbema, Director of Public Health, London Borough of Lewisham

Outline and recommendations

This report sets out the current context and drivers for health and care across the borough and recommends that members of the Board agree to the development of a new health and wellbeing strategy.

The board is recommended to:

- Agree to the development of a new health and wellbeing strategy to reflect the current health and care context and address local health and care priorities.
- Agree to a programme of local stakeholder engagement to help develop and produce the new strategy.
- As members, take part in a series of workshops to contribute to the development of the new strategy reviewing the aims, priorities and any associated delivery plan.
- Endorse the proposed next steps as set out in paragraph 7.1.

Timeline of engagement and decision-making

1. Summary

- 1.1. This report sets out the current context and drivers for health and care across the borough and recommends that members of the Board agree to the development of a new health and wellbeing strategy.

2. Recommendations

- 2.1. Members of the Health and Wellbeing Board are recommended to:
 - Agree to the development of a new health and wellbeing strategy to reflect the current health and care context and address local health and care priorities.
 - Agree to a programme of local stakeholder engagement to help develop and produce the new strategy.
 - As members, take part in a series of workshops to contribute to the development of the new strategy reviewing the aims, priorities and any associated delivery plan.
 - Endorse the proposed next steps as set out in paragraph 7.1

3. Policy Context

- 3.1. The Health and Social Care Act 2012 established Health and Wellbeing Boards and placed a duty upon them to prepare and publish joint health and wellbeing strategies to meet the needs identified in their joint strategic needs assessment.
- 3.2. Lewisham's health and wellbeing strategy will underpin the Council's Corporate Strategy, contributing in particular to ensuring everyone receives the health, mental health, social care and support services that they need.

4. Background

Lewisham's first health and wellbeing strategy (2013-2023) was published in December 2013 and contained three overarching aims:

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- **To improve health** – by providing a wide range of support and opportunities to help adults and children to keep fit and healthy and reduce preventable ill health.
- **To improve care** – by ensuring that services and support are of high quality and accessible to all those who need them, so that they can regain their best health and wellbeing and maintain their independence for as long as possible.
- **To improve efficiency** – by improving the way services are delivered; streamlining pathways; integrating services, ensuring that services provide good quality and value for money.

4.2 The strategy also identified nine priority areas for action over the 10 years which were largely shaped through the JSNA and various stakeholder engagement activity. These priority areas were as follows:

1. Achieving a healthy weight
2. Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years
3. Improving immunisation uptake
4. Reducing alcohol harm
5. Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking
6. Improving mental health and wellbeing
7. Improving sexual health
8. Delaying and reducing the need for long term care and support
9. Reducing the number of emergency admissions for people with long-term conditions

4.3 In 2015, the strategy was refreshed and focused on a smaller number of short term priorities for action over a three year period (2015-18). These revised priorities were as follows:

1. To accelerate the integration of adult, children's and young people's care
2. To shift the focus of action and resources to preventing ill health and promoting independence
3. Supporting our communities and families to become healthier and more resilient, which will include addressing the wider determinants of health

5. Context and drivers

5.1. At both national and local level, it is recognised that health and care systems are facing significant financial challenges and an increasing demand for services. Current health and care systems are not sustainable in their current form. This alongside an ageing population and increasing expectations necessitate transformational change.

5.2. The *NHS Long Term Plan*, published last year, sets out the key ambitions for health and care over the next ten years. The plan builds on the policy platform laid out in the *NHS five year forward view* which articulated the need to integrate care to meet the needs of a changing population and commits, amongst other things, to reducing pressure on A&E departments, establishing primary care networks and to developing fully integrated community based care. This has local implications for the delivery of health and care.

5.3. In April 2020, a South East London Clinical Commissioning Group will be formed from the current six south east London CCGs. The new CCG will be responsible for the

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commissioning of health services for its population with decision-making for primary, community (mental and physical), prescribing and all client group commissioning formally delegated to a Borough Based Board as a prime committee of the CCG. Lewisham Council, which also has commissioning responsibilities, including for social care and public health services, will continue to work closely with the new CCG and borough based boards.

- 5.4. At a regional-level, south east London's Sustainability and Transformation Partnership (STP), Our Healthier South East London (OHSEL) was the first area of London to be part of the next wave of Integrated Care Systems (ICS) in England.
- 5.5. The south east London ICS brings together local health and care organisations and local councils to re-design care and improve population health, through shared leadership and collective action. The aims of South East London ICS will build on the collaboration of the partners to date through Our Healthier South East London, to integrate local services and help people stay well for longer by supporting them to lead healthier lives, manage their own health conditions and provide good access to care when they need it, often closer to where they live.
- 5.6. At a borough-level, Lewisham Health and Care Partners continue to work together to achieve a sustainable and accessible health and care system to support people to maintain and improve their physical and mental wellbeing, to live independently and to have access to high quality care when needed. Local plans and priorities developed by partners include supporting the development of integrated care arrangements for community based care in Lewisham, focusing on managing resources effectively to deliver value and improvements to the whole system. This work encompasses further integration of commissioning across adults and children and the exploration of integrated provider arrangements around mental health and care at home. Local priorities and aims reflect those articulated in Our Healthier South East London (OHSEL).

6. Developing a new Health and Wellbeing Strategy

- 6.1. The Health and Wellbeing Board has a statutory responsibility for the development and oversight of the local health and wellbeing strategy and ensuring that it remains fit for purpose. The Board also facilitates partnership collaboration and whole system change over the longer term.
- 6.2. Following evaluation of the previous strategy in 2018, consideration should be given to broadening the strategy's aims and priorities. In addition, to promote sustainability in the system, individuals should be encouraged to take greater control and responsibility for their own health and care with an emphasis on prevention and this needs to be reflected in any new strategy.
- 6.3. In the development of the new strategy, consideration should also be given to whether it should incorporate the wider contributory factors to a person's overall health and sense of wellbeing such as housing, education, employment (the wider determinants of health), the environment and places that we live, in addition to our health and care system as outlined in the recent King's Fund publication on Population Health.
- 6.4. A new strategy should also reflect the Board's current focus on the need to address health inequalities in Black, Asian and Minority Ethnic (BAME) groups as it remains a locally agreed priority for both Lewisham BAME communities and statutory partners.
- 6.5. Consideration should also be given to how the Health and Wellbeing strategy could better align with the iThrive framework model which is being promoted throughout the Council and the CCG. The framework aims to create an accessible portal for individuals and families to access services which meet their needs. Both the new Early Help strategy and SEND strategy will be applying the iThrive approach.

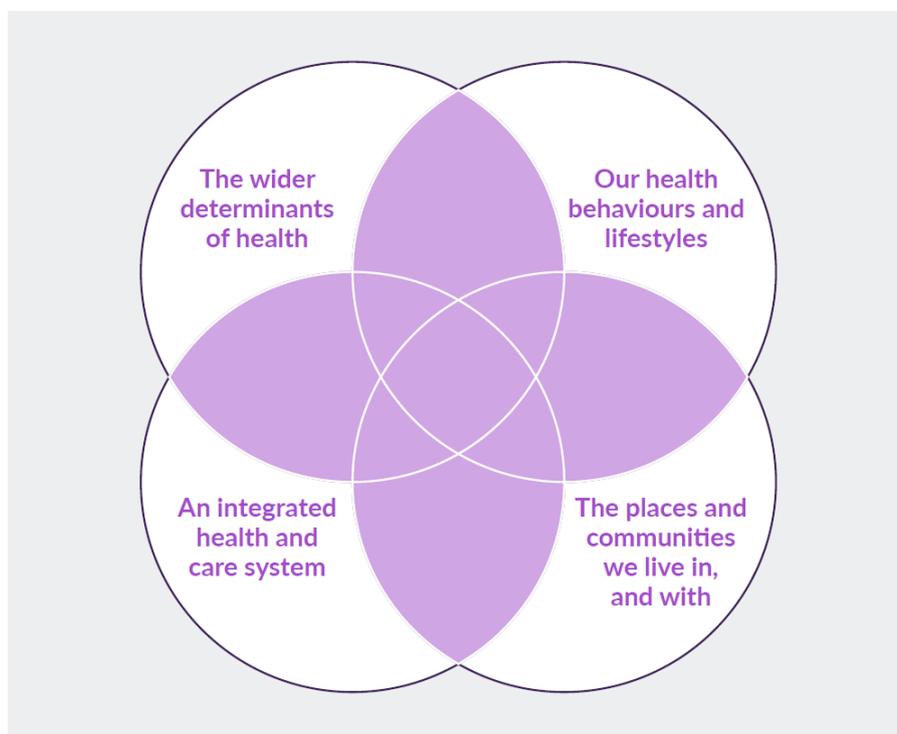
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- 6.6. Throughout this process, effective and ongoing engagement with communities will be essential. Local people, service users, patients and VCS organisations must be involved so that their voice is heard alongside that of the professionals. Healthwatch and Rushey Green Timebank have critical roles to play in the undertaking of this activity.
- 6.7. In light of the above, any revised approach to the aims contained within the Health and Wellbeing Strategy should include consideration of the following:
- Quality of Life – too many people live with preventable ill health or die too early in Lewisham. Health inequalities persist and the wider contributory factors to a person’s quality of life and overall wellbeing require focused attention to enable all people in Lewisham to live well for longer.
 - Quality of Health, Care and Support – People’s experience of health, care and support is variable and could be improved. The system needs to evolve from a provider-focused one. The individual needs to be empowered to be in control of their own health and wellbeing through accessible information and local support, available closer to home.
 - Sustainability – there are increasing levels of demand - population growth, age, complexity of need – and the financial resources are limited. The local health and wellbeing system must be forward looking and adaptable to such competing pressures. The longer term focus must be on sustainable solutions.



(Source: King’s Fund, 2019)

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7. Next steps

7.1. If the Board are in agreement to the development of a new Health and Wellbeing Strategy, the following steps will be needed:

- Agreeing and identifying the resource required to support the development of a new strategy.
- Developing an approach to the revised strategy that is both flexible and sustainable i.e. one that remains adaptable to longer-term future changes whilst delivering within tight financial constraints.
- Identifying interconnected aims for the strategy, that are broader, more holistic and give due consideration to a person's overall wellbeing.
- Agreeing partnership priorities that underpin any revised aims, informed by data from the Joint Strategic Needs Assessment, public and stakeholder engagement.
- Developing a focused short-term delivery plan (3 years in length) that can be measured, with refreshed outcomes in line with the new aims and priorities.

8. Financial implications

8.1. The confirmation of resource required to develop the strategy will be sought from partners represented on the Board to either commission an external agency to develop the strategy or backfill existing officer time.

9. Legal implications

9.1. The Health & Wellbeing Board has a statutory obligation to develop and implement a Health and Wellbeing Strategy.

10. Equalities implications

10.1. The Health and Wellbeing Strategy is aimed at reducing health inequalities within the local population, with a focus on addressing the needs of the most disadvantaged in our communities.

11. Climate change and environmental implications

11.1. It is possible that some of the actions delivered within the Health and Wellbeing Strategy, such as those focussed on smoking cessation, may have a direct, positive impact on the environment.

12. Crime and disorder implications

12.1. There are no crime and disorder implications from this report.

13. Health and wellbeing implications

- 13.1. The development and implementation of a new Health and Wellbeing Strategy will have a directly positive impact on the health and wellbeing of Lewisham residents.

14. Report author and contact

- 14.1. Dr Catherine Mbema, Director of Public Health, catherine.mbema@lewisham.gov.uk

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Health and Wellbeing Board

Health and Wellbeing Board – Revisions to Membership

Date: 12 March 2020

Key decision: No.

Class: Part 1

Ward(s) affected: All

Contributors: Tom Brown, Executive Director Community Services

Outline and recommendations

The purpose of this brief report is to update the Health and Wellbeing Board on three proposed revisions to the membership of the Board for 2020/21, two of which will be put to the next Council AGM for approval.

The Health and Wellbeing Board is requested to note the proposed changes to membership of the Board.

Timeline of engagement and decision-making

Proposed changes to the Board membership have been considered in accordance with advice provided by the Head of Law at Lewisham Council.

1. Summary

- 1.1. This report provides members with three proposed changes to the membership of the Health and Wellbeing Board, two of which will be put to the next Council AGM for approval.

2. Recommendations

- 2.1. Members of the Health and Wellbeing Board are requested to note the following:
 - a) That the proposed changes to both the Clinical Commissioning Group and VCS representation on the Board for 2020/21 will be referred to the next Council AGM for approval.

- b) That the proposed change to NHS England representation on the Board from 2020/21 onwards be agreed by members.

3. Policy Context

- 3.1. Health and Wellbeing Boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population.
- 3.2. The work of the Health and Wellbeing Board directly contributes towards the priority of '*Delivering and defending: health, social care and support*' within the Corporate Strategy. This priority aims to ensure that everyone receives the health, mental health, social care and support services they need.

4. Background

- 4.1. Lewisham's Health and Wellbeing Board was set up in response to the Health and Social Care Act 2012. The Act specifies that the Board's membership must, as a minimum, include:
- a) At least one Councillor of the local authority who is nominated by the Mayor (and may include the Mayor);
 - b) The Council's Director of Adult Services;
 - c) The Council's Director of Children's Services;
 - d) The Council's Director of Public Health;
 - e) A representative of the Healthwatch organisation for the area;
 - f) A representative of each relevant clinical commissioning group; and
 - g) Such other persons or representatives of such other persons as the Council thinks appropriate.
- 4.2. Following its initial set-up in 2013, the Council must now consult the Health and Wellbeing Board before making further appointments, though this does not apply to Mayoral nominations.
- 4.3. As a Council committee, the Health and Wellbeing Board is governed by the Council procedure rules as set out in the Council's Constitution. The Council, in the Constitution has made provision that "normally" two representatives of the voluntary sector will be appointed to the Board with voting rights.
- 4.4. Paid officials of the Council, Clinical Commissioning Group or Healthwatch, if appointed as members, are not to be allowed to vote. If those groups appoint representatives who are either the Chair of a member of their managing committee or equivalent body, they may vote, provided they are not also an employee of that organisation. See **Appendix A** for current voting entitlements of all Board members.
- 4.5. The NHS Commissioning Board (NHS England) must appoint a representative for the purpose of participating in the preparation of Joint Strategic Needs Assessments and the development of joint Health and Wellbeing Strategies, and to join the Health & Wellbeing Board when it is considering a matter relating to the exercise, or proposed exercise of the NHS Commissioning Board's commissioning functions in relation to the area, **if it is requested to do so by the Board.**

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5. Proposed changes to membership of the Board for 2020/21

- 5.1. There are three proposed changes to membership of the Board for 2020/21. The CCG and VCS changes will be put to the next Council AGM for approval. The NHS England change can be agreed by the Board without Council approval. Details of these changes are as follows:

Clinical Commissioning Group

According to the Council's Constitution, composition of the Health and Wellbeing Board is to include one "representative of Lewisham Clinical Commissioning Group". From 1 April 2020, following a merger, there will be a single integrated NHS South East London CCG (SELCCG). As Lewisham CCG will cease to exist after 1st April 2020, this representative will be the **Lewisham borough SELCCG representative**. In reality it will remain the same person (Dr Faruk Majid). The Council's Constitution will be updated to reflect this change.

Voluntary and Community Sector

Lewisham's Constitution also states that there should be "other persons as the Council thinks appropriate. This will normally include 2 representatives from the voluntary sector". At present there is a representative from Voluntary Action Lewisham (VAL) and a representative of the VCS more broadly. Having a VAL representative on the Board was deemed appropriate due to VAL's function as the umbrella organisation providing capacity-building support for the VCS in Lewisham. However the appropriate Council funding and responsibilities for this function were transferred to Rushey Green Time Bank towards the end of 2019. It is therefore appropriate that the VAL representative should step down to be replaced by a **Rushey Green Time Bank representative**.

NHS England

Lewisham's Constitution states that the NHS Commission Board (now NHS England) must appoint a representative for the purpose of participating in the development of a joint Health and Wellbeing Strategy if "requested to do so by the Board". In 2013, the Board requested this representation and the Director of Nursing for South London was nominated and approved. Initially this was Jane Clegg, who attended until May 2015 as a non-voting member. She was due to be replaced by Gwen Kennedy, however there is no record that Gwen Kennedy has actually attended the Health and Wellbeing Board. As there is sufficient coverage from a commissioning perspective across the Board membership, **it is proposed that formal NHS England representation be discontinued from 2020/21**. This should not have any noticeable impact as there has not been any actual NHS England attendance at the Board for almost five years.

- 5.2 Whilst the changes to membership detailed above are anticipated to take effect from 1 April 2020, the development of a new Joint Health and Wellbeing Strategy (2021-27) is likely to require further membership revisions. This will be to ensure that it remains fit for purpose and that the appropriate organisations to deliver the strategy objectives are properly represented. It is therefore proposed that a further review of Board membership will be undertaken once the development of the new strategy is completed. This is likely to be at the end of this calendar year at the earliest.

6. Recommendations

- 6.1. The following proposed changes are recommended:
- i. Representation by Lewisham Clinical Commissioning Group at the Board to be replaced by representation from the South East London Clinical Commissioning

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Group with effect from 1st April 2020. The Council's Constitution to be updated to reflect this change.

- ii. The representative from Voluntary Action Lewisham is to stand down following Council AGM approval.
- iii. Rushey Green Time Bank to nominate a new representative to the Board for approval by the Council AGM.
- iv. Members to agree that formal NHS England representation on the Board be discontinued from 2020/21.
- v. Membership of the Board to be reviewed again following the development of the new Joint Health and Wellbeing Strategy (2021-26).

7. Financial implications

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

8. Legal implications

- 8.1. The Health and Social Care Act 2012 specifies that the Board membership must at a minimum include a '*representative of each relevant clinical commissioning group*'. As the Lewisham CCG will cease to exist from 1st April 2020, a representative from the South East London Clinical Commissioning Group must be nominated to join the Board instead.

9. Equalities implications

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

10. Climate change and environmental implications

- 10.1. There are no specific climate change and environmental implications arising from this report.

11. Crime and disorder implications

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

12. Health and wellbeing implications

- 11.1 Health and Wellbeing Boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population. It is therefore important that appropriate organisations are represented at the Board. This includes the Clinical Commissioning Group and the local Voluntary and Community Sector.

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13. Glossary

Term	Definition
Clinical Commissioning Group	Clinical Commissioning Groups (CCGs) were created following the Health and Social Care Act in 2012, and replaced Primary Care Trusts on 1 April 2013. They are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
Corporate Strategy	The Corporate Strategy sets out how Lewisham Council plans to deliver for our residents over the next four years (2018-2022).
Health and Social Care Act 2012	The Health and Social Care Act 2012 is an Act of the Parliament that provided for an extensive reorganisation of the structure of the National Health Service (NHS). It abolished NHS primary care trusts and Strategic Health Authorities and transferred health care funds to several hundred "clinical commissioning groups", partly run by GPs in England.
Health and Wellbeing Board	Health and Wellbeing Boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population.
Healthwatch	Healthwatch England is a national body established under the Health and Social Care Act 2012, supported through a network of local Healthwatch organisations across each of the 152 local authority areas. Its purpose is to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf. The Healthwatch network works together to share information, expertise and learning in order to improve health and social care services.
NHS England	NHS England oversees the budget, planning, delivery and day-to-day operation of the commissioning side of the NHS in England as set out in the Health and Social Care Act 2012.
Voluntary and Community Sector (VCS)	The voluntary and community sector(VCS), or third sector is incredibly diverse and covers everything from neighbourhood watch groups to social enterprises to national and international charities and everything in between. Voluntary groups usually have a mix of paid staff and volunteers whilst community groups tend to be run by volunteers.

14. Report author and contact

- 14.1. If there are any queries about this report then please contact Stewart Weaver-Snellgrove on 020 8314 9308 or email stewart.weaver-snellgrove@lewisham.gov.uk.

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Appendix A – Voting Eligibility

The following table details the voting eligibility of current Health and Wellbeing Board members:

Name	Representing	Voting Member
Damien Egan	London Borough of Lewisham	Yes
Councillor Chris Best	London Borough of Lewisham	Yes
Dr Faruk Majid	Lewisham Clinical Commissioning Group	Yes
Val Davison	Lewisham and Greenwich NHS Trust	Yes
Donna Hayward-Sussex	South London and Maudsley NHS Trust	Yes
Dr Simon Parton	Lewisham Local Medical Committee	Yes
Chris Wykes Driver	Voluntary Action Lewisham	Yes
Roz Hardie	Voluntary and Community Sector	Yes
Tom Brown	London Borough of Lewisham	No
Gwen Kennedy	NHS England	No
Michael Kerin	Healthwatch	No
Pauline Maddison	London Borough of Lewisham	No
Dr Catherine Mbema	London Borough of Lewisham	No

Quorum

The quorum for meetings of the Health and Wellbeing Board requires 3 voting members, at least one of whom must be a member of the Council and one must be a representative of the Clinical Commissioning Group.

Notes:

- 1) Where Council officers are appointed to the Health and Wellbeing Board, they will not be entitled to vote.
- 2) Where an organisation (Clinical Commissioning Group, Healthwatch, or otherwise) appoint an employee to the Health and Wellbeing Board that employee will not be allowed to vote. This rule will not apply to representatives of the voluntary sector appointed by the Council.

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Health and Wellbeing Board

‘Shaping places for healthier lives’ programme – expression of interest

Date: 12th March 2020

Key decision: No

Class: Part 1

Ward(s) affected: All

Contributors: Dr Catherine Mbema, Director of Public Health, Lewisham Council

Outline and recommendations

This report summarises an expression of interest made by Lewisham Public Health for the Shaping places for healthier lives programme. This programme aims to support innovation in five local systems over three years through funding and a learning approach to act on the wider determinants of health.

Members of the Board are recommended to:

- Note the contents of the report and expression of interest

Timeline of engagement and decision-making

1. Summary

- 1.1. This report summarises an expression of interest made by Lewisham Public Health for the Shaping places for healthier lives programme. This programme aims to support innovation in five local systems over three years through funding and a learning approach to act on the wider determinants of health.

2. Recommendations

- 2.1. Members of the Board are recommended to:
 - Note the contents of the report and expression of interest

3. Policy Context

- 3.1. The Health and Social Care Act 2012 required the creation of statutory Health and Wellbeing Boards in every upper tier local authority. By assembling key leaders from the local health and care system, the principle purpose of the Health and Wellbeing Boards is to improve health and wellbeing and reduce health inequalities for local residents.
- 3.2. The activity of the Health and Wellbeing Board (HWB) is focussed on delivering the strategic vision for Lewisham as established in Lewisham's Health and Wellbeing Strategy.
- 3.3. The work of the Board directly contributes to the Council's new Corporate Strategy. Specifically *Priority 5 – Delivering and Defending: Health, Social Care and Support – Ensuring everyone receives the health, mental health, social care and support services they need.*
- 3.4. In July 2018, the Health and Wellbeing Board agreed that the main area of focus for the Board should be tackling health inequalities, with an initial focus on health inequalities for Black Asian and Minority Ethnic (BAME) communities in Lewisham.

4. Background

- 4.1. The Shaping places for healthier lives programme will fund five projects to make sustainable changes to local systems, which are consistent with improved population health, and designed to last beyond the lifetime of the programme.

Learning will be captured to allow these approaches to be applied in other areas and to

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wider health-related issues. The objectives of the programme are to:

- mobilise cross-sector action on the wider determinants of health through sustainable system change at a local level
- support local authorities to facilitate and enable local partnerships for system change on the wider determinants of health
- learn how to make changes that impact on the wider determinants of health so that learning can be shared.

4.2. The application process has several stages, during which applicants will receive support to develop their proposals. Following an expression of interest and submission of a further developed proposal, 12 applicants will be supported with a development grant of up to £20,000 plus expert advice to fully develop their final proposal through system mapping, developing a theory of change and building local partnerships. Grants will be awarded to five selected proposals, up to a total of £300,000 over three years (https://www.local.gov.uk/sites/default/files/documents/25.151%20CHIP%20Shaping%20Places_04_1%20WEB.pdf).

5. Lewisham Expression of Interest

5.1. The Lewisham expression of interest for this programme was made to directly link into the existing Health and Wellbeing Board work around addressing BAME health inequalities.

5.2. The expression of interest proposed a project to further explore the role of communities and community level action to address BAME health inequalities. The project was proposed to work on the hypothesis that effectively engaging BAME communities in addressing health inequalities associated with BAME ethnicity will contribute to a reduction in these inequalities.

5.3. There is good evidence available to show that several community-related factors are important in driving health inequalities that include 'how much control people have over resources and decision-making and how much access people have to social resources, including social networks, and communal capabilities and resilience' (UCL Institute of Equity, 2013).

5.4. Evidence for community-centred approaches to address these factors is therefore growing, with some data now available showing return on investment for employing these approaches in local areas. The proposed project will aim to contribute to this evidence base with a focus on using these approaches to specifically address ethnic health inequalities for those who are from a BAME background in a local authority setting.

5.5. The complete expression of interest can be found in the background papers for this report and was submitted to the Local Government Association in January 2020.

6. Financial implications

6.1. Five successful local partnership applications for the programme will be awarded a total of £300,000 of funding over three years.

7. Legal implications

7.1. There are no specific legal implications of this report.

8. Equalities implications

8.1. The expression of interest for the programme specifically works to address health inequalities in BAME communities in Lewisham.

9. Climate change and environmental implications

9.1. There are no specific climate change or environmental implications of this report.

10. Crime and disorder implications

10.1. There are no specific crime and disorder implications

11. Health and wellbeing implications

11.1. A successful application would support existing work to improve health and wellbeing and reduce health inequalities in BAME communities in Lewisham.

12. Background papers

12.1. Shaping places for healthier lives programme, expression of interest.

13. Report author and contact

13.1. Dr Catherine Mbema, Catherine.mbema@lewisham.gov.uk

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Shaping Places for Healthier Lives Programme

EXPRESSION OF INTEREST

Project name:	Tackling Black, Asian and Minority Ethnic (BAME) Health Inequalities in Lewisham – the role of community-centred approaches
Lead council:	Lewisham Council
Partners:	Lewisham BME Network
Expression of interest contact:	Catherine Mbema
Job Title:	Interim Director of Public Health
Email Address:	Catherine.mbema@lewisham.gov.uk

- Your application will be evaluated on four questions with a word limit of 2000 words for the whole application. Weightings for each question are given.
- No attachment or links will be assessed and scored.

1. What is the problem you want to address and outcome you want to focus on for the project? What is the evidence of a high level of local need either in the area as a whole or in a target population within the borough? (Weighting 30%)

Ethnicity is an important determinant of health

There is good evidence to show that ethnicity or ethnic identity impacts upon health outcomes irrespective of other socioeconomic factors (1). Though not typically classified as a 'wider' determinant of health, ethnicity or ethnic identity is an increasingly important determinant of health given the increasing diversity of local authority areas in England like Lewisham, where an estimated 48% of residents are from a Black, Asian or Minority Ethnic (BAME) background. Ethnicity both drives inequality in health outcomes and the distribution of the more typical wider determinants of health (e.g. education, housing, and employment) in populations. More specifically, being from a BAME background is associated with several poorer health outcomes and inequalities in wider determinants of health both nationally and in the London Borough of Lewisham. We would therefore like to focus a project on the impact of being a member of a BAME community in Lewisham on specific health outcomes. The project will focus on BAME ethnicity as a determinant of health and the communities within which BAME residents live and socialise in as a wider determinant.

(186 words)

Black, Asian and Minority Ethnic (BAME) health inequalities in Lewisham

In Lewisham, there are significant inequalities for BAME residents in health indicators related to cancer, childhood obesity and mental health, which can be summarised as follows:

1. Cancer

Lewisham Black African residents are underrepresented in urgent 2 week wait referrals for cancer in comparison to their White counterparts. Eligible Black African residents also have lower bowel cancer screening uptake rates in comparison to their White counterparts.

2. Childhood Obesity

Looking at data on all excess weight (overweight and obesity) from the National Child Measurement Programme (NCMP), Black and Minority Ethnic (BME) children in both reception and Year 6 in Lewisham are more likely to carry excess weight.

3. Mental Health

Those from Black ethnic groups are overrepresented in acute adult mental health services in Lewisham and are underrepresented in Child and Adolescent mental health services (CAMHS).

(146 words)

Action to address BAME health inequalities to date

There is strong political and partnership support for taking action to address BAME health inequalities in Lewisham. Our Health and Wellbeing Board, chaired by our directly elected Mayor Damien Egan, has made tackling BAME health inequalities one of its main priorities and has called on system leaders from partner organisations that sit on the Health and Wellbeing Board to commit to actions to address health inequalities around cancer, obesity and mental health. These three areas of focus were selected following analysis of available data to identify what the most significant inequalities are for BAME communities in Lewisham. A partnership action plan to articulate these commitments is being developed by a BAME health inequalities working group, which will include working with the Lewisham BME network. The BME network is a community development project, managed by the Stephen Charitable Lawrence Trust and funded by the London Borough of Lewisham. The Network is comprised of over 120 BAME stakeholder groups, all working to support Lewisham's BAME community organisations and the communities they serve.

(178 words)

Communities and action to address BAME health inequalities

The importance of local level action to address ethnic inequalities in both health outcomes and the wider determinants of health has been highlighted in recent guidance around taking action to address ethnic health inequalities (PHE, 2018). 'The meaningful engagement and involvement of minority ethnic communities, patients, clinical staff and people' has also be highlighted as being paramount to both understand need and ensure that the most effective interventions are employed to address inequalities (PHE 2018). This project will therefore aim to build on existing evidence around community participation, co-production and health by focusing on the role of communities as a wider determinant of health on improving BAME health inequalities in indicators for cancer, childhood obesity and mental health in Lewisham. Our proposal is to develop and evaluate an effective range of community-centred approaches, particularly around participatory planning and co-production, for BAME communities in Lewisham to be involved in partnership action to address the BAME health inequalities outlined above in Lewisham.

(168 words)

(Total: 678 words)

2. How does your proposal meet the overall programme design features, namely: (Weighting 40%)

a. Complex system perspective

BAME inequalities in health around cancer, mental health, and childhood obesity in Lewisham are the result of a complex interplay of factors including the impact of racism, discrimination and exclusion on individuals and communities; health seeking behaviours in respective BAME communities; health related practices and beliefs; differential access to preventative, community and specialist care/interventions; and differential access to important wider determinants of health. There are also nuances within different ethnic groups that fall within the BAME definition that adds to the complexity of involving communities in planning and taking effective action to address these inequalities. In order to develop an effective range of community-centred approaches with BAME communities to address these health inequalities, it will be critical to take a complex system perspective. This perspective will enable recognition of both the complexity and broad range of intersecting factors that result in ethnic health inequalities, some of which fall outside of local influence.

(147 words)

b. A systems approach

At the outset of this project, a systems mapping exercise will be required to provide a local understanding of the interaction of system factors that result in health inequalities for our BAME communities around cancer, childhood obesity and mental health, including using available data to identify which specific BAME groups are affected by particular inequalities e.g. Black African communities and bowel cancer screening uptake. This mapping will provide a valuable overview of system factors and where community-centred approaches, particularly participation and co-production, will be most effectively employed to impact upon addressing these BAME health inequalities. The mapping will also take into account where these approaches are already being used in the borough in order to complement and enhance rather than duplicate existing activity.

(123 words)

c. Partnership working

Since our proposed project will require interaction with many factors across systems, partnership working will be integral to project. This will build on existing the partnership in place to address BAME health inequalities via the Lewisham Health and Wellbeing Board including health, social care and voluntary sector partners: Lewisham and Greenwich Healthcare Trust, Lewisham Clinical Commissioning Group, South London and the Maudsley NHS Foundation Trust, Healthwatch Lewisham, Lead member for Public Health, and Lewisham Council. Partnership with the Lewisham BME network and other voluntary and community sector organisations who represent and have links to the BAME communities that this project is focusing on will be important. As far as possible the project will seek to build on existing partnerships and networks in the borough, and recognise existing groups, partnerships and initiatives that have effective connections with the communities that fall within the BAME definition.

(143 words)

d. Potential for learning

This project has significant potential to provide learning for other local areas that are diverse and see similar health inequalities in their BAME communities to Lewisham, particularly other urban or metropolitan areas of the country. Lewisham Public Health have already made contact with Birmingham and Bristol to think about how we can share existing learning to improve some health outcomes for our respective BAME populations. We have also conducted learning workshops with those working on the Black Thrive initiative, which aims to improve health and wellbeing for Black residents in Lambeth.

In the recently published Public Health England (PHE) guidance around addressing ethnic inequalities in health (PHE, 2018), it is noted 'that there remain significant gaps in data and a lack of robust evidence on effective interventions' to address ethnic health inequalities (PHE, 2018). This project will therefore make some contribution towards addressing this gap in evidence, specifically for addressing BAME health inequalities.

(153 words)

3. What is the hypothesised link between the action(s) you intend to take on wider determinants of health and improved health outcomes? (Weighting 15%)

Communities and action to address BAME health inequalities

This project will work on the hypothesis that effectively engaging BAME communities in addressing health inequalities associated with BAME ethnicity will contribute to a reduction in these inequalities. The mechanism of effective engagement can comprise of a number of community-centred approaches, ranging from community strengthening to establishing effective partnerships and collaborations for planning and co-production of projects. The mechanisms to be used in this project will be determined following a systems mapping exercise with a range of stakeholders and partners; further analysis of existing data for the health inequalities around cancer, childhood obesity and mental health; and review of the most effective interventions that may best be applied to the Lewisham context.

Evidence for community engagement and participation to improve health outcomes and reduce health inequalities

There is good evidence available to show that several community-related factors are important in driving health inequalities that include 'how much control people have over resources and decision-making and how much access people have to social resources, including social networks, and communal capabilities and resilience' (UCL Institute of Equity, 2013). Evidence for community-centred approaches to address these factors is therefore growing, with some data now available showing return on investment for employing these approaches in local areas. This project will aim to contribute to this evidence base with a focus on using these approaches to specifically address ethnic health inequalities for those who are from a BAME background in a local authority setting.

(247 words)

4. Outline your initial plans for monitoring the impact of your action(s) on the wider determinants of health. (Weighting 15%)

The existing Lewisham Health and Wellbeing Board work to address BAME health inequalities will be overseen and monitored via a partnership action plan and corresponding indicator framework to track changes in indicators demonstrating BAME health inequalities for cancer, childhood obesity and mental health. This action plan and indicator framework will be overseen by both the Lewisham Health and Wellbeing Board and Lewisham Council Corporate Equalities Board.

In order to assess the impact of additional community-centred approaches to support this work, we will seek an external evaluation partner to capture the specific contributions of these approaches to addressing ethnic health inequalities. The rationale for this will be to contribute to the evidence base for the use of community-centred approaches to impact on health inequalities and the evidence base around approaches that can be employed to address ethnic health inequalities. The evaluation work will as much as possible also follow a community-centred ethos by involving communities in the design and commissioning of the evaluation work.

(163 words)

Shaping Places for Healthier Lives Learning Network

The Shaping Places for Healthier Lives programme aims to share learning and best practice to encourage and support wider local action. The learning network is an opportunity for all local authorities to benefit from the programme even if they are not selected to progress to the second phase or three-year programme.

There will be regular events and engagement opportunities throughout the three-year programme open to all interested local authorities. These may include:

- Regular learning and showcasing events
- Programme materials such as blogs, webinars and case studies
- Workshops (participation may operate on a first come first serve basis)

If you would like to receive updates on the Shaping Places for Healthier Lives programme and upcoming events and opportunities, please join the programme mailing list and provide contact details below:

I would like to join the Shaping Places for Healthier Lives programme mailing list:

Contact email address: Catherine.mbema@lewisham.gov.uk



Health and Wellbeing Board

Response to the Care Quality Commission Stakeholder Survey 2019

Date: 12 March 2020

Key decision: No.

Class: Part 1

Ward(s) affected: All

Contributors: Tom Brown, Executive Director Community Services

Outline and recommendations

The purpose of this report is to update all members of the Health and Wellbeing Board on the feedback provided to the Care Quality Commission (CQC) on their performance, in response to their Stakeholder Survey 2019.

Members of the Health and Wellbeing Board are recommended to note the contents of this report.

Timeline of engagement and decision-making

The submission of a response to the CQC Stakeholder Survey on behalf on the Health and Wellbeing Board was a collaborative effort. The Executive Director for Community Services invited representatives from Adults and CYP Joint Commissioning, Public Health and the Lewisham Clinical Commissioning Group to assist in the completion of the online survey at a meeting held on 15 January 2020.

1. Summary

- 1.1. This report provides members with a summary of the formal response made to the Care Quality Commission (CQC) Annual Stakeholder Survey 2019, on behalf of the Health and Wellbeing Board.

2. Recommendations

- 2.1. Members of the Health and Wellbeing Board are requested to note the contents of this report.

3. Policy Context

- 3.1. The Care Quality Commission is the independent regulator of all health and adult social care in England.
- 3.2. The CQC make sure health and social care services provide people with safe, effective, compassionate, high-quality care and they encourage care services to improve.
- 3.3. In their role they register care providers, monitor, inspect and rate services, take action to protect people who use services and publish their views on major quality issues in health and social care.

4. Background

- 4.1. The Health and Wellbeing Board received an email invitation from the Chief Executive Officer of CQC (Ian Trenholm) in December 2019 to participate in their Annual Stakeholder Survey.
- 4.2. The survey covered the following:
 - a) How useful the information CQC publish about care quality was to Lewisham HWB in planning and conductive its activities.
 - b) How CQC worked with Lewisham HWB.
 - c) Whether there was a single shared view of quality and the impact of this.
- 4.3. The CQC was seeking considered and comprehensive responses to this survey but only one response could be submitted on behalf of Lewisham's HWB.
- 4.4. The survey covered a range of stakeholder activities, but not provision of health or social care services, as CQC gathers this information about them through its annual provider survey. The activities covered by the survey were:

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- Encouraging or supporting organisations to improve the quality of health or social care services.
 - Encouraging or supporting organisations to coordinate care across organisational or service boundaries.
 - Helping address organisational or service failure.
 - Commissioning health or social care services.
 - Representing the views of the public and people who use services and ensuring their voices are heard.
 - Representing the views of stakeholders involved in health or social care e.g. providers, professionals, commissioners etc.
 - Encouraging or supporting individual users to choose between services or get the best from their service.
 - Regulating, monitoring or otherwise overseeing activities of health or social care providers or professionals.
- 4.5 The survey closed on Sunday 19 January 2020 and results will be published in CQC's Annual Report and Accounts. Lewisham's HWB will not be identified in any reporting.

5. CQC Stakeholder Survey 2019

- 5.1. The CQC Stakeholder Survey 2019 comprised four sections detailed as follows:
- **Section 1:** About Lewisham Health and Wellbeing Board
 - **Section 2:** How CQC works with Lewisham Health and Wellbeing Board
 - **Section 3:** Usefulness of CQC information about care quality
 - **Section 4:** Is there a shared view of quality?
- 5.2. Representatives of Lewisham's Health and Wellbeing Board completed and submitted their response to this survey on 15 January 2020. A copy of this response can be found in **Appendix A**.

6. Financial implications

- 6.1. There are no specific financial implications arising from this report.

7. Legal implications

- 7.1. There are no specific legal implications arising from this report.

8. Equalities implications

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

9. Climate change and environmental implications

- 9.1. There are no specific climate change and environmental implications arising from this

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report.

10. Crime and disorder implications

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

11. Health and wellbeing implications

11.1 Results will be published from the survey in CQC's Annual Report and Accounts and the findings may appear in other publications and documents. The Health and Wellbeing Board may wish to consider this findings once published.

12. Glossary

Term	Definition
Care Quality Commission	The Care Quality Commission is the independent regulator of all health and adult social care in England.
Health and Wellbeing Board	Health and Wellbeing Boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population.
Stakeholder	A person, group or organisation that has interest or concern in an organisation.

13. Report author and contact

13.1. If there are any queries about this report then please contact Stewart Weaver-Snellgrove on 020 8314 9308 or email stewart.weaver-snellgrove@lewisham.gov.uk.

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Appendix A: Lewisham's Health and Wellbeing Board response to the CQC Stakeholder Survey 2019

Section 1: About Lewisham HWBB

What geographical area does Lewisham HWBB cover?

One or more Local Authority areas
(Borough, City, County or District)

Please select the Local Authority areas which Lewisham HWBB covers

London Borough of Lewisham

Which of the following are key activities of Lewisham HWBB?

Encouraging or supporting organisations to improve the quality of health or social care services **Yes**

Encouraging or supporting organisations to coordinate care across organisational or service boundaries **Yes**

Helping address organisational or service failure **No**

Commissioning health or social care services **No**

Representing the views of the public and people who use services and ensuring their voices are heard **Yes**

Representing the views of stakeholders involved in health or social care
E.g. providers, professionals, commissioners **Yes**

Encouraging or supporting individual users to choose between services or get the best from their service **No**

Regulating, monitoring or otherwise overseeing activities of health or social care providers or professionals **Yes**

Section 2: How CQC works with Lewisham HWBB

Please say whether you agree or disagree with the following statements:

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We have an effective working relationship with CQC **Disagree**

CQC collaborates effectively with organisations like Lewisham HWBB **Disagree**

CQC recognises the contributions we make through our key activities to influence quality improvement across the whole health and social care sector **Neither agree nor disagree**

Coordination of information gathering

Does CQC ever request information from Lewisham HWBB?

No

Please say whether you agree or disagree with the following statements:

CQC requests for information from us sometimes duplicate those of other regulatory, monitoring or oversight bodies

CQC sometimes requests information from us that is already in the public domain or available in routinely collected datasets

CQC liaises with us to coordinate gathering information and views from people who use services, carers or the public **Disagree**

CQC liaises with us to avoid both of us asking service providers for the same information

CQC understands what matters to people who use services **Don't know**

Outside of CQC gathering specific information related to an inspection, how often does CQC engage with you to understand what you know about people's experiences of care in services in your area? Please select the answer closest to the frequency of contact you have.

Never

In an ideal world how would your organisation want to share people's experiences of care with CQC?

During face to face meetings with inspection teams.

CQC registration

Please say whether you agree or disagree with the following statement:

Registering with CQC helps to drive improvement in providers

Agree

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CQC wants to ensure that registration is not a barrier to potentially good services entering the market. Do you have any views on whether you think this is the case or not? Have you had any experience of this that you would like to share with us? **No**

Innovation and technology

Please say whether you agree or disagree with the following statement:

CQC's regulatory activities enable and encourage innovation and technology in health and care services that have the potential to improve the quality of care

Neither agree nor disagree

Coordination when care quality changes or is poor

Please say whether you agree or disagree with the following statements:

We are confident that CQC can pick up important changes in service quality in between inspections **Disagree**

We are confident that CQC can respond appropriately if they pick up changes in quality in between inspections **Neither agree nor disagree**

If CQC have concerns about the quality of care provided by a service in our area, then they inform us **Agree**

If we have concerns about the care quality of a service, then we inform CQC **Strongly agree**

Is there other information that CQC should draw upon, or give a greater focus, to help understand the quality of care in services? If so, what and why?

This could include information you hold and/or information you are aware of that other stakeholders may hold too.

The CQC should be better using local feedback and local intelligence. We know what is working locally, we know where there are complaints - the CQC should be better and more frequently engaging with us.

How can we improve the way we work with and use information from national and local partners to identify cultures in services that may lead to abuse or breaches of human rights?

Through better engagement with organisations like ours.

Please say whether you agree or disagree with the following statements:

CQC are effective in advancing equality for people using services (e.g. on the grounds of disability, race, gender, sexual orientation, religion and belief) **Disagree**

CQC are effective in ensuring that people using services have their human rights upheld **Disagree**

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Please say whether you agree or disagree with the following statements:

If CQC decide to close or suspend a service in our area, then they inform us	Agree
If CQC decide to close or suspend a service in our area, then they work with relevant stakeholders to minimise any disruption to people who use services	Agree
If CQC decide to put a provider in our area in special measures, then they inform us	Strongly agree
If CQC decide to take other enforcement actions against a provider in our area, then they inform us	Agree
If we decide to take formal action in relation to care quality of a service, then we inform CQC	Agree

Information exchange about care quality

Please say whether you agree or disagree with the following statements:

If we have any questions about CQC information on care quality, then CQC is responsive	Agree
If we request additional information on care quality to that which CQC publishes routinely, then CQC is responsive	Disagree
If CQC requests information from us, then those requests are reasonable	

What would enhance coordination, information exchange or other aspects of the way CQC works with Lewisham HWBB?

CQC being more proactive, more engagement with the HWBB rather than just the individual partners/members/organisations in isolation.

Section 3: Usefulness of CQC information about care quality

In the last 12 months, which CQC information has Lewisham HWBB used in planning or conducting its activities? For local system reviews please consider the last 24 months.

CQC ratings of the quality of services	No
CQC Inspection reports of individual service providers	No
CQC local system review reports of health and social care for people aged 65+	No

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CQC "State of Care" reports	Yes
CQC "Driving Improvement" reports	Yes
Other national level CQC reports	Yes
NHS Improvement / CQC ratings of the use of resources by Acute Hospital Trusts (?)	No
NHS Improvement / CQC reports of the use of resources by Acute Hospital Trusts (?)	No

Which CQC State of Care reports published in the last 12 months has Lewisham HWBB used?

State of Care 2018/19 (Published October 2019)	Yes
State of Care 2017/18 (Published October 2018)	Yes
The state of care in independent doctor and clinic services providing primary medical care (Published March 2019)	No
The state of care in independent ambulance services (Published March 2019)	No

Which CQC Driving Improvement reports published in the last 12 months has Lewisham HWBB used?

Driving improvement: Case studies from eight independent hospitals (Published June 2019)	No
Driving improvement through technology (Published July 2019)	No

Which other national level CQC reports published in the last 12 months has Lewisham HWBB used?

Beyond barriers: how older people move between health and care in England <i>Findings from 20 Local System Reviews (published July 2018)</i>	Yes
Effective staffing case studies (Published September 2019)	No
Mental Health Act Code of Practice 2015: An evaluation of how the Code is being used (Published June 2019)	No

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Smiling matters: oral health care in care homes (Published June 2019)	No
Medicines in health and adult social care: Learning from risks and sharing good practice for better outcomes (Published June 2019)	No
Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and or autism (interim report) (Published May 2019)	No
Opening the door to change: NHS safety culture and the need for transformation (Published December 2018)	No
Equally outstanding: Equality and human rights - good practice resource (Published November 2018)	No
Quality improvement in hospital trusts: Sharing learning from trusts on a journey of QI (Published September 2018)	No
Sexual safety on mental health wards (Published September 2018)	No
Monitoring the Mental Health Act in 2017/18 (Published February 2019)	No

Over the last 12 months, Lewisham HWBB's efforts to encourage or support organisations to improve the quality of health or social care services have been enhanced by:

CQC ratings of the quality of services	
CQC inspection reports of individual service providers	
CQC local system review reports	
CQC "State of Care" reports	Agree
State of Care 2017/18 (published October 2018)	Agree
Other CQC "State of Care" reports	Neither agree nor disagree
CQC "Driving Improvement" reports	Neither agree nor disagree
Other national level CQC reports	Agree

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Driving improvement through technology (July 2019) **Disagree**

Driving improvement: Case studies from eight independent hospitals (June 2019) **Disagree**

Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and or autism (interim report) (May 2019)

[NICE: Quality improvement resource for adult social care](#)

Over the last 12 months, Lewisham HWBB's efforts to encourage or support organisations to coordinate care across organisational or service boundaries have been enhanced by:

CQC local system review reports

CQC "State of Care" reports **Agree**

State of Care 2017/18
(published October 2018) **Agree**

Other CQC "State of Care" reports **Neither agree nor disagree**

Other national level CQC reports [\(?\)](#) **Neither agree nor disagree**

CQC "Driving Improvement" reports [\(?\)](#) **Neither agree nor disagree**

Driving improvement through technology (July 2019) **Disagree**

Driving improvement: Case studies from eight independent hospitals (June 2019) **Disagree**

Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and or autism (interim report) (May 2019)

[NICE: Quality improvement resource for adult social care](#)

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Over the last 12 months, Lewisham HWBB's efforts to represent the views of the public and people who use services and ensure their voices are heard have been enhanced by:

CQC ratings of the quality of services

CQC inspection reports of individual service providers

CQC local system review reports

CQC "State of Care" reports **Disagree**

State of Care 2017/18
(published October 2018) **Disagree**

Other CQC "State of Care" reports **Disagree**

CQC "Driving Improvement" reports **Disagree**

Other national level CQC reports **Disagree**

Driving improvement through technology (July 2019) **Disagree**

Driving improvement: Case studies from eight independent hospitals (June 2019) **Disagree**

Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and or autism (interim report) (May 2019)

Over the last 12 months, Lewisham HWBB's efforts to represent the views of stakeholders involved in health or social care (e.g. providers, professionals, commissioners) have been enhanced by:

CQC ratings of the quality of services

CQC inspection reports of individual service providers

CQC local system review reports

CQC "State of Care" reports **Agree**

State of Care 2017/18
(published October 2018) **Agree**

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Other CQC "State of Care" reports	Neither agree nor disagree
CQC "Driving Improvement" reports	Neither agree nor disagree
Other national level CQC reports	Neither agree nor disagree
Driving improvement through technology (July 2019)	Disagree
Driving improvement: Case studies from eight independent hospitals (June 2019)	Disagree
Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and or autism (interim report) (May 2019)	

Over the last 12 months, Lewisham HWBB's efforts to regulate, monitor or otherwise oversee activities of health or social care providers or professionals have been enhanced by:

CQC ratings of the quality of services

CQC inspection reports of individual service providers

CQC local system review reports

CQC "State of Care" reports	Agree
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State of Care 2017/18 (published October 2018)	Agree
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Other CQC "State of Care" reports	Neither agree nor disagree
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CQC "Driving Improvement" reports	Neither agree nor disagree
-----------------------------------	-----------------------------------

Other national level CQC reports	Neither agree nor disagree
----------------------------------	-----------------------------------

Driving improvement through technology (July 2019)	Disagree
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Driving improvement: Case studies from eight independent hospitals (June 2019) **Disagree**

Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and or autism (interim report) (May 2019)

Our organisation feels able to rely on:

CQC's ratings

CQC's inspection reports of individual service providers

CQC's publications **Agree**

If you can, please give an example illustrating how information from CQC enhances the planning or conduct of Lewisham HWBB's activities

State of Care reports give contextual information and local reports give us lines of enquiry.

Usefulness of CQC information about care quality

What would enhance Lewisham HWBB's use of CQC information?

CQC engagement with the Board to understand local concerns and give and receive contextual information.

Section 4: Is there a shared view of quality?

Please say whether you agree or disagree with the following statements

Lewisham HWBB and CQC have a shared view of what good quality care looks like **Agree**

CQC and other stakeholders, such as local authorities, clinical commissioning groups or other regulators have a shared view of quality **Agree**

Single shared view of quality (?)

A number of national level health and social care organisations, including CQC, and other regulators and oversight bodies, have agreed a definition of quality, focused on high-quality, person-centred care for all. This means care which is safe, effective and provides a positive experience by being caring and responsive. Services are well-led, use resources sustainably and are equitable to all.

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There is more information for healthcare in the National Quality Board document "[Shared commitment to quality](#)" and for adult social care in the "[Quality Matters](#)" document.

Is Lewisham HWBB familiar with either of these documents?

Yes

Please say whether you agree or disagree with the following statements about the national definition (i.e. that high quality care is: safe, effective, caring, responsive, well-led, uses resources sustainably and is equitable to all):

The national definition captures the most important dimensions of quality	Agree
Lewisham HWBB work to support and enable quality is consistent with the national definition of quality	Agree
CQC's work is consistent with the national definition of quality	Agree
The work of other regulatory, monitoring and oversight bodies is consistent with the national definition of quality	Agree
CQC promotes the national definition of quality	Agree

Please say whether you agree or disagree with the following statements about impact of the national definition (i.e. that high quality care is: safe, effective, caring, responsive, well-led, uses resources sustainably and is equitable to all):

The national definition of quality facilitates the exchange of information about care quality between CQC and ourselves	Neither agree nor disagree
The national definition of quality reduces duplicate information requests from regulatory, monitoring and oversight bodies	Neither agree nor disagree
The national definition of quality helps us to gather useful and influential information and views from service users, carers or the public	Neither agree nor disagree
The national definition of quality helps us to gather useful and influential information and views from groups that we represent	Agree

What do you think will be the main challenges and opportunities for providers in delivering good quality care in the future and what do these mean for how we might regulate in the future?

Resources and workforce.

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There is a challenge that the CQC is set up in lines of acute, mental, community health providers and services - in an integrated world how do you manage and understand and effectively review organisational and system responsibilities and boundaries in your work.

Please use this box to make any further comments about CQC

We would welcome regular representation at the Board of a CQC representative who has an understanding of the breadth of the CQCs work in the borough.

Almost there!

You are now almost at the end of the survey.

Would you like a copy of your responses to be emailed to you?

Yes

Submit your responses

You have now reached the last page of the survey and your responses will be analysed by CQC after the closing date.

To avoid reminder emails being sent, please click "Finish" at the foot of this page. Your responses to the survey will be submitted to CQC, and you will not be able to access or edit your responses.

For a copy of your responses to be emailed to you, please type an email address in the box below and click "Finish". We will remove the email address before we analyse the survey responses.

Note that the email may not be neatly formatted and may include additional text from questions judged not to be relevant to Lewisham HWBB, which you were therefore not asked.

Email address:

salena.mulhere@lewisham.gov.uk

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Health and Wellbeing Board

Lewisham Clinical Commissioning Group (CCG) Annual Report 2019-20

Date: 12 March 2020

Key decision: No.

Class: Part 1

Ward(s) affected: All

Contributors: Charles Malcolm-Smith, Deputy Director (Strategy & OD), Lewisham CCG

Outline and recommendations

This report briefly sets out the proposed structure of Lewisham CCG's annual report for 2019-20, including content of the performance report. This will be submitted to NHS England in May, alongside the CCG accounts. The final report will be available to the Board at a later date.

The Health and Wellbeing Board is requested to note the contents of this report. If Board members have any particular comments or feedback then these may also be shared with the report author.

Timeline of engagement and decision-making

There is a statutory requirement for the Health and Wellbeing Board to be consulted in the preparation of Lewisham CCG's annual report.

A fully audited and signed annual report and accounts for Lewisham CCG must be submitted to NHS England by 28 May 2020.

1. Summary

- 1.1. This report provides members of the Health and Wellbeing Board with an update on the CCG's annual report and accounts for 2019/20.

2. Recommendations

- 2.1. Members of the Health and Wellbeing Board are asked to:
- Note the deadline for the CCG Annual Report and accounts for 2019/20 and its outline content areas that will include a performance analysis, including its relationship with the Board and contribution to local plans and strategies.

3. Policy Context

- 3.1. Lewisham CCG is required to publish, as a single document, an annual report and accounts. NHS England will incorporate this into their consolidated accounts which, in turn, form part of the Department of Health's consolidated accounts incorporating all its arm's length bodies.
- 3.2. A requirement of the Health & Social Care Act 2012 is that the annual report includes the CCG's contribution to local plans and strategies and that the Board is consulted in this regard in the preparation of the annual report.

4. Background

- 4.1. NHS England has communicated a structure for the annual report and accounts as per the Department of Health manual for accounts, which provides guidance on preparing and completing annual report and accounts. By 28th May fully audited and signed annual report and accounts for the CCG must be submitted, as approved in accordance with the CCG scheme of delegation and signed and dated by the accountable office and appointed auditors.

5. Lewisham CCG Annual Report 2019-20

- 5.1. The overall structure of the report will cover:
- a) Performance report
 - b) An overview
 - c) A performance analysis
 - d) Accountability report
 - e) Corporate governance report
 - f) Remuneration and staff report
 - g) Financial statements
- 5.2. The performance report overview will provide a short summary of the organisation from the CCG Accountable Officer i.e. its purpose, key risks to the achievement of its objectives and how it has performed during the year. While the analysis will report on the most important performance measures and provide longer term trend analysis where appropriate. Key measures to typically report on include financial performance, the CCG assurance framework, Better Care Fund metrics, outcome framework and any local indicators (quality, patient safety etc.), and NHS Constitution standards.
- 5.3. The draft report and accounts will be subject to review by NHS England and CCG audit committee and auditors. The final report will be available to the Board.

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6. Financial implications

- 6.1. The annual report and accounts will include the CCG's financial position and main areas of expenditure.

7. Legal implications

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

8. Equalities implications

- 8.1. The report will include an explanation of how the CCG has discharged its duty to reduce inequalities under section 14T of the Health and Social Care Act 2012. This will involve assessing how effectively we have discharged our duty to have regard to the need to reduce inequalities, acting in consultation with the Health & Wellbeing Board.

9. Climate change and environmental implications

- 9.1. The annual report includes a sustainable development update, including, travel energy use and carbon footprint.

10. Crime and disorder implications

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

11. Health and wellbeing implications

- 11.1. The CCG's positive relationship with the Health & Wellbeing Board and other local partners, and contribution to the delivery of local strategies and priorities will be integral to the report, for instance the work of the Lewisham Health & Care Partners (LHCP) and adult integration programme in the development of the whole system model of care.
- 11.2. The CCG has engaged with the board on CCG system reform proposals and on the south east London response to the NHS Long-Term Plan, as well as contributing to the sub-group of the board that leads on the development of the Joint Strategic Needs Assessment (JSNA) topic areas and reports.
- 11.3. The CCG's Strategy & Development and clinical directors committees have used the outcomes of the JSNA reports on respiratory and mental health to inform the strategic priority developments of the CCG.
- 11.4. Comments and feedback from members of the Board on the CCG's contributions to these areas, and others, are welcomed.

12. Background papers

12.1 The Department of Health manual for accounts can be found [here](#).

13. Report author and contact

13.1 If there are any queries about this report then please email Charles Malcolm-Smith at charles.malcolm-smith@nhs.net.

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Health and Wellbeing Board

Lewisham Safeguarding Children Annual Report 2018-19

Date: 12 March 2020

Key decision: No.

Class: Part 1

Ward(s) affected: All

Contributors: Nicky Pace, Lewisham Safeguarding Children Board (LSCB) Independent Chair & Mick Brims, Strategic Safeguarding Lead, Lewisham Safeguarding Children Partnership (LSCP)

Outline and recommendations

Local Safeguarding Children Boards (LSCBs) were established with the purpose of ensuring that agencies keep local children and young people safe and that where they have intervened they have made a positive difference in children's lives. The purpose of this report is to update the Health and Wellbeing Board on the work of the LSCB for the period 2018-19.

The Health and Wellbeing Board is requested to note the contents of this report.

Timeline of engagement and decision-making

In addition to the work of Lewisham Council, the annual report includes contributions from the following partner agencies that highlight their respective activities to safeguard children:

- Lewisham and Greenwich NHS Trust (LGT)
- Safer Lewisham Partnership
- Children and Adolescent Mental Health Service (CAMHS)
- London Ambulance Service (LAS)
- London Community Rehabilitation Company
- Phoenix Community Housing
- Metropolitan Police Service - South East Basic Command Unit
- NHS Lewisham Clinical Commissioning Group (CCG)
- Lay Members
- National Probation Service
- Youth First

1. Summary

- 1.1. This Annual Report covers the period April 2018 to March 2019. The LSCB is required to report on progress against the priorities set for the previous year and plan any changes to local safeguarding priorities for the next year, taking into account national priorities and local needs, and any issues arising from Serious Case Reviews and multi-agency audits.
- 1.2. At the ending of this reporting period, the LSCB was preparing to transfer to the new national arrangements of the Safeguarding Children's Partnership in July 2019. Therefore, the next Annual Report (2019-20) will encompass the final quarter of the LSCB before transfer.

2. Recommendations

- 2.1. Members of the Health and Wellbeing Board are requested to note the contents of this report.

3. Policy Context

- 3.1. Statutory Guidance within '*Working Together to Safeguard Children*', requires each LSCB to publish an annual report on the effectiveness of child safeguarding and the promotion of the welfare of children in the local area. The report should provide an assessment of the performance of local safeguarding services and show how areas of development will be addressed. Working Together requires that the report is submitted to the Chief Executive of the Council and the Chair of the Health and Wellbeing Board.
- 3.2. The work of the LSCB directly contributes towards the priority of '*Giving children and young people the best start in life*' within the Corporate Strategy. This priority aims to ensure that every child has access to an outstanding and inspiring education, and is given the support they need to keep them safe, well and able to achieve their full potential.

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4. Background

- 4.1. The Lewisham Safeguarding Children Board comprises all partner agencies with a key contribution to child protection and safeguarding in the Borough. In developing the Annual Report partners contributed to the evidence detailed and summaries of relevant safeguarding activity for the period 2018-19.

5. Financial implications

- 5.1. The operation of the LSCB is funded by the council and partners. There are no specific financial implications to this report.

6. Legal implications

- 6.1. Section 13 of the Children Act 2004 requires each Local Authority to establish a local safeguarding children's board for their area and specifies the organisations and individuals (other than the local authority) that should be represented on the board.
- 6.2. The LSCB has a range of roles and statutory functions including developing local safeguarding policies and procedures and scrutinising local arrangements. The strategy, objectives and functions of the LSCB are described as follows:
- Coordinate what is done by each personal body whoever sits on the board for the purpose of safeguarding and promoting the welfare of children in the area.
 - To ensure the effectiveness of what is done by each personal body for those purposes.
- 6.3. The revised Working Together 2015 guidance places responsibilities on the LSCB to deliver a stronger leadership role around local safeguarding practice and directly influence multi-agency and single agency requirements as well as requiring the establishment of a single assessment approach and supporting framework. The revised regulatory framework also includes a judgement on the effectiveness of local safeguarding boards with a focus on assessing the impact of the board's activity on frontline practice and the positive difference made to children and local communities.

7. Equalities implications

- 7.1. The work of the LSCB is particularly focused on the protection of vulnerable groups in the child population, such as those with disabilities and girls at risk of violence and sexual exploitation. The majority of data considered by the LSCB is analysed using equalities data where that is available.

8. Climate change and environmental implications

- 8.1. There are no specific climate change and environmental implications arising from this report.

9. Crime and disorder implications

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

10. Health and wellbeing implications

- 10.1 Lewisham LSCB is focused on enhancing the safeguarding of children within Lewisham through multi-agency communication and collaboration to create positive outcomes for children and families. A focal element of LSCB work is facilitation and promotion of effective multi-agency co-operation, to ensure the continuing good health, safety and well-being of children within the aegis of LSCB safeguarding priorities.
- 10.2 Each contributing agency to this annual report has reported on progress against LSCB safeguarding priorities for the 2018-19 year, with improved health and well-being outcomes an integral aspect of positive safeguarding outcomes.
- 10.3 Whilst there are no specific health or well-being implications arising from this report, achieving positive health and well-being outcomes remains a key element of the LSCB multi-agency approach to safeguarding children in Lewisham.

11. Report author and contact

- 11.1. If there are any queries about this report then please contact Eileen Bezuidenhout on 020 8314 3396 or email Eileen.Bezuidenhout@lewisham.gov.uk.

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**Lewisham
Safeguarding**
Children Board



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Foreword from the Independent Chair, Nicky Pace

As the Independent Chair of the Lewisham Safeguarding Children Board (LSCB) I am pleased to present the Annual Report for the period April 2018 to March 2019. This will be my last Annual report as I intend to step down from the role in September 2019 and a new role of Independent Scrutineer will be recruited.

Local Safeguarding Children Boards (LSCBs) were established with the purpose of ensuring that agencies keep local children and young people safe and that where they have intervened they have made a positive difference in children's lives. The LSCB has a really important role in coordinating and ensuring the effectiveness of what is done by each and every person involved in protecting children and it carries statutory responsibilities for safeguarding children in Lewisham. It is made up of senior managers within organisations in Lewisham who hold responsibility for safeguarding children in their agencies, such as children's social care, police, health, schools and other services including voluntary bodies. The LSCB monitors how they all work together to provide services for children and ensure children are protected.

The last year has seen the development of the new Multi-agency Safeguarding Arrangements which will replace LSCBs. The Partnership Plan for Lewisham will be published by the end of June 2019 and the new arrangements will be in place by September 2019. There has been careful planning and consultation over the last year to develop this plan. Where possible the plan focusses on reducing duplication, joining up with other partnership groups and across boundaries as much as possible, with a real focus on making a difference to front line practice to safeguard children and builds on what we know works well. The challenge over the next year will be to ensure that replacing the LSCB with the new arrangements is done carefully and the transition is carefully monitored and reviewed. It is

recognised that the next year will be challenging for all agencies, with considerable change within their own organisations and we will need to ensure the focus and delivery of services to vulnerable children, young people and families is not adversely affected.

Lastly, I would like to thank the Board staff, for their continued support in the functioning and promotion of the LSCB. I would also like to thank members of the Board, from across the partnership of our voluntary, community and statutory services and all the frontline practitioners and managers for their commitment, hard work and effort in keeping children and young people safer in Lewisham.



Nicky Pace

LSCB Independent Chair

Overview of the Board

What is a Local Safeguarding Children Board?

Local Safeguarding Children Boards (LSCBs) were established by the Children Act 2004.

The LSCB is a statutory body and was established in 2006 in accordance with the statutory duties set out in the '*Children Act 2004*'. The activities undertaken by the LSCB reflect the requirements of the Act, and are based upon the objectives set out in Chapter 3 of '*Working Together to Safeguard Children 2015*:

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- (a) To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area, and
- (b) To ensure the effectiveness of what is done by each such person or body for those purposes.

About the Lewisham Safeguarding Children Board

The LSCB is the statutory mechanism for agreeing how the relevant agencies in each local area will co-operate to safeguard and promote the welfare of children in that locality, and for ensuring the effectiveness of what they do. Governed by the statutory guidance in Working Together to Safeguard Children 2015 and the Local Safeguarding Children Board (LSCB) Regulations 2016, Members of the Lewisham Safeguarding Children board (LSCB) are senior managers from a range of different organisations who hold strategic roles in relation to safeguarding / child protection. They are expected to be able to speak for their organisations with authority,

commit their organisations on policy and practice issues, and hold their organisations to account on their safeguarding/child protection practice.

The LSCB has a responsibility to ensure that organisations are fully meeting their safeguarding obligations effectively, and can hold them to account if they are not.

The LSCB works to achieve this by:

- Leading collaboration across all agencies in the community
- Developing and setting policies and procedures
- Monitoring and auditing the implementation of these policies and procedures
- Conducting audits to ensure the effectiveness of what is done by agencies individually and collectively to safeguard and promote the welfare of children
- Conducting Serious Case Reviews when a child dies or is seriously harmed and abuse or neglect is suspected to improve practice across agencies
- Conducting Child Death Reviews to better understand how and why children in the locality die and use these findings to take action to prevent other deaths
- Ensuring appropriate multi-agency training is available and effective
- Promoting awareness and action in the wider community

The LSCB Main Board

This is made up of representatives of the member's agencies. Board members must be sufficiently senior so as to ensure they are able to speak confidently and sign up to agreements on behalf of their agency, and make sure that their agency abides by the policies, procedures and recommendations of the LSCB. Please see the Appendices to see our attendance in 2018/2019.

The Executive Board

The Executive Board manages the business and operations of the LSCB, ensuring there are clear governance arrangements in place and drives forward the strategic priorities as outlined in the Business Plan.

Independent Chair

The LSCB has an Independent Chair who is subject to an annual appraisal to ensure the role is undertaken competently and that the post holder retains the confidence of the LSCB members. The Chief Executive of Lewisham Borough Council and Executive Director for Children & Young People appoints the Chair.

Lewisham Borough Council

Whilst the Chair and the LSCB Board itself is independent, Lewisham Council is responsible for establishing and maintaining the Local Safeguarding Children Board (LSCB) on behalf of all agencies.

The Executive Director of Children & Young People and the Director of Children's Social Care are required to sit on the Main Board of the LSCB, as this is a pivotal role in the provision of children's social care within the local authority.

Lead Member for Children's Services

The Lead Elected Member holds responsibility for making sure that the local authority fulfils its legal responsibilities to safeguard children and young people. The Lead Member contributes to the LSCB as a participating observer and is not part of the decision-making process.

Partner Agencies

All partner agencies responsible for safeguarding children in Lewisham are committed to ensuring the effective operation of the LSCB as a multi-agency safeguarding group. This is supported by the LSCB governance document and partnership protocol, which sets out the governance and accountability arrangements.

Designated Professionals

Health commissioners should have a Designated Doctor and Designated Nurse to take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across the local area. Designated professionals are a vital source of professional advice on safeguarding children matters to partner agencies and the LSCB. There is a Designated Doctor and a Designated Nurse in post in Lewisham, who play an active role in the LSCB and its task groups.

Lay Members

Lewisham LSCB has two local residents acting as Lay Members who support stronger public engagement in local child protection and safeguarding issues and contribute to an improved understanding of the LSCB's work in the community. Both Lay Members play an active role in the work of the LSCB and its task groups.

Effectiveness of the Board

The Board is required to report on progress against the priorities set for the previous year and plan any changes to local safeguarding priorities for the next year, taking into account national priorities and local needs, and any issues arising from SCRs and multi-agency audits. When deciding our priorities, we acknowledge that our core business of safeguarding children is on-going, including identifying, assessing and providing services and help to those children who need protection. In deciding the Board's improvement priorities, we consider how well we have delivered our priorities from the previous year and if further work is needed. S

Summary of our Key Priorities for 2018-2019	Summary of our Key Achievements for 2018-2019
Priority 1: Neglect Improve the effectiveness of agencies and the community in identifying and addressing neglect.	<ul style="list-style-type: none"> • The LSCB continued to provide a comprehensive rolling programme of safeguarding training to inform practitioner's knowledge and skills in order to appropriately identify and address matters of neglect. • The Neglect Task & Finish Group concluded its work in January 2018 reviewing the Neglect Toolkit and Strategy. The strategy and toolkit will be reviewed in in January 2021, with the review process to commence in the summer of 2020. . Neglect remains a LSCB Priority and further initiatives to improve practice and outcomes for children at risk of or suffering neglect will be explored in the 2019-20 year going forward.
Priority 2: Governance and Performance Increasing the effectiveness of the LSCB as a truly effective agent in securing positive outcomes for children, in protecting them from abuse and exploitation.	<ul style="list-style-type: none"> • LSCB Performance Framework reviewed in 2018 was implemented via the MESI Sub-Group. Key indicators from across the partnership were captured and scrutinised within the MESI Task Group. • Consistent audit schedule ensured the monitoring of single and multi-agency audits. A MESI Audit Subgroup was created and multi-agency audits were completed to understand the scope of Contextual Safeguarding issues and the multi-agency response to this issue in Lewisham. A multi-agency audit was also completed to understand the scope of Child Mental Health concerns within Lewisham, including a direct survey of a cohort of children and questionnaire responses from parents alongside agency data and case audits. • Regular scrutiny and challenge of partnership agency data. • Regular meeting of Chairs of Partnership Boards, ensuring consistent safeguarding messages. Further developing these relationships is a priority for 2019-20. Audit outcomes were shared with some partnership boards.
Priority 3: Self-harm and suicide prevention To ensure that parents and professionals are aware of the risks associated with self-harm behaviour and suicide ideation so children and young people can be better supported from harming themselves	<ul style="list-style-type: none"> • The LSCB continues to offer training packages on self-harm, on the LSCB training programme. • The LSCB also provided a Safeguarding Briefing in September 2018 regarding 'Self-harm & Suicidal Ideation & Young People'. This was sent to a wide network of safeguarding professionals across Lewisham and was made publicly available on the LSCB website. • LSCB Development Officer also provided information and resources to raise awareness amongst safeguarding professionals regarding children's mental health and supported an awareness-raising event in conjunction with Children's Social Care.

**Summary of our Key Priorities
for 2018 -2019**

Summary of our Key Achievements for 2018-2019

Priority 4:
Voice of the child and community
Ensuring that the voices of children and young people influence learning, best practice and the work of the LSCB.

- Continuing, regular interface with Young Mayor’s Forum.
- LSCB facilitated two events to bring together a number of young person-led school advisory councils and youth advisory groups alongside the Young Mayor’s group and the Children in Care Council to share the safeguarding priorities they had been developing in their respective groups. The purpose of these events was to share ideas across a range of children within the borough and understand the work that these advisory groups were under-taking to inform safeguarding priorities going forward.
- Development of the LSCB website to use as an interactive tool with children and young people continues. LSCB Development Officer is planning to update all ‘Children & Young People’ pages on the website with the direct input of young people.
- LSCB Introductory Presentations for professionals, young people and community have continued.
- LSCB website has continued to improve communication with professionals, parents and carers and the community – web data suggests that the website is frequently viewed for information, signposting and resources. The website has also raised the profile of various safeguarding issues and the work of the LSCB via publication of Serious Case Reviews and provision of guidance for children, parents and professionals around safeguarding in Lewisham.
- Monthly themed Safeguarding Briefings have continued, ensuring that key safeguarding messages reach professionals across the partnership and providing links onward to specialist or more detailed safeguarding information. These are also available on the LSCB website.

Priority 5:
Missing, Exploited & Trafficked
Increasing the effectiveness of agencies and the community in identifying and addressing Child Sexual Exploitation, children going missing and trafficked.

- Weekly MET operational meetings have continued to discuss individual cases, whilst monthly MET tactical meetings have continued to look at trends/hotspots of concern and borough-wide intelligence from operational work around MET issues. A quarterly LSCB Strategic MET Task group has continued to guide the wider strategic response to MET concerns within Lewisham.
- LSCB MET Strategy reviewed in January 2019 to re-define and the purpose of MET groups within Lewisham and their role in combating Missing, Exploitation & trafficking concerns in the borough. From the refreshing of the MET Strategy and further development of a model of working with MET concerns rooted in Contextual Safeguarding principles, the outline documentation for the LSCB ‘Concern Hub’ was developed, with implementation of the Concern Hub to replace the MET Strategic Task group in the 2019-20 year.
- Contextual Safeguarding Multi-agency Audit addendum conducted in December 2018, following on from a previous MET audit in May 2018, developing an understanding of partnership thresholds for working with young people where there were contextual safeguarding concerns.
- The LSCB continues to offer multi-agency CSE, Missing & Trafficking training and will look to develop its training offer alongside the developing Concern Hub.

LSCB Task Groups

Monitoring, Evaluation and Service Improvement Task Group (MESI)

Chaired by Agency Representative: Nicky Pace, LSCB Independent Chair

What did we do?

Last year we developed a new meeting structure to provide greater capacity for challenge and scrutiny of safeguarding issues across the partnership by refocusing the Monitoring, Evaluation & Service Improvement (MESI) group. An operational Audit group was set up, separate from and reporting to MESI to provide greater focus on multi-agency audit function.

The aim of this work group is to support multi-agency engagement and monitor partners' contribution to safeguarding children and young people. It will do this by effectively monitoring, scrutinising and evaluating safeguarding practice undertaken by agencies within Lewisham. It will focus on the quality assurance of multi-agency arrangements, practice and service delivery and identify areas of development and barriers to learning, improvement and change. It will also monitor the LSCB Business Plan and dataset.

What was the impact?

It was anticipated that the MESI group would be able to focus on wider safeguarding issues whilst providing scrutiny of multi-agency operational practice issues, particularly where there may not be the opportunity to do so in LSCB Main Board meetings.

Development of a multiagency dataset – considerable work has been undertaken this year to finalise the multiagency data set, those proxy indicators required to monitor performance of safeguarding across the partnership. However, there has been some difficulties this year in the Children's Social Care data, which has slowly evolved so that some safeguarding areas can now be reported upon, but there is more still to be done. The Lewisham and Greenwich Trust has identified and provided a robust performance dashboard. It has continued to prove difficult to receive data from other agencies, which has meant that the analysis of the data and understanding the impact of this upon multi-agency safeguarding arrangements for children continues to be a challenge.

Multi-Agency Audits Sub Group - Audits for 2018-19

Chaired by Amanda Harris, Quality Assurance Manager, Children's Social Care

During 2018-2019, we planned and completed a Child Mental Health (CMH) multi-agency audit in conjunction with Greenwich Local Safeguarding Children Board. We also completed a 'live audit' in December 2018 regarding cases where there were contextual safeguarding concerns for young people living in the community (as an addendum audit from a previous MET audit, which was submitted to main MESI subgroup in May 2018). We planned a 'Thresholds' audit, which will be finalised by August 2019. These audits all supported the named LSCB priorities and had been set by the LSCB Main Board.

Child Mental Health (CMH) Audit

The CMH Audit will be taken to the LSCB Main Board on 26.06.2019, having already been agreed by main MESI; this audit took place over a number of months and highlighted several types of audit activity which shone a light on partner processes and practice locally in responding to concerns about young people's mental health. The analysis of the main themes from the audit activity (multi-agency file audit, practice events, questionnaires, feedback from parents and young people) evidenced the need to consider:

- improvement work across the partnership,
- the further development of joint CMH protocol across agencies (previously recommended from SCR work),
- a review of the CAMHS waiting list,
- development of a way of responding to families and young people which is more immediate and remains in touch with them where they are referred to CAMHS,
- consideration of longer interventions than are currently commissioned locally,
- the development of clear multi-agency 'step down' processes and services for young people to access for post CAMHS work.

When considering any changes needing to be recommended as a result of previous learning or priorities, the CMH Audit identified a need for improved care planning across agencies when considering work with child mental health issues. This is a theme that has been identified in previous audit and serious case reviews and will benefit from MESI scrutiny going forward to share learning and support improved multi-agency care planning for children with mental health issues.

Missing, Exploited, Trafficking Contextual Safeguarding Audit & Addendum

A previous MET audit (missing, exploited and trafficked children) which was completed in May 2018 was presented and agreed by main MESI subgroup, but was not then finalised by the LSCB Main Board. It was agreed that more work was to be undertaken. This report with the subsequent addendum work, the 'Live' contextual safeguarding audit, from December 2018, will be put to the LSCB Main Board on 26.06.2019. This report will provide a fuller picture of work across the partnership with children at risk of going missing, being exploited or trafficked. The first MET report was shared with the MET Task group and Youth Offending Service (YOS) in September 2018 to assist consideration of future strategic development of work with such young people, as was also reported on last year in the LSCB 2017-18 Annual Report.

The latest addendum audit report will also consider partnership thresholds for working with contextual safeguarding risks for older young people on the cusp of adulthood will recommended that a piece of outstanding practice be shared more widely across the partnership.

Changes made as a result of this previous learning and in working toward LSCB priorities are hard to measure at this stage whilst resultant actions are being completed to complement wider strategy across the partnership. In CSC, there is considerable work being undertaken in relation to intervening in contextual safeguarding issues, including a service re-design, refresh of the hub arrangements for sharing information, assessing risk and immediate responses and the establishment of a dedicated service for this cohort of children in the Early Help offer. This has included strengthening partnership arrangements. All of the above work fits with the current priorities of the LSCB.

The third audit regarding thresholds in MASH is being collated and will be reported on in August 2019.

Impact of audit

The impact of the CMH audit and the MET and 'Live audit' will be clearer in time as actions are implemented as noted above. The participation events were well attended by partners regarding CMH, a subject most professionals are aware of and interested in. Education and Health partners report that the impact of undertaking multi-agency audit activity alongside other demands for audit in their agencies is at times very challenging. GPs historically and currently are not able to complete case file audits or attend audit events easily, and the GP Designated Lead has had to find ways to support other health professionals to complete case file audits.

Where there were tasks to follow up from audit activity this has happened, particularly on contextual safeguarding cases; respective CSC Service Managers have ensured they have tracked actions. Learning from multi-agency audits needs to become more widely disseminated into partner agencies and routes and opportunities for this to happen developed; this could be linked to learning from Serious Case Reviews (SCRs), given the new proposed LSCB/LSCP partnership arrangements.

Views of parents/carers/children/young people were included in the CMH audit work. Surveys of young people during other LCSB events were helpful and highlighted the need to think more creatively across the range of LCSB activities. In audit work, we need to develop the understanding of consent and information sharing across the partnership especially when older children's consents are needed, to improve audit planning and improve best practice. Some designated leads and partners required some support when considering safeguarding issues

within the principles of audit under safeguarding board activity, consent dispensation and when to seek consent from parents and young people to support practice and support audit. Audit tools regarding consent need to be further developed; a subgroup of partners could lead on this work.

What we plan to do next?

Audit themes need to be set and discussed by partners in relation to the new partnership priorities. The voices of children and feedback from service users should be planned for in audit work as this was previously under-developed. Improvements in the CMH Audit along with practice events and the use of SCIE methodology should be further supported.

Consistent partner participation in audit work would improve audit activity across the partnership and further exploration is needed to understand how best to engage partners in multi-agency audit activity alongside their daily safeguarding roles. Use of a strengths-based and appreciative style in audit work has been well-received and should continue.

Thresholds regarding MASH and partnership working from the early analysis of the current Threshold Audit require ongoing audit. Information sharing between partners and how confident partners are about this needs to be considered further. Contextual safeguarding, neglect and domestic abuse remain local key areas of enquiry, along with the involvement of fathers and family networks in multi-agency work to safeguard children.

Audit tools need further development aligning these to the Signs of Safety practice model. Tasks arising from audit need to be tracked, actioned and reported on by partners, with this being less developed in the work to date and the MESI group needs to consider how to most effectively support audit work via contextual

information analysis and liaison with the audit chair to increase audit capacity and timeliness.

Example of effective practice

There were examples of good practice throughout the audit work, but one case in particular, the live audit demonstrated good multi-agency partnership working; the questionnaires for young people used at an education summit represented a good use of forums to gain feedback and should be further developed (see above); practice events were well received and were a useful way of engaging safeguarding partners.

What do we plan to do next?

The MESI will continue in a different form under the new arrangements and the next year. The partnership aims to have a clear and shared understanding of the data so that we have a shared language to articulate the challenges and the impact we want to make. It also aims to have performance measures that are based on a shared understanding of what success should look like from the perspective of children, young people and their families.

The purpose of this group will focus on monitoring and evaluating the effectiveness of what is being achieved the partners, individually and collectively. Multi-agency audits help to measure the quality, effectiveness and outcomes of safeguarding work across the partnership. Members of this group participate in audit activities including case audits, interviews with children, young people and parents, surveys, consultations and discussions with practitioners and triangulate this information to establish the quality of safeguarding delivery, identify areas that require further improvement and influence system change.

It will ensure plans are delivered including the actions arising from the SCRs currently being undertaken. It will hold partners to account for their safeguarding practice during the transition to the new safeguarding arrangements and any changes to partnerships structures. It will also hold the LSCB Board partners to account for the delivery against the identified safeguarding priorities for 2019-20.

Policies Procedures & Training Task Group (PPT)

Chaired by Belinda Chideme, Trust Lead Named Nurse – Lewisham and Greenwich NHS Trust and Dr Sian Morgan Named Doctor University Hospital Lewisham

What did we do since the last year? *(in relation to safeguarding children or to support the LSCB priorities 2018/19)*

- Policies and guidelines which have a multiagency interface have been reviewed and updated in line with changes in national legislation :
 - Protocol for the Management of actual or suspected bruising in immobile infants
 - Information & Referral to LADO Process
 - Domestic Abuse Policy
- Learning from Serious Case Reviews is reflected in the Training programme – 4 sessions specifically about the recently published SCR's have been advertised.
- £800 saving by moving Safeguarding Level 2 to online, and offering more Safeguarding Level 3 classes.
- New courses added to the training programme as a result of learning from serious case reviews.
- For the first time LSCB afternoon briefings being delivered at Lewisham Hospital to ensure clinical staff have the opportunity to attend.

- The first Early Help Champions ‘train-the-trainer’ training session was held. The objective is for all partner agencies to identify professionals who can attend the session – so they can train more professionals within their respective agency.

What do we hope to achieve in the next year?

- Training course on Male Victims of Domestic Violence to be added to the MARAC training programme.
- Specific action to increase enrolment to LSCB courses by practitioners working in voluntary and faith organisations.
- Discussions to be held with Greenwich in light of the anticipated changes from LSCBs to Safeguarding Partnerships.
- To have Early Help Champions from all LSCB partner agencies trained and delivering training in their respective agency.
- To have the LSCB website act as a first point of contact or directory in regard to available safeguarding training and resource from various organisations, voluntary and statutory.
- Partner agencies to continue to offer relevant training courses, their service can deliver via the LSCB Training Programme.
- There will be an increased focus on including sessions that will enable practitioners to formulate strategies to listen to the voice of the child – including those with complex health and social needs.
- The LSCB currently has Female Genital Mutilation (FGM) sessions delivered by the African Advocacy Foundation this is a West African organisation which focuses on West African practices. In the next year the LSCB will include ECRO – they focus on the Kurdish Pakistani community. Changes are being

made in recognition to the different challenges and client groups the respective organisations work with.

- Policies and guidelines which have a multiagency interface will continue to be reviewed and updated to ensure they are in line with national legislation, including:
 - Children not brought an appointment
 - Parental Mental Health & Child Welfare Protocol
 - Forced Marriages
 - Working with Parents who Misuse Substances

Challenges/risks?

- A relatively high number of PPT members have not attended meetings, which has an impact on the completion or closure of actions.
- A number of training courses are under-subscribed, which can result in the sessions being re-arranged or if necessary, cancelled. A wider issue across the training program is non-attendance by professionals who have booked a training course, thus reserving training places that are not always utilised.
- The matter regarding whether private nursery staff are expected to pay to attend sessions needs to be resolved – as private nurseries do not contribute to the LSCB – yet they are one of the agencies with a high number of subscribers.

Example of effective practice?

- The lunchtime briefings covering serious case reviews will be facilitated jointly between Health and Children’s Social Care professionals.

How has the voice of the child been considered?

- A good number of the training sessions provide an opportunity for practitioners to formulate strategies to listen to the voice of the child – including those deemed to have mental capacity but are vulnerable and those with complex health and social needs i.e. diminished mental capacity.

Case Review Panel (CRP)

Chaired by: Nathan Glew Service Manager, Quality Assurance, Lewisham Council Children Social Care

Case Review Panel (CRP)

Chaired by: Karen Neill, Interim Service Manager, Quality Assurance, Lewisham Council Children's Social Care, until May 2018 and then by Nathan Glew, Head of Quality Improvement, Lewisham Council Children's Social Care, from June 2018.

What did we do?

In 2018/2019 the group met on five occasions and undertook the functions of:

- Determining whether cases met the Working Together 2015 criteria for a Serious Case Review (SCR) or a Learning Review.
- Managing the transitional arrangements towards Child Safeguarding Practice Reviews following the introduction of Working Together 2018, including convening Rapid Reviews within timescales set by the new National Child Safeguarding Practice Review Panel from 29.06.2018.
- Making a recommendation to the Chair of the LSCB in relation to the type of reviews to undertake.
- Commissioning Learning Reviews and/or SCRs.

- Managing the process of completing Review reports.
- Overseeing that actions and recommendations were implemented and learning was embedded within agencies.

This work enabled the LSCB to undertake its statutory functions in relation to SCRs. The process has been to review what is known about a case, gather initial information from agencies (such as chronologies) and then make a

recommendation about whether the criteria for a SCR is met. If a SCR was commissioned, the group managed the production of the SCR report and considered any potential media interest.

When the criteria for a SCR was not met but there were possible learning/key issues arising from the case, the Panel might then recommend a multi-agency case Learning Review to ensure actions were taken and learning implemented to improve safeguarding practice.

What was the impact?

In 2018/2019 the group met five times to consider ten serious incidents and make recommendations to the LSCB Independent Chair. Through the transitional arrangements between Working Together 2015 and 2018, the National Panel began to introduce a requirement for Rapid Reviews following notification, four of which have now been undertaken.

One case met the criteria for a SCR and was commissioned to have an independent reviewer with considerable relevant experience. This SCR is currently in the final stages of report writing.

Four other cases were identified as requiring multi-agency Learning Reviews and in three of these cases, independent reviewers were commissioned. All three are currently near completion. For the most recent Learning Review, a decision was

taken to pilot the use of an Appreciative Inquiry model of reviewing, led by an interim Head of Service in Children’s Social Care, using a single multi-agency practitioner event which has yet to take place. The aim of this is to increase opportunities for multi-agency collaborative learning and strengthening partner working relationships, as well as reducing bureaucracy.

One other case, whilst not meeting the criteria for either a SCR or Learning Review, was identified for a Serious Incident Review undertaken by Health Services and an Internal Management Review undertaken by Children’s Social Care. The learning from both reviews will be collated and shared across the new Lewisham Safeguarding Children Partnership (LSCP) which replaces the LSCB in response to the Children and Social Work Act 2017.

LSCB partners are also currently contributing to a SCR being undertaken by Wandsworth Safeguarding Children Board under Working Together 2015.

A decision was also taken to undertake a Domestic Homicide Review (DHR) rather than a SCR or Learning Review, in relation to a young person, particularly as she had not long been resident in Lewisham at the time of her death and was therefore not known to LSCB partner agencies.

At the beginning of 2018/19, three SCRs were current which have all now been concluded and are awaiting publication in August 2019. In addition to the LSCB website, all SCRs are published on the NSPCC website. The repository provides a single place for published case reviews to make it easier to access and share learning at a local, regional and national level.

An issue of national significance has been the rise in serious incidents relating primarily to contextual safeguarding issues, such as “county lines,” gang related activities and criminal and sexual exploitation. The above Domestic Homicide Review has been included in the National Panel’s first thematic review, which has a focus on criminal exploitation. In this context, the CRP has been involved in an

ongoing discussion involving Ofsted, the National Child Safeguarding Practice Review Panel, and the Department for Education in relation to the criteria for notification and local or national Child Safeguarding Practice Reviews. Where the CRP has recommended such incidents have not met the criteria for SCRs/Learning Reviews/Practice Reviews, the National Panel has accepted its recommendations for their inclusion in a local thematic review of homicides and attempted homicides in Lewisham from January 2017 to December 2018, overseen by the Safer Lewisham Partnership and supported equally by the Lewisham Safeguarding Children Partnership and the Lewisham Safeguarding Adults Board.

The CRP has overseen the learning from SCRs, Learning Reviews, and Child Safeguarding Practice Reviews, to support partner agencies to implement recommendation and learning.

What we plan to do next?

The CRP will be developed into the “Learning from Practice Group” in the LSCP and will work closely with MESI and the other sub groups of the partnership to develop a broad culture as a learning organisation and a dynamic self-improving system. This will include giving consideration to: the development of a Learning Hub approach; more appreciative and collaborative learning models of undertaking reviews; and how we better learn and improve from good practice, for example via Serious Success Reviews.

We will be working to create combined key messages from practice reviews, delivering consolidated learning and promoting improvement across the partnership.

We will work with the coming Concern Hub and national partners to further clarify the most effective criteria and processes for notification and review in relation to serious incidents concerning contextual safeguarding issues.

We will further develop and embed our processes for ensuring effective Rapid Reviews, (including their relationship with Child Death Overview Panel “Rapid Response” meetings) following notification to the National Child Safeguarding Practice Review Panel.

Child Death Overview Panel (CDOP)

Chaired: Pauline Cross, Consultant Midwife in Public Health and Senior Public Health Strategist, Public Health team, London Borough of Lewisham.

What did we do? (In relation to safeguarding children or to support the LSCB priorities 2018/2019)

Chapter 5 of Working Together to Safeguard Children 2015 places duties on Local Safeguarding Children Boards to review deaths of all children who normally reside in the area. This has been a statutory duty since April 2008. The new statutory guidance published in July 2018 will see changes to this process in the coming year. Currently, Child Death Overview Panels (CDOPs) are the means by which local LSCBs discharge this responsibility. Babies who are stillborn and planned terminations carried out within the law are excluded from the review.

Panel members decide what, if any, actions could be taken to prevent such future deaths and make recommendations to the LSCB or other relevant bodies so that action can be taken. CDOP referred 3 deaths to the SCR panel during 2018-19, 1 of which was taken forward by the SCR panel, 1 was taken forward for a domestic homicide review and 1 was not taken forward.

Lewisham CDOP received 27 child death notifications from 1st April 2018 to 31st March 2019 of which 13 were unexpected deaths. This was the same figure as the previous year. The complexity of the deaths reviewed has continued to be of

concern this year and included deaths in which there were significant concerns about the wider family and in particular the siblings of the child that died.

More detailed analysis on all deaths of Lewisham children will be contained within the CDOP annual report which will be completed later this year.

A total of 25 deaths were reviewed by Lewisham CDOP over the course of 2018/19 though some of these deaths occurred before 1st April 2018. 17 of the deaths reviewed (68%) had modifiable factors. 7 (28%) of the 25 deaths were related to perinatal/neonatal events, extreme prematurity being the leading cause of death in Lewisham and nationally. 5 (20%) of deaths were due to sudden unexpected death in infancy and 4 (16%) to chromosomal, genetic or congenital abnormality.

Example of effective practice

In line with one of the main purposes of CDOP, i.e. to learn from the tragic deaths of children in order to prevent future deaths, Lewisham CDOP has initiated a number of work programmes to ensure learning is disseminated among partner agencies.

These include:

- Continuation of a Safer Sleep/Prevention of SIDS training programme to health professionals, foster carers and children’s centre staff in Lewisham
- Prevention of Prematurity research trial (POPPIE trial) at LGT supported by academic partners, which commenced in May 2017 has now completed and is due to report in July 2019
- CDOP Newsletter sent out 3 times a year to Lewisham and Greenwich Hospital (LGT) staff, GPs and other partners to share learning from our reviews

- Audit of support given to children, young people and parents when children present to A&E with self-harm or a suicide attempt. This identified gaps in information giving. The audit lead, under the supervision of CDOP has produced information packs which will be given to young people and parents aiming to promote good mental health and enable young people and their parents to be informed about support available when they are discharged
- CDOP has continued to facilitate the discussions between LGT and the Mayor's Office for Policing and Crime (MOPAC) and these discussions have secured agreement that MOPAC funding will enable the siting of a youth service in the A&E departments in Lewisham and Greenwich in order to reduce youth violence and better support young people attending A&E.

Missing, Exploited and Trafficked (MET) Subgroup (to be re-named as 'Concern Hub')

Chaired by Geeta Subramaniam-Mooney Director Public Protection and Safety, Andy Furphy Detective Superintendent Police, Lucie Heyes Director Children Social Care.

What did we do?

The Borough developed a forward-thinking model in 2016 which did not focus on 'labels' of types of risks such as youth offender/ CSE; but took an approach which recognised the drivers and multiple complex issues that affect children and young people as well as focussing on preventative aspects and earlier support. The Missing, Exploited and Trafficked strategy was developed alongside a Serious Youth Violence Prevention Panel.

Following on from this, the LSCB is planning to move to a 'Concern Hub' model. This model came from current structures being reviewed, taking into account a number of changes in our understanding and focus on a public health/whole systems approach to violence as well as rationalising multi agency actions for exploited children.

The Concern Hub model will work with children and young people up to the age of 25 primarily, includes missing, Child sexual exploitation, child exploitation, harmful sexual behaviour, county lines, serious youth violence and gangs.

The focus of the change is to:

- Provide a preventative offer of support for the client and family with earlier identification of risk
- Provide a multi-agency forum to jointly risk assess/ safety plan and agreed joint actions and lead agency
- Use a contextual safeguarding approach to make short/ medium and longer term change
- Join up resources across a cohort of children and young people to avoid duplication

The focus will remain on:

- Under 25 year old young people
- Using the Violence Reduction Hub Model as a basis
- Including Missing, Exploited and Trafficked cases
- Including the current Serious Youth Violence cohort of Red, Amber
- Including Habitual Knife Crime subjects
- Including the green cases from the Met Police Gangs Matrix

Outcomes from the Concern Hub:

These will be reviewed quarterly, but initially the performance framework will include:

Borough wide:

- Reduction In Violence with Injury
- Reduction In Knife crime
- Reduction in violence with injury knife crime
- Improved response to CSE and Child exploitation

For those on the cohort of the Concern Hub:

- Reduction in Concern
- Positive change in involvement in education, training or employment
- Stable accommodation
- Progress regarding wellbeing

Safeguarding outcomes:

- Understand and better co-ordinate the risks of exploitation (link to Rescue and Response)
- Mapping peers and creating plans that address safeguarding needs including siblings and parents
- Focus on perpetrators to prevent repeated victimisation and break cycle of exploitation
- Trauma-informed and strength based approaches to reduce fear, increase hub staff wellbeing and capacity to manage stress and Vicarious Trauma.

What is the anticipated impact?

It is anticipated that the Concern Hub's multi-agency response within a contextual safeguarding approach will have a significant impact for children and young people at risk of going missing and/or at risk of exploitation or violence.

Impact will be measured through the Concern Hub dashboard, which will provide detailed information which will support analysis of:

- Trends
- Key concerns
- Interventions used and impact in reducing concern

The impact of the Concern Hub will be monitored through the quarterly SLCB Concern Hub Strategic Meeting.

What we plan to do next?

- Review the Concern Hub's impact and explore opportunities for evaluation once this initiative goes live
- Increase partners to support the interventions and work of the Concern Hub
- Use findings from the work of the Concern Hub to inform commissioning decisions

LSCB Statutory Functions

Children's Social Care

Lewisham Children's Social Care experienced a number of changes through 2018/19, prompted by a programme of reviews during spring and summer 2018, which identified the 2016–18 programme of improvement was not having sufficient impact. The improvement plan was refreshed through the summer of 2018 following the appointment of a new permanent Director of Children's Social Care (Lucie Heyes) and the establishment of an Improvement Board, chaired by the Lead Member for Children's Services (Cllr Chris Barnham). With renewed energy and council support the improvement programme has picked up the pace of change and started to improve safeguarding and looked after services for children and families.

Compared to other London Boroughs, Lewisham has higher than average numbers of children subject to child protection plans, court proceedings and coming into care (becoming looked after). Part of the improvement programme is to bring these numbers down to be comparable with others. The way we are doing this is by working differently with families and taking a more proportionate approach to managing risk. In early 2019 Children's Social Care began implementing a new Signs of Safety social work practice framework, which is aimed developing a more collaborative style of practice putting the child, young person and their naturally occurring network of support at the very centre of creating safety. The key areas of improvement are:

- To strengthen the Multi-Agency Safeguarding Hub (MASH), which is the referral route for all children for whom people may have safety or welfare concerns. In July 2018 a focused visit from Ofsted recommended a number of improvements to the MASH. These recommendations are being followed up, to improve the service provided at the front door.
- To increase management oversight has been to support newly qualified social workers and help ensure children and families are receiving the right services at the right time.
- In January 2019 Children's Social Care introduced a new performance and quality assurance framework to help improve standards of practice, they are also in the process of re-designing their ICT systems, reduce bureaucracy to enable social workers to spend more time with families.
- A new workforce development programme is in development to reduce the number of changes that children and families experience and to ensure social workers have the skills and knowledge to work with some of the most challenging situations.
- Young people at risk of exploitation and violence in the community is a growing area of concern and plans are underway to develop a specialist team to work closely with partners in youth offending services and police to find effective ways to keep young people safe in the community
- For children with disabilities a number of improvements have been made, such as training for social workers on different communication methods, a new care package team has been developed to better support families with complex care packages. A new transition team is being established to better

help young people transitioning to adults care services when they reach adulthood.

- A new foster carer recruitment strategy to attract more local residents to become foster carers for our looked after children. This is to help our most vulnerable children in care to remain local and connected to their families, schools and communities.
- To develop a new Early Help Strategy to ensure that families below the children’s social care threshold receive support to avoid escalation.

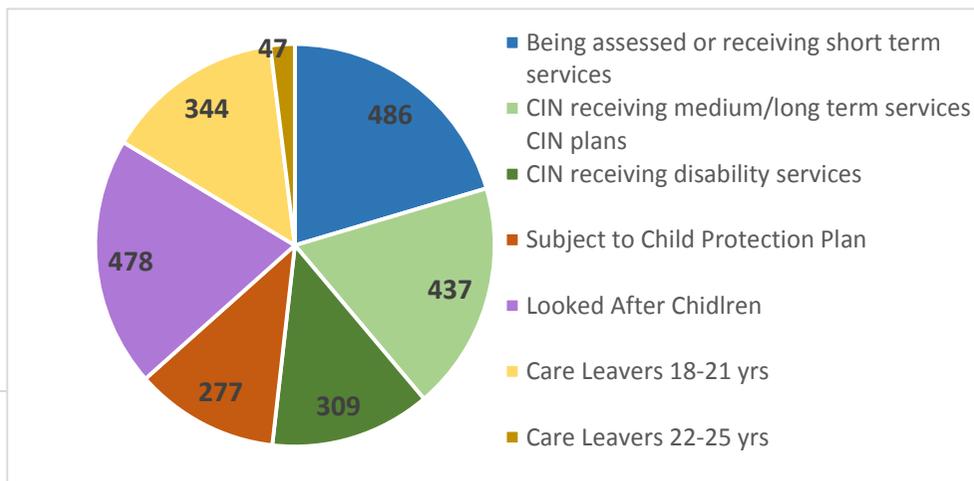
The improvement plan sets out a three year programme, with further changes to be made through 2019 – 2021. Lewisham is expecting a full Ofsted inspection in 2019, where services and the improvement plan will be comprehensively reviewed by the regulator.

Details of Lewisham Children’s Social Care Children in Need and performance benchmarked against other Local Authorities can be found at:

<https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2018-to-2019>

As at 31/12/18 Lewisham Children’s Social Care was working with 2,378 children.

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Lewisham Early Help, Multi-Agency Safeguarding Hub (MASH) & Children at risk of Missing, Exploitation & Trafficking

Lewisham’s Multi-Agency Safeguarding Hub (MASH) continues to build upon the strong multi-agency membership developed since its inception. After a refresh in January, the MASH has been refining its multi-agency response to notifications from professionals and members of the public, on the welfare of children. The MASH is a ‘single front door’ triage system, which makes a swift initial assessment of the child’s needs against the LSCB Continuum of Need (CON).

The MASH aims to identify which children can be supported either by universal services in the community or via the local Early Help offer (CON Level 1 and 2) and which require a statutory social work assessment (CON Level 3 or 4) in a 24 hour period. Through 2018-19 the MASH received 18,706 contacts, on average 1,559 per month. Of these 22.2% (4170) met the threshold for a Children’s Social Care statutory social work assessment of need and in some cases, for a s.47 Child Protection Enquiry, which may also involve the police.

At the time of writing, a review of services for children at risk of going Missing or being Exploited or Trafficked (MET) is underway in conjunction with the LSCB. A new operational and LSCB strategic group (the ‘Concern Hub’) is in the process of being developed to provide support to safeguarding professionals working with children who may be at risk of going missing from home or care, being exploited or trafficked. It is anticipated that the Concern Hub will meet quarterly to look at strategic safeguarding issues and initiatives in these safeguarding areas, including developing an enhanced dataset that will support auditing going forward. The review of Children’s Services work around missing, children at risk of exploitation and trafficking is also considering re-organisation of some service areas to provide a dedicated staffing resource to enhance practice and support the introduction of a contextual safeguarding approach with these children and young people.

Looked After Children (LAC)

There were 491 Looked After Children in Lewisham at the end of March 2019. Looked After Children and 18–25 year old young people who have formerly been in care combined comprise over 35% of all children and young people that Children’s Social Care are working to safeguard, support and care for at any given time. Services for Looked After Children receive separate council scrutiny via the Corporate Parenting Board. The LSCB and its successor safeguarding body in Lewisham will maintain a close relationship with the Corporate Parenting Board. The LSCB will also work with Children’s Services as the review of services to oversee and scrutinise multi-agency arrangements to safeguarding Looked After Children who go missing and are at risk of exploitation, trafficking and abuse.

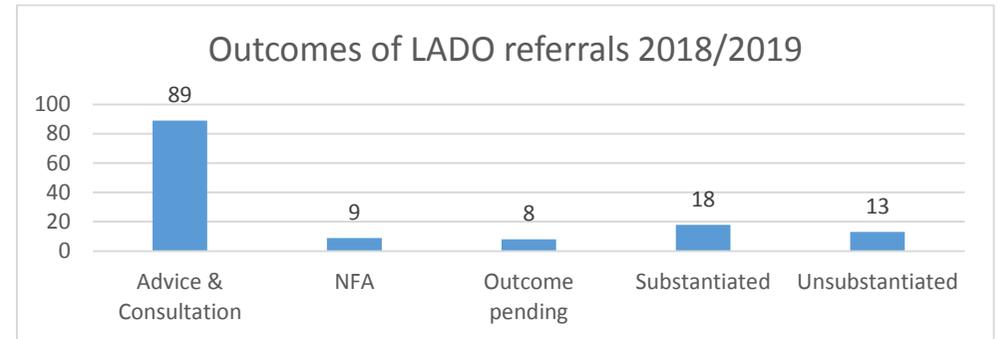
Children’s Services continues to work towards improving the physical, emotional health and education outcomes for Looked After Children and retains a focus on ensuring placement stability for children in care to provide a solid, supportive base for Looked After Children to thrive and achieve.

Designated Officer (LADO)

The Local Authority Designated Officer (LADO) in Lewisham fulfils the local authority duty outlined in Working Together 2018 “to be involved in the management and oversight of allegations against people who work with children.” The LADO receives contacts relating to allegations of this type for oversight and for direct investigation where required.

In 2018-19, the LADO received 342 contacts, an increase of 10 since the previous year. Many of these contacts were initially resolved by providing advice, whilst 40% were taken forward for further investigation. Of the 137 LADO contacts that became investigations, 129 were concluded at the end of 2018-19, of these the

allegations were found to be substantiated in 18 cases (14%). In the majority of situations the circumstances can be managed through advice and consultation; 68% of cases are resolved within 7 days, 90% in 31 days.



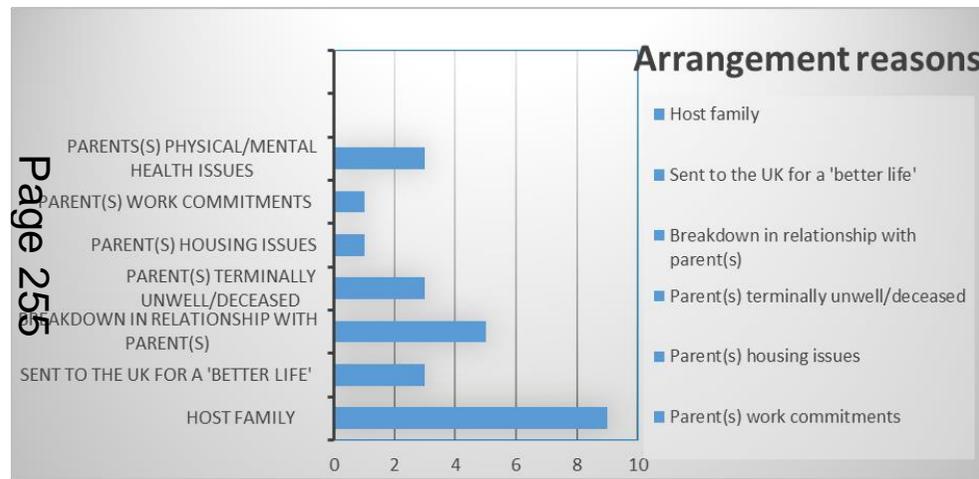
Private Fostering

Private fostering is defined as ‘a child who is under the age of 16 (18 if disabled) and who is cared for, and provided with accommodation, by someone other than the parent a person who is not the parent but who has parental responsibility, or a close relative defined in this context as a brother, sister, aunt, uncle, grandparent or step-parent.

Children in private fostering arrangements are potentially vulnerable and the Local Authority must be notified. During 2018/19 Children’s Social Care received 25 notifications of new possible arrangements in Lewisham, a decrease from 2017/18 (No.43). The decrease is due to one of the main agencies for a private language school ceasing to host international students. Lewisham continues to have a number of international students staying with host families. There has also been an increase in the number of young people whose relationship with their parents has broken down and they are staying in Private Fostering arrangements. We also

have a number of children who have been sent to the UK to stay with family members for a 'better life'.

Notifications are received from the Home Office, Schools, Host agencies, CAFCASS and with the Council or from other Councils. 14 of the 25 notifications received were assessed as new Private Fostering arrangements, this combined with 10 known existing arrangements means there are 24 Private Fostering arrangements being monitored by Children's Social Care. The vast majority of arrangements are assessed as providing safe care for the children.



Partnership Activity to Safeguard Children

Lewisham and Greenwich NHS Trust (LGT)

Chaired by/Agency Representative: Belinda Chideme, trust lead named nurse for safeguarding children, Lewisham and Greenwich NHS Trust

What did we do? (In relation to safeguarding children or to support the LSCB priorities 2018/2019)

Evidence for and evaluation of effectiveness

Key performance indicators are monitored and reported on a quarterly basis to the Lewisham Safeguarding Children Board and monthly to the Lewisham Clinical Commissioning Group.

Due to active involvement with three safeguarding children boards, the Safeguarding Children Team undertook a range of audits this past year including audits into the effectiveness of supervision and training, the quality of record keeping across community and acute sites and the appropriate management and risk assessment (RAG rating) of paediatric ED attendances.

The Safeguarding Children Team contributed to a Lewisham Safeguarding Children Board (LSCB) Multi Agency Deep Dive Audit: Child Mental Health and Well-being. This was also a joint audit with the Greenwich Safeguarding Children Board (GSCB). The results and recommendations were shared with all partners.

As of 01.04.2018, the data collected for Emergency Department (ED) attendances has been extended to include themes around child sexual exploitation, gang/youth violence activity, missing and trafficking.

Changes made as a result of previous learning/priorities and new developments

The LGT's safeguarding children training has been updated in line with changes made to the Intercollegiate Document: Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019).

The LGT's safeguarding supervision policy has been updated to reflect national and local changes and incorporates feedback and findings from previous audits. Safeguarding supervision has been extensively re-mapped to widen the breadth of professionals receiving this within LGT.

Other policies that are currently being updated include the 'Was Not Bought' policy and the overarching 'Safeguarding Children and Young People' policy.

Learning events have been delivered following findings from recent serious case reviews.

Fit with and contribution to LSCB current priorities

Themes around neglect, self-harm, child sexual exploitation and children and young people missing, trafficked or involved in serious youth violence are addressed within current training.

Any attendance to ED in which the above concerns are analysed at the weekly ED safeguarding meeting, to ensure robust actions have been taken to safeguard the children / young people involved.

The Trust has contributed towards three learning reviews and two SCR's which are currently awaiting publication.

What was the impact?

Views of parents/carers/children/young people

The Trust uses the Friends and Family Test and encourages participation from parents and children.

Parents and children (if age appropriate) are invited to meetings where their care is discussed and where hearing the voice and wishes of the child is actively encouraged.

Improvements this year-what are we doing better as a result of the activity?

All three local Safeguarding Children Boards have shared their plans. Bexley had already shared plans to be a standalone partnership. Lewisham and Greenwich have one Business Manager, but they have kept the respective subgroups separate. The Child Death Overview Panel will be joint between Lewisham, Greenwich and Bexley.

Level 3 training now includes a session delivered by the Named Nurses; the session is dedicated to disseminating learning from local serious case reviews. The plan is for the Named Nurses to deliver a session based on 2 reviews which involve

children who were known to Lewisham and the Greenwich hospital/services. The training now includes specialist topics presented by an external speaker.

Enhanced supervision has been introduced. This is a forum in which senior service leads can discuss complex cases and / or those cases which involve a large number of professional input. This was devised following learning from a recent serious case review.

What we plan to do next?

Challenges and priorities for this year (2019/2020)

A key challenge this year has been in reaching compliance with Level 3 Safeguarding children training. Key staff groups have been identified where low compliance is an issue and support has been put in place to overcome any barriers to accessing training.

To continue to build frontline staff knowledge and competence in the early identification of vulnerabilities and thereby enable a quick response (early intervention).

To review and strengthen safeguarding processes, safeguarding supervision and practice within maternity services.

To strengthen safeguarding supervision provision and embed a new enhanced (multi-agency) supervision model.

To continue to roll out safeguarding supervision across site for community midwives and specialist midwives.

To raise the profile of contextual safeguarding and an understanding of early help services, across all sites.

To review and strengthen frontline staff knowledge on FGM and Harmful Practices.

To participate in partnership initiatives aimed at supporting children and young people at risk of child sexual exploitation, gang/youth violence activity, missing and trafficking.

Safer Lewisham Partnership

For 2019-2020 the Partnership seeks to focus on:

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- In taking a public health approach to tackling violence there will be a collective and whole system approach to reducing exploitation, harm and violence.
 - The partnership will build on the foundations in place towards making Lewisham a trauma informed borough;
 - The strength of our response places equal focus on victims and perpetrators to help support and bring about positive change

In taking a public health approach to tackling violence there will be a collective and whole system approach to reducing exploitation, harm and violence.

(See Lewisham's Public Health approach to Violence Reduction - <https://lewisham.gov.uk/inmyarea/publicsafety/our-public-health-approach-to-reducing-violence>)

Violence is not normal nor acceptable. Many of the factors that may lead to violence include exposure to violence, experiences to adverse childhood experiences and the environments in which we live from birth to older age. Greater understanding of these aspects will seek to promote preventative approaches, promote protective factors and build resilience for individuals and the community as a whole. Violence prevention needs to be seen as a key part of tackling inequalities.

Lewisham is taking a public health approach to reducing violence which means:

- Understanding the extent of all violence, where and how it happens and who is affected to better inform including youth violence, domestic abuse, and sexual violence.
- Understanding that violence damages physical and emotional health and can have long-lasting negative impacts. It increases individuals' risks of a broad range of health damaging behaviours – including further violence – and reduces their life prospects in terms of education, employment and social and emotional wellbeing.
- A wide range of factors relating to individuals, their relationships, and the communities and societies in which they live can interact to increase or reduce vulnerability to violence. Issues such as Adverse Childhood Experiences (ACEs) can have significant impacts on families.
- There are a wide range of strategies that can be used to address risk factors for violence and promote protective factors across all ages. Some can be implemented universally and others are targeted specifically. Using evidence based models will shape impact.
- Working with the strengths that exist in communities to listen and collaborate on designing solutions together.

- Dialogue that challenges social norms aim to prevent violence by making it less socially acceptable.
- The safer Lewisham partnership will play a significant coordinating role through the newly formed violence reduction board.

The Aim is to:

- Reduce the impacts and actual violence across Lewisham
- Identify the causes of violence in Lewisham, and act to deliver short and longer term reductions
- Listen and work with communities to build on their strengths and deliver solutions together.
- Create a learning environment for continuous improvement.
- Impact positively on wider social, economic and health outcomes for our residents.

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The partnership will build on the foundations in place towards making Lewisham a trauma informed borough;

“**Safety**—Throughout the organisation, staff and the people they serve feel physically and psychologically safe.” **Guiding Principles of Trauma-Informed Care, 2014.**

“A **trauma-informed** service system and/or **organisation** is one in which all components of the system have been reconsidered and evaluated in the light of a basic understanding of the role that violence and **trauma** play in the lives of people seeking or referred to services.

ACES provide a measure of traumatic experiences in childhood are used to influence prevention and predict future harm. According to Scottish research people with 4 or more Adverse Child Experiences (abuse,neglect, household dysfunction) are:

- **14** times more likely to have been a victim of violence over the last 12 months
- **15** times more likely to have committed violence against another person in the last 12 months
- **16** times more likely to have used class A drugs
- **20** times more likely to have been incarcerated at any point in their lifetime.

Lewisham will aim to adopt the following principles and apply to organisations throughout the borough:

- **Safety** – creating spaces where people feel culturally, emotionally and physically safe
- **Transparency and Trustworthiness** – full and accurate information about what’s happening and what's likely to happen next
- **Choice** – an approach that honours an individual’s dignity
- **Voice** – creating the opportunity where the individuals views, opinions and feeling are heard and acknowledged
- **Collaboration and mutuality** – healing happens in relationship and partnerships with shared decision making
- **Empowerment** – Recognition of an individual’s strengths. These strengths are built on and validated.

To achieve these outcomes the following is needed:

- **Realising the prevalence** of trauma through a consistently applied training program

- **Recognising and supporting** how stress and fear affects all individuals involved with the program, organization or system, including its own workforce
- **Resisting re-traumatisation**, labelling and re-victimisation
- **Responding** by putting this knowledge into practice. The Trauma Recovery Model responds to readiness of intervention to underlying need.
- **Restorative**: Using conflict or an incident as an opportunity to repair harm and heal relationships

The strength of our response places equal focus on victims and perpetrators to support and bring about positive change

Studies of trauma among groups of young people found that:

- 91% of violent young offenders have experienced abuse or loss
- 40% of female and 25% of male youth in custody have suffered violence at home
- 33% of female offenders have suffered sexual abuse

Research also indicates that offenders are more likely than non-offenders to have suffered adverse effects from traumatic experiences, which appear to be linked to offending behaviour. Trauma can result in inappropriate aggression and is strongly associated with a range of problematic behaviour including violence, antisocial/criminal conduct, sex offending and substance misuse. We understand that many child and adult offenders will have been subject to a range of adverse experiences, from substance misuse problems, difficult family backgrounds including experience of childhood abuse or time spent in care, unemployment and financial problems, to homelessness and mental health problems and this knowledge underpins our trauma informed, restorative approach to tackling offending. However we also acknowledge that there are victims of the crimes

perpetrated by these exploiters and our focus on supporting these victims must remain resolute.

Services for all victims will:

- Support through a recognition of trauma to assist with recovery
- Provide safety advice and planning
- Support participation in the criminal justice processes as appropriate improving compliance to the victims code of practice
- Crime prevention advice for all
- Restorative approaches to help heal the harm caused.

Lewisham approach to breaking the victim/offender cycle will:

- Focus on both the individuals and their families, understanding the dynamics of these relationships and interactions.
- Aim to stop re-victimisation within interpersonal relationships.
- Explore appropriate perpetrator desistance programs.
- Create approaches to tackle specific victim/perpetrator relationships
- Focus on how perpetrators are supported to change and understand the impact of their harmful behaviour.
- Be developed as a multi-agency **Concern Hub**, which will work with children under 25; those who are missing or who are victims of child sexual exploitation, child exploitation, harmful sexual behaviour, county lines, serious youth violence and gangs.
- Challenge social norms to making interpersonal violence of all kinds less socially acceptable.

- Coordinate this work through the Violence Reduction Board, the Concern Hub and the Violence Against Women and Girls Steering Group.

Action at all levels

- **Lewisham is committed to tackling and reducing the impacts of violence and crime on our communities**, linking into strategies and plans that are in place such as the Violence against Women and Girls (VAWG) Plan 18-21, knife crime action plan 18/19, the Public health approach to violence framework 2019, the children and young person's plan 2019 and building stronger communities programme.
- Working with colleagues in **other London boroughs** on this agenda to share practice and findings will help to build the evidence base and opportunities for collaborative working. Doing more together helps to bring about greater change and impact.
- Working with the **London Mayor's office for policing and crime (MOPAC)** is essential to ensure that Lewisham are learning from and feeding into the work of the Violence Reduction Unit for London. This focus for London is essential as our communities are affected by what occurs across London. Accessing resources for Lewisham community and voluntary sector groups, partners and the Council will be a priority where available.
- Working at a **National level** to influence policy and bring about whole scale change is something we will continue to do working with colleagues in the Ministry of Justice, Home Office, National Crime Agency, and Department of Education. Lewisham is constantly learning from its approach to date and are keen to ensure that this is fed into National learning to help greater understanding about violence.

Children and Adolescent Mental Health Service (CAMHS)

Safeguarding Children Supervision arrangements

In CAMHS there is a Safeguarding doctor and a Safeguarding lead who are available to discuss concerns for children with mental health problems and safeguarding needs. All CAMHS staff receive inter-disciplinary and disciplinary supervision.

Our Priorities:

- For all staff to access appropriate level 3 Child Safeguarding Training.
- To ensure all children who access CAMHS with safeguarding needs are identified.
- To ensure that where safeguarding needs are identified they are appropriately discussed on a daily basis with senior staff and a care plan is in place.
- To ensure that we jointly work with multi-agency staff to support children with mental health and safe guarding needs

What did we do?

Neglect	<ol style="list-style-type: none"> 1. CAMHS staff have training and knowledge to identify both gross and subtle neglect. 2. CAMHS staff have access to discuss concerns and formulate plans to safeguard children with neglect in the context of complex mental health concerns with senior staff, on-call Consultant, Safe Guarding Doctor, trust Lead Safeguarding Nurse and doctor.
Governance and performance	<ol style="list-style-type: none"> 1. The SLAM trust safeguarding board works closely with the local Lewisham safeguarding lead and doctor to ensure trust wide policies and procedures in line with the local performance targets are met.

	<ol style="list-style-type: none"> The monthly CAMHS senior strategy meeting monitors performance related to safeguarding and addresses any concerns both at trust level and locally for Lewisham CAMHS. All CAMHS staff have access to joint Level 3 safeguarding training which includes case study and discussions of children presenting with complex mental health needs and safeguarding needs
Self-harm and suicide prevention	<ol style="list-style-type: none"> All CAMHS staff have training in eliciting concerns around self-harm and discussing safety plans with children and young people presenting in crisis. Lewisham CAMHS strives for 100% compliance with 7 day follow-up of all children presenting with suicidal and self-harm concerns to ED at UHL to reduce risks. Lewisham CAMHS is a partner in I-Thrive Self-harm and Suicide Prevention strategy in Lewisham.
Voice of the child and community	<ol style="list-style-type: none"> Lewisham CAMHS has a thriving YAG (Youth Advisory Group) group which is an active young people's forum which helps shape the way Lewisham CAMHS delivers services for children with mental health problems. The award winning Alchemy project organises on-going inclusive groups for children, which are co-produced by young people. The parents group for children presenting with complex mental health needs is a space for parents to share experiences.
Missing, exploited and Trafficked	<ol style="list-style-type: none"> The safeguarding lead monitors and liaised closely with the MASH team on vulnerable children. Safeguarding leads will liaise with the Concern Hub when implemented. The safeguarding lead continually escalates and work closely with relevant agencies to ensure safety of vulnerable young people.

London Ambulance Service (LAS)

Our priorities in 2018-19

- Secure sufficient resources to develop safeguarding in the Trust
- Monitor trust's safeguarding processes and compliance
- Support Trust with safeguarding practice & requirements
- Assure Trust processes by driving consistency & improvement in safeguarding practice
- Forge effective relationships internally and externally

What did we do?

- Secured funding to increase safeguarding team by 100% to enable a dedicated safeguarding specialist in each area of Trust.
- 7% increase in safeguarding concerns and referrals to 23,471.
- Introduced 24/7 safeguarding telephone line for staff
- >90% safeguarding training Compliance
- Introduced Quarterly Safeguarding Newsletter
- Produced new safeguarding pocketbook for staff
- Introduced Chaperone and Supervision policies
- Held Safeguarding Conference for over 170 staff and partners
- Introduced Learning Disability and Mental Capacity Act Strategies.

Our priorities for 2019-20

To be outstanding in quality standards and drive continual improvements

- Excellent Governance and Assurance of Trusts safeguarding processes and compliance
- Development of the Safeguarding Team
- Successful delivery of safeguarding training plan, local education and supervision
- Safeguarding innovation and review current practices to identify cost savings.
- Ensure integration of 111 & IUC
- Forge effective relationships internally and externally to safeguarding children and adults

In conclusion the LAS is committed to safeguarding and has invested in the safeguarding team to ensure trust is compliant with standards and provides the highest level of care for its most vulnerable patients.

The Full LAS annual report can be found on the Trust website.

London Community Rehabilitation Company (CRC)

AJ Brooks, Contracts and Partnerships Manager, London Community Rehabilitation Company

What did we do?

In 2018/2019 LCRC have sought to further embed the utilisation of our internal safeguarding assessment to inform our practice. These safeguarding assessments, which were a large part of our previous year's work program, act to obtain the necessary information in relation to a Service User's contact with children and young people under the age of 18 so that the risk that they may pose to them can be managed from the outset. In embedding this LCRC have invested heavily in a new case recording and assessment tool, Omnia, which helps to support the individual practitioner's assessment process by highlighting the evident risks and intuitively seeking the necessary risk management plans to reduce the perceived risks.

Further to this, LCRC have implemented local geographical area Public Protection Boards, where safeguarding risk management processes and procedures are discussed both independently, but also in relation to the other public protection themes including Domestic Abuse, Serious Group Offending and Extremism. These local Boards are attended by senior management and operational leads to help understand the local picture and drive forward the actions that stem from these meetings. Oversight to these Boards is through LCRC's strategic Public Protection Board which is chaired by our Director.

In order to improve partnership work and operational responses to the actions stemming from the Public Protection Boards, we have also established 'Subject Matter Expert' (SME) roles in each of our teams. These SMEs are tasked with ensuring the implementation of any improvement actions, leading peer learning on

specific safeguarding themes picked up out of our monthly and quarterly audits and providing a single point of contact for our safeguarding partners.

What was the impact?

The addition of the Public Protection Boards allows an extra level of operational and strategic oversight to our case management and risk assessment. This additional oversight has shown to have a positive impact on the safeguarding practices in Lewisham as evidenced through our monthly audit data. At the start of 2018, when our safeguarding training program was drawing to a conclusion from the previous year, the sufficiency of our safeguarding practices were assessed by our central Quality & Performance team to be around the 33% mark. However, at the end of 2018/19 the monthly audit showed a marked improvement in the sufficiency with a score of 100%.

What we plan to do next?

With the recent announcement that offender management function of Probation services managed by the CRC's across the country will be re-nationalised by Spring 2021, in 2019/20 we are heading into a period of substantial change. In order to ensure the smooth transition of cases in the lead up to the re-nationalisation and therefore the on-going effective management of risk, we will be looking to continue to strengthen the partnership work we do with the National Probation Service.

Phoenix Community Housing

Leon Yohai, Head of Housing Management

What did we do in 2018-19?

In 2018-19 to support the LSCB in safeguarding children and deliver its priorities we:

LSCB Priority	Our Support
Neglect	<ul style="list-style-type: none"> Implemented guidance for staff on what they should do if they come across children who are home alone when visiting properties.
Governance, performance, analysis and outcomes	<ul style="list-style-type: none"> Implemented the restructure of our Safeguarding Panel, updated our Terms of Reference and reporting procedures. Reviewed our Safeguarding training programme. Ensured the Designated Officer and Deputy attended Designated Officer training.
Missing, exploitation and trafficking	<ul style="list-style-type: none"> Delivered a workshop for staff on Modern Day Slavery and continued to promote our Anti-Slavery and Human Trafficking Statement as part of our development of new services.
Voice of the child and community	<ul style="list-style-type: none"> Reviewed our Young Makers Agency activities and our approach to working with children and young people. Reviewed our Community Engagement and Empowerment Strategy, this includes specific

	objectives to support and empower children and young people.
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Evidence for and evaluation of effectiveness

Evidence is monitored through an action plan by our Safeguarding Panel alongside a suite of key performance indicators (KPIs). The Safeguarding Panel is chaired by the Designated Officer and reports to the Executive Team quarterly. The Safeguarding Panel reports to the Board quarterly through KPIs and an annual performance report.

Our Phoenix Gateway Committee selected the suite of KPIs whilst our Resident Scrutiny Panel monitor them on quarterly.

We also reviewed our activities with children and young people against the NSPCC Safeguarding Standards and Guidance for the Voluntary and Community Sector.

Changes made as a result of previous learning/priorities and new developments

Fit with and contribution to LSCB current priorities

Our plans and priorities support the LSCBs priorities but as a landlord, we deliver limited activities and services directly to children and young people which means our impact is less direct.

What was the impact?

Key learning included:

- The need for clear specific guidance to support staff with facilitating or running children and young people activities.

- The benefits of separating our adult and children safeguarding procedures.
- The benefits of supporting staff dealing with safeguarding cases in different ways, for example: learning circles and Mental Health First Aiders.

Views of parents/carers/children/young people

We have a specific complaints and feedback form for children and young people at our events and activities.

Improvements this year-what are we doing better as a result of the activity?

Following the restructure of our panel we are now able to monitor our cases more frequently and with structured reviews.

What we plan to do next?

What have you identified-This will inform priorities for next year
Challenges and priorities for this year (2019/2020)

Our Plans for 2019-20:

- Review our Safeguarding Policy as part of good practice and to ensure that there is clear definition and separation of Adult and Children needs.
- Develop guidance for our teams when they offer work experience or volunteering for people under 18
- Implement procedures and a commissioning checklist to support staff specifically working with children, young people and young adults.
- Improve compliance with Safeguarding Training (87.65% at year-end) and implement a new training programme.

- Start implementation of our reviewed Community Empowerment Strategy 2019-22. A key theme of the strategy is to improve life chances of children, young people and their families. Outcomes will be assessed against community based interventions as part of the delivery.
- Improve our approach to procurement with a focus on contract management audits. This will ensure that our contractor’s policies and procedures related to safeguarding are robust.

Example of effective practice

Our Community Engagement and Empowerment Strategy included reviewing current practice. We took a risk-based approach to activities we will deliver directly and those where we will commission others who have more specialist skills to work on our behalf; particularly when this involves working with younger children.

Metropolitan Police Service – South East Basic Command Unit

Joe Foley, Detective Superintendent, Metropolitan Police Service

What did we do? (In relation to safeguarding children or to support the LSCB priorities 2018/2019)

Evidence for and evaluation of effectiveness

Changes made as a result of previous learning/priorities and new developments

Fit with and contribution to LSCB current priorities

South East Basic Command Unit are committed to safeguarding children and young people. Our ambition is to provide better outcomes for the most vulnerable people in our communities by keeping them safe from harm. The delivery of Safeguarding

is considered a core component of policing but inevitably it crosses over into other areas of activity in the Police Service, as well as having a direct focus in the new established South East BCU Safeguarding Hub.

What did we do? Why?

The South East Basic Command Unit has a CID Proactive Unit, whose remit includes safeguarding young people being recruited into gangs who go on to be missing from home or care and safeguarding young people becoming victims of gang-related violence or intimidation. By conducting home visits with children and their parents, the team gather relevant information which would be shared via Police Systems for long-term support and awareness with partnership engagement. Officers will listen and provide the relevant safety advice/support referrals if the subject has expressed the wish to exit a gang.

These home visits also provide reassurance as well as reality to the child, detailing the consequences of criminality in an effort to deter them from criminality. It is anticipated that in future, information where required will be shared through the Concern Hub meeting, so all partner agencies are actively involved in the overall support to the child who may have become involved in gangs as well as the mechanism to identify potential gang risks to any siblings. This forum will also provide overall support options to parents and carers, providing them with information in relation to County Lines (CL) and Child Sexual Exploitation (CSE), detailing what they should look for and how they could best safeguard their child.

A dedicated PC attends schools (particularly those identified as having CSE/CL recruiters) to present on these dangers and how to negate them. The CID Proactive team proved critical in developing effective, sustainable working relationships to minimise harm to young people who were reported missing and will take proactive accountability if county line/human trafficking investigation is involved.

Multi-Agency Safeguarding Hub (MASH) and Youth Offending Service

Police officers within the MASH team work in partnership with Children's Social Care, Health, Housing and the MPS Child Abuse Investigation Team, delivering proven early intervention.

Since the BCU Transformation, CAIT referral officers - supported by Police Community Liaison Officers (PCLOs) – will also be in the MASH to allow fast time information-sharing between agencies to enhance the safety of children and where absolutely necessary, support children being removed from unsafe environments.

As areas of learning are identified, including through Serious Case Reviews, these are shared throughout the MASH, to frontline officers and within the community. The team now delivers on Operation Encompass, which was incorporated and went live in January 2019. This provides Lewisham schools that have opted in to receive information from police of a domestic incident that has occurred, where a child was present when police attended. This allows a cohesive awareness to partners for safeguarding children.

The MASH has been enhanced with the CASO Referral Desk forming part of the Lewisham MASH. Case conferences are progressed more quickly and Social Worker interaction is face-to-face, which leads to closer inter-departmental working between MASH police and CAIT, smoother information-sharing and timely, swifter safeguarding outcomes. The drive for 2019/2020 will be to examine more cases to try and identify and support a greater number of vulnerable children within Lewisham; this is currently on target to proceed. The Youth Offending Service (YOS) also works closely with the MASH, forming strong partnership-working between YOS police and Children's Social Care, ensuring that safeguarding concerns are shared through the MASH and protective/support plans created quickly.

The work volumes through the police MASH team are substantial, and this translates into a constant stream of referrals through to CSC partners. Although challenging, CSC continue to effectively review and manage this demand, reviewing each of the referrals to provide timely interventions to vulnerable families where appropriate. Between April 2018 and May 2019, a total of 7594 PAC and Pre-Birth PACs relating to children were processed through the police MASH team, with the vast majority of these reports shared with CSC partners. The MASH team also dealt with 242 complex multi-agency reports to target concerns relating to vulnerable children and families. Complex matters relating to CSE, Child Criminal Exploitation, Female Genital Mutilation and many other serious concerns are identified, reviewed and progressed on a weekly basis.

In April 2019, 492 police Merlin reports were processed, of which 472 were shared with CSC partners. In May 2019, 497 merlin reports were processed of which 428 were shared with CSC partners.

The police MASH team also deals with all child death notifications through partner agencies; this is through a new process known as ECDOP. Police also cover Rapid Response strategy meetings when required. MASH also deal with all Sarah's Law (Child Sexual Offences Disclosure or CSOD); liaising with CSC partners for complex or high risk cases. MASH deal with all external enquiries from other police services relating to child safeguarding, where the local authority needs to be made aware. The impact of the co-location and ongoing development of MASH is clear to see, and the police MASH team have an excellent working relationship with CSC at all levels. Over the past year, this has meant that when difficult and complex cases are identified through Merlin/MASH, we have addressed them effectively and expeditiously to achieve the best outcome for the vulnerable child or young person. We look to build on this great work over the coming year.

Safeguarding in Schools

Safeguarding is the schools police officers' main role. Lewisham have dedicated Safer Schools Officers, who regularly interact with pupils through work with the pastoral staff of all secondary schools and at safeguarding meetings, assemblies with teachers, pupils and parents. By interacting through school youth council meetings and surgeries, the Schools Officers listens to student concerns, identify and address children who come to notice re: missing, drugs, CSE, gangs, knife crime and domestic abuse concerns. Going forward, the most high risk cases will be referred through to Concern Hub meetings. These cases will then be discussed with leading professionals including Early Help, Children's Social Care, YOS, CSE leads, Police Missing teams, St. Christopher's, Youth First, Refuge, NHS, Probation, Compass and Trilogy plus. It is anticipated that care strategies will be developed by this group within these meetings to ensure there is that safeguarding support around risk for these children and young people.

Dedicated CSE and Missing Teams

The South East Basic Command Unit now has a dedicated CSE and Missing Unit with a direct focus on Contextual Safeguarding. Significant work has taken place regarding Child Sexual Exploitation (CSE) and Human Trafficking within the Borough; dedicated teams have established clear reporting pathways and a structure for referrals has been developed to assist safeguarding partners. A new Missing policy identifies robust supervision and proactivity of prevention for missing people and this will be a key principle in the upcoming Concern Hub, which will focus on all contextual safeguarding concerns in Lewisham, with the right professional membership present to prevent, protect and avoid. Police and Lewisham partners continue to have a good relationship with the Metropolitan Police's centrally based Sexual Exploitation Team, who have delivered training to every Schools Officer on the Borough to assist in identifying young people who may be subjected to CSE. The CSE team have developed a training package for Borough

Officers. Reporting pathways for officers to make referrals are developed with the MASH team.

What was the impact?

The impact and effectiveness can be clearly seen through the ongoing implementation of focused delivery of contextual safeguarding (including the planned implementation of the Concern Hub), which provides better outcomes for the most vulnerable people in our communities by keeping them safe from harm. The promotion of greater partnership working, early intervention and support for vulnerable children with particular emphasis placed on securing suitable accommodation and support for at risk children in preference of enacting Sect 46 powers by police. This greater knowledge and understanding ensures officers and staff feel more confident in knowing when and how they can share data/information; with or without consent. MPS places emphasis to all that consent / concern should not be a barrier to sharing vital, accurate, relevant and proportionate information relating to the safeguarding concerns of a child who has come to notice of police or a partner agency. The direction from the Pan London MASH protocol document, and recent reports lean towards a stronger and more relevant information sharing stance. This allows quicker identification and investigation into those children identified as being most at risk.

As areas of learning are identified, including through Serious Case Reviews, these are shared throughout the MASH, to frontline officers and within the community. MPS also have Dedicated Inspection teams who conduct inspections of work undertaken by individual teams. Learning is disseminated across the Basic Command Unit to ensure an improvement in performance focussing on prevention, protection, prosecution, support and learning development and early intervention in all areas of safeguarding. SE Safeguarding Hub have created an

internal audit team to dip sample cases to identify and disseminate further learning opportunities.

Ongoing training to front line officers and support staff to ensure they are fully aware of the resources available to them in Children's Services, including the MASH team, professional's consultation line, in hours, and out of hours social worker advice and support. In addition, training/advice to MASH team partners and managers within children's services to explain police procedures/actions.

Further examples of effective practices include new searchable BRAG features on Merlin to assist with accurate record keeping and the establishment of consistent daily meetings with partners and missing children co-ordinators to discuss MASH cases and other safeguarding cases.

What we plan to do next?

Protect and support: Focus on what matters most to Londoners

Quality assurance processes by the safeguarding boards and partners provide reassurance that basic practice across all agencies is effectively safeguarding young people.

Ensuring support to vulnerable adults, children and young people who have been exploited is delivered, ensuring that what is offered is appropriate for each individual, child or young person based on their gender, age, ethnicity, disability, and the nature of the exploitation that they have experienced.

The Safeguarding Boards to develop their individual and collective expertise through joint learning exercises and strong collaboration across the South East. Partnerships to be open to joint commissioning opportunities. Set strategic

direction for safeguarding across the BCU, understanding the strategic partnerships to deliver a best framework.

Knowing our problem and knowing our response: Mobilise partners and the public

Continually developing and understanding our problem profile in the context of vulnerability, perpetrators and the spaces and places they frequent online and offline.

Professionals who come into contact with adults, children and young people have relevant and proportionate knowledge of the broader profile of vulnerability. This includes the factors that exacerbate risk and the consequential vulnerabilities arising from exploitation.

Engaging, educating and empowering the broader community forums a critical element and this work will be directly supported and informed by the Adult and Child Safeguarding Boards of Lewisham (and by the subsequent body that will replace the LSCB in 2019-20).

Analytical support – to be coordinated across a range of agencies to identify themes, patterns and trends relating to vulnerability. Stronger intelligence gathering and sharing across the partnerships on individuals, peer groups and geographic hotspots engages a tactical response from the partnership to make young people and vulnerable adults safer. This intelligence should include information gathered from young people, their families and the wider community.

Contextual safeguarding – We will ensure that our safeguarding response is contextual in relation to the people and places we, as a partnership, are protecting from harm. This approach will address all safeguarding matters across all age

ranges from young children through to elderly adults that officers come across on a daily basis.

Disruption and Prosecution: Achieve the best outcomes in the pursuit of justice and in support of victims

Working with Professionals to identify, assess and mitigate any vulnerabilities that might reduce the chances of young people exiting gang culture or involvement in youth crime and violence.

Ensure robust policing responses to perpetrators are in place: agreeing and monitoring investigation plans to run alongside support plans developed in response to a child sexual exploitation referral.

Engage with agencies to effectively share information and routinely utilise intelligence-led disruption in relation to any local businesses, individuals or groups associated with exploitation.

Through intelligence and partnership meetings ensure all agencies flexibly apply the full range of disruption tactics available through both criminal and civil routes to protect children and young people, including powers available in relation to licensing, health and safety, fraud, housing provision and other related legislation. Mechanisms put in place to ensure young people demonstrating harmful sexual behaviours are identified and support put in place to address their behaviours, with their own vulnerabilities and developmental stage being considered within any response.

Robust offender management strategies post-conviction and/or effective intervention strategies that reduce the risk presented by identified abusers.

Learning, Developing & Support

Ensure that mechanisms are in place to capture learning from a number of sources; Local, Partnership, OFSTED, JTAI, HMIC, SCR, SAR, DHR. We will be able to demonstrate how that learning informs practise. Internal and multi-agency audits used to support learning and development of practise.

As part of Tri-Borough considerations, completing the implementation of the Bexley local learning hub (which brings frontline practice challenges to the board) to assist evaluation of Lewisham & Greenwich's learning models and to work towards a hub model and priorities as part of Tri-Borough multi-agency safeguarding arrangements supported by the early adopters bid to Department of Education.

Establishing an annual programme of safeguarding partnership improvement and delivery priorities that are shared across the new BCU.

Establishing shared mechanisms and processes for initiating local serious case reviews, which incorporate a shared Tri-Borough, multi-agency serious incident and learning sub-group. Each review to be led by one of the three participating local authorities and published across the local areas. This strand will also consider the provisions of a bi-annual learning and improvement report (with conference) for the local tri-borough area.

Establishing Tri-Borough arrangements following the death of a child. Ensure that we learn from these as part of business as usual.

Explore Omni-competence and continual professional development in the safeguarding arena. Look for local, regional and national best practise to support the development of Police Safeguarding Professionals.

Deliver training around Mental Health training to all SE BCU frontline officers.

Prevention and early intervention

The performance of Early Help systems to reduce the need for statutory interventions – effectively dealing with need and vulnerability. Early Help is subject to ongoing scrutiny by the safeguarding boards testing the difference it is making to children and young people's lives.

Young people who are particularly vulnerable to exploitation (i.e. looked after children, missing children) are identified early and supported by their families/carers, professionals, and their community to prevent and build resilience against exploitation.

Schools deliver high quality Sex and Relationships Education (SRE) and take a whole-school approach to gender equality, safeguarding, and preventing exploitation.

Professionals engaged in providing universal and targeted services to adults young people, empowering them to identify harmful behaviours and supporting them to build positive and healthy attitudes towards relationships and friendships, gender identity, and sexuality.

Public trust is built through proven and visible positive attitudes towards all cases involving vulnerable persons. It is essential that Police and the local authorities of Lewisham, Greenwich and Bexley have current and effective information sharing agreements.

Attending all initial case conferences – achieving 100% performance - following onto 100% attendance at review case conferences.

NHS Lewisham Clinical Commissioning Group (CCG)

Agency Representative on Safeguarding Board:

- Martin Wilkinson Managing, Director (Attends LSCB Executive)
- Dr Abimbola Adeyemi, Designated Doctor Safeguarding Children & Consultant Community Paediatrician (LSCB Board and subgroups)
- Maureen Gabriel, Designated Nurse Safeguarding Children & LAC (LSCB Board & Subgroups)
- Dr Agelika Razzaque, Executive Lead Safeguarding Adults & Children/ A CCG Clinical Director (GP) (Attends LSCB Board)

As a health commissioning organisation, Lewisham CCG has a statutory duty to ensure that all health providers, from whom the CCG commissions services, promote the welfare of children and protect children from abuse or the risk of abuse. This includes specific responsibilities for Looked After Children and for supporting the Child Death Review process.

The CCG also supports NHS England with the quality assurance of Primary Care Services (GP, Independent Practitioners and private hospital services in the Borough). This role includes safeguarding assurance as well as strategic leadership and influencing.

What did we do?

- CCG fulfilled statutory functions. There were no gaps in safeguarding roles within the CCG.
- CCG contributed to the LSCB (Executive and Main Board) and its subgroups.
- CCG gained assurance of provider health services safeguarding arrangements by embedding safeguarding into contract monitoring arrangements,

monitoring at the Clinical Quality Review meetings (CQRG) for the local hospital and the Mental Health Trust and by Designated professionals attendance at assurance meetings at these meetings.

- All CCG staff received safeguarding training and are compliant.
- CCG provided Safeguarding Children Level 3 training for General Practitioners, Practice Nurses and other primary care clinicians. Training incorporated learning from serious case reviews and learning reviews, raised awareness of the particular safeguarding needs of disabled children with complex needs and involved applying a range of knowledge and understanding to solve practical child abuse situations such as Child Sexual Exploitation, Domestic Violence.
- 150 clinical staff in primary care were trained during the year.
- CCG facilitated bi-monthly GP Safeguarding Leads meetings. A wide range of safeguarding cases including findings of serious case reviews was discussed. Guest speakers imparted additional safeguarding information on variety of topics such as, Information Governance & GDPR, Neglect Toolkit, Domestic Violence, Lewisham Threshold Document & MASH, Fabricated & Induced Illness CCG ensured primary care contribution to serious case reviews and learning reviews.
- CCG actively contributed to implementation of the New Safeguarding Partnership arrangements and Child Death Review process.

Changes made as a result of previous learning/priorities and new developments

- Lewisham CCG appointed Primary Care Safeguarding Children Practitioner to work alongside the Named GP & Designated Professionals for Safeguarding to ensure Primary Care contributes effectively to the safeguarding agenda in the borough.

- Work has commenced to complete safeguarding children audits in primary care (Recommended from serious cases reviews and learning reviews).

What was the impact?

- i. CCGs are membership organisations that bring together General Practices (GPs) to commission local health services for the population in the area. An advantage of the CCG being a clinically-led organisation is that the CCG is in the position of being able to take account of the experience of patients who are best placed as service users, to know the right services for the area and can comment objectively when new services are commissioned. The CCG ensures that safeguarding is included in all contracts of the services from which it commissions. For example, access to health services locally for children with complex needs was reviewed as part of the NHS Transformation plans. Children with complex needs have increased vulnerability and may be at more risk of abuse and neglect. Safeguarding was considered in the development of the service. This has resulted in a revised service offer for the community nursing of children with complex needs and the implementation of a Hospital at Home scheme.
- ii. The CCG Designated professionals have supported local health providers and the Local Authority with assistance from NHS England to implement the CP-IS (Child Protection Information Sharing Project). This process has taken a number of years to embed. This has improved identification of vulnerable young people and unborn children on CP plans and also for Looked After Children who attend Emergency Departments (ED) or other unscheduled health care settings anywhere in the Country where CP-IS is also implemented. An example of how this is enabled is if a child from Lewisham attends a Dorset hospital, the emergency department in Dorset checks the NHS Spine for information that Lewisham Local Authority has uploaded to

the NHS Electronic Spine. An electronic message is sent to Lewisham Local Authority to indicate the child or young person had attended the ED. CP-IS does not contain the contents of the medical record of attendance. Agencies must still communicate for further clarity.

- iii. The CCG has improved engagement with the safeguarding children agenda in primary care.

Challenges and priorities for this year (2019/2020)

The CCG will need to fulfil its statutory key role in the revised Safeguarding Partnerships under Working Together 2018. This includes:-

- Fulfilling the strong leadership responsibilities placed on it working alongside the local authority chief executive and chief officer of police as the lead representatives with accountability under the legislation.
- Setting the vision, strategy and policy direction for Lewisham's safeguarding arrangements.
- Ensuring wider accountability across services.
- Delivering a fully accountable multi-agency system for safeguarding and protecting children in all settings.
- Holding to account all providers of health services on how effectively they participate and implement the local arrangements.

The CCG together with the Local authority will need to ensure implementation of the changes in Child Death Review Process (CDR).

Lay Members

The attendance of our Lay Members at Board meetings and Task Groups has been instrumental in offering a unique perspective. Both Lay Members are residents of Lewisham, and this provides an insight into local issues and concerns in our borough. Although it is not a requirement of the role, both of our lay member's contribution to the LSCB are assisted by their backgrounds in children services.

What did we do?

In 2018/2019, in addition to attending our Main Board meeting, both Lay Members were actively involved in 3 of our Task Groups, including being a Panel Member on all of our SCRs. Sonia Chambers is a member of our Communications and Publications Task Group, including being a panel member on 2 SCRs, while Derek Churchman is a member on our MESI Task Group, and a panel member on 1 SCR.

What was the impact?

Having our Lay Members involved in some of our Task Groups contributed to the LSCB priorities. Lay Members are asked to provide feedback on how the Board's business is done and how children and their views can be better incorporated. This is especially useful in our SCRs, so as to ensure we get it right for children.

National Probation Service

The National Probation Service (NPS) is responsible for the following areas of work:

- Advice to the Judiciary with regard to sentencing and Parole decisions
- The management of:
 - High risk offenders
 - MAPPA offenders (all categories and levels, irrespective of risk)
 - Foreign national offenders who receive 12 months or more custody or community sentence and who are in scope for deportation
 - Offenders where there is significant public interest
- Approved Premises
- Victim Contact Service

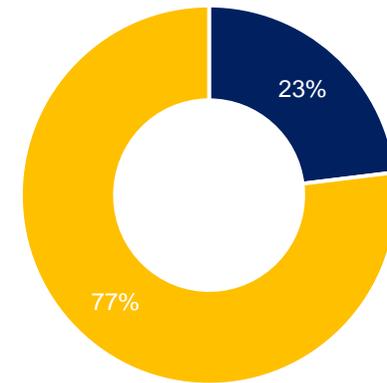
The National Probation Service is divided into six regions and Wales. NPS London is divided into 12 Local Delivery Units, each covering 2-3 London Boroughs. NPS Lewisham and Southwark is one of those clusters.

In Lewisham, the NPS currently manages approximately 570 cases (excluding those cases who are being moved to the new Offender Management in Custody system). The current caseload is a mixture of both community and custody cases, with approximately two thirds of service users being supervised in the community on either a Licence, a Community Order or a Suspended Sentence Order.

NPS is committed to Safeguarding Children and it contributes to protecting vulnerable children and young people by undertaking the following:

- Advice to Courts: In appropriate cases NPS will contact Children’s Social

Youth First Participants 2018/19



Care pre-sentence to find out if a defendant is known and if there are any safeguarding issues that need to be taken into consideration prior to making a sentencing proposal.

- All service users have a thorough assessment after they have been sentenced, whether in custody or in the community. This assessment (OASys) provides a holistic picture of risks and needs presented by each individual, there are specific questions in relation to safeguarding Children. There are also specialist assessments in relation to Sex Offending and Domestic Abuse. Once the risk and needs are assessed, risk management and sentence plans are developed to address the issues identified in the assessments. Risk management can include restrictive measures such as preventing those who pose identifiable risks from having contact with children.

- Referrals – NPS staff will make appropriate referrals into Lewisham MASH, in order to instigate child protection investigations and to alert partnership agencies to concerns about children.
- Multi-agency partnership working. NPS contributes to a range of Multi-agency structures including MAPPA, MARAC, Care Plan Approach and other case conferences. The aim is to share information and ensure the holistic management of service users and that risk to children is minimised.
- Senior Management participation in strategic boards including the Lewisham Safeguarding Children’s Partnership.
- All NPS Staff, including administrative staff, are required to undertake basic Child Safeguarding and Domestic Abuse training in the form of an e-learning module. All practitioners are required to undertake more advanced Child Safeguarding/Domestic Abuse training in the form of face to face training. Ad hoc briefings and workshops are also delivered to staff. Staff are also encouraged to attend Local Authority training where available.
- A Lead Practitioner who participates in Lewisham MASH is provided. The lead practitioner also provides advice and support to Probation colleagues in the form of workshops and case discussions.
- Practice is audited using Her Majesty’s Inspectorate of Probation (HMIP) criteria. Learning is shared with practitioners across the borough. The case audit tool asks specific questions regarding safeguarding activity and these audits take place every 6 weeks. All staff are required to part during the year.
- Work with the Youth Offending Team to improve transition from youth to adult services – this has included the new implementation of the new ‘transition programme’. The programme consists of 4 modules and is designed to improve the transition of young adults from the YOS to Probation.

Youth First

Youth First has been delivering youth provision under contract with LBL for three years. Our core activity is the delivery to all young people in Lewisham aged 8 to 19 (up to 25 for those with special educational needs) of ‘free at the point of access’ youth clubs and adventure playgrounds, both during school terms and holidays. These are run across six directly run youth clubs, three commissioned youth clubs and five directly run adventure playgrounds. In addition this year Youth First has increase service with a Lewisham based street based team. Sessions are sometimes broken into specific age and/or gender. Youth First also commissions additional targeted activities and provision for example sports, gender specific programs and skills based provision.

In 2018/19 we have seen real growth in attendance by young people year on year. With c.84,500 visits in 2018/19 compared to c.81,000 in 2017/18. This year’s attendance includes c.5000 individual young people of which around 1,500 attended regularly (defined as eight times in any school term or 24 times per year as opposed to the government definition of five times a year). As we reach more young people we have a better chance to safeguard them.

Safeguarding due to our location

The location of our sites whilst inherited and often unchanged for many years is not simply accidental nor has it been without relatively regular review by LBL, including within the past five years. In 2018/19 we have increased provision in central Lewisham with our pop up Youth Club at Glassmill Leisure Centre. All our sites are by design in areas of high deprivation and as such more accessible and attended by children and young people with a higher prevalence of associated vulnerabilities including a high proportion of attendance from areas of deprivation as defined by both Indices of multiple deprivation (IMD) and the income deprivation affecting children index (IDACI). Whilst this does not of course

demonstrate that those who attend have vulnerabilities it does demonstrate that there is a higher probability that our sites safeguard those who need it the most.

Universal School Safety Program

In its second & third years the Universal School's Safety Program (USSP), funded by MOPAC, LBL and Youth First directly, was delivered by Youth First and Compass to 1420 pupils in 52 Year seven forms across nine Lewisham secondary schools (Forest Hill Boys, Addey and Stanhope, Bonus Pastor, Prendergast Hillyfields, Haberdashers Hatcham College, Sedgehill School, Prendergast Vale, Haberdashers Askes Knights Academy).

The scheme uses informal education techniques/youth work to teach young people about issues relating to the borough's five key safety themes. These are: how to stay safe (including the danger of knives), the dangers of substance misuse, the importance of healthy sex and relationships, online safety and bullying. Sessions are delivered to a full year seven cohort in a single day of revolving sessions.

To date the feedback from both pupils and schools has been very good with a vast majority saying they learnt valuable information and that it was preferable to receive the subject matter from youth workers rather than their teachers. Many young people also reported that they now knew where to get additional support and Youth First reports an uptake of universal youth provision (youth clubs and adventure playgrounds) off the back of sessions.

Youth First and LBL are currently looking for funding to expand the program to more schools and, at schools request, in-house youth club curriculum, colleges and PRUs.

Partnership working, Workforce Development and Quality Mark

In addition Youth First run two inset weeks per year and all year round for staff to access training through LSCB training provision but also internal training programs. All senior staff which manage youth and Adventure Playgrounds are trained to level three safeguarding and have also trained as lead professionals, Trauma and restorative informed practitioners.

Youth First has 6 out of 10 directly delivered youth clubs which are Bronze London Youth Quality Mark approved with the other units working towards accreditation.

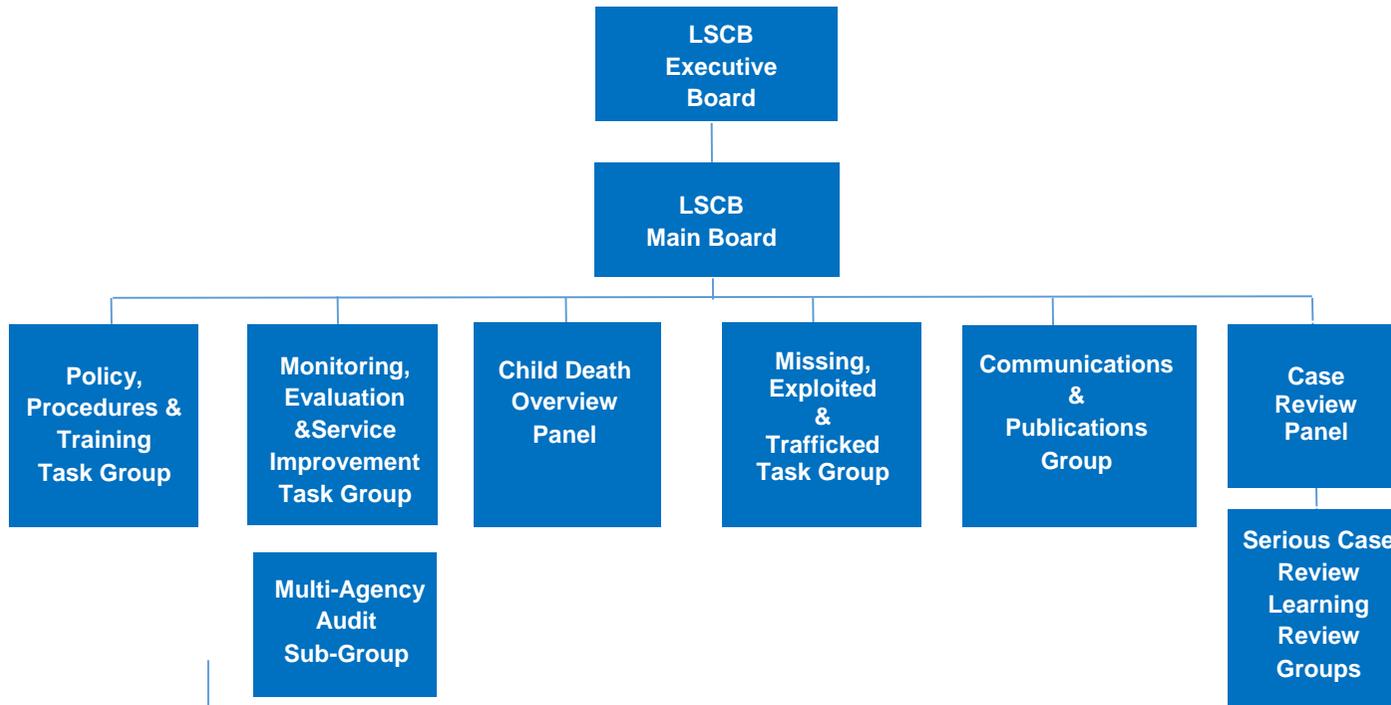
Youth First works in close partnership with LBL Targeted Services, Children's Services, Youth Offending Service (YOS), local schools and are active members of Early Help Services, Safe Spaces, Compass and Kooth. Youth First will be a member of the Concern Hub also.

Appendices

Lewisham Safeguarding Children Board Business Structure Chart



Lewisham Safeguarding Children Board Business Structure Chart



There is also a quarterly Chairs of Task Groups meeting, which meets approximately 4 weeks prior to each Main Board

LSCB Financial Arrangements for 2018-19

Income:

Organisation	LSCB contribution 2015/2016	LSCB contribution 2016/2017	LSCB contribution 2017/2018	LSCB contribution 2018/2019
Lewisham CCG	45,110	45,110	50,110	45,110
LBL Children's & Young People's service	83,280	83,280	88,280	83,280
Cafcass	550	550	550	550
Community Rehabilitation Company	1,000	1,000	1,000	1,000
London Fire Brigade	N/A	N/A	500	500
London Probation	2,000	2,000	1,850	1000
Metropolitan Police Service	5,000	5,000	5,000	5,000
Lewisham & Greenwich NHS Trust	22,555	22,555	27,555	22,555
South London and Maudsley NHS Foundation Trust	22,555	22,555	22,555	22,555
Total:	182,350	182,350	197,400	181,550

Training Summary

LSCB Training Delivered 2018-19

Lunchtime Briefings

Children Missing Education
Fabricated & Induced Illness Awareness
Introduction to Safeguarding Children & Young People in Lewisham
Learning from Domestic Homicide Reviews
Learning from Serious Child Safeguarding Practice Reviews
Multi-Agency Risk Assessment Conference (MARAC) Awareness
Safeguarding Sexually Active Young People
Understanding the Different Strands of Violence Against Women & Girls
Workshop to Raise Awareness of Prevent
Young Carers & Hidden Harm (parents who substance misuse)

Half Day Courses

Gangs, Exploitation & Effective Practice
Safe Recruitment
Sexual Violence and Exploitation Amongst Young People (Peer-on-Peer Abuse)
Workshop to Raise Awareness of Prevent – Greater Depth

Full Day Courses

Breast Ironing & Harmful Cultural Violence
Child Sexual Abuse in The Family
Child Trafficking, Modern Slavery and the National Referral Mechanism
Child Sexual Exploitation – Advanced
Cultural Competence in Safeguarding Children & Young People
Domestic Violence & Abuse Awareness
Early Help Champions
Neglect
Safeguarding Children Affected by Parental Substance Misuse
Safeguarding Children Level 3 – Designated Safeguarding Leads
Safeguarding Sexually Active Young People
Self-Harm & Suicide Ideation in Children & Young People
Working with Challenging & Hard to Help Families
Working with Perpetrators of Domestic Violence

100% delegates agreed to share learning with their colleagues

Working with Perpetrators of Domestic Violence
Delegate Comment

"I am better able to explore incidents of violence with perpetrators and assess future risk"

100% delegates experienced an overall increase in knowledge, skills and understanding in each of the training courses delivered.

Child Sexual Abuse in The Family Course Delegate Comment

"I will be able to support the child / family through the process of recovery and repair and ensure correct information is shared with professionals."

Delegates rated Trainers performance as Good or Excellent

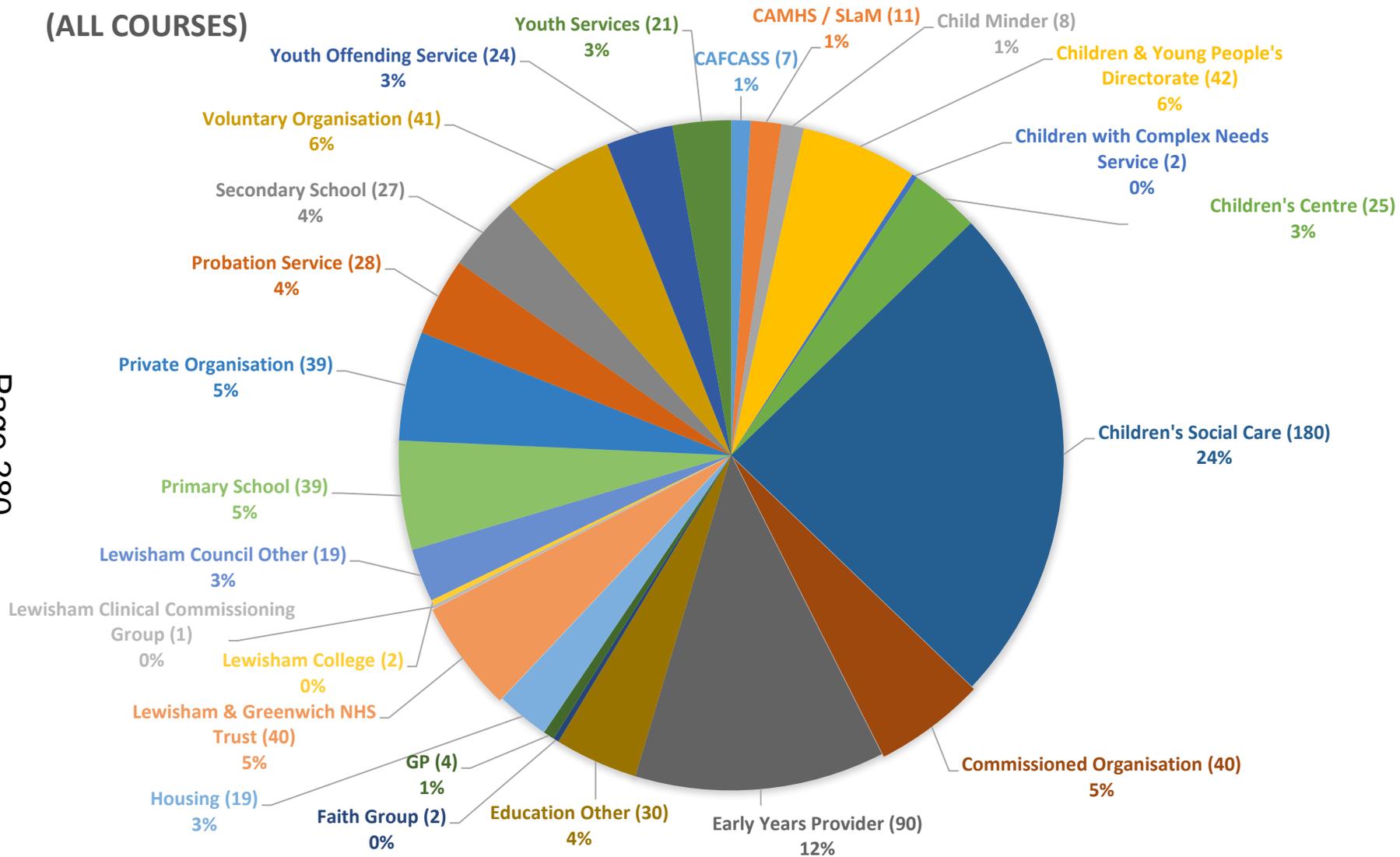
Child Sexual Exploitation Advanced Delegate Comment

"This course will enable me to support and guide staff on resources to use to engage young people"

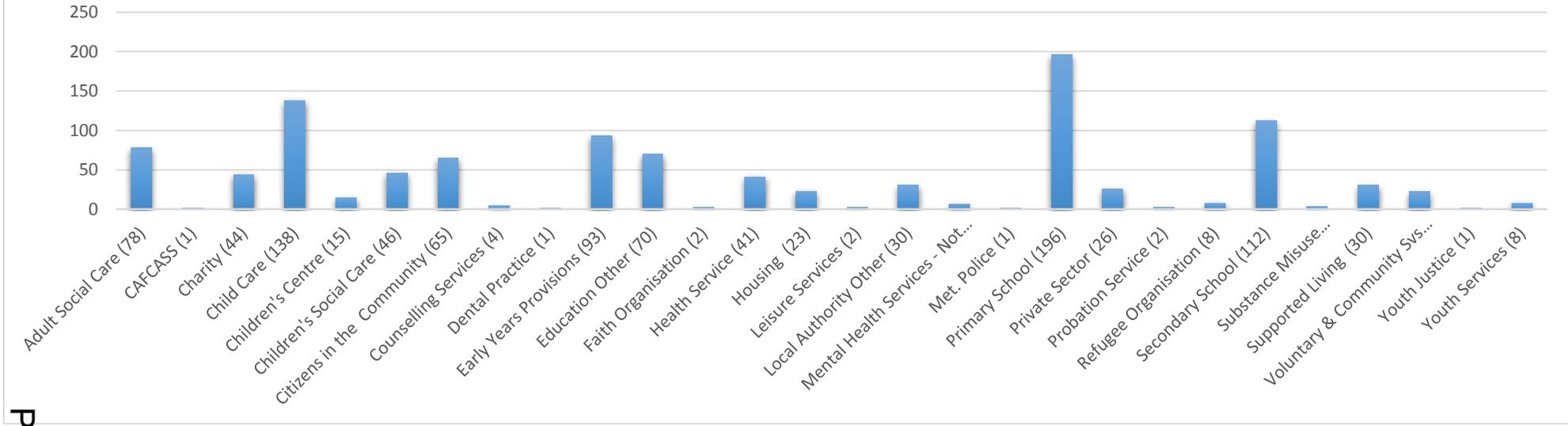
Delegates had a good understanding of where to seek further advice and support in each subject.

AGENCY ATTENDANCE (ALL COURSES)

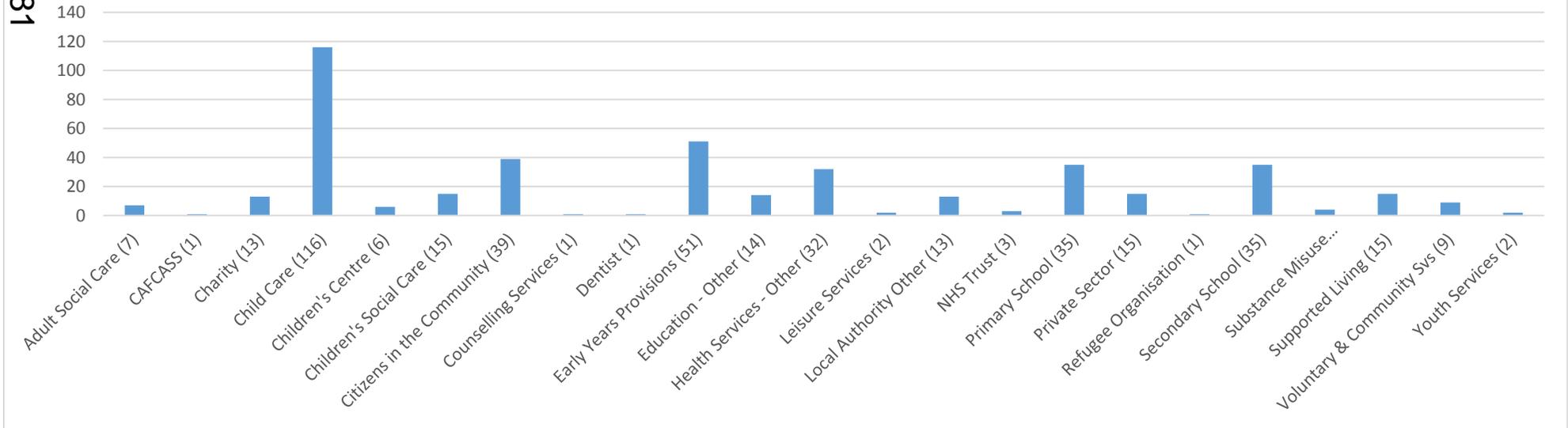
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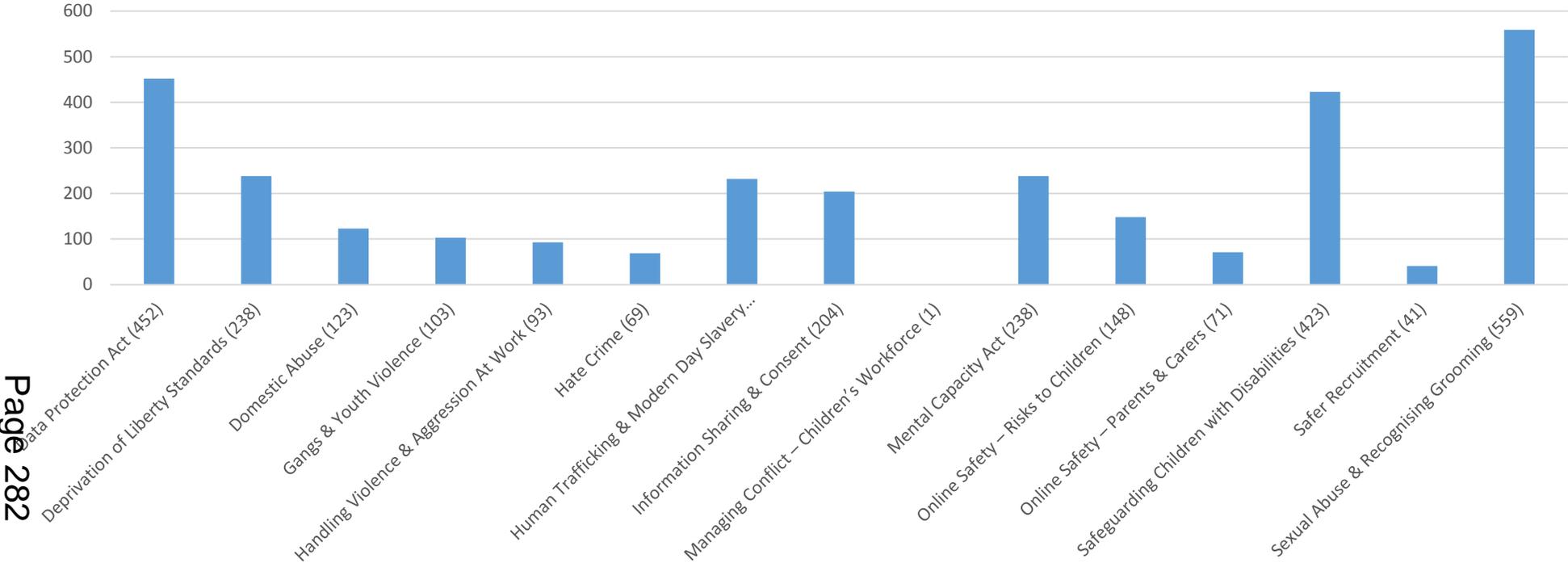
MeLearning Safeguarding Children Level 1 (by delegate role)



MeLearning Safeguarding Children Level 2 (by delegate role)



All Other MeLearning (by numbers of completed courses)



Safeguarding Children Level 3 – Designated Safeguarding Leads (Full day)

No delegates had additional requirements, such as wheelchair access.

1512 Individuals viewed the course on the LSCB Website

4x courses were completed in 2018-19

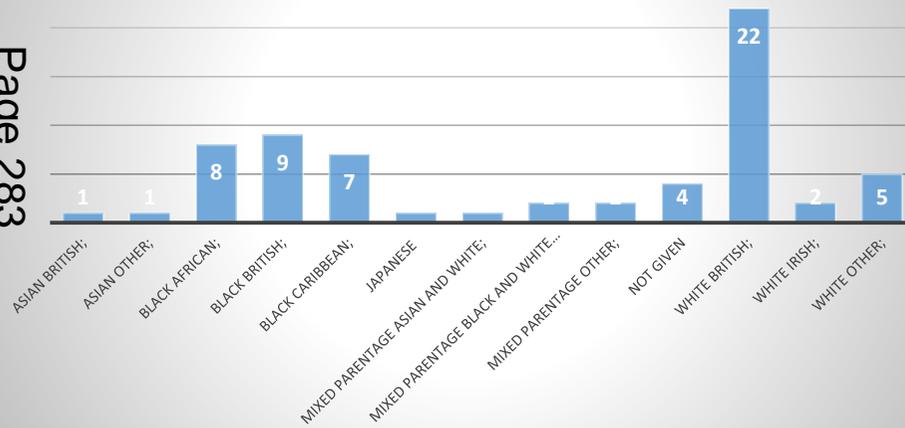
119 Individuals booked to attend the training, out of a possible 80 spaces available

65 individuals attended training (81.3%)

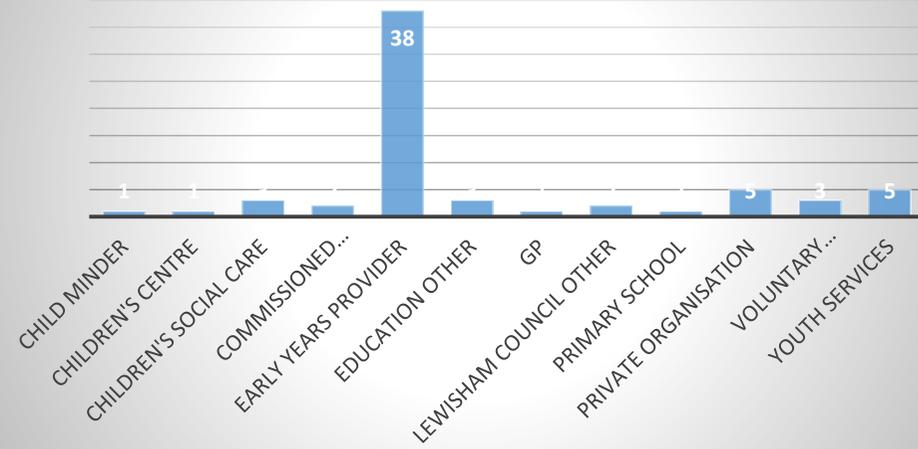
99% of delegates agreed to share the learning with their colleagues and line manager.

Equal Opportunities Monitoring

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Agency Type



Delegates said they would go for additional advice and support from:-

LSCB Website
x37

MASH
x13

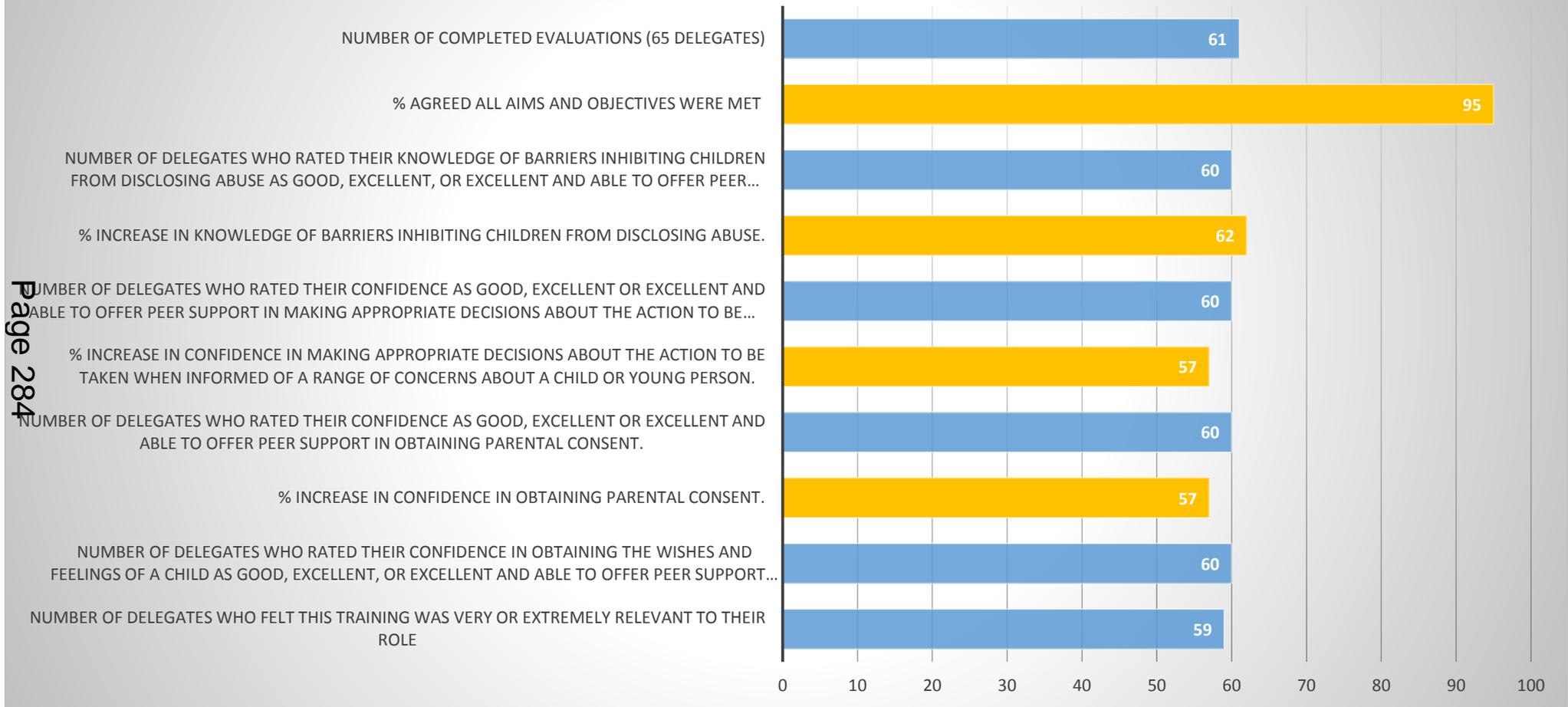
Line Manager
x5

London Child Protection Procedures
x10

LADO
x 4

Key: Orange = % Blue = Numbers

Learning Evaluation Statistics



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"I am working with young people so I will be able to identify the triggers and safeguard even better."

"I am more confident about my role and what action and discussions to have."

"Content was very good and it is so relevant to my practice. It has provided me with more confidence."

"Much clearer about the relevant legal documents and guidance."

"Understanding of bigger picture when looking into concerns."

Neglect – An Analytical Approach (Full Day)

No delegates had additional requirements, such as wheelchair access.

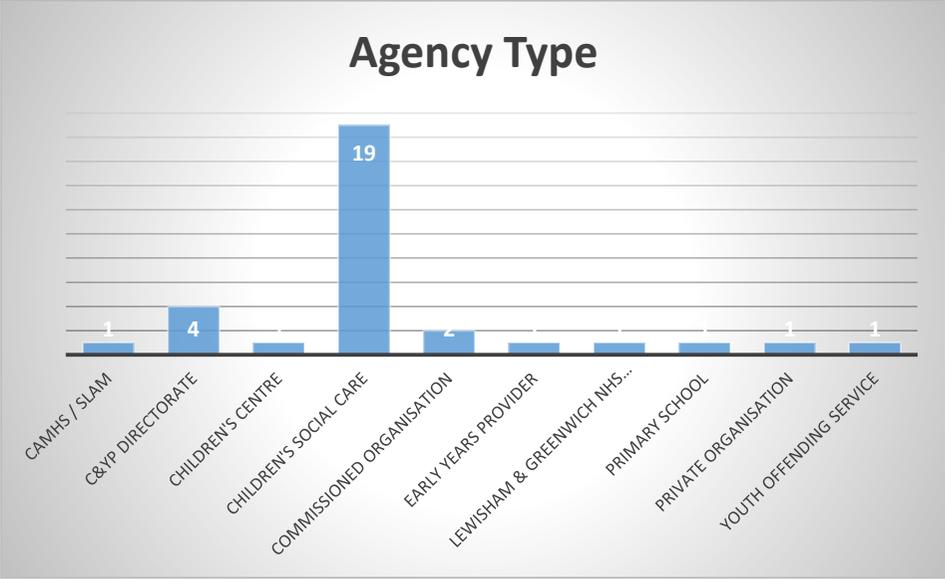
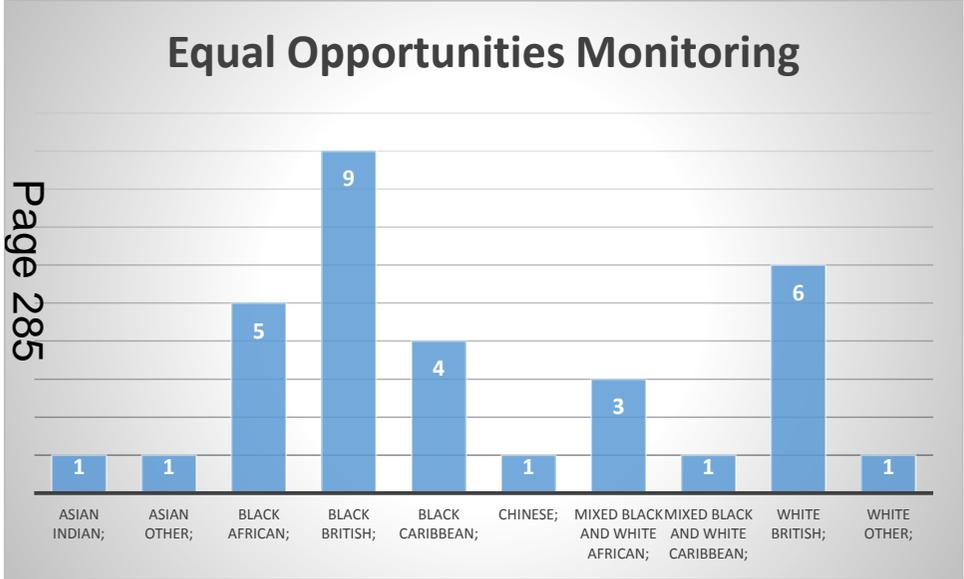
1086 Individuals viewed the course on the LSCB Website

2X courses were completed in 2018-19

41 Individuals booked to attend the training, out of a possible 40 spaces available

32 individuals attended training (80%)

All delegates agreed to share the learning with their colleagues and line manager.



Delegates said they would go for additional advice and support from:-

LSCB Website
x14

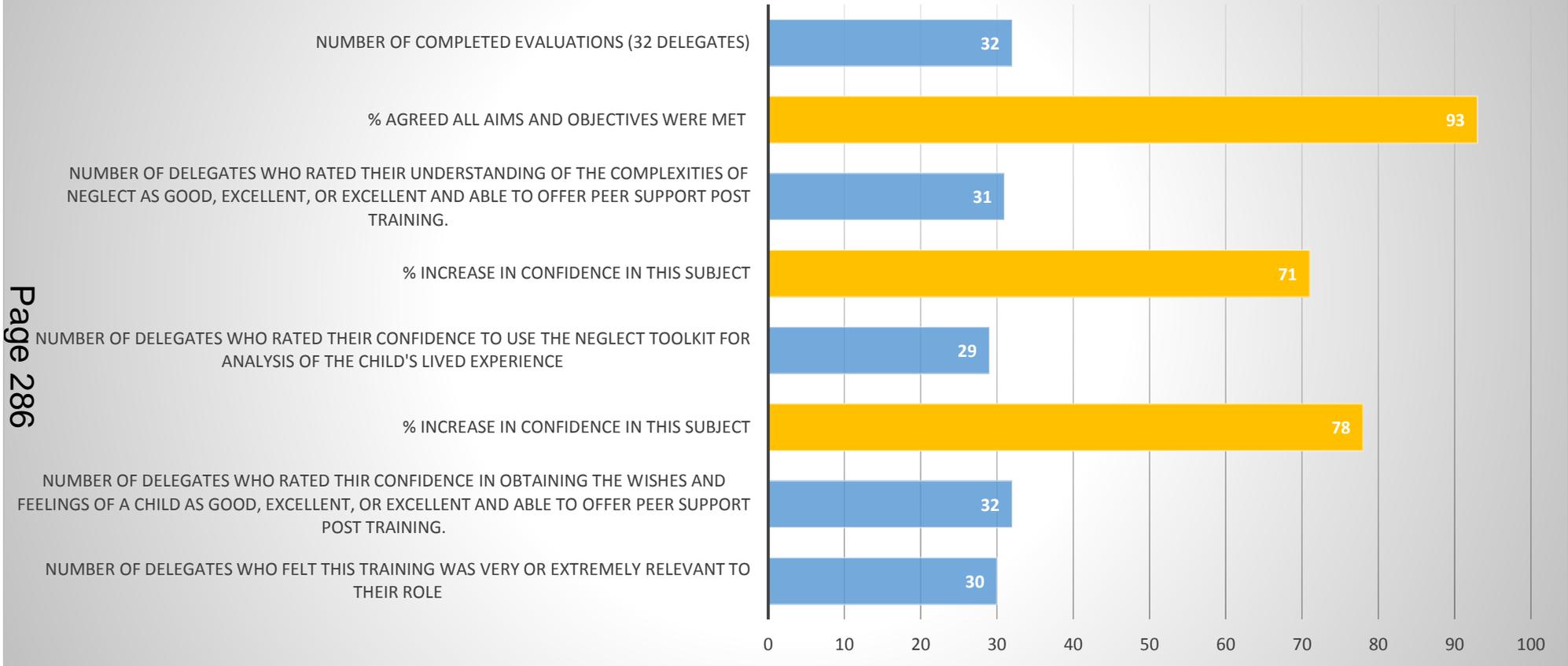
Line Manager
x9

Work in Partnership with Other services
x3

Neglect Toolkit
x2

Key: Orange = % Blue = Numbers

Learning Evaluation Statistics



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“This helped to refresh my knowledge in this area and given me key ideas on how to improve practice and support families.”

“Being able to explain and support parents to hold their child in mind.”

“Looking at neglect through a different lens and language to use with parents.”

“Exploring different ways in learning to deal with neglect and difficult parents.”

“It has helped to challenge parents and get them to think about their child's views. Help to set baby steps.”

Self-Harm & Suicide Ideation in Young People Awareness (Full Day)

No delegates had additional requirements, such as wheelchair access.

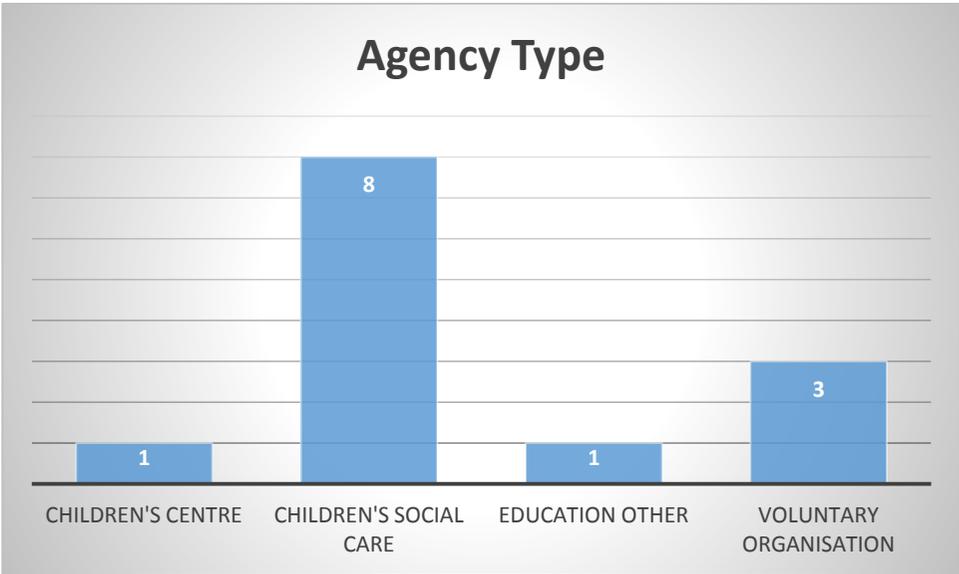
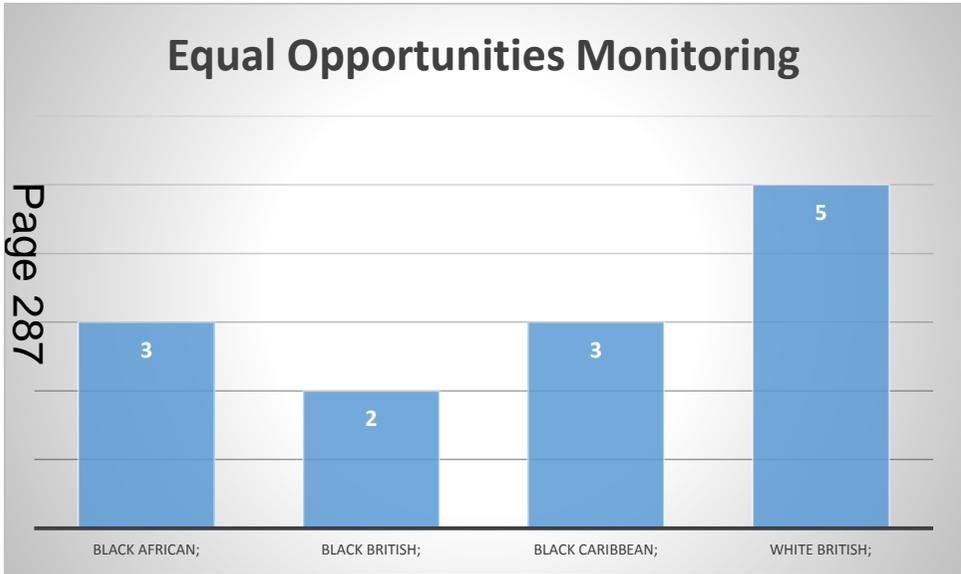
833 Individuals viewed the course on the LSCB Website

1x course was completed. **1x** course was cancelled by the trainer due to service pressures. The course content has been reviewed for the 2019 training programme

19 Individuals booked to attend the training, out of a possible 20 spaces available

15 individuals attended training. (75%)

99% of delegates agreed to share the learning with their colleagues and line manager.



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Delegates said they would go for additional advice and support from:-

LSCB Website
x7

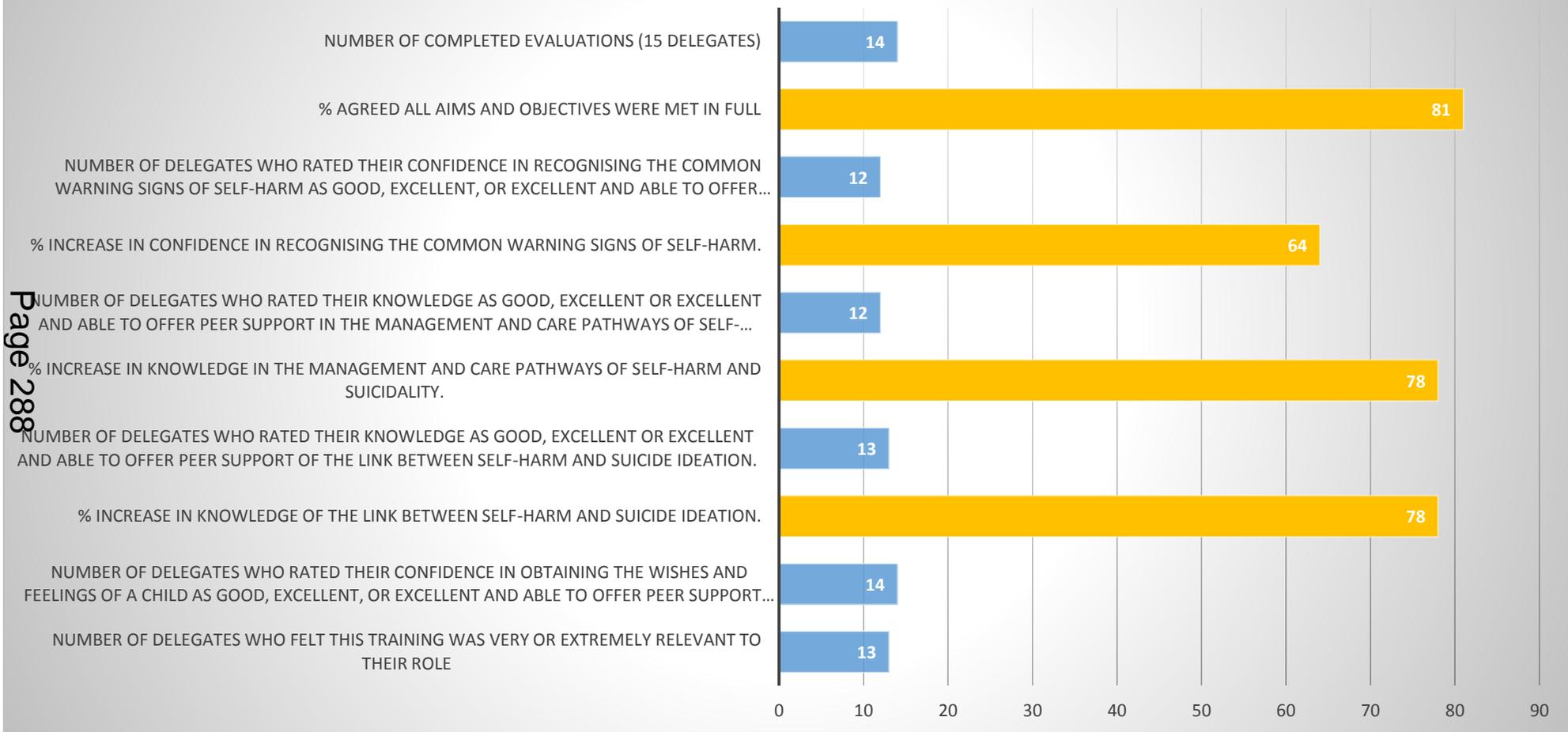
Line Manager
X3

Lewisham CAMHS
X5

Other Online Resources x7

Key: Orange = % Blue = Numbers

Learning Evaluation Statistics



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“Will feel less worried about discussing the topic with young people.”

“I will be able to have a more informed decision when it comes to dealing with children who self-harm.”

“Better knowledge of management pathways and self-harm increased awareness and confidence in assessing self-harm.”

“I am now confident in being able to approach and discuss with individuals their mental health issues.”

Child Sexual Exploitation Advanced Course (Full Day)

No delegates had additional requirements, such as wheelchair access.

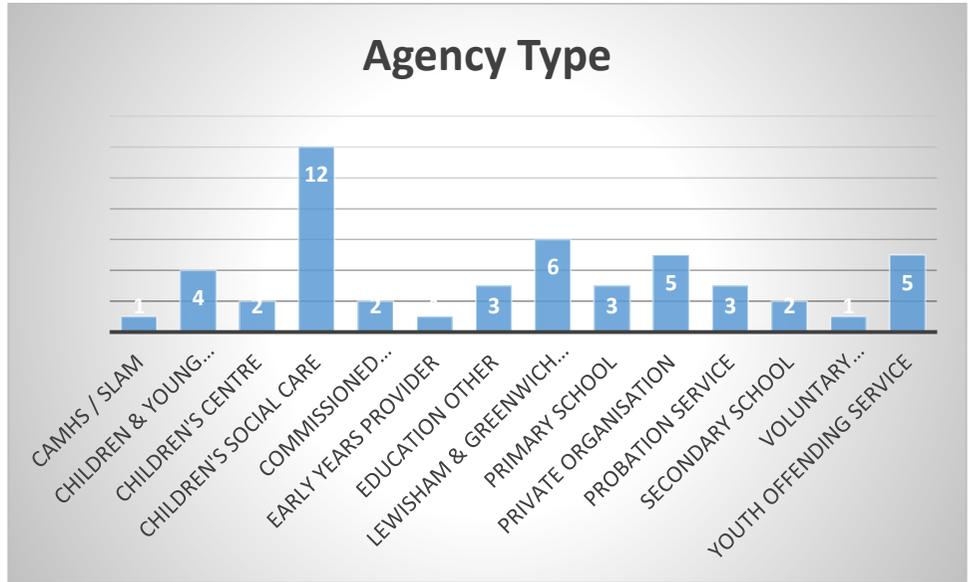
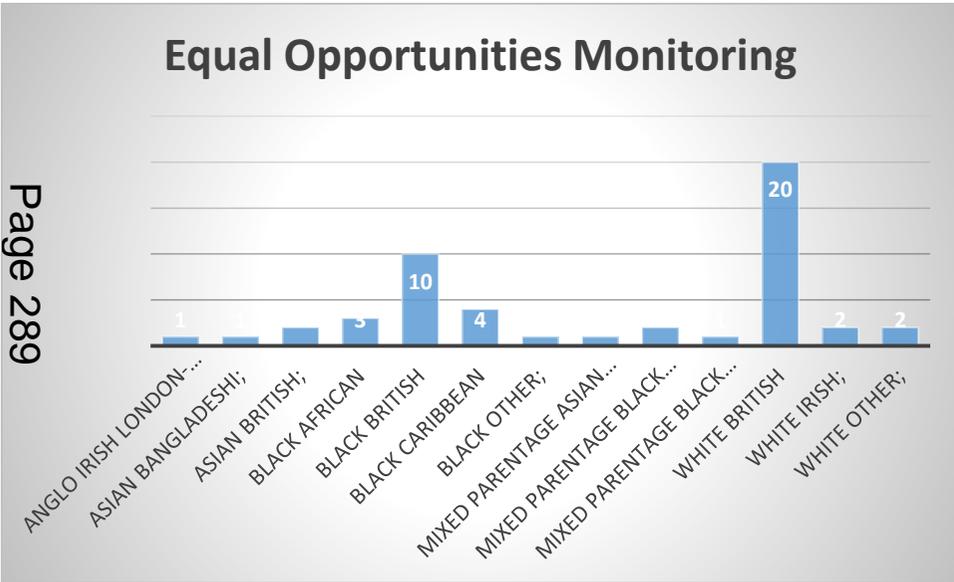
901 Individuals viewed the course on the LSCB Website

3x courses were completed in 2018-19

89 Individuals booked to attend the training, out of a possible **90** spaces available

50 individuals attended training. (55.6%)

All delegates agreed to share the learning with their colleagues and line manager.



Delegates said they would go for additional advice and support from:-

LSCB Website
x16

Line Manager
X4

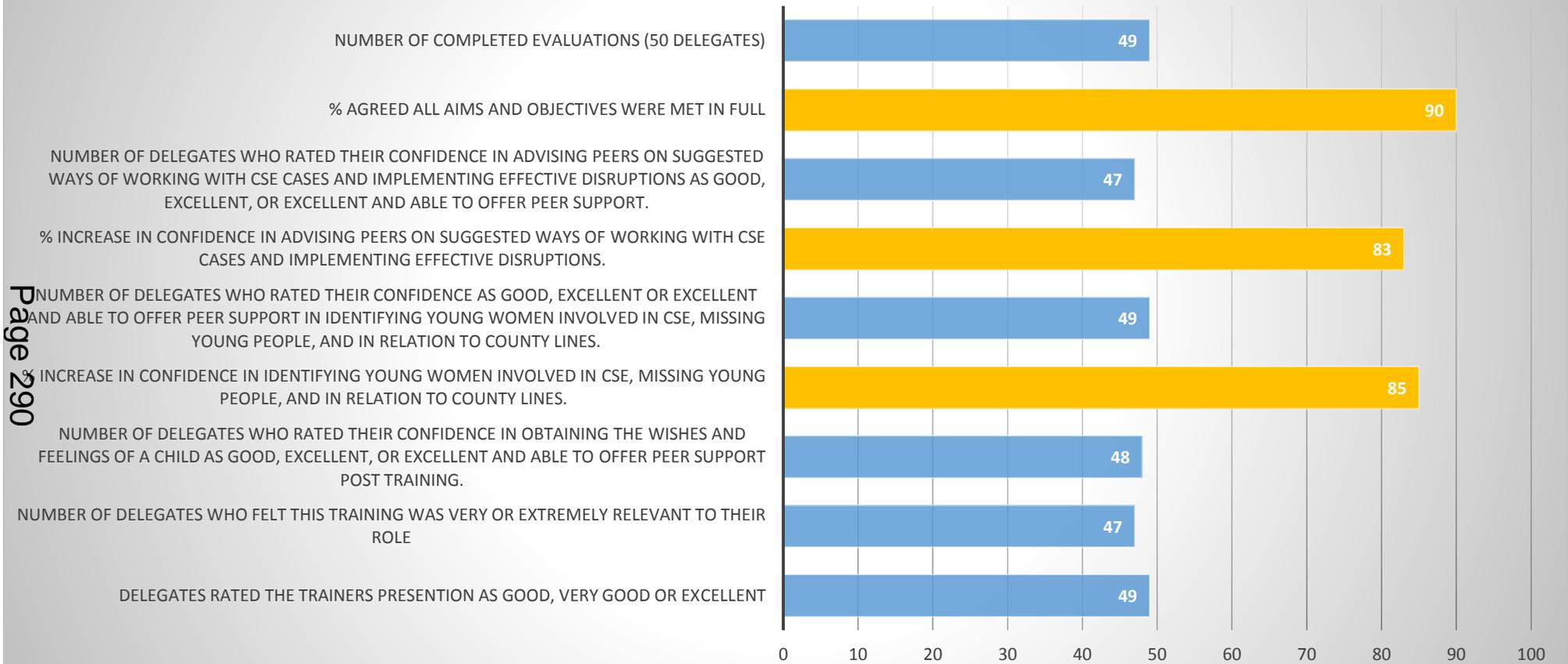
Safer London
X32

MASH
X11

CEOP Website
x27

Key: Orange = % Blue = Numbers

Learning Evaluation Statistics



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“I will be able to identify signs and symptoms of trauma in CSE.”

“Consider CSE in younger children i.e. 12+ and consider the impact of trauma.”

“I have a deeper understanding of trauma and CSE, plus contextual safeguarding.”

“It will help me in working with children where there are CSE and county lines concerns.”

“Numerous toolkits available online and can be used with young people for direct work.”

The training data above provides an outline of some key elements of the larger LSCB Training Program in 2018-19.

Core Safeguarding Training

As outlined on pages 49-52 above, the LSCB has managed to train large numbers of people who work with children and young people in Lewisham across a wide range of safeguarding topics.

Me-Learning (E-Learning)

The Me-Learning (Online learning) for Safeguarding Children Level 1 course trained 1069 individuals in 2018-19, with safeguarding partners in Primary and Secondary Schools, Adult Social Care, Child Care, Early Years and Charities being some of the agencies that most frequently utilised this safeguarding training offer. The Me-Learning Level 2 Safeguarding Children course has now transitioned to being an online course, which has led to a resultant increase from 40 individuals trained in 2017-18 to 430 individuals in 2018-19. This has provided greater reach for this more advanced safeguarding course, with Child Care professionals, Early Years Providers, Primary and Secondary Schools and members of the public being those who most frequently accessed this e-learning training offer.

The LSCB also offers a wide array of additional safeguarding Me-Learning courses, having trained hundreds of additional individuals online around a range of safeguarding issues ranging from Safeguarding Children with Disabilities, Sexual Abuse and Online Safety, Human Trafficking & Modern Day Slavery, Data Protection and Information Sharing and Consent being some of the more heavily subscribed e-learning courses. Overall, 2995 individuals were trained in Me-Learning courses across the LSCB training offer in 2018-19.

The LSCB also offers Level 3 Safeguarding Children for Designated Safeguarding Leads 'classroom' learning. This training is targeted at professionals who are the identified lead for safeguarding within their organisation (eg. School Designated Safeguarding Leads). The LSCB trained over 60 designated safeguarding leads in 2018-19, with a take-up rate of over 80% for this course. When taking into account all other LSCB Classroom Learning courses, 741 individuals received LSCB training in 2018-19.

LSCB Priority-Linked Training

The LSCB maintains a range of safeguarding priorities and information relating to a sample of courses that link directly to LSCB Priorities have been listed above at pages 54-58. Attendance has varied at some courses and work will be ongoing in 2019-20 to enhance awareness of LSCB training courses to continue to share information to develop practice around areas such as Neglect, Suicidal Ideation & Self-Harm and Child Sexual Exploitation alongside Core Safeguarding Training. Feedback from delegates who have attended priority-linked training has been very positive, with noted increases in knowledge, confidence and the ability to support others when confronted with these issues when working with children and families.

Training Program Development & Improvement

Over 2018-19, the LSCB has expanded its training program on safeguarding issues such as Breast Ironing, Child Sexual Exploitation Champions, Lunchtime Introductory Safeguarding Briefings for safeguarding partners and expanded the number of Safeguarding Children Level 3 – Designated Safeguarding Leads from 2 to 4 sessions annually and commissioned additional training on Working with Challenging and Hard to Help Families and Safeguarding Children affected by Parental Substance Misuse.

Looking forward, the LSCB is looking to support professionals to develop their knowledge and skills within a Trauma-Informed Approach to safeguarding, in line with Leisham's wider Public Health approach to key issues such as violence reduction for young people. A series of courses will be provided by Solace Women's Aid on a pro bono basis to enhance practice around Working with Perpetrators of Domestic Violence. A Gaming & Gambling Harm Prevention Program will also be offered by YGAM (charity) and the LSCB will implement a LADO Awareness Lunchtime Briefing for safeguarding professionals.

LSCB Task Groups

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Aims to safeguard children and young people from harm as a result of going missing; child sexual exploitation; or trafficking for exploitation arising as a consequence of being the victim of trafficking including County Line drug dealing.

Responsible for considering cases in light of the Serious Case Review criteria as set out in Working Together to Safeguard Children 2015 and making recommendations to the Independent Chair

Reviews the deaths of all children in Lewisham: this became a statutory duty in April 2008



Responsible for monitoring and evaluating the effectiveness of what is done by agencies both individually and collectively to safeguard and promote the welfare of children

Responsible for communicating and raising awareness of the need to safeguard and promote the welfare of children and how this can best be done by agencies, children and young people, families and the community.

Responsible for developing policies and procedures to safeguard children and ensuring that multi-agency training on safeguarding is provided in order to meet local needs

The Business Unit also co-ordinates a meeting of the Task Group Chairs, who meet before each LSCB Main Board Meeting.



Health and Wellbeing Board

Performance Dashboard Exceptions Report

Date: 12th March 2020

Key decision: No

Class: Part 1

Ward(s) affected: All

Contributors: Dr Catherine Mbema, Director of Public Health, Lewisham Council

Outline and recommendations

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

The Board is recommended to note performance as measured by health and care indicators set out in the attached dashboard

Timeline of engagement and decision-making

1. Summary

- 1.1. This report provides members of the Health and Wellbeing Board with an update on performance against its agreed priorities within the Health & Wellbeing Strategy.

2. Recommendations

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

3. Policy Context

- 3.1. The Health and Social Care Act 2012 established Health and Wellbeing Boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. The activity of the Health and Wellbeing Board is focused on delivering the strategic vision for Lewisham as established in Shaping our Future – Lewisham’s Sustainable Community Strategy, and in Lewisham’s Health and Wellbeing Strategy.
- 3.2. The work of the Board directly contributes to the priority outcome in Shaping our Future that communities in Lewisham should be Healthy, Active and Enjoyable – where people can actively participate in maintaining and improving their health and wellbeing.
- 3.3. The Health and Social Care Act 2012 placed a duty on local authorities and their partner clinical commissioning groups to prepare and publish joint health and wellbeing strategies to meet needs identified in their joint strategic needs assessments (JSNAs). JSNAs then inform Health and Wellbeing Strategies. Lewisham’s Health and Wellbeing Strategy was published in 2013.
- 3.4. The Health and Social Care Act also required Health and Wellbeing Boards to encourage persons who arrange for the provision of any health or social services in the area to work in an integrated manner, for the purpose of advancing the health and wellbeing of the area.

4. Background

- 4.1. In response to the request from members of the Board, the Director of Public Health has worked alongside colleagues within Adult Social Care, Children’s Services and the

Clinical Commissioning Group (CCG) to produce a dashboard of indicators which would assist members in monitoring health and wellbeing improvements across Lewisham and the effectiveness of the integrated adult care programme.

- 4.2. The dashboard also includes a number of indicators (including those on low birth weight, immunisation and excess weight) that are also included in the 'Children and young people have good physical and emotional health' priority of the Children and Young People's Partnership Plan (2019-22).

5. Health and Wellbeing Board Performance Dashboard Update

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

- 5.2 Updated indicators since the previous period of data availability are commented on below. Where performance has deteriorated, commentary on actions being taken to improve the position has been provided.

5.3 Overarching Indicators of Health & Wellbeing

The latest data for **premature mortality from Cardio-vascular disease** has increased and is now significantly higher than the England rate. This bucks the almost constant downwards trend since 2000. **Low Birth weight of all babies** has increased, and has is once again significantly higher than England.

Male and Female life expectancy data should be published in December 2019. Dashboard and this paragraph will then need updating.

5.4 Priority Objective 1: Achieving a Healthy Weight

Lewisham is now significantly lower than the national average for **adult excess weight**.

Regarding excess weight in children, Reception year performance has increased compared to the previous year, however does remain lower than England and the 2016/17 level. For Year 6 children there was an overall reduction in excess weight for the second year in a row and obesity has also decreased. 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. The participation rate returned to be above the 90% target rate for both year groups.

The latest data on **Maternal excess weight** shows an improvement, yet almost half of pregnant women are overweight at their booking midwife appointment. This increases the risk of poor pregnancy outcomes and is a risk factor for childhood obesity. Lewisham **breastfeeding rates at 6-8 weeks** continue to exceed target, with rates amongst the highest in England.

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

Both **breast and bowel cancer screening** data should be updated in early 2020, please check and update dashboard and this paragraph. **Cervical cancer screening** has now been split into age groups, for women aged 25-49, there was a slight increase for 2019 compared to 2018, however uptake is still significantly below the national average.

Under 75 Mortality from all cancers has improved and is now similar to the national average. Early diagnosis of cancer has decreased, however this data is classified as

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experimental by the Office for National Statistics and will be replaced by a different indicator in future years.

5.6 Priority Objective 3: Improving Immunisation Uptake

The most recent data on **over 65 flu immunisation uptake** has seen a drop in uptake and remains below the England average and the national target (75%). (needs comment)

HPV vaccine uptake rate (due in Feb 2020) – update dashboard when available and amend paragraph. Also mention that boys now receiving the jab.

Uptake of the second dose of measles, mumps and rubella vaccine has remained stable and above the London average but needs to improve to reach to the England average and hit the target (91.1%) and achieve herd immunity. Update comment.

5.7 Priority Objective 4: Reducing Alcohol Harm

Alcohol related admissions have fallen again and remain significantly below the England average. (Still on 2017/18 data, check if this has been updated for 2018/19 in time for board)

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

Smoking prevalence has increased slightly but remains in-line with London and England. **The self-report rate for smoking quitters per 100,000 population** has increase and is outperforming London and England.

Smoking status at time of delivery has increased marginally but remains significantly below the national average.

5.9 Priority Objective 6: Improving mental health and wellbeing

Prevalence of Serious Mental Health Conditions has remained stable but is still significantly higher than the England average. Prevalence is similar to neighbouring boroughs. **Prevalence of depression** has increased slightly, yet remains significantly lower than the national average. Improving Access to Physiological Therapies performance service data continues to improve.

BAME mental health is an area that the Health and Wellbeing Board are focussing on (enter sentence updating progress to date)

5.10 Priority Objective 7: Improving sexual health

The rate of **chlamydia diagnoses per 100,000 young people aged 15-24 years** has increased and remains above the national average. This performance should be seen in context of the proportion of young people now screened for chlamydia. In 2018, 28.7% of people aged 15-24 were screened, in 2015 it was 50.3% of the same population. The **legal abortion** rate has increased and remains significantly higher than the London and England average. **Teenage conceptions** have decreased and are in-line with England.

People presenting with HIV at a late stage of infection has increased but remains in-line with the national average. Lewisham are currently working with the Elton John Aids Foundation to increase HIV testing both in hospital and primary care. Furthermore the Lambeth, Southwark and Lewisham (LSL) Sexual Health Strategy has identified late diagnosis of HIV as a critical target. In producing the strategy it was found that certain

groups had a higher proportion of people with late diagnosis. This insight means that the same groups will be increasingly targeted for screening.

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

Within Lewisham's wider integration framework, health and care partners have continued to focus on these priority areas. The Better Care Fund metrics remain the overarching measures by which progress and performance against these priority areas has been measured. The four national metrics are:

- Non elective admissions
- Admissions to residential and care homes
- Effectiveness of reablement
- Delayed transfers of care (DTC)

As at December 2018, performance was on track to meet target in all four measures. Full year (2018-19) figures will be available in summer 2019. These metrics continue to be monitored by health and care partners, both by individual organisations and jointly through the BCF.

6. Financial implications

- 6.1. There are no specific financial implications arising from this report. A range of activity designed to improve performance against these indicators is funded from the Public Health budget using the ring fenced Public Health Grant. This expenditure is reviewed regularly and reallocation to address indicators with poor performance is possible.

7. Legal implications

- 7.1. The statutory requirement to have a Health and Wellbeing Strategy is set out above.

8. Equalities implications

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

9. Climate change and environmental implications

- 9.1. There are no specific climate change or environmental implications of this report.

10. Crime and disorder implications

- 10.1. There are no specific crime and disorder implications

11. Health and wellbeing implications

- 11.1. These metrics have been selected to assist members in their assessment of the impact and success of the plans and activities in relation to the Health and Wellbeing Strategy.

12. Report author and contact

- 12.1. Dr Catherine Mbema, Catherine.mbema@lewisham.gov.uk

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Appendix A - Health and Wellbeing Board Performance Metrics - March 2020

Updated indicators are in bold		Frequency	Latest Period of Availability	Previous Available Period (Lewisham)	Latest Available Period (Lewisham)	London	England	England Benchmark	Direction from Previous Period	Data Source
Overarching Indicators										
1a	Life Expectancy at Birth (Male)(yrs)	Annual	2015-2017	79.1	79.0	80.5	79.6	sig lower	↓	ONS
1b	Life Expectancy at Birth (Female)(yrs)	Annual	2015-2017	83.3	83.7	84.3	83.1	sig higher	↑	ONS
2	Under 75 mortality rate from CVD (DSR)	Annual	2016-2018	80.7	86.0	70.5	71.7	sig higher	↑	PHOF 4.04i
3	Low Birth Weight of all babies (%)	Annual	2017	7.3	8.1	7.7	7.4	sig higher	↑	P00455/CHIMAT Profile
Priority Objective 1: Achieving a Healthy Weight										
4	Excess weight in Adults (%)	Annual	2017/18	57.8	55.6	55.9	62.0	sig lower	↓	PHOF C16
5a	Excess weight in Children - Reception Year (%)	Annual	2017/18	17.6	21.3	21.8	22.6	similar	↓	PHOF 2.06i
5b	Excess Weight in Children - Year 6 (%)	Annual	2017/18	37.9	37.3	37.9	34.3	sig higher	↓	PHOF 2.06ii
6	Maternal Excess Weight at <13 weeks gestation(%)	Quarterly	Q2 2019/20	50.5	45.6	-	-	-	↓	Lewisham & Greenwich Trust Data
7	Breastfeeding Prevalence 6-8 weeks (%)	Quarterly	Q1 2019/20	79.3	78.7	-	47.6	sig higher	↓	NHS ENGLAND
Priority Objective 2: Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years										
8a	Cancer screening coverage - breast cancer (%)	Annual	2018	67.8	69.3	69.3	74.9	sig lower	↑	PHOF C24a
8b	Cancer screening coverage - cervical cancer (women aged 25 to 49) (%)	Annual	2019	66.2	66.7	61.5*	69.8*	sig lower	↓	PHOF C24b
8c	Cancer screening coverage - bowel cancer (%)	Annual	2018	46.7	47.0	50.2	59.0	sig lower	↑	PHOF C24d
9	Early diagnosis of cancer (%)	Annual	2017	52.4	47.0	52.7	52.2	-	↓	PHOF 2.19 – experimental statistics
10	Conversion of Two Week Wait Referrals to Cancer Diagnosis (%)	Annual	2017/18	4.3*	4.5*	-	7.5*	sig lower	↑	PHE Fingertips Cancer Services Portal
11	Under 75 mortality from all cancers (DSR)	Annual	2016-18	146.7	134.0	120.1	132.3	similar	↓	NHSIC - P00381/ PHOF E05a
Priority Objective 3: Improving Immunisation Uptake										
12	Uptake of the second dose of Measles Mumps and Rubella Vaccine (MMR2) at five years of age (%)	Quarterly	Q1 2019/20	85.3	85.1	76.1	85.6	similar	↓	COVER Programme
13	HPV Vaccine Update (All Doses) %	Annual	2017/18	75.5	79.5	81.0	83.1	similar	↑	PHOF - D04e
14	Uptake of Influenza vaccine in persons 65+ years of age %	Annual	2018/19	68.1	64.5	65.4	72.0	sig lower	↓	PHOF D06a
Priority Objective 4: Reducing Alcohol Harm										
15	Alcohol related admissions (ASR per 100,000 pop)	Annual	2017/18	526	537	533	632	sig lower	↑	PHOF 2.18
Priority Objective 5 : Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking										
16	Smoking Prevalence in adults (18+) - current smokers (APS)(%)	Annual	2018	15.5	16.7	13.9	14.4	similar	↑	PHOF 2.14
17	4 week smoking quitters (crude rate per 100,000)	Annual	2018/19	2,329	2,344	1,960	1,894	sig higher	↑	Smoking Quitters
18	Smoking status at time of delivery (%)	Annual	2018/19	5.4	5.7*	5.0	10.8	sig lower	↑	PHE Tobacco Profiles
Priority Objective 6: Improving Mental Health and Wellbeing										
19	Prevalence of Serious Mental Illness (%)	Annual	2018/19	1.33	1.34	1.12	0.96	sig high	→	Quality Outcomes Framework
20	Prevalence of Depression 18+ (%)	Annual	2018/19	8.2	8.8	7.7	10.7	sig lower	↑	Quality Outcomes Framework
21	Improving Access to Physiological Therapies (IAPT) referrals entering treatment (%)	Annual	2018/19	16.9	18.1	17.3	17.7	similar	↑	SLaM
22	Proportion of those accessing IAPT who moved to recovery (%)	Annual	2018/19	52.9	51.8	51.0	52.0	similar	↑	SLaM
Priority Objective 7: Improving Sexual Health										
23	Rate of chlamydia diagnoses per 100,000 young people aged 15 to 24 (crude rate)	Annual	2018	2,627	3,248	2,610	1,975	sig higher	↑	PHOF 3.02i/3.02ii (NCSP & CTAD)
24	People presenting with HIV at a late stage of infection (%)	Annual	2016-2018	40.5	44.3	37.1	42.5	similar	↑	PHOF 3.04
25	Legal Abortion rate for all ages (crude rate per 1000 women aged 15-44 yrs)	Annual	2018	23.1	24.3	21.1	17.5	sig high	↑	ONS Abortion Stats
26	Teenage conceptions (Rate per 1,000 15-17 Yr olds)	Annual	2017	22.1	20.8	16.4	17.8	similar	↓	PHOF 2.04
Better Care Fund Metrics										
27	The proportion of those aged 65+ who received reablement services after hospital discharge	Annual	2017/18	2.3	4.0	3.8	2.9	-	↑	Better Care Fund, NHS England
28	Residential Admissions Rate (per 100,000 65+ population)	Annual	2017/18	687.4	541.2	406.2	585.6	-	↓	Better Care Fund, NHS England
29	Average daily rate of delayed transfers of care (per 100,000 population aged 18+)	Annual	2017/18	7.3	5.7	-	12.4	-	↓	Better Care Fund, NHS England

Appendix A - Health and Wellbeing Board Performance Metrics - March 2020

Updated indicators are in bold	Frequency	Latest Period of Availability	Previous Available Period (Lewisham)	Latest Available Period (Lewisham)	London	England	England Benchmark	Direction from Previous Period	Data Source
30 Non-Elective Admissions (per 100,000 population)	Annual	2017/18	-	-	-	-	-	-	Better Care Fund, NHS England

Key

sig high -significantly higher than England; sig low - significantly lower than England
 similar - statistically similar to England
 DSR - Directly Standardised Rates
 ASR - Age Standardised Rates
 ISR - Indirectly standardised Rates
 PHOF - Public Health Outcome Framework

Links to Source with their abbreviations

<http://www.phoutcomes.info/>
<http://www.phoutcomes.info/profile/sexualhealth>
<https://www.indicators.ic.nhs.uk/webview/>
<http://www.hscic.gov.uk/qof>
<http://ascof.hscic.gov.uk/>
<http://www.productivity.nhs.uk/>
<https://www.nhscomparators.nhs.uk/NHSComparators/HomePage.aspx>

	Latest period highlighted
	Statistically Better than England
	Statistically Similar to England
	Statistically Worse than England
	Blank where no statistical comparison could be made

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

Public Health Outcomes Framework (PHOF)
 Public Health England Sexual Health Profiles
 NHS Indicator Portal (NHSIC) by Health and Social Care Information Centre (HSCIC)
 Quality and Outcomes Framework (QOF) by HSCIC
 Adult and Social Care Outcomes Framework (ASCOF)
 NHS Better Care Better Value Indicators
 NHS Comparators by HSCIC

Data Quality Issue has been reported with this indicator, interpret with caution