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DATE: 29th August 2017

To: Members of the
HEALTH AND WELLBEING BOARD

Councillor David Jefferys (Chairman)
Councillor Robert Evans (Vice-Chairman)
Councillors Ruth Bennett, Stephen Carr, Mary Cooke, Ian Dunn, Judi Ellis, Angela Page and Diane Smith

London Borough of Bromley Officers:

Janet Bailey	Director of Children's Social Care
Stephen John	Director of Adult Social Care
Dr Nada Lemic	Director of Public Health

Clinical Commissioning Group:

Dr Angela Bhan	Chief Officer - Consultant in Public Health
Harvey Guntrip	Lay Member-Bromley CCG
Dr Andrew Parson	Clinical Chairman CCG

Bromley Safeguarding Adults Board

Lynn Sellwood	Independant Chair - Bromley Safeguarding Adults Board

Bromley Safeguarding Children Board:

Jim Gamble QPM	Independent Chair - Bromley Safeguarding Children Board

Bromley Voluntary Sector:

Linda Gabriel	Healthwatch Bromley
Colin Maclean	Community Links Bromley

A meeting of the Health and Wellbeing Board will be held at Bromley Civic Centre on **THURSDAY 7 SEPTEMBER 2017 AT 1.30 PM**

MARK BOWEN
Director of Corporate Services

Copies of the documents referred to below can be obtained from http://cds.bromley.gov.uk/

AGENDA

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTEREST

3 MINUTES OF THE MEETING HELD ON 30TH MARCH 2013 (Pages 1 - 12)

4 QUESTIONS FROM COUNCILLORS OR MEMBERS OF THE PUBLIC

In accordance with the Council's Constitution, questions to this Committee must be received in writing 4 working days before the date of the meeting. Therefore please ensure questions are received by the Democratic Services Team by 5.00pm on Friday 1st September 2017.

5 UPDATE ON THE DEVELOPMENT OF THE HOMELESS STRATEGY

A verbal update will be provided by the Director of Housing.

6 PRESENTATION ON THE NEW PHARMACEUTICAL NEEDS ASSESSMENT

A PowerPoint presentation will be delivered by Vanessa Lane-Director of Web Star Lane Consulting Services.

7 SOCIAL ISOLATION--LOCAL AWARENESS CAMPAIGN AND ACTION PLAN UPDATE. (Pages 13 - 28)

8 THE IRIS PROJECT (IDENTIFICATION AND REFERRAL TO IMPROVE SAFETY) IN BROMLEY (Pages 29 - 34)

9 BCF PLAN 2017-2019 (Pages 35 - 76)

10 DELAYED TRANSFER OF CARE PERFORMANCE (Pages 77 - 80)

11 SCOPING PAPER FOR FALLS TASK AND FINISH GROUP (Pages 81 - 84)

12 CONSULTATION ON THE LONDON HEALTH INEQUALITIES STRATEGY (Pages 85 - 152)

Members are requested to comment on the Strategy, so that the HWB can consider a response.

13 2016--2017 WINTER REVIEW (Pages 153 - 164)

14 UPDATE ON THE MENTAL HEALTH STRATEGIC PARTNERSHIP

An update on the work of the Mental Health Strategic Partnership will be provided by Mr Harvey Guntrip.

15 MATTERS ARISING AND WORK PROGRAMME (Pages 165 - 176)

16 EMERGING ISSUES

Members of the Board are invited to highlight any matters that they regard as emerging issues.

17 ANY OTHER BUSINESS

18 DATE OF THE NEXT MEETING

The date of the next meeting is 30th November 2017

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HEALTH AND WELLBEING BOARD

Minutes of the meeting held at 1.30 pm on 30 March 2017

Present:

Councillor David Jefferys (Chairman)
Councillor Diane Smith (Vice-Chairman)
Councillors Ruth Bennett, Ian Dunn, Robert Evans and Colin Smith

Janet Bailey, Director of Children's Social Care
Stephen John, Director of Adult Social Care
Dr Nada Lemic, Director of Public Health
Alicia Munday, Education, Care & Health Services

Dr Angela Bhan, Chief Officer - Consultant in Public Health
Dr Andrew Parson, Clinical Chairman CCG

Linda Gabriel, Healthwatch Bromley
Colin Maclean, Community Links Bromley

Also Present:

Adam Smith, Jason Stanton, Debra Weekes, Ann Wilbourn

128 APOLOGIES FOR ABSENCE

Apologies were received from Harvey Guntrip, Lorna Blackwood, Jim Gamble, Hannah Norgate and Councillor Stephen Carr.

129 DECLARATIONS OF INTEREST

Councillor Ruth Bennett declared an interest as her husband sat on the Mytime Board.

130 MINUTES OF THE PREVIOUS MEETING

Councillor Evans referred to Minute 114 which was the Primary Care Co-Commissioning Report. He referenced the sentence '*However, some people had been brought back to south east London to assist'* and requested some clarification concerning this. Dr Bhan explained that this was a reference to former employees of the Primary Care Trust who had been seconded to assist the CCG in activities such as intervention and monitoring.

RESOLVED that the minutes be agreed as a correct record.

131 QUESTIONS FROM COUNCILLORS OR MEMBERS OF THE PUBLIC

Written questions had been received from Mrs Susan Sulis, Secretary of the Community Care Protection Group.

The questions and the written answers are appended to the minutes.

132 MATTERS ARISING AND WORK PROGRAMME

CSD 17032

The Board noted the HWB Matters Arising and Work Programme report.

It was anticipated that the matter of 'Falls' would be discussed at the June meeting.

It was noted that the letter from the HWB to NHS England concerning the problems faced by local pharmacies had not been drafted. It was anticipated that the letter would be drafted shortly.

It was noted that Bromley CCG had been awarded full delegation of primary care commissioning.

It had been resolved previously that enquiries be made to see if a phlebotomy clinic could be hosted at Bromley Civic Centre. The update concerning this was still required.

RESOLVED that

(1) the letter from the HWB to NHS England concerning the problems faced by local pharmacies be drafted

(2) the Board is updated with the outcome of enquiries to see if a phlebotomy clinic could be hosted at Bromley Civic Centre

133 TRANSFORMING CARE REPORT

The Transforming Care report was drafted by Sonia Colwill (Director of Quality and Governance-Bromley CCG). The verbal presentation on the report was given by Andrew Royle (LBB Strategic Commissioner--Disability Services). The purpose of the report was to provide an update concerning those patients that fulfilled the requirements for the Care and Treatment Review.

The Board heard that there had been an increase in the number of children being referred into the Transforming Care Programme. This was a risk to both the CCG and LBB in terms of increased cost pressures as they turned 18 and needed to access adult health and care services.

Patients had to meet the relevant criteria to be accepted onto the Transforming

Care Programme. The patient would have an inpatient bed either for mental health and or for behavioural health care needs AND also would have learning disabilities or be on the autistic spectrum disorder.

The CCG had a mandatory obligation to report upon these patients, and would be held responsible for outcomes by NHS England. As of 10th March 2017, LBB had nine patients that fell within the Transforming Care Criteria.

The Vice Chairman asked why nothing was listed on the report under the heading of 'Financial Implications.' Mr Royle responded that this was because the financial risks were not quantifiable.

The Chairman suggested that it may be a good idea if the report was seen by the Care Services PDS Committee, but this was not a formal resolution of the Board.

RESOLVED that the Transforming Care report be noted.

134 PRIMARY CARE CO-COMMISSIONINIG UPDATE

Dr Bhan informed the Board that full delegation of commissioning to the CCG had now been granted. The term 'co-commissioning' would be obsolete going forward. It had been agreed that the CCG would need extra staff to help with the additional work involved, now that full delegation had been achieved. This being the case, it had been decided that some staff would be seconded from NHS England to assist. Dr Bhan mentioned that six south London CCGs worked collaboratively to share resources. A team was being established to take care of routine business administration functions.

Dr Bhan explained that the NHS would continue to manage complaints and the appointment of individual GPs. A Primary Care Team was being developed, and this would be managed by Jessica Arnold (Head of Primary and Community Care-Bromley CCG). The seconded team from the NHS would be managed by Southwark CCG, based at Skipton House. A Memorandum of Association (MOU) had been formulated between all of the six south London CCGs. There was also an MOU agreed between Southwark CCG and NHS England.

New protocols would be developed to deal with conflicts of interest. A Primary Care Committee had also been set up and was meeting on 4th May. Underneath the Primary Care Committee would sit a steering group and a clinical referral group. The membership of the Primary Care Committee would be the same as the Joint CCG Committee, with additional representation from the Local Medical Council (LMC). The final structure of the combined operating model would be decided in due course.

Dr Bhan informed the Board that the CCG had recently received their finalised budget allocation, and this was less than had been anticipated.

Dr Bhan reflected on some of the advantages of the new delegated structure:

- The improvement of Care Pathways

- Sensitive and specific work could be undertaken with GP practices
- Better monitoring of GPs, leading to better quality GPs
- The development and improvement of GP Practices
- CQC visits to GP surgeries would be programmed in-this was something new for GP surgeries

Dr Bhan notified the Board that one practice in Bromley had been rated as inadequate. She continued that there was currently a lack of GPs and Practice Nurses, and so the CCG had to consider what they could do to provide support in these circumstances. Councillor Evans asked what was wrong with the practice that had been found to be inadequate. Dr Bhan explained that this was to do with the organisation of the practice—issues such as systems, processes and training, but was not related to the provision of care and treatment.

The Chairman acknowledged the complexities involved, but was hopeful that delegated authority would assist with the integration process. He stated that this was a major change in healthcare provision. The Board noted that Dr Agnes Marossy was being seconded for an 18 month period to work with Bromley CCG.

Dr Lemic commented that LBB was only a small commissioner, but had previously liaised with NHS England. Now LBB would need to link with the CCG. It was also the case that NHS England would still commission some services and so it was important that all parties linked together properly.

RESOLVED that the Primary Care update be noted.

135 SUSTAINABILITY AND TRANSFORMATION PLANS VERBAL UPDATE

The Sustainability and Transformation Plan (STP) update was provided by Dr Bhan.

A Committee in Common was discussing the feasibility of three orthopaedic centres of excellence being developed in the south east instead of two. It was hoped that clarification around this would be achieved by the end of April. Community based care was developing around London. LBB was the leading borough in delivering ‘8-8’ care. This was being delivered by the Bromley GP Alliance. The Board heard that a new mental health group was being formed, and good developments were being made in renal and cardiac services. It was also the case that a review of estates was ongoing.

Dr Bhan and Dr Parson were engaged in the STP in different ways, and Dr Parson was leading on the development of clinical programmes. It was noted that there was an engagement gap that existed between the CCG and with local authorities and the public; the CCG were keen to support and develop engagement.

The Chairman was impressed with the energy and creativity that was being put into the process of developing the STP.

RESOLVED that the update on the STP plans be noted.

136 CAMHS TRANSFORMATION PLAN 2016/17 UPDATE

The CAMHs Transformation Plan update was written and presented by Daniel Taegtmeyer from Bromley CCG.

The Board was asked to note the outcomes arising from the first two years of the CAMHs Transformation Plan Implementation. The Board was also asked to note the proposed road map to implementing the full transformation by 2020. It was noted that the CAMHS Transformation Plans refresh had been developed collaboratively between the CCG, LBB and delivery and service sector partners.

Mr Taegtmeyer informed the Board that data indicated that:

- Improved experiences and outcomes were being reported
- More children and young people were entering the system now than ever before
- More young people were now getting their needs met earlier
- Fewer children and young people were needing to be referred onto specialist community CAMHs
- Referrals were coming from wider sources
- The majority of children and young people (CYP) were having their needs met in 6 sessions
- Presentations to A&E by children in crisis had remained stable
- Admissions to specialist hospitals had fallen by 36% in the last two years

However, it was still the case that too many young people were presenting in crisis, too many admitted to specialist hospitals and too many had been referred to the Eating Disorder Service.

Mr Taegtmeyer referred to the 'Future in Mind' report that was published by NHS England in March 2015. The report can be accessed via the following link: https://www.england.nhs.uk/blog/martin-mcshane-14/

'Future in Mind' (FIM) was a five year project running from 2015 to 2020. The aim of the project (which was supported by NHS funding) was to improve the wellbeing and mental health of CYP. Bromley CCG would receive £660.000 over this period to support the work locally.

The Board heard that the CAMHs Transformation Plan allocations for 2015-2016 to 2017-2018 were:

- Specialist eating disorder service
- Investment in the co-production programme
- Investment in a Tier 2.5 capacity initiative via a single point of access
- Autism support
- ASD/Complex Communication Disorder Diagnostic Service

- Investment in a School Resilience and School Responder Service
- Investment in a Tier 3 Capacity Initiative
- Investment in Bromley Y electronic data systems
- Waiting times initiative
- Health and Justice Capacity Initiative
- Youth Mental Health First Aid

Note--Bromley Y is a long established local charity offering free therapeutic support to young people between the ages of 0 - 18 years. The link to their web page is: https://www.bromleywellbeingcyp.org/about-us

The Board were informed that as a result of these allocations, patients had experienced a step by step improvement and greater accessibility to better quality services, and so more CYP had been able to have their emotional and mental health needs met earlier, and with quicker responses. School staff were now reporting more confidence in managing crisis presentations in schools. It was hoped that improved data collection and analysis would improve the commissioning of mental health services.

The Chairman and Dr Parson thought that the report was good news, and Dr Parson asked if there had been any change in the age range of the children and young people being referred. Mr Taegtmeyer responded that the main age for referrals was 14-16. The Board agreed that an update on progress should be submitted in 2018.

RESOLVED that the report be noted and that an update on the CAMHs Transformation Plan be brought back to the Board in 2018.

137 SOCIAL ISOLATION-LOCAL AWARENESS CAMPAIGN AND ACTION PLAN

This report was presented Alicia Munday (ECS Programme Manager) as Denise Mantell, was on maternity leave.

The report was presented to the HWB following on from the Adult Services Stakeholder Conference that had been held in November 2016. The report outlined the action plan that would drive the Social Inclusion Campaign. The campaign included the development of a social isolation resource on Bromley My Life, a Social Awareness Week and work by partners to assist people who were experiencing social isolation.

The Chairman was pleased with the report and thought that it was very positive.

RESOLVED that

(1) the action plan be agreed and that members of the Board promote the required actions within their individual agencies

(2) the Board receive an update on the Action Plan prior to the awareness

week in the Autumn

138 PHLEBOTOMY UPDATE

A review of phlebotomy services in hospitals had just been completed.

Three phlebotomy hubs were working across Bromley. These were located at Orpington, Penge and Bromley Town Centre. Places had not been filled as quickly as anticipated. The model seemed to be a good option. It was also the case that an anti-coagulation service was being developed.

RESOLVED that an update be brought to the Board in six months.

139 PRESENTATION FROM BROMLEY MY TIME

The Presentation from Bromley Mytime was delivered jointly by:

- Adam Smith—Leisure Division Manger
- Jason Stanton-Operations Director
- Debra Weekes—Partnership Manager
- Ann Wilbourn-Prime Time Manager

The Board heard that Mytime Active invested over £418,000 to make improvements to the Spa changing rooms, the West Wickham changing rooms and the soft play area at the Walnuts Leisure Centre. It was also noted that they had secured an additional £156,535 of external funding to deliver a range of community programmes. This was all part of a commitment to invest locally.

Mytime was committed to supporting under represented groups to become more active, with 59% of people benefiting from a discounted membership fee. Mytime hoped that they would be able to support LBB in some way in terms of strategy and direction.

The Board heard that Mytime was just coming to the end of a three year project with Sport England. A Bid had been submitted to raise funding that would provide more activities for older people.

The Board were provided with details of the ‘My Future Project’ that was taking place on the Ramsden Estate as it had been identified that more activities were required for young people on the estate. Free sport and dance activities had been provided since 2008. Another project that was mentioned was Artstrem, where work had been undertaken with Bromley College and other partners. This had been described as a ‘model of good practice’ by the Arts Council England.

Schemes for adults who were not active and had medical issues were also being run, this was part funded by the CCG. Two of these schemes were ‘Heart Start’ and ‘Fresh Start’. Individuals engaged on these schemes reported that they remained largely more active after completing the schemes. Just over half of them also reported an increase in self-esteem. Mytime were ambitious to increase the

number of people engaged, and would be happy to work with LBB to increase service provision. It was noted that they also ran a stroke prevention programme.

A full range of services was also offered to older people that were aged 60 and over, including those with learning disabilities. The services aimed to break the problems associated with isolation and to promote independence. This was achieved by running 80 classes per week in ten sites across the Borough. A new programme being developed in conjunction with MENCAP was planned for after Easter.

The Chairman enquired what LBB could do to assist. Mr Smith responded that Mytime was looking to create self-sustaining pathways. He asked that the Board think of the services that they provided, and engage with them. He asked that GP's promote the Fresh Start and Heart Smart programmes.

Colin Mclean noted the social prescribing element and cautioned against duplication.

Cllr Bennett enquired how much could be done practically to assist the frail elderly. The response was that some sessions were specifically designed for people with disabilities and for people who were nervous in the water. The relevant adjustments could be made, and instructors would be provided with extra training if appropriate. It was noted that the oldest member lived in Biggin Hill and was aged 93.

RESOLVED that the Mytime update be noted.

140 BETTER CARE FUND 2016/2017 PERFORMANCE UPDATE

The report provided an overview of the third quarter performance of the Better Care Fund for 2016/17, for both the expenditure and activity levels to the end of December 2016.

The report was presented to the HWB as it was the second performance report on the Better Care Fund 2016/17, and the Board needed to be kept informed of the position of the pooled fund and the progress of the locally agreed Better Care Fund schemes.

The Board was being asked to note the report and the latest financial position, performance and progress of the Better Care Fund Schemes.

Dr Bhan updated the Board and commenced by stating that more equipment had been provided for care homes. More care was being provided for those patients that were leaving hospital. The success of the Dementia Hub was noted.

Projects had been developed to increase support to care homes. A rapid response service had been developed to provide an alternative to the 999 service.

Another scheme that had been developed was the 'red bag' scheme.
When a care home resident needed to go into a hospital, a red bag was packed

for them. It contained their details, vital information about their health conditions, supplies of medicine, and a change of clothes for when they were ready to be discharged. It would also include their care passport. This had succeeded in reducing the average time of stay in hospital for elderly people from 12 days to eight days.

Resources were also being used to support the Transfer of Care Bureau (TOCB). A formal review of the TOCB was being undertaken as there had been issues around services connected to the TOCB not integrating properly.

The Chairman stated that the HWB had a statutory duty to sign off BCF funding.

Cllr Dunn referred to page 4 of the report that referenced delayed transfers of care. The report stated that there had been 2385 delayed transfers of care in quarter three, and that Bromley had not achieved the number of planned reductions for that quarter. Cllr Dunn queried how the delayed transfer of care numbers could be valued. It was agreed that this was a matter that could be looked at in the June meeting.

RESOLVED that the value of delayed transfers be looked at in the June meeting.

141 THE IRIS PROJECT

This item was deferred to the June meeting.

142 EMERGING ISSUES

No emerging issues had been identified by members for consideration.

143 INTEGRATED CARE NETWORKS UPDATE REPORT

A paper had been written for the attention of the Board by Daniel Knight (Interim Project Manager-Bromley CCG).

The Board heard that the ‘Proactive Pathway’ had been mobilised at the end of October 2016 and good progress has been made with weekly integrated Multidisciplinary Team meetings (MDTs) now happening across all three networks. Since the last report to the Health and Wellbeing Board in November 2016, the CCG had received a report from providers on the first 100 patients to go through the Proactive Care Pathway. It was too soon to assess the full impact of the pathway; there had been positive case studies. A dashboard was being developed to monitor patient activity before and after the patient entered the Proactive Pathway; this dashboard would be monitored via the ICN steering group. An independent quantitative and qualitative evaluation of the ICN Proactive Pathway had been commissioned by the CCG and was being undertaken by the Health Innovation Network (HIN), with a final report expected to the CCG in July 2017.

Some delay against the plan had been experienced due to a slippage in recruitment. Dr Bhan stated that a recovery plan was in place.

A new Frailty Unit had been developed which had made a significant positive impact on care pathways. Dr Bhan stated that she would like to get colleagues from social care more involved.

RESOLVED that an ICN update be brought to the meeting in September.

144 BRIEFING NOTE ON THE PHARMACEUTICAL NEEDS ASSESSMENT 2018

The Board noted the briefing report.

The Board was informed that a draft PNA would be presented to members for consideration in September. This would be followed by a 61 day consultation period.

RESOLVED that a draft PNA would be presented to the Board for consideration in September.

145 DEVELOPMENT OF THE TRANSFER OF CARE BUREAU

An update on the TOCB was provided in the BCF update.

146 ANY OTHER BUSINESS

No other business was discussed.

147 DATE OF THE NEXT MEETING

The next meeting is scheduled for Thursday 15th June 2017 at 1.30pm.

The meeting will take place in Bromley Civic Centre.

WRITTEN QUESTIONS TO THE BOARD

The Meeting ended at 3.09 pm

HEALTH AND WELLBEING BOARD
30th March 2017

WRITTEN QUESTIONS TO THE HEALTH AND WELLBEING BOARD

Written Questions to the Health and Wellbeing Board received from Mrs Susan Sulis, Secretary, Community Care Protection Group

With regard to 'The State of Child Health' report by the Royal College of Paediatrics and Child Health published on 26th January 2017:

1) The RCPCH reports that "those from the most deprived backgrounds experience much worse health, compared to the most affluent".

   Although Bromley has identified areas of serious deprivation in the borough, why does the Council not link this issue, and identify the actions needed to ameliorate the effects of poverty?

2) The RCPCH explains that poor nutrition, caused by poverty produces obesity, along with other factors, linked to poverty.

   Does the Director of Public Health acknowledge the relationship?

3) Besides removing barriers to provision of free food by Bromley Foodbanks, like the commercial rent the Council charges Orpington Foodbank, what other steps should the Council take to improve nutrition for poor Bromley children?

Answers:

1) Deprivation is taken into account when providing health services in the Borough. Community Health Services such as Health Visitors allocate the Health Visiting staff to areas using a formula which uses indicators of deprivation. Addressing inequalities in health, including those due to deprivation, is part of the role of Community Health Services.

2) The causes of obesity are complex. Although it is true that obesity rates are higher in more deprived areas, this will also be linked to physical exercise and eating behaviour as well as nutrition.

3) Health Visitors work closely with the staff in the Children and Family Centres. These centres work hard to engage families from more deprived areas. Parenting groups include information about nutrition and this is also part of the role of the Health Visitor. All Health Visitors and Children and Family Centre staff have been trained in supporting young families around nutrition.

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London Borough of Bromley—Health and Wellbeing Report

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**7 September 2017**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**Social Isolation – Local Awareness Campaign and Action Plan Update**
Contact Officer:	Denise Mantell, Strategic & Business Support Tel: 020 8313 4113 E-mail: denise.mantell@bromley.gov.uk
Chief Officer:	Ade Adetosoye OBE, Deputy Chief Executive & Executive Director, Education, Care and Health
Ward:	N/A

1. Summary

The Adult Services Stakeholder Conference on social isolation was held in November 2016. The Health and Wellbeing Board received the subsequent action plan at its meeting in March. This report outlines progress on the action plan that will drive the Social Inclusion campaign, including the development of a social isolation resource on Bromley MyLife, a Social Isolation Awareness Month in the autumn, work by partners to assist people who are experiencing social isolation and baseline KPI information from the annual and biennial national surveys.

2. Reason for Report going to Health and Wellbeing Board

2.1 In March the Health and Wellbeing Board agreed to the action plan to develop awareness and knowledge of social isolation and organise a campaign to signpost people experiencing social isolation. The Board asked that an update on the action plan be brought to the Board in September 2017.

3. Recommendations

3.1 Members of the Health and Wellbeing Board are asked to note the progress on the action plan and to promote these actions, including the Social Isolation Awareness Month, within their individual agencies.

3.2 That the Board note the measures by which social isolation can be measured in Bromley in comparison to other authorities in England.

3.3 That Board members advise of additional ways to advertise the Social Isolation Awareness Month throughout Bromley.

Health & Wellbeing Strategy

1. Related priority: Diabetes Hypertension Obesity Anxiety and Depression Children with Complex Needs and Disabilities Children with Mental and Emotional Health Problems Children Referred to Children's Social Care Dementia Supporting Carers

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Financial

1. Cost of proposal: Not Applicable:

2. Ongoing costs: Not Applicable:

3. Total savings: Not Applicable:

4. Budget host organisation:

5. Source of funding:

6. Beneficiary/beneficiaries of any savings:

Supporting Public Health Outcome Indicator(s)

Yes

4. COMMENTARY

4.1. The issue of social isolation was highlighted at the Adult Services Stakeholder Conference held in November 2016. Social isolation can affect a number of vulnerable groups such as the elderly, people with physical disabilities, learning disabilities or mental ill-health, young parents and care leavers without a local support structure. Carers can also be impacted especially when they are caring many hours a week. Social isolation can impact on an individual's physical and mental wellbeing as well as leaving them at greater risk of abuse.

4.2. The recommendations developed as an outcome of the Social Isolation Conference were consolidated into an action plan and the Health and Wellbeing Board agreed at its meeting in March to support the campaign to raise awareness of social isolation and signpost people to services and activities. An update on the action plan was requested for September 2017.

ACTION PLAN

4.3. The updated Social Isolation Action Plan (Appendix 1) outlines progress on the various workstreams for the London Borough of Bromley and the Health and Wellbeing Board members to carry out in order to raise awareness of social isolation and to prevent vulnerable individuals becoming socially isolated.

4.4. The Action Plan covers the following main areas:

- Developing a Social Isolation section on Bromley MyLife focussing on 3 areas:
    1. Information on social isolation in Bromley for use by third sector organisations in planning services and supporting bids for grant-funding from national and regional bodies

2. Providing information on activities for individuals to access and also organisations which signpost
3. Information and suggestions for individuals or community organisations who want to volunteer or organise activities for people who are socially isolated

- A Social Isolation Awareness Campaign in November which informs organisations about social isolation and its impact whilst encouraging individuals to take part in activities through invitations to community activities or befriending activities in their own homes.
- A number of specific actions by partners using various methods to decrease social isolation and increase take up of activities.
- Work being undertaken with groups of potentially vulnerable individuals aimed to prevent them becoming socially isolated.

4.5. There has been some delay in developing the Bromley MyLife Social Isolation area for the third sector due to staffing issues in late spring and the summer. However, it is anticipated that work commencing in mid-August will make information available in the autumn as indicated on the revised timescales shown in the action plan.

4.6. During the summer the tendering for the Primary and Secondary Intervention Service has progressed and now been awarded. In addition, the social prescribing portal for the Proactive Care and Elderly Frail pilot of the Integrated Care Network has been developed and begun to be used. Both these services provide information and sign-posting about activities which can alleviate social isolation, therefore discussions are being held in August between commissioners, the Bromley Third Sector Enterprise and Bromley MyLife to ensure that the three projects go forward in alignment and that there is no unnecessary use of resources and duplication of information. Information on activities will be available for Social Isolation Awareness Month.

4.7. It was originally envisioned that a Social Isolation Week would be held in the autumn. However, it was realised that extending it to a month would give more flexibility to promote awareness of social isolation and for organisations to hold local events. Therefore, November has been chosen as the Social Isolation Awareness Month which will encompass Self-Care Week, which will link in with the campaign. The month would focus on:

- raising awareness of the impact of social isolation on individuals with community groups, local businesses and health and social care professionals and encouraging them to reach out to those members of their communities who would wish to increase their links with individuals and groups.
- targeting those who are socially isolated and encourage them to join schemes that provide befriending for those unable to leave their homes or that offer transport to activities or to take part in new activities and interest groups or to restart interests that have lapsed.

The Bromley Communications and Engagement Network, comprising health and social care commissioner and provider leads, will play a key part in advertising the month to their staff and service users.

4.8. A number of the actions are focussed on promoting existing services such as Adult Education and Children and Family Centres to those who are socially isolated or using existing channels to promote these and other activities. One of the outcomes of the Adult Education service, which was previously re-configured, is to build skills such as language, literacy and numeracy as well as providing opportunities for more specialist skills and activities which will mitigate against social isolation. The re-tendered Family Nurse Partnership and Health Visitor service continues to promote the use of the Children and Family Centres by being located there and sign-posting to services and activities.

4.9. During the year services have been developed or are starting in the near future which link into social isolation and so these have been added to the action plan. Linkages are being made with these services so that those who are already isolated or at risk of isolation can be sign-posted to the services and activities identified as part of the Social Isolation Awareness Campaign. These include:

- The Care Navigators in the Integrated Care Networks.
- The Transfer of Care Bureau – many older patients who are being discharged from hospital do not have levels of need for services but have no other local support and they would benefit from being supported to access befriending services or other local activities.
- More Homes for Bromley – support for those in temporary accommodation to access local activities.
- Primary and Secondary Intervention Service – those with low level needs will benefit from becoming more involved in their community and mitigate against becoming socially isolated.

4.10. The actions are built around number of approaches which are proven to impact positively on social isolation:

- Understanding that communities are a source of opportunities and strengths through the resources of individuals and community groups of all kinds. Communities are not limited to geographical areas but also to common interests or life events;
- Utilising community spaces, such as libraries, halls, churches and green spaces as well as using venues such as cafes, pubs and cinemas;
- Building skills of individuals including language skills and use of technology especially social media;
- Preventing social isolation from developing by supporting people to connect to their communities and neighbours especially at times of changes in their lives.

OUTCOMES

For Individuals and Community Groups

4.11. It is envisaged that achieving the objectives in the action plan will lead to outcomes including:

- Greater understanding of social isolation and its impact on individuals among residents and community groups;
- Community groups and third sector organisations will be able to attract more funding into the borough to tackle social isolation due to readily available information about socially isolation, its impact in Bromley and activities that work;
- New activities are created by community groups and other organisations whilst promoting existing activities to new members;
- Individuals and families will be able to easily locate appropriate services and activities to increase contact outside the home. Professionals and volunteers will be able to signpost individuals to activities, peer support, befriending and services to reduce their social isolation;
- More people will have the opportunity to take part in community activities and local services;
- An increase in residents building skills which will increase opportunities for employment and connecting with their families, friends and communities;
- Specific groups of residents at risk of social isolation including young parents, care leavers and those in temporary accommodation will receive information and support to

form relationships and support groups in their new circumstances and take part in activities in their neighbourhood;
- Increased opportunities to volunteer which itself mitigates against social isolation;
- More residents are aware that their socially isolated neighbours will be more vulnerable to abuse, particularly financial abuse and scams, and know how to report concerns;
- Increasing the numbers of people volunteering in the community.

For Health and Social Care

4.12. Research has shown that people who are socially isolated and feel lonely are more likely to visit their GP or Accident and Emergency department, be admitted to hospital or move into a care home. This is because of the impact of social isolation on their physical health and mental wellbeing. Social isolation can increase levels of physical inactivity which leads to a greater likelihood of developing long term conditions.

4.13. Therefore working to connect people who are socially isolated with others, or prevent social isolation from developing, will lead to better physical outcomes for individuals as well as increased mental wellbeing. In turn this should lead to a reduced or delayed need to access health and social care services. These include:
- Reducing numbers of GP visits because of a health issue due to social isolation or because individuals do not feel they have anyone to talk to about their feelings.
- Reducing visits to A&E and re-admissions by those who are socially isolated.
- Delaying the need for social care support.
- Reducing the risk of financial abuse and being victims of scams among older people as well as other types of abuse.

KEY PERFORMANCE INDICATORS

4.14. The Adult Social Care Survey and Carers Survey were carried out in 2016/17 with a sample of those receiving services from Bromley Council and those known to Bromley Council as having a caring role. Combined they show that 277 (28%) of the 974 respondents stated that they do not have as much social contact as they would like and 71 of these said that they are socially isolated.

4.15. National data is now available for the Carers Survey and this shows that fewer carers (11.3%) in Bromley stated they are socially isolated than nationally (16.%). National data is not available for the Adult Social Care Survey until mid-September, but the 2015/16 survey had 158 individuals (24.4%) stating they did not have as much social contact as they would like and 41 people (6.2%) of these said that they are socially isolated.

	Adult Social Care Survey 2015/16		Carers Survey 2016/17	
	Bromley	England	Bromley	England
Have some social contact, but not enough	18.2%	16.3%	33.8%	48.3%
Have little social contact and feel socially isolated	6.2%	4.3%	11.3%	16.2%
Total	24.4%	20.6%	45.1%	64.5%

4.16. For those not known to social care the new Primary and Secondary Intervention Service have a number of monitoring outcomes related to those using befriending services, a sitting service and peer support groups all of which can help individuals and carers to be less socially isolated. Measuring the impact of this service on reducing social isolation is also under discussion.

5. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

Vulnerable people and children are more likely to be abused if they are socially isolated. Social isolation can also have an impact on an individual's physical health and their wellbeing. The actions outlined in this report will help partner organisations and individuals find local support which can help prevent social isolation for adults and so reduce its impact. One of the actions is to raise awareness of the vulnerability of older residents who are socially isolated to scams and financial abuse.

6. FINANCIAL IMPLICATIONS

Not applicable.

7. LEGAL IMPLICATIONS

8. Not applicable.

Bromley Health and Wellbeing Board
Social Isolation Action Plan

	Recommend-ation	Actions	Timescale	Lead	Agency	Progress
Recommendation 1: Bromley MyLife Social Isolation Area						
1.1	Provide support for 3rd Sector in planning services	1.1.1 Develop a profile of the local population potentially at risk of social isolation through links to the JSNA etc	*2016 JSNA- September 17* 2017 JSNA– October/ November 17	Michael Watts/ Helen Buttivant	SBSS, LBB	Delayed due to staffing issues Information from JSNA 2016 will be identified and included on the professionals area JSNA 2017 - information relevant to social isolation will be identified and added to Bromley MyLife NB It was proposed that the new HWB Strategy will include the issue of social isolation
		1.1.2 Map responses to the social isolation question from the Adult Services Care Survey (ASCS) and Carers Survey at ward level and below	15/16 data – April 17 16/17 data – September 17	Andy Edney	ICT, LBB	Data produced for 3 maps: ASCS 15/16 ASCS 16/17

	Recommend-ation	Actions	Timescale	Lead	Agency	Progress
						Carers 16/17
		1.1.3 Map local and national work identifying people at risk of social isolation and methods of support	September 17	Denise Mantell/ Josepha Reynolds	SBSS, LBB	Information gathered and to be uploaded to Bromley MyLife
		1.1.4 Update maps detailing location of Bromley support services on MyLife	*September 17*	Michael Watts	SBSS, LBB	Delayed due to staffing issues

	Recommend-ation	Actions	Timescale	Lead	Agency	Progress
1.2	Provide information for individuals and organisations who signpost	1.2.1 Improve signposting and tagging throughout MyLife to enable individuals and organisations to identify services and activities which may support people at risk of social isolation	*August - October 17*	Michael Watts	SBSS, LBB	Initial work delayed due to staffing. On-going discussions with partners in the voluntary sector to ensure a joint approach is taken in the provision of such information to avoid duplication.
		1.2.2 Voluntary sector and communities to provide information on their services and others known to them	*September – October 17*	Denise Mantell	SBSS, LBB	See above 1.2.1
		1.2.3 Create a form to search all activities/services on MyLife by geographical area, age and type of activity	*September – October 17*	Michael Watts	SBSS, LBB	Delayed due to staffing issues
		1.2.4 Carry out an awareness campaign with the voluntary sector that they can update their information themselves	*December 17*	Michael Watts	SBSS, LBB	Delayed due to staffing issues

	Recommend-ation	Actions	Timescale	Lead	Agency	Progress
1.3	How individuals and community groups can help people who are socially isolated or at risk	1.3.1 Develop a section containing information about how individuals can help those who are socially isolated on a one to one basis	September – October 17	Denise Mantell/ Michael Watts	SBSS, LBB	In progress
		1.3.2 Identify existing national and local schemes in Bromley and schemes being run elsewhere	September – October 17	Denise Mantell/ Michael Watts		In progress

	Recommend-ation	Actions	Timescale	Lead	Agency	Progress
Recommendation 2: Social Isolation Awareness Campaign						
2.1	Develop promotion materials for Bromley MyLife Social Isolation area and awareness week	2.1.1 Refine and produce publicity materials	September 17	Michael Watts		
2.2	Organise an awareness month – November 17	2.2.1 Promote with bodies such as Domiciliary Care Forum, town centre and high street organisations	July – October 2017	Denise Mantell	SBSS, LBB	In progress
		2.2.2 HWB members to promote awareness of social isolation in their organisations	July – October 2017	Cllr Jefferys	HWB members	
		2.2.3 Awareness events/promotion of activities to be organised by statutory sector, voluntary and community groups and housing associations	July – October 2017	Co-ordination – Denise Mantell	Individual agencies and groups	In progress
		2.2.4 Promote events on Bromley MyLife	*October - Nov 2017*	Michael Watts	SBSS, LBB	
2.3	Promote with Bromley Federation of Housing Associations	Present item on social isolation workstreams to Federation's annual conference	*Autumn 2017*	Denise Mantell	SBSS, LBB	Meeting deferred to the autumn

	Recommend-ation	Actions	Timescale	Lead	Agency	Progress
Recommendation 3: Increase Social Prescribing in Bromley						
3.1	Pilot social prescribing as part of the Integrated Care Network	3.1.1.Community Links Bromley is leading a BTSE project to develop a social prescribing portal for the Proactive Care and Elderly Frail pilot	April 17 – April 18	Colin Maclean	CLB/BTSE	The social prescribing database for older people and their carers began on 13 July 2017 and is now being used by the Care Navigators to signpost to activities
Recommendation 4: Social Care Newsletter to all residents						
4.1	Include a section on Social Isolation in Council Newsletters	4.1.1 Write article including references to MyLife section	Autumn 17	Denise Mantell	SBSS, LBB	Item linking social isolation and scams/ financial abuse to be included in Community Safety Partnership autumn newsletter

	Recommend-ation	Actions	Timescale	Lead	Agency	Progress
Recommendation 5: Social Isolation is part of all Health and Wellbeing Members Planning in Bromley						
5.1	Link with Better Care Fund projects which have a social isolation prevention element	5.1.1 Development and launch of the Primary and Secondary Intervention Service	October 17	Alicia Munday/ Josepha Reynolds	Health Integration Programme, LBB/CCG	New service to begin on 1 October including specific elements to alleviate social isolation. Links to the social isolation work are being made.
		5.1.2 Launch and development of Goodgym project	March 17	Sarah Wemborne	Health Integration Programme, LBB/CCG	Programme launched in March 17, but disappointing attendance has led to re-locating the runs in the Penge area at the end of July since when greater attendance has been seen. So far group projects have taken place, but no 1 to1 sessions.
		5.1.3 Work with the Transfer of Care Bureau to make resources produced for Social Isolation Awareness Campaign available to those being discharged from hospital	September-November 17	Denise Mantell/Jodie Adkin	CCG/SBSS, LBB	Initial discussions have taken place to utilise social isolation awareness resources with appropriate patients.

	Recommend-ation	Actions	Timescale	Lead	Agency	Progress
Recommendation 6: Raise awareness of Adult Education services						
6.1	Include Adult Education services on Bromley MyLife	6.1.1 Update Adult Education information on Bromley MyLife as needed	Spring 17 *and ongoing*	Carol Arnfield	Adult Education, LBB	Completed and on-going for each academic year
		6.1.2 Promote Adult Education area on MyLife	Summer 17 *and ongoing*	Michael Watts	SBSS, LBB	Completed
Recommendation 7: Intergenerational Work to tackle social isolation						
7.1	Understand extent of intergenerational work already taking place in borough	7.1.1 Investigate intergenerational work with Affinity Sutton	*August-October 17*	Denise Mantell	SBSS, LBB	
		7.1.2 Explore any intergenerational work undertaken through schools	*September - October 17*	Denise Mantell	SBSS, LBB	
		7.1.3 Explore intergenerational work with Bromley Youth Council	*September - October 17*	Denise Mantell	SBSS, LBB	
7.2	Promote examples of intergenerational work from outside borough	7.2.2 Research other projects eg North/South London Cares	May – September 17	Denise Mantell	SBSS, LBB	In progress

	Recommend-ation	Actions	Timescale	Lead	Agency	Progress
Recommendation 8: Tackling social isolation among Care Leavers and Young Parents						
8.1	Care Leavers are supported to integrate with the community they are settled in	8.1.1 Work with support providers to ensure they are aware of all relevant community activities and opportunities in the area	May – September 17	Sara Bowrey	Housing Needs, LBB	
8.2	Young parents are signposted to information on services and activities in their community	8.2.1 Family Nurse Partnership and Health Visitors to promote activities and services when in contact with young parents and link to Children's Centres to prevent social isolation	Summer 17 On-going	Jenny Selway	Public Health, LBB	New contract to start on 1 October. Sign-posting to services and activities will continue. Integration with Early Intervention and Family Support service will support this work.
		8.2.2 Children and Family Centres promote activities and services through Bromley MyLife	October 17	Rachel Dunley	CSC, LBB	Calendar of activities at each Children and Family Centre are on Bromley MyLife
New Recommendation: Promoting local activities with those in temporary accommodation						
9.1	Those in temporary accommodation are supported to connect with their new communities	9.1 Promote activities on Bromley MyLife with existing and new schemes such as More Homes for Bromley	From Oct 17	Denise Mantell/Sara Bowrey	Housing Needs/ SBSS, LBB	

Key

BTSE – Bromley Third Sector Enterprise
CCG – Clinical Commissioning Group
CLB – Community Links Bromley
CSC – Children's Social Care
ICT – Information and Communications Technology
LBB – London Borough of Bromley
SBSS - Strategic & Business Support Services

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**7th September 2017**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**The IRIS Project (Identification and Referral to Improve Safety) in Bromley**
Contact Officer:	*Rachel Nicholas* *Contract Manager: Victim Support* Tel: 07824896099 Rachel.Nicholas@victimsupport.org.uk *Bob Parker* *Interim Safeguarding Adults Project Lead: BCCG* Tel: 01689 866156 bobparker@nhs.net ,
Chief Officer:	Angela Bhan
Ward:	All wards

1. Summary

Since November 2015, GP practices in Bromley have benefitted from the IRIS Project (Identification and Referral to Improve Safety) which was commissioned in response to a Domestic Homicide Review following the death of a Bromley resident in November 2013. At least 6 Domestic Homicide Reviews in the South of London have recommended improvement in detection of domestic violence and early intervention from GPs or other health providers.

Bromley Clinical Commissioning Group has been in partnership with Victim Support since November 2015 to provide training and support to GP practices in Bromley around domestic violence/abuse. This is a local Project supported by the National IRIS Team, and funded by the Mayor's Office on Police and Crime (MOPAC), with additional financial support from BCCG for the GP Clinical Lead.

IRIS develops responses to improve early detection and develop support pathways for domestic violence within General Practice. The service delivers a training and support programme targeted at primary care clinicians and administrative staff leading to improved numbers and quality of referrals to specialist domestic abuse services, and improved recording and identification of women experiencing domestic abuse.

The IRIS model of care provides GP practices with:-

- Local named Independent Domestic Violence and abuse Advocate-Educators (IDVA-E) who receive all referrals from clinicians and provide feedback to those clinicians. They are hosted by the Domestic Violence and Abuse (DVA) specialist third sector organisation (Victim Support).
- Very-direct care pathways to access specialist local DVA services by integrating third sector organisations with Primary Care.
- Free on-site customised health-focused DVA training delivered by a local GP (who is trained to be a clinical specialist in DVA) and the IDVA-E.

The GP Clinical Lead supports local practices by promoting IRIS services and attends appropriate steering groups and Professional DVA forums. The GP Clinical Lead also provides ongoing support to nominated practices as outlined in the GP Clinical Lead Job Description.

As the only stakeholder group that consistently and actively engages with both victims and perpetrators, GP surgery staff have a crucial role in identifying domestic abuse and in preventing homicides. GPs are well placed to identify both victims and perpetrators through connected health needs including amongst other things injury, depression and substance misuse. The information held by GPs is often invaluable, it helps 'fill the gaps', especially when a victim and/or perpetrator has not had contact with any other statutory body.

IRIS Project surveys indicate women attending intervention practices were 22 times more likely than those attending control practices to have a discussion with their clinician about a referral to an advocate. This resulted in them being six times more likely to be referred to an advocate. Women attending intervention practices were three times more likely than those attending control practices to have a recorded identification of DVA in their medical record.

By having a designated role providing specialist advice, training and support to clinical staff working in Primary Care, the Project has improved awareness of both the impact of domestic violence amongst patients and identified how best to support the patient's needs in relation to the offenses. Evidence from other areas show that almost 50% of supported victims will report to the police, compared with just 16% of unsupported victims, as reported in the Home Office document 'Crime in England & Wales' 2008/9.

Progress of the Bromley IRIS Project:
Year 1 of the Project encountered initial challenges, and was not as effective as planned, despite remedial efforts. There was some progress to build upon, but this fell short of the targets that had been set (25 GP practices involved in the Project by year end out of 45 total practices). In Autumn 2016 new personnel were brought into the Project and it was re-launched. This resulted in greatly increased activity and improved quality such that the original targets were largely met by August 2017 (25 practices have commenced training, of those 19 are fully trained, and the others are booked onto the final training sessions).

Bromley IDVA-Es support survivors by providing crisis intervention work, this includes: risk assessment, safety planning, support through the Criminal Justice system, and multi-agency working with agencies such as Social Services and Police. The IDVA-E will also advocate for survivors with agencies such as children's services to ensure the survivors wishes and feelings are heard. Additionally, the AE provides a safe place for the survivor to talk and being believed is a huge first step to overcoming the abuse.

Most reassuringly, 89 referrals have been made into the IRIS service by Bromley GPs in the period from December 2016 to mid-August 2017. This is a very significant increase in referrals from GP practices in the previous year; such early intervention and referral is vital to support victims break the cycle of abuse There have also been 5 referrals to Bromley MARAC (Multi-agency Risk Assessment Conference) of complicated high-risk cases that needed a holistic multi-agency approach. The work of the project has also directly led to over a dozen reports of offences to the Police and, to date, 3 successful prosecutions of perpetrators of Domestic Violence in the Borough of Bromley.

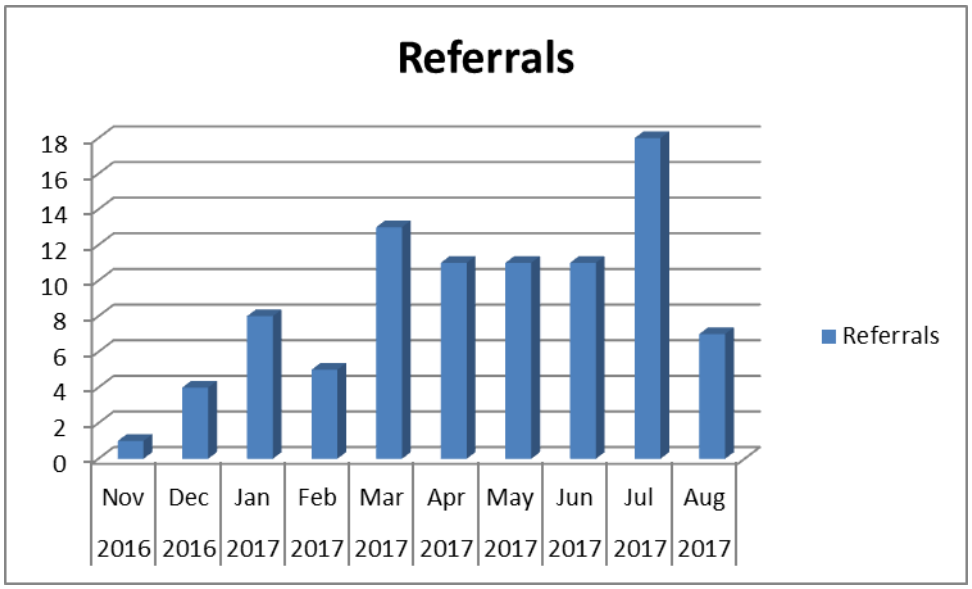
The IRIS Project also has strong links with the other DV services in the Borough of Bromley, including (from a health perspective) the provision of IDVA services in A & E, which have been shown to be effective at identifying those victims who either are not GP registered or who effectively cannot use their GP due to perpetrator coercion etc.

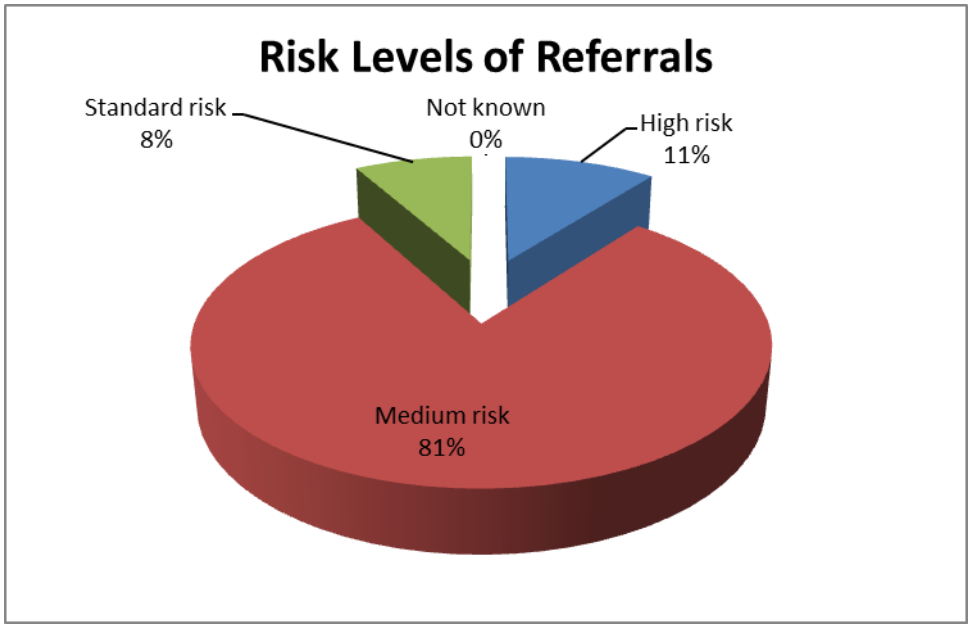
Quotes from Bromley clients:

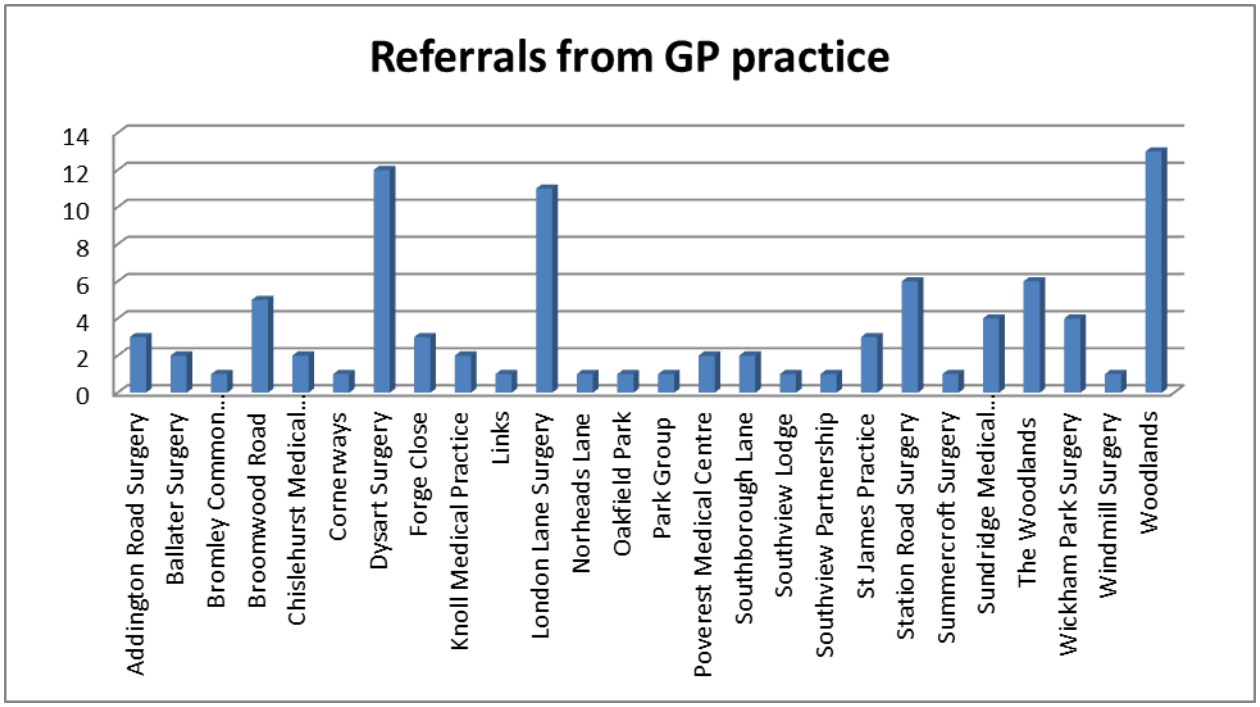
- “thank you so much for all your help, you’ve been my light at the end of the tunnel”
- “even after speaking to you once, I feel so much better to know someone cares”
- “having you to talk to has given me the strength to make these changes”

Quotes from Bromley GPs:

- “The training should be mandatory for all NHS staff”
- “Knowing [the IDVA-E] provides an amazing element to supporting patients, we are able to say we know her and trust her”
- “IRIS has allowed us to transform how we support patients”







Funding:

MOPAC funding for the pilot IDVA-E post-holder to continue work with the original 25 practices has been secured until the end of March 2018 (25 practices is the maximum capacity that the IRIS model will allow 1 wte IDVA-E to support). However, MOPAC has not provided further funding beyond this date, nor will MOPAC provide additional funding to extend the project to other GP practices during 2017. MOPAC funding is intended as pilot funding and is not an alternative to permanent funding. BCCG has approved funding for the GP Clinical Lead until end of March 2019.

There is a funding gap for a pro rata IDVA-E post to work with the remaining 20 GP practices that were not part of the first tranche during the period to end of March 2018. BCCG and its partners are actively considering what other sources of funding might be available to provide a pro-rata IDVA-E for these practices.

Longer-term, evidence from other areas shows that DV referrals from GP practices tend to tail-off if dedicated support is withdrawn – not least because of GP practice staff turnaround over time. We therefore consider that it would be an advantage to have a permanent dedicated GP Domestic Violence Champion within Bromley and permanent IDVA resources focussed upon women (and those men) who attend their GP for whom domestic abuse is an issue.

2. Reason for Report going to Health and Wellbeing Board

The purpose of bringing this report to the Board's attention is that it provides a powerful and practical example of how local innovation, partnership and good practice has had a significant impact upon the lives of (mostly) women and their children in Bromley, and the necessity of exploring ways in which this support can be made permanent. The report raises the issue of the ongoing need for domestic violence services within Bromley, and the desirability of providing support to GP practices through the services of a permanent GP Domestic Abuse Champion and dedicated IDVA resources.

This report directly links to the Joint Stratgic Needs Assessment (JSNA) 2016 at section 3: Domestic Abuse. The Executive Summary concludes '*There is a need for increased education and awareness of domestic violence and the domestic violence services available in Bromley.*

Domestic Abuse is the third priority area for the Bromley-wide Strategic Safety Partnership 2017 -19.

3. SPECIFIC ACTION REQUIRED BY HEALTH AND WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

Whilst this report does not specifically require actions from any other organisation, it is relevant to the strategic priorities of the Bromley Community Safety Partnership, Bromley Safeguarding Children's Board, Bromley Safeguarding Adults Board, London Borough of Bromley, NHS England (London) and NHS health provider organisations, and Third Sector partners such as Victim Support and Bromley & Croydon Women's Aid.

Health & Wellbeing Strategy

1. Related priorities:

- Anxiety & Depression,
- Children with Mental & Emotional Health Problems,
- Children Referred to Children's Social Care,
- Supporting Carers.

Financial

1. Cost of proposal: Not Applicable:

2. Ongoing costs: Not Applicable:

3. Total savings: Not Applicable:

4. Budget host organisation:

5. Source of funding:

6. Beneficiary/beneficiaries of any savings:

Supporting Public Health Outcome Indicator(s)

Yes: Public Health Outcome Indicator 1.11 (August 2016).

The Bromley IRIS Project offers provisions in line with the NICE public health guidance on domestic violence and abuse (PH50) which recommends offering specialist advice, advocacy and support in settings where people may be identified or may disclose that domestic violence and abuse is occurring.

4. COMMENTARY

5. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

The Bromley IRIS Project has had a direct and measurable impact upon the health & wellbeing of women (mainly) who are subject to domestic abuse and of their children.

Whilst the Health & Wellbeing Strategy 2012-15 does not specifically address domestic abuse/violence, it is undoubtedly the case that it impinges on several of its key priorities relating to mental health, and to the wellbeing of children and young people, and of other vulnerable people in Bromley (domestic abuse may occur in any familial setting and may include people who have a disability, mental health issue or who are older people; and is an issue for both heterosexual and LGBTQI people).

6. FINANCIAL IMPLICATIONS

The cost of Domestic Abuse in Bromley

Female population in Bromley over the age of 15 years: Number of victims of domestic abuse based on population size (Home Office) as reported in 'The Cost of Domestic Violence': September 2004, Professor Sylvia Walby (University of Leeds).

16-59 year olds (male & female) (1000)	Physical & mental health care costs	Criminal justice costs	Social services costs	Housing and refugee	Civil legal services	Lost economic output	Total costs (not including human & emotional)	Human & emotional costs
156	£9.6m	£7.0m	£1.6m	£1.1m	£2.1m	£10.6m	£31.9m	£54.9m

These equate to a cost per person per year:

£6,154 per person for health; £20,450 per person overall.

According to a report by the Domestic Abuse & Violence Against Women and Girls Commissioner for the London Borough of Bromley the most accurate (95%) figures for the following years are:-

- 2011/12 - 1413 cases reported as DVA incidents = cost to health £8,695,602.00
- 2012/13 – 1412 cases reported as DVA incidents = cost to health £8,689,448.00

www.statisticsauthority.gov.uk//assessment-report-102-crime-statistics-in-england-and-wales

These figures cannot quantify the wider impact of domestic abuse and violence within Bromley, but we know from research and professional experience that children and other vulnerable family members are at risk within households where domestic abuse/violence is apparent, and that this is likely to have both direct and indirect lifelong consequences for the physical and mental health of children in particular.

7. LEGAL IMPLICATIONS

None identified.

8. IMPLICATIONS FOR OTHER GOVERNANCE ARRANGEMENTS, BOARDS AND PARTNERSHIP ARRANGEMENTS, INCLUDING ANY POLICY AND FINANCIAL CHANGES, REQUIRED TO PROCESS THE ITEM

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**7th September 2017**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**Better Care Fund – Local Plan 2017-19**
Contact Officer:	Jackie Goad, Executive Assistant, Chief Executive's Tel. 020 8461 7685 Email: Jackie.goad@bromley.gov.uk
Chief Officer:	Ade Adetosoye, Deputy Chief Executive and Executive Director of Education, Care and Health Services, London Borough of Bromley Angela Bhan, Chief Officer, NHS Bromley Clinical Commissioning Group
Ward:	All

1. Summary

1.1 The Better Care Fund brings together health and social care budgets. The fund puts a requirement upon Clinical Commissioning Groups (CCG) and Local Authorities (LA) to pool budgets. Commissioners are then expected to use the pooled fund to integrate and join up services for the benefits of local residents using health and care services.

1.2 For the years 2015/16 and 2016/17 individual annual spending plans were developed and approved by the Health & Wellbeing Board prior to being submitted to NHS England for approval. A key change to the policy framework since 2016-17 is the requirement for plans to be developed for the two year period 2017-2019.

1.3 The Government considers the Better Care Fund to be a key tool in driving forward the agenda for integration of health and social care services and the BCF plan must set out how local authorities and CCGs are going to achieve further integration by 2020.

1.4 It is a requirement that the plan for the fund be signed off by the Health and Wellbeing Board.

2. Reason for Report going to Health and Wellbeing Board

All plans must be taken through and formally signed off by local Health and Wellbeing Boards before the final plan can be submitted to NHS England on 11th September 2017

3. SPECIFIC ACTION REQUIRED BY HEALTH AND WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

Formal agreement and consent to the final plan being submitted to NHS England

Health & Wellbeing Strategy

1. Related priority: General overarching regard to local health and care priorities.

Financial

1. Cost of proposal: £22,125k for 2017/18 and £22,670k for 2018/19

2. Ongoing costs: £22,125k for 2017/18 and £22,670k for 2018/19

3. Total savings: Not Applicable:

4. Budget host organisation: Local Authority

5. Source of funding: Top slicing of existing budgets (primarily BCCG budgets) to create the BCF in 2015/16

6. Beneficiary/beneficiaries of any savings: n/a

Supporting Public Health Outcome Indicator(s)

Yes:

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4. COMMENTARY

4.1 The full plan for submission has been attached for Members, which sets out in detail the plans for 2017-19. The narrative plan also provides an insight into the work of BCCG and the Local Authority to transform local services and address the national conditions placed against the fund.

4.2 The submission and assistance process is detailed in the timetable below

Milestone	Date
Publication of Government Policy Framework	31 March 2017
BCF Planning Requirements, BCF Allocations published	4 July 2017
Planning Return template circulated	w/e 7 July 2017
First Quarterly monitoring returns on use of IBCF funding from Local Authorities.	21 July 2017
Areas to confirm draft DToC metrics to BCST	21 July 2017
BCF planning submission from local Health and Wellbeing Board areas (agreed by CCGs and local authorities). All submissions will need to be sent to DCO teams and copied to england.bettercaresupport@nhs.net	11 September 2017 Scrutiny
Scrutiny of BCF plans by regional assurers	12–25 September 2017
Regional moderation	w/c 25 September 2017
Cross regional calibration	2 October 2017
Approval letters issued giving formal permission to spend (CCG minimum)	From 6 October 2017
Escalation panels for plans rated as not approved	w/c 10 October 2017
Deadline for areas with plans rated approved with conditions to submit updated plans	31 October 2017
All Section 75 agreements to be signed and in place	30 November 2017
Government will consider a review of 2018-19 allocations of the IBCF grant provided at Spring Budget 2017 for areas that are performing poorly. This funding will all remain with local government, to be used for adult social care	November 2017

4.3 The submission timetable is exceptionally tight as final guidance was not published until 4th July. As such there was no earlier opportunity to present this item to the Health and Wellbeing Board for discussion. However, officers have been meeting through the Joint Integrated Commissioning Executive (JICE) to produce and finalise the plan.

4.4 Policy requirements

4.4.1 The two key changes to the policy framework since 2016-17 are:

- A requirement for plans to be developed for the two year period 2017-2019 rather than a single year
- The number of national conditions which local areas are required to meet has been reduced from eight to four.

4.5 National Conditions

4.5.1 The four national conditions that Bromley are required to meet are:

1. The BCF Plan must be jointly agreed and signed off by the HWB
2. The NHS contribution to Social Care is maintained in line with inflation
3. An agreement to invest in NHS commissioned out-of-hospital services
4. Implementation of the High Impact Change Model for managing Transfer of Care

4.5.2 The onus is on local areas to demonstrate how they will use the pooled fund created under BCF to address these specific requirements. NHS authorisation will be on the basis of the local plan addressing each of these conditions.

4.6 Further Integration of health and social care

4.6.1 The 2015 Spending Review set out the Government's intention that, by 2020, health and social care will be more fully integrated across England. BCF plans for 2017-19 must also therefore set out the joint vision and approach for integration and how CCGs and local authorities are working towards better co-ordinated care, both within the BCF and in wider services.

4.7 An example of further integration and joint commissioning through BCF

4.7.1 The re-procurement of BCGG's community health services contract has involved developing innovative models of integrated community-based care that meet the needs of a growing population, many of whom have complex health needs.

4.7.2 The tender has included Children's Community Services, Adult Community Based Services and Integrated Rapid Response and Transfer of Care Services and also the joint commissioning of social care services including Reablement and Intermediate Care.

4.7.3 The specification for the new social care services were jointly developed by officers from BCCG and LBB to ensure that they meet the needs of all Bromley residents and by aligning social care services as part of the wider community health contract it has been possible to procure a holistic service that offers residents a seamless approach to care in the community and an integrated approach to working across the various hospital discharge pathways.

5. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

5.1 Whilst the Better Care Fund has general overarching regard to local health and care priorities, the BCF plan places special focus on services which support vulnerable people by facilitating hospital discharge, supporting better and speedier recovery following a period of hospitalisation, and preventing vulnerable people going into crisis by providing the necessary ongoing support within the community so that they can remain independent in their own homes.

6. FINANCIAL IMPLICATIONS

6.1 The Better Care Fund Allocation for 2017/18 is £22,125,000 and £22,670,000 for 2018/19 and is made up of both revenue and capital expenditure streams. The funding is ring fenced for the purpose of pooling budgets and integrating services between Bromley Clinical Commissioning Group and the local authority.

6.2 Monitoring of the expenditure takes place on a quarterly basis and has to be reported back to NHS England. Regular updates of the progress on expenditure will also be reported to the Health & Wellbeing Board.

6.3 The BCF expenditure assumptions for 2017/18 and 2018/19 are detailed in the table below.

BCF 2017/18 AND 2018/19

Responsibility	BCF Heading	Description	2017/18 budget £'000	2018/19 budget £'000
LBB	Reablement services	Reablement capacity	853	870
CCG	Intermediate care services	Winter Pressures Discharge (CCG)	646	659
LBB	Intermediate care services	Winter Pressures Discharge (LBB)	1,027	1,048
CCG	Assistive Technologies	Integrated care record	433	441
CCG	Intermediate care services	Intermediate care cost pressures	625	638
LBB	Assistive Technologies	Community Equipment cost pressures	422	431
LBB	Personalised support/ care at home	Dementia universal support service	520	531
CCG	Personalised support/ care at home	Dementia diagnosis	620	632
LBB	Improving healthcare services to care homes	Extra Care Housing cost pressures	418	427
CCG	Improving healthcare services to care homes	Health support into care homes/ECH	314	320
CCG	Assistive Technologies	Self management and early intervention (inc Vol sector)	1,047	1,068
CCG	Support for carers	Carers support - new strategy	633	646
CCG	Risk Pool	Risk against acute performance	1,347	1,374
CCG	Risk Pool	Transfer of care bureau	611	623
LBB	Personalised support/ care at home	Protecting Social Care	8,977	9,156
LBB	Personalised support/ care at home	Disabled Facilities Grants - CAPITAL	1,838	1,976
CCG	Support for carers	Carers Funding	527	538
CCG	Reablement services	Reablement Funds	952	971
LBB	Reablement services	Reablement Funds	315	321
		Total Recurrent Budget	**22,125**	**22,670**

7. LEGAL IMPLICATIONS

7.1 The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund and which requires that in each area the CCG transfer minimum allocations into one or more pooled budgets established under S75 of that Act. NHS England and the Government allocate the Better Care Fund to local areas based on a framework agreed with Ministers. NHS England will approve the plans for spend in consultation with Department of Health and Department for Communities and Local Government.

7.2 For 2017-18 and 2018-19, the allocations are based on a mixture of the existing Clinical Commissioning Group allocations formula, the social care formula, and a specific distribution formula for the Disabled Facilities Grant element of the Better Care Fund.

8. COMMENT FROM THE CHIEF OFFICERS OF EACH ORGANISATION

The plan for 2017-19 represents significant progress over the last year and towards our ambition to transform local health and care services supporting our providers to deliver joined up community care that provides better outcomes for our residents. Over the next two years we will continue to build on our joint programmes and further explore opportunities for greater levels

of integration in order to maximise the efficient use of resources and the improved effectiveness of our services.

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Bromley's Better Care Fund 2017-19

A Local Plan

BCCG & LBB

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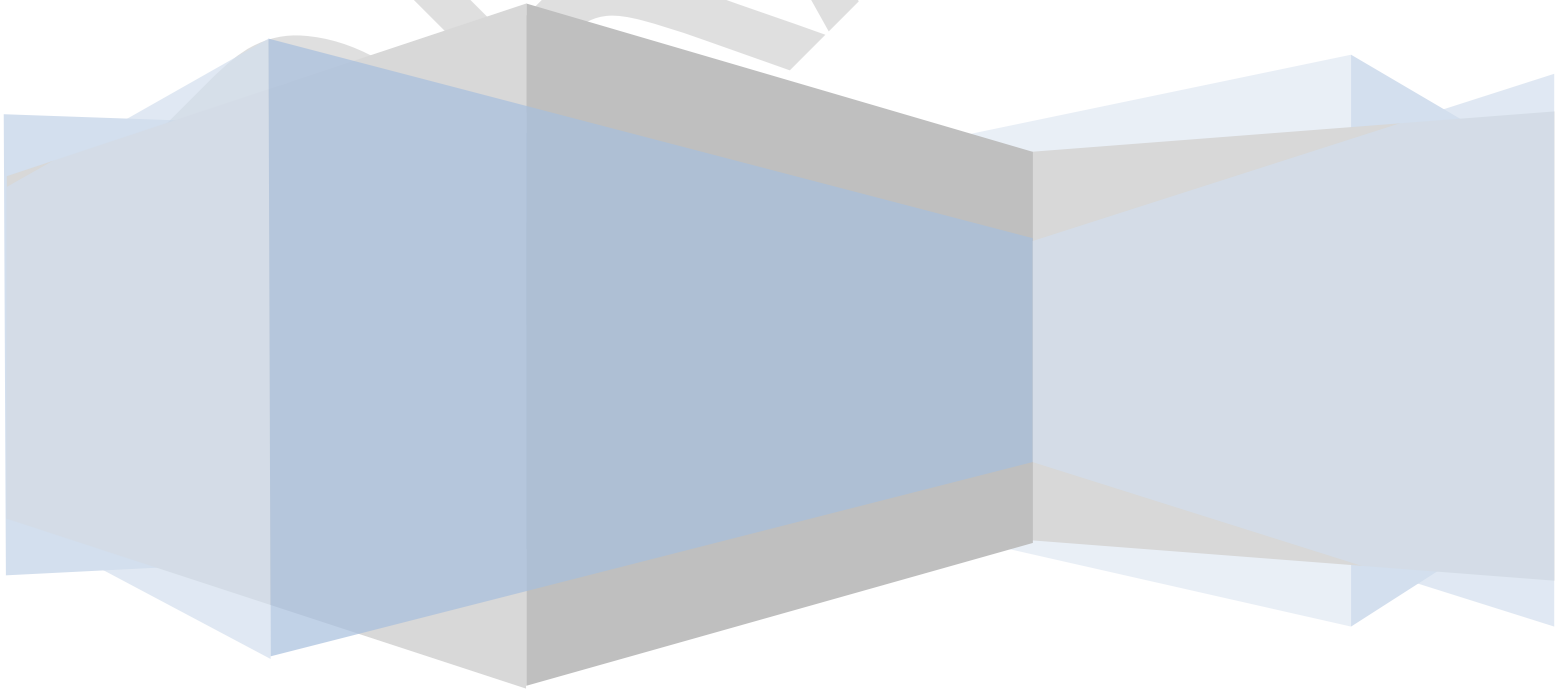

Contents

DRAFT

1. BCF Allocation for Bromley and Authorisation

Local Authority	London Borough of Bromley
Clinical Commissioning Group	Bromley
Date agreed at Health and Well-Being Board:	
Date submitted to NHS England:	
Minimum required value of pooled budget 2017/18	£22,125,000
Total agreed value of pooled budget 2017/18	£22,125,000
Minimum required value of pooled budget 2018/19	£22,670,000
Total agreed value of pooled budget 2018/19	£22,670,000

Signed on behalf of Bromley Clinical Commissioning Group	
Signature	
By	Angela Bhan
Position	Chief Officer
Date	

Signed on behalf of the London Borough of Bromley	
Signature	
By	Ade Adetosoye
Position	Deputy Chief Executive & Executive Director Education, Care & Health Services
Date	

Signed on behalf of the Bromley Health and Wellbeing Board	
Signature	
By	Councillor Jefferys
Position	Chair of Health and Wellbeing Board
Date	

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2. Introduction and Background

2.1. The Better Care Fund (BCF) grant is ring fenced for the purpose of pooling budgets and integrating services between Clinical Commissioning Groups (CCG) and Local Authorities (LA) for the benefits of local residents using health and care services.

2.2. For 2017/18 the total Better Care Fund will be increased from £3.9 billion to £5.128 billion and to £5.650 billion in 2018/19 with the inclusion of an additional £1.115 billion social care grant funding for 2017/18 increasing to £1.5 billion in 2018/19 as announced at Spring Budget 2017. £3.582 billion will be taken from NHS England's allocation to CCGs to establish the fund in 2017/18, with a further £431 million contributed from the Disabled Facilities Grant to Local Authorities.

2.3. There are two key changes to the policy framework since 2016/17. The first main change is that the framework covers the two financial years 2017-19 and the requirement for plans to cover the two year period rather than a single year as before. The second change sees a reduction in the number of national conditions that areas are required to meet, reducing from eight down to four. Areas will however be encouraged to maintain progress on the policy areas which are no longer national conditions through their BCF plans, as they remain important for the delivery of wider integration commitments.

2.4. With the Government's ambition that all areas graduate from the Better Care Fund to be more fully integrated by 2020 areas are asked to set out how they are going to achieve further integration by 2020. The plan should therefore align with the local NHS five year Sustainability and Transformation Plan (STP) produced jointly by NHS partners, local authorities and other partners and which set out plans for the future of health and care services.

2.5. In this Local Plan Bromley sets out a joint spending plan to be approved by NHS England as a condition of the NHS contribution to the Fund being released into pooled budgets. The plan sets out a strategic approach to administering the BCF in line with local and national drivers. It recognises the need to address the national conditions that come with Better Care Funding but also seeks to utilise the fund to make longer term systematic changes to the overall structure of the health and care economy in the borough.

2.6. This plan should be read in conjunction with other local strategic documents including the ***Health and Wellbeing Strategy***, the ***Out of Hospital Strategy*** and Bromley's ***Integrated Commissioning Plan*** attached at the end of this plan.

2.7. The minimum required value of pooled budget for Bromley for 2017/18 is £22,125,000 and £22,670,000 for 2018/19.

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3. National Timeline

3.1 The submission and assistance process will follow the timetable below

Milestone	Date
Publication of Government Policy Framework	31 March 2017
BCF Planning Requirements, BCF Allocations published	4 July 2017
Planning Return template circulated	w/e 7 July 2017
First Quarterly monitoring returns on use of IBCF funding from Local Authorities.	21 July 2017
Areas to confirm draft DToC metrics to BCST	21 July 2017
BCF planning submission from local Health and Wellbeing Board areas (agreed by CCGs and local authorities). All submissions will need to be sent to DCO teams and copied to england.bettercaresupport@nhs.net	11 September 2017 Scrutiny
Scrutiny of BCF plans by regional assurers	12–25 September 2017
Regional moderation	w/c 25 September 2017
Cross regional calibration	2 October 2017
Approval letters issued giving formal permission to spend (CCG minimum)	From 6 October 2017
Escalation panels for plans rated as not approved	w/c 10 October 2017
Deadline for areas with plans rated approved with conditions to submit updated plans	31 October 2017
All Section 75 agreements to be signed and in place	30 November 2017
Government will consider a review of 2018-19 allocations of the IBCF grant provided at Spring Budget 2017 for areas that are performing poorly. This funding will all remain with local government, to be used for adult social care	November 2017

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4. Local Vision and Evidence Base

4.1. Our vision is to reduce health inequalities and improve the health and wellbeing of people living and working in Bromley by delivering integrated health and care that focuses on maximising people's health, wellbeing and independence. Our current Health and Wellbeing Strategy, developed with key health, local authority and community stakeholders describes its strategic vision for every resident as, "Live an independent, healthy and happy life for longer".

4.2. To improve the quality of life and wellbeing for the whole population of Bromley and particularly those with complex health needs and to ensure that more of our population stays well, avoiding the need for hospitalisation or institutional care, we must continue to work more collaboratively and in more integrated ways with cross sector partners, commissioners and providers, including local residents, voluntary organisations and community groups.

4.3. Locally we face similar challenges that are experienced nationally. The numbers of older people in Bromley are rising and health and social care provision needs to reflect the increased need.

4.4. Our priority areas are defined through the Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing Strategy The headlines for Bromley's population of over 326,000, as set out in the JSNA 2016 are:

- Bromley has a greater number of older residents than any other London Borough. The proportion of older people (65 years and over) is currently 17.7% and is predicted to rise to 19.1% by 2026.
- Life expectancy at birth in Bromley has been rising steadily over the last 20 years, currently at 81.4 years for men and 84.9 years for women.
- There is an 9.7 year gap for men and 6.7 years for women between the highest and lowest life expectancy wards in Bromley
- Mortality in Bromley is chiefly caused by circulatory disease (29.1%) and cancer (29%) with higher mortality rates for both conditions in more deprived areas of the borough.
- There is evidence to show that there are many people living in Bromley with undiagnosed hypertension, and a number of people with known hypertension which has not been adequately controlled
- Diabetes represents a continuing challenge in Bromley. The number of people affected has continued to rise since 2002.
- The number of people in Bromley with dementia continues to rise, especially in the over 85 year age group
- The number of live births has increased since 2002, but is projected to decrease by 2021.
- Bromley has the sixth highest proportion of adult overweight and obese in London, 63.8% and rising.
- Over 2,500 people in Bromley (almost 1% of the adult population) have been identified by GPs as experiencing serious mental illness.
- Estimates suggest that the level of drinking in people in Bromley is similar to that for London and England, with 17% of people in the increasing and high risk categories.
- Local GP data suggests that 21% of men and 6% of women drink above the recommended levels of alcohol each week and this is most prevalent in those aged between 40 and 69 years.

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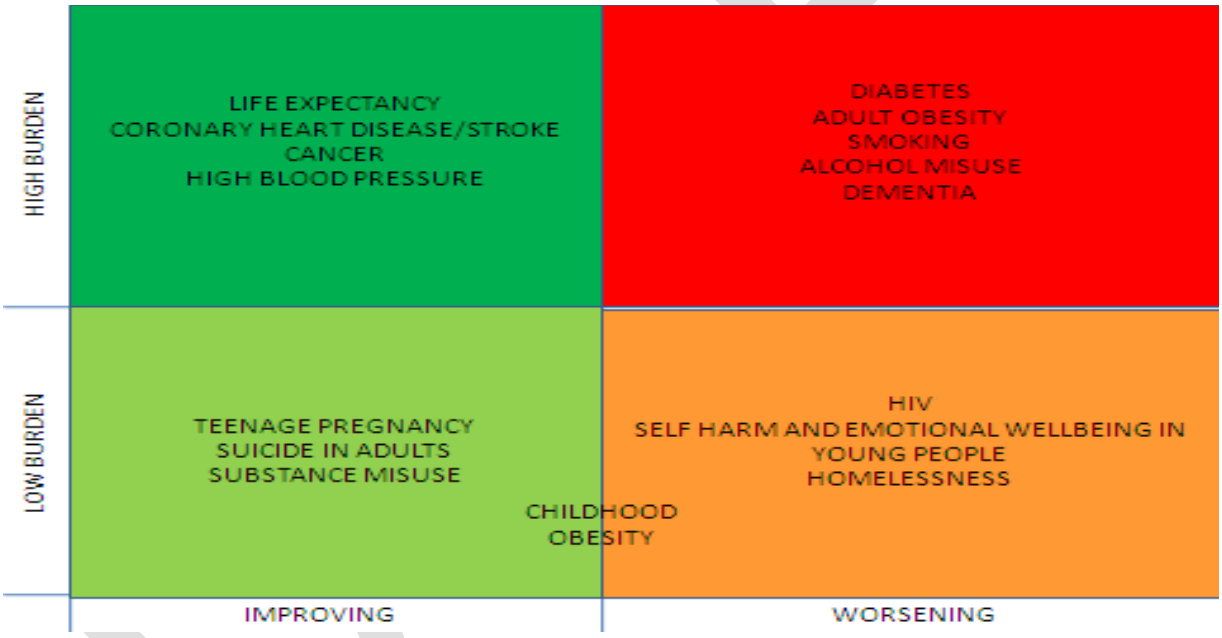
- The volume of households faced with homelessness continues to rise
- The number of people with learning disabilities under the age of 64 years is predicted to rise by 9.2% over the next eight years.
- The number of people in Bromley with physical disability or sensory impairment continues to increase.
- Data from the 2011 census indicates that 10% of Bromley's population (approximately 31,000 people) are carers. Just over 6000 of these carers provide more than 50 hours of unpaid care per week.
- There were a significant numbers of attendances relating to conditions which might be better dealt with in settings other than A&E e.g. attendance for intramuscular or intravenous injections, catheter problems, blood tests, feeding tube problems.

4.5. *Figure 1* below shows our relative priorities of the key health issues. The highest priority is allocated to the issues creating the highest burden which appear to be worsening over time.

Figure 1: JSNA Priorities



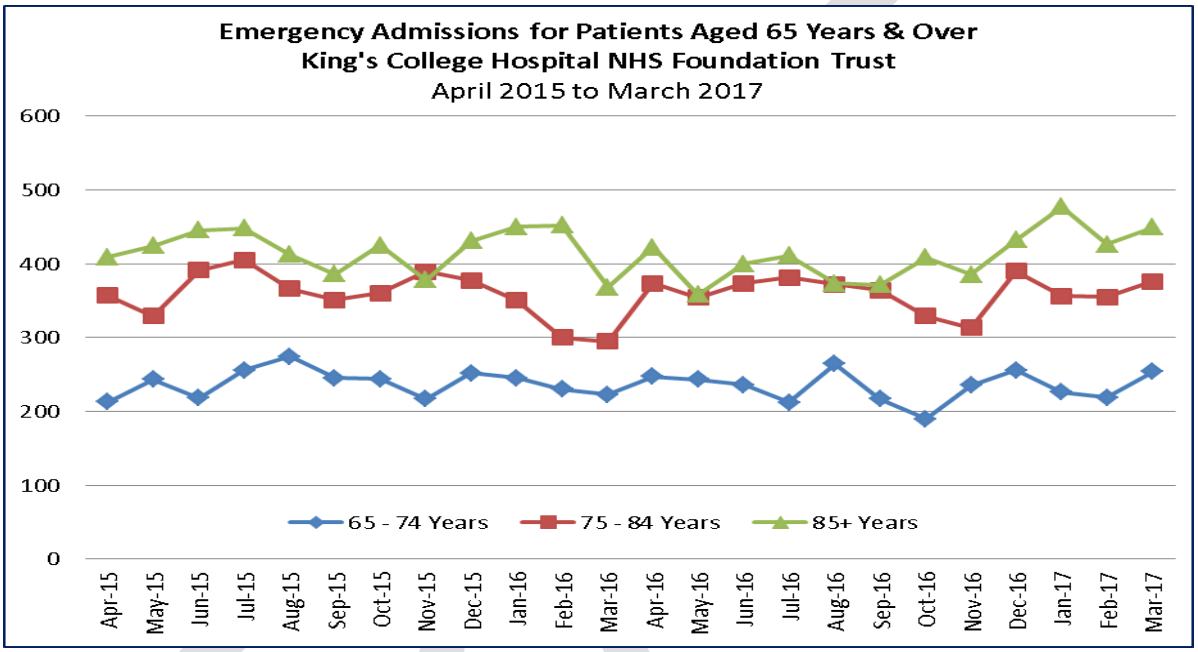
4.6 Following a recent review of our JSNA for 2016, our new HWB Strategy for 2017 will be produced towards the end of this year and will be based on pathway based priorities for vulnerable groups. This will include the elderly, the socially isolated and those with mental health issues. The health and wellbeing of children will also be integral to the revised strategy.

Evidence from analysis of emergency admissions

4.7. Analysis performed on hospital admissions data for Bromley patients shows that around 57% of emergency admissions are for patients aged 65 years and over.

4.8. *Figure 2* below sets out these admissions by age band for this cohort of patients from April 2015 to March 2017 at Kings College Hospital (PRUH & Denmark Hill).

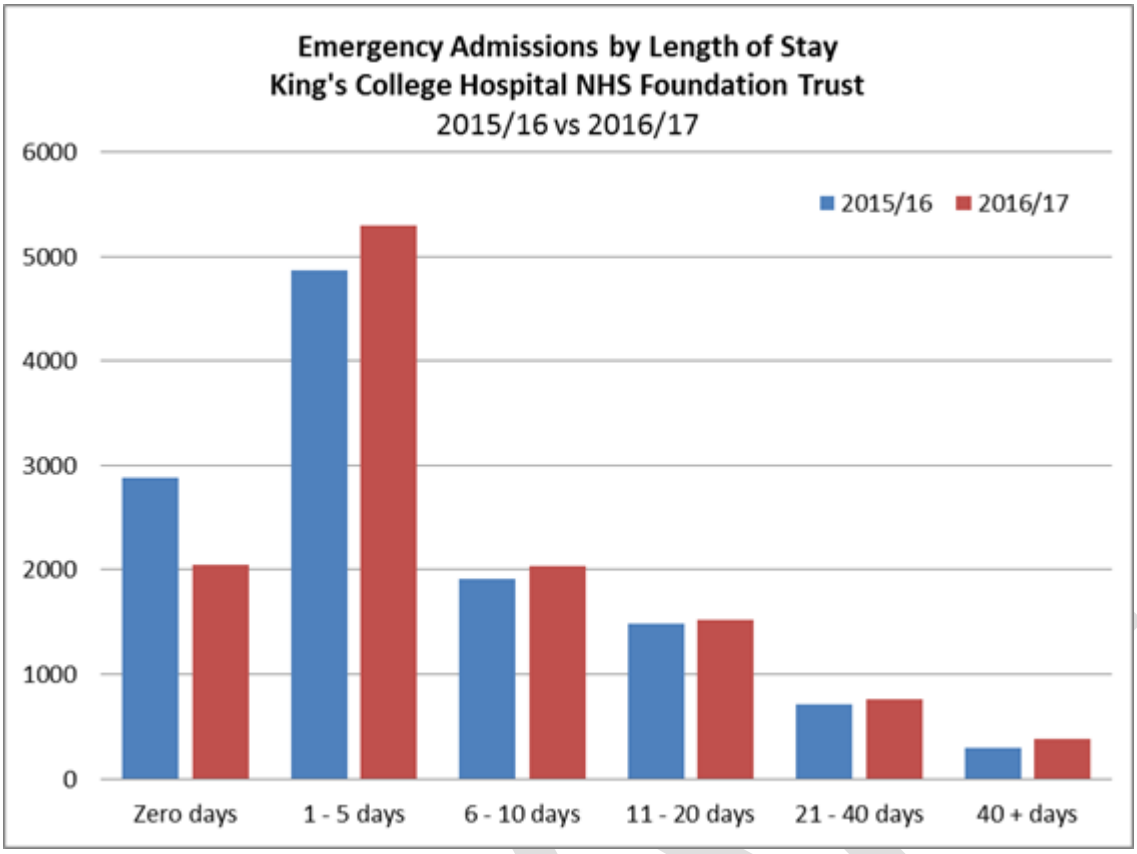
Figure 2: Emergency Admissions for Patients aged 65 years and over



4.9. Whilst admissions for this cohort of patients appears relatively static (a 1% decrease year on year), there has been some significant changes to length of stay bands for these patients when 2016/17 is compared with 2015/16.

4.10. *Figure 3* sets out the length of stay bandings for the two years. It shows a 28.3% increase in admissions where patients stay in hospital for more than 40 days, this equates to 83 more long stay patients in 2016/17.

Figure 3: Emergency Admissions length of stay for Patients aged 65 years and over



4.11. This may suggest the number of complex admissions is rising. The number of zero length of stay admissions decreased by 835 (28.9%) in 2016/17.

4.12 The decrease is most likely due to changes in coding by the Trust; whereby Ambulatory Care Unit activity is now recorded as outpatient attendances rather than emergency admissions as it was in 2015/16.

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5. Delivering Integrated Care - Our Progress to Date

5.1 To meet the increasing care needs of our rising population, in a way that enables people to live more independently with complex long-term conditions, Bromley commissioned two significant change projects in 2015/16, in line with the national conditions and the metrics within the BCF and the wider policy directives set out in the Health and Care Act 2012, Care Act 2014 and NHS Five Year Forward View

5.2 The BCF plan for 2016/17 was therefore aligned with our change programmes and rather than a sequence of small impact projects, funding was used to underpin the wider objectives to move care from an acute setting into the community. As such BCF spend was targeted in community based services from preventative services through to supporting winter pressures through increased discharge capacity.

5.3 *Figure 4* below details how all our shared projects within the BCF aimed to reflect back to the outcomes below.

Figure 4: Golden Thread from National conditions to local outputs

An increase in planned community based activity (especially prevention and targeted interventions)	**A decrease in unplanned acute activity (and where an admission is unavoidable improved outflow back into an appropriate community services)**
Local Change Programme 1: **Integrated Care Networks**	**Local Change Programme 2**: **Discharge team and step up/ step down service recommissioned**
Outputs that require investment: ➢ Shared MOU between 'Pillar' Providers ➢ Outcome based incentives ➢ Outcome based contracts ➢ Social prescribing and prevention ➢ Self-management ➢ Single point of access/ Demand management ➢ Comprehensive IAG services ➢ 3 clear ICNs co-ordinating resources ➢ Risk stratification of local population ➢ Personal health budgets	**Outputs that require investment:** ➢ Multi-professional discharge team ➢ One referral route ➢ New workflow for packages and budget management ➢ 7 day operation all year round ➢ Wider range of step up/ step down services ➢ Improved reablement capacity ➢ Flexible innovative interventions ➢ Increase in step up services

Local Change Programme 1 – Integrated Care Networks

5.4 The national Five Year Forward View (5YFV) sets out a clear direction for the NHS to develop new models of care, aiming to have more integrated services with patients at the centre. To turn this vision into a reality, barriers between primary, community and hospital care will need to be removed so that we focus on systems of care and not organisations. This will help in providing more personalised and coordinated health services for patients. The 5YFV recommends that more care needs to be provided out of hospital, and services need to be integrated around the patient so that all their health needs are met.

5.5 Over the last year in Bromley we have started to make this vision a reality for our most vulnerable patients. Following the publication of our Bromley Out of Hospital strategy in the Autumn of 2015, 2016/17 saw the successful implementation and development of proactive and frailty pathways of care and the establishment of three Integrated Care Networks (ICNs) to provide a framework for delivering joined up care.

5.6 The three integrated care networks have been developed with local partners, clinicians and patients with staff from a range of services and organisations working together in multidisciplinary teams. Each ICN covers one-third of the population and brings together services delivering proactive care for patients with complex care needs. The aim is to keep these patients well and avoid a crisis, which may lead to them having to go into hospital. This new method of working is changing the way these patients receive care and how it is arranged for them.

5.7 The Proactive Pathway was mobilised at the end of October 2016 and good progress has been made with weekly integrated Multidisciplinary Team meetings (MDTs) now happening across all three networks. Patients are proactively identified by their GP and assessed by a community matron before a discussion with a multidisciplinary team of staff working within the ICN. This team works very closely together to support those patients and help keep them well. New ‘Care Navigator’ roles have also been created to support patients and signpost them to the services they need, including voluntary sector services where suitable.

5.8 The ICN’s have now seen around 700 patients through the pathway with a number of patients benefiting from onward referrals on to Age UK for additional support, we are currently working through the data to get a break down of those patients who required a referral to social care post MDT and those that had a change to their care package.

5.9 While it is too soon to assess the full impact of the pathway there have already been positive case studies.

5.10 The following two case studies illustrate examples of positive outcomes, including a reduction in the number of emergency contacts.

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Case Study 1: "SG"

"SG" is a 59 year old male known to the community mental health team. He has had a series of emergency calls to 111 and visits to the PRUH Emergency Department. A visit to the patient showed that home hygiene is compromised, he is struggling to survive on benefits and his home was cold through lack of heating.

Advice was given on benefits and the need to maintain provisions e.g. buy non-perishable items. Contact was made with a food bank to provide assistance, EDF energy to place credit on his meter and credit was added to his Oyster card to enable him to travel to planned medical appointments.

In the six weeks before the MDT intervention, SG had called 111 on 16 occasions and visiting A&E 4 times. Six weeks after there have been no emergency contacts.

Case Study 2: "CS"

"CS" is a 74 year old female currently receiving reablement following an inpatient episode. She lives alone in an upper floor flat. Her carer is a friend but she doesn't live nearby.

She has a complex history of severe COPD (known to Community Respiratory team), Ischemic Heart Disease and confusion. Oxygen was prescribed but later removed on safety grounds. In the last two years she has had an acute myocardial infarction and breast cancer. She will not accept support with personal care, is non-compliant with medication and refuses to attend a memory clinic.

Actions include memory assessment, establishment of power of attorney with next of kin, a social care package following reablement, review from Medicine Optimisation Service, and oxygen re-established following disconnection of unused gas cooker. Bromley Care Coordination are now providing support.

Medicine compliance is now greatly improved resulting in a reduction in calls to primary care. Measures are now in place to prevent secondary care admission.

5.11 Some patients, particularly those who are older and frail, may need to have some hospital inpatient care, so the CCG has also invested in two new community wards at Orpington Hospital. The aim of the inpatient element of care is to provide short-term hospital care for frail patients who either need an assessment and a little bit more help so they can get back to independent living, or who have been in the Princess Royal University Hospital (PRUH) and need additional support to help prepare them to leave hospital.

5.12 A dashboard is being finalised to monitor patient activity before and after the patient enters the Proactive Pathway and it will be monitored via the ICN steering group. An independent quantitative and qualitative evaluation of the ICN Proactive Pathway has also been commissioned and should be finalised during September.

5.13 The next workstreams that have been agreed by the ICN Board are :

- Care Homes
- Urgent Care Admissions for People at End of Life
- Integrated Discharge (Therapies)
- Integrated Heart Failure service

5.14 The focus for 2017-18 will be the complete mobilisation of Proactive and Frailty pathways and to continue to monitor progress in order to improve with the overall aim of embedding into business as usual.

5.15 A key enabler to the ICNs progress to date has been the current Memorandum of Understanding (MOU) put in place with system providers. The MOU runs until September 2017, as such, an Alliance contract is currently being drafted with the aim of moving even further with strengthening integrated working across the system. This is being discussed through the summer with the aim of having it in place for the Autumn/Winter.

5.16 The Alliance Agreement (AA) helps to build on the current MOU and aims to help the system move forward to a potential Accountable Care System in the future. If the AA is delayed, an extension to the MOU will be put in place to mitigate any potential gap.

Figure 5: Current ICN Governance Structure

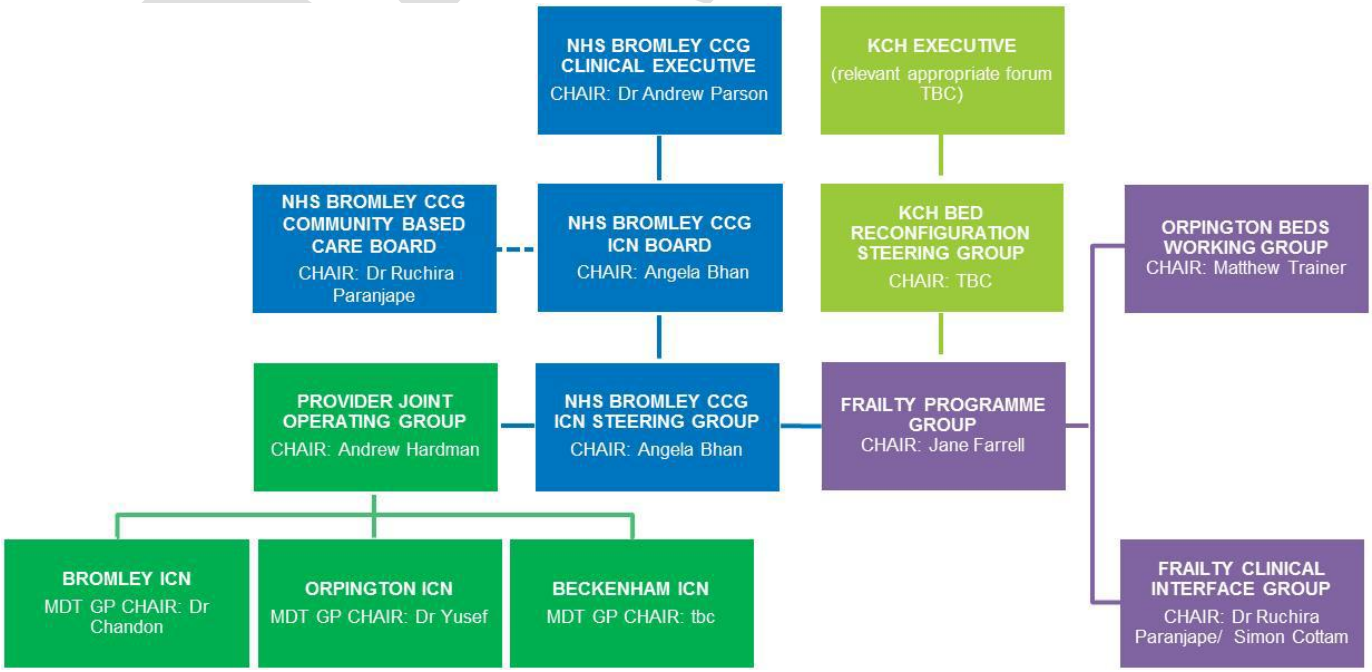

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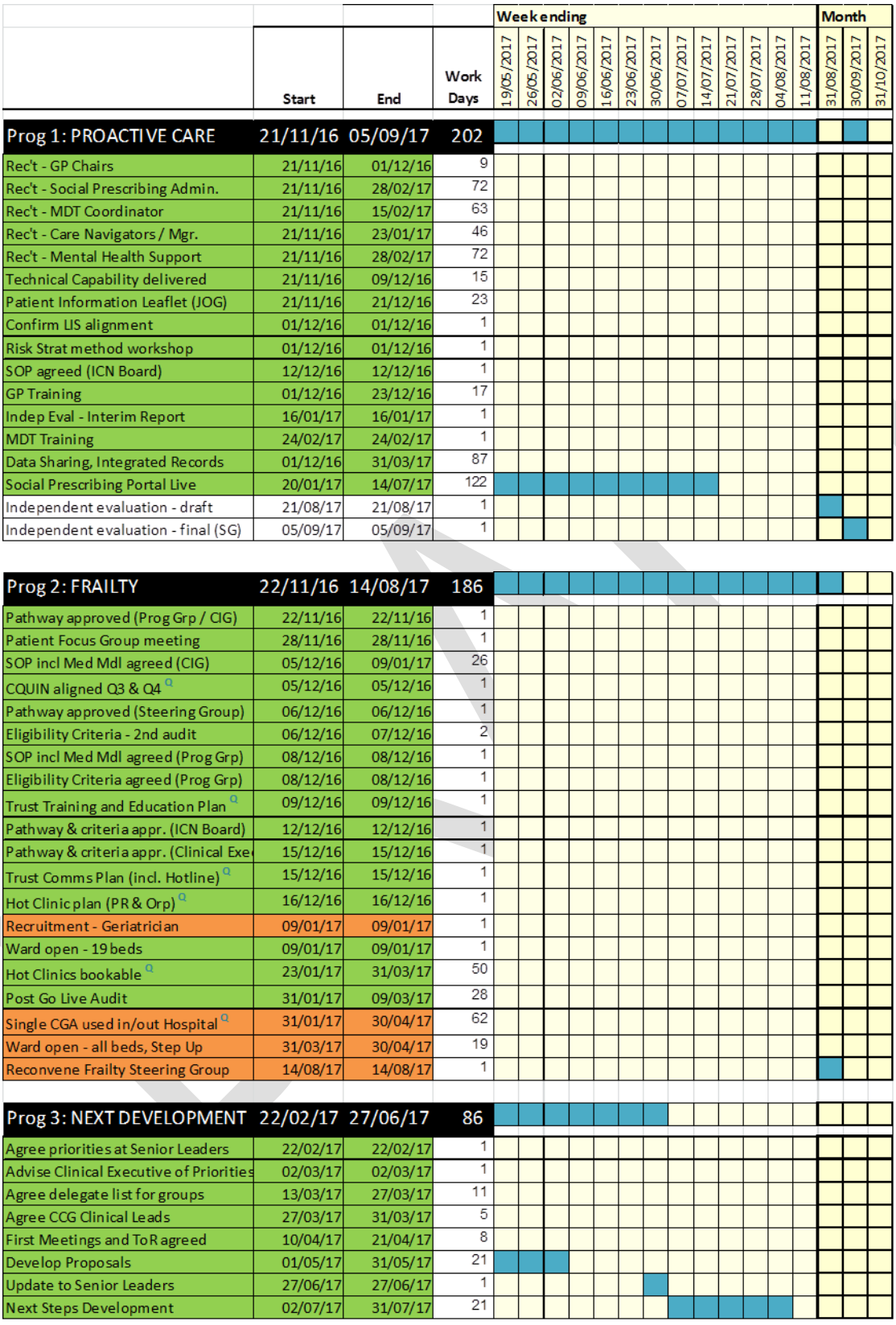
Figure 6: High Level Programme Plan for 2017



	Start	End	Work Days
Prog 1: PROACTIVE CARE	**21/11/16**	**05/09/17**	**202**
Rec't - GP Chairs	21/11/16	01/12/16	9
Rec't - Social Prescribing Admin.	21/11/16	28/02/17	72
Rec't - MDT Coordinator	21/11/16	15/02/17	63
Rec't - Care Navigators / Mgr.	21/11/16	23/01/17	46
Rec't - Mental Health Support	21/11/16	28/02/17	72
Technical Capability delivered	21/11/16	09/12/16	15
Patient Information Leaflet (JOG)	21/11/16	21/12/16	23
Confirm LIS alignment	01/12/16	01/12/16	1
Risk Strat method workshop	01/12/16	01/12/16	1
SOP agreed (ICN Board)	12/12/16	12/12/16	1
GP Training	01/12/16	23/12/16	17
Indep Eval - Interim Report	16/01/17	16/01/17	1
MDT Training	24/02/17	24/02/17	1
Data Sharing, Integrated Records	01/12/16	31/03/17	87
Social Prescribing Portal Live	20/01/17	14/07/17	122
Independent evaluation - draft	21/08/17	21/08/17	1
Independent evaluation - final (SG)	05/09/17	05/09/17	1
Prog 2: FRAILTY	**22/11/16**	**14/08/17**	**186**
Pathway approved (Prog Grp / CIG)	22/11/16	22/11/16	1
Patient Focus Group meeting	28/11/16	28/11/16	1
SOP incl Med Mdl agreed (CIG)	05/12/16	09/01/17	26
CQUIN aligned Q3 & Q4 [Q]	05/12/16	05/12/16	1
Pathway approved (Steering Group)	06/12/16	06/12/16	1
Eligibility Criteria - 2nd audit	06/12/16	07/12/16	2
SOP incl Med Mdl agreed (Prog Grp)	08/12/16	08/12/16	1
Eligibility Criteria agreed (Prog Grp)	08/12/16	08/12/16	1
Trust Training and Education Plan [Q]	09/12/16	09/12/16	1
Pathway & criteria appr. (ICN Board)	12/12/16	12/12/16	1
Pathway & criteria appr. (Clinical Exe	15/12/16	15/12/16	1
Trust Comms Plan (incl. Hotline) [Q]	15/12/16	15/12/16	1
Hot Clinic plan (PR & Orp) [Q]	16/12/16	16/12/16	1
Recruitment - Geriatrician	09/01/17	09/01/17	1
Ward open - 19 beds	09/01/17	09/01/17	1
Hot Clinics bookable [Q]	23/01/17	31/03/17	50
Post Go Live Audit	31/01/17	09/03/17	28
Single CGA used in/out Hospital [Q]	31/01/17	30/04/17	62
Ward open - all beds, Step Up	31/03/17	30/04/17	19
Reconvene Frailty Steering Group	14/08/17	14/08/17	1
Prog 3: NEXT DEVELOPMENT	**22/02/17**	**27/06/17**	**86**
Agree priorities at Senior Leaders	22/02/17	22/02/17	1
Advise Clinical Executive of Priorities	02/03/17	02/03/17	1
Agree delegate list for groups	13/03/17	27/03/17	11
Agree CCG Clinical Leads	27/03/17	31/03/17	5
First Meetings and ToR agreed	10/04/17	21/04/17	8
Develop Proposals	01/05/17	31/05/17	21
Update to Senior Leaders	27/06/17	27/06/17	1
Next Steps Development	02/07/17	31/07/17	21

Community Health Services

5.16 The ambitious and extensive process to re-procure BCGG's community health services contract which ends in November 2017 has involved developing innovative models of integrated community-based care that meet the needs of a growing population, many of whom have complex health needs; testing these models with local people, and agreeing who will provide these services.

5.17 The tender has included Children's Community Services, Adult Community Based Services and Integrated Rapid Response and Transfer of Care Services and also the joint commissioning of a number of Social Care services including Reablement and Intermediate Care.

5.18 By aligning social care services as part of the wider community health contract it has been possible to procure a holistic service that offers residents a seamless approach to care in the community and an integrated approach to working across the various hospital discharge pathways.

Primary and Secondary Intervention Services

5.19 Also in line with the NHS five year forward view the new model of care for Bromley makes a concerted effort to bring in the third sector as a core provider. The newly formed Bromley Third Sector Enterprise has been a result of the sector coming together, with support from commissioners, to form a collegiate. The local voluntary sector now has a place on the Executive Leaders board along with all the main providers in the local system.

5.20 The proposal to create a Primary and Secondary Intervention fund within the Better Care Fund for the provision of primary and secondary intervention services was jointly approved in September 2016. The joint strategy set out a framework through which to design a set of Third Sector services that support people in the community to maintain their independence and delay and prevent the need for high cost care packages and early admissions to care homes and/or hospital.

5.21 The procurement process commenced in November 2016 and the contract award recommended for the Primary and Secondary Intervention Services in July 2017. The new services are due to mobilise from 1st October 2017.

5.22 The Primary and Secondary Intervention services will provide the following eight services:

- ✓ Carers Support Services
- ✓ Services to Elderly Frail
- ✓ Services for Adults with Long Term Health Conditions
- ✓ Services for Adults with Physical Disabilities
- ✓ Services for Adults with Learning Disabilities
- ✓ Mental Health Support Services
- ✓ Single Point of Access
- ✓ Support to the Sector

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5.23 The services will deliver a cohesive set of targeted preventative services where the impact can be evidence and measured by tracking service users through the NHS number. The outcomes of the new services will be:

- ✓ To reduce the requirement for unplanned care and resulting emergency admissions
- ✓ To prevent and delay the requirement for long term care packages
- ✓ To support residents to remain independent in their local communities
- ✓ To build capacity in local communities by demonstrating economic impact and leveraging in further funding from other sources
- ✓ To leverage in further external funding to the sector
- ✓ To shape local services to facilitate social benefit to service users creating added value

5.24 The services are universal but are targeted at vulnerable groups. The services sit in front of eligible services and manage demand to reduce increasing demographic pressure on social care and health services.

5.25 The services will work within a larger system in order to provide effective Primary and Secondary Intervention for Bromley residents. The BCCG Out of Hospital Transformation Strategy outlines the creation of an integrated and sustainable programme to keep people within their community, primarily through the work of the ICNs. The Primary and Secondary Intervention Services link with the Care Navigator role which is a fundamental part of the ICN development. The navigators will signpost residents to the appropriate channels for support, including these services, thereby avoiding more formal interventions from social care and health.

5.26 A percentage of the total funding envelope will be kept as an innovation fund. This is to encourage innovation within the service and respond to any changing or developing needs for service users. This will promote sustainability and allow flexibility within the service provision.

5.27 Whilst the funding at this stage is primarily focused on adult's preventative services in line with the ICNs, there is nothing to preclude utilising this model if it proves successful to support wider preventative agendas. It could also be used to support public health preventative activities where these providers may be suitable to deliver their programmes.

Dementia Hub

5.28 The Dementia Hub was commissioned to establish a clear pathway for people with dementia and their carers following diagnosis. The service supports people in the early stages to ensure that support planning is in place, which will allow people to remain independent for as long as possible and delay or prevent the need for social care or health crisis as far as possible.

5.29 The service was tendered in February 2016 and went live in October 2016. It is provided by a partnership of organisations: Bromley and Lewisham Mind, Age UK Bromley and Greenwich, Oxleas NHS Foundation Trust and Carers Bromley. This collegiate approach provides a wraparound service for people who are diagnosed with dementia, their families and their friends.

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5.30 This is particularly important as Bromley's ageing population means that the level of people suffering from dementia in the borough is higher than any other London borough.

5.31 Whilst there were existing services established, there was no clear pathway and finding out about these services was challenging for many people. This service provides 'a one stop shop' in terms of information, advice, support and planning for both the service user and the carer.

5.32 This is primarily encouraged through a direct route from the Memory Clinic. Anyone who is diagnosed with dementia at the Memory Clinic is signposted to the Dementia Hub for support. This means that people diagnosed with dementia have support in the community that is quickly and clearly communicated by clinicians.

5.33 People are also encouraged to self-refer to the Hub. This is predominantly used by people who were diagnosed before the Hub was in place, or for people who have had a worsening in their condition since diagnosis and may need more ongoing support than their initial engagement with the Hub.

5.34 Anyone diagnosed with dementia can be visited in their own home to plan support around their needs and receive information about dementia, their rights and local services. Everyone is treated individually and provided with information and support that is right for them.

5.35 Families and friends caring for a person with dementia can benefit from information, training and workshops to learn about dementia. Local activity and support groups are available for people with dementia and their carers to meet other local people with similar experiences of dementia. Personalised coaching in the home is also available for individual carers and family groups. This ensures that carers are better equipped to offer support and help manage changing dementia care needs, as they plan for the future.

5.36 The Bromley Dementia Support Hub volunteer befrienders are available to provide companionship, support to carry out everyday activities in the home and local community, help for people to stay active and give family carers a break from caring. It is crucial that whilst living with dementia, people are not isolated.

5.37 Since going live in October 2016 the number of cases allocated to a dementia advisor has increased with 43% of referrals being allocated in the first quarter 2017/18 compared to an average of 31% across 2016/17 and positive outcomes are being achieved.

5.38 The case studies provide examples of positive outcomes for both a carer of a person with dementia and a person diagnosed with dementia.

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Case Study 1:

Number of contacts
6 telephone calls
1 letter
2 office visits
Length of engagement: From 16th March 2017 – case still open

Outcomes:
• Carer attended Family Carers Information workshops for carers of a person with a dementia. This helped to enhance her knowledge and understanding of Dementia and to find out about the help and support available in the community.
• Carer is now attending the Carers Coffee Morning at Carers Bromley which provides a space for her to meet other carers, have discussions with other carers in similar situations and alleviate some of the isolation she was experiencing.
• Carer received emotional support and was given the opportunity to be listened to and discuss her caring role and the effect on her.
• Carer is now aware of the support available to her and receives the Carer Bromley newsletters.
• Carer was assisted in contacting Bromley Council Tax services regarding her husband's council tax discount.

Case Study 2:

Number of contacts
7 phone calls
1 home visit
2 personal contacts at a dementia café
Length of engagement: From 6.02.2017 – case still open

Outcomes:
• M. now able to bathe safely and potential injury accident, from faulty bath lift prevented.
• Social Services now engaged with client, exploring options to make stair lift safer.
• M. now has access to chiropody which both improves her mobility and her wellbeing.
• M. now has access to financial support around taxis
• M. and her family are currently considering information sent around meals and reading and health and welfare power of attorney.

5.38 The Better Care Fund supported the development of the Dementia Hub through aligning the CCG and Council's priorities around dementia diagnosis and support. This is evident through the unique clinical and third sector partnership that provides the services.

5.39 The success of the hub has led to more early intervention and prevention services being jointly commissioned using the Better Care Fund, which are due to go live in October 2017

Care Homes

5.40 The Bromley Joint Strategic Needs Assessment 2015 gave an in depth analysis of people in care homes identifying that people in care homes are more likely than the general population over the age of 65 years to have two or more comorbidities. Extra care housing residents tend to have a higher number of comorbidities than the care home residents, but care home residents are more likely to suffer from dementia, and to have mobility problems than the extra care housing residents.

5.41 The care home population present a more complex healthcare challenge. Compared with the over 65 population as a whole, care home residents are far more likely to have a diagnosis of dementia or stroke, and overall more likely to be suffering from heart disease, kidney disease, cancer or diabetes.

5.40 Our primary goal is to support people in their own home for as long as possible. If this is no longer viable, it is important to ensure that the best possible care within the allocated resources is provided to those in residential settings.

5.41 Bromley has 67 Care Homes, 18 nursing, 45 residential and 4 mixed and 6 Extra Care Housing schemes. There are approximately 829 nursing home residents, 971 residential home residents and 285 extra care home residents.

5.42 Bromley is keen to develop stronger oversight of Care Homes and the development of shared priorities is important to ensure that this happens.

5.45 The outcomes for improving the joint oversight and work with care homes are:

- Ensuring higher quality of care for care home residents
- Reducing hospital admissions and delayed transfers of care
- Supporting independence for vulnerable residents
- Creating a sustainable and diverse care home economy in Bromley

5.46 *Table 1* summarises Bromley's care home projects currently in progress.

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Table 1

Workstream	Owner	Status	By
Care home strategy	LBB and CCG	A joint care home strategy is being developed to provide the strategic focus and vision statement for LBB and the CCG's work with care homes going forward.	Oct-17
Discharge to assess pilot	LBB and CCG	A range of discharge to assess beds are being procured over the winter period to reduce delayed transfers of care. The beds will be supported by increased community care support.	Oct-17
Shared monitoring information	LBB and CCG	The Continuing Healthcare and LBB contract monitoring team are developing a shared quality assessment framework to provide stronger oversight of the quality of care in care homes.	Sept-17
Block nursing beds procurement	LBB	LBB is procuring a new block nursing beds contract. This aims to increase the number of providers who have block contracts with LBB and ensure continued provision for social care funded residents.	Jan-18
Red bag implementation	CCG	The CCG is rolling out the hospital discharge bag to all care homes. This will improve communication with the hospital and reduce the length of hospital stays.	Apr-18
VMO support to care homes	CCG	The CCG is procuring a new model of GP support to care homes to ensure a parity of care from primary care providers.	Apr-18
MDT support to care homes	CCG	The CCG is expanding the new ICN model of care in Bromley to provide additional and targeted support to care homes. This will improve the health of residents in care homes and prevent unnecessary hospital admissions.	Jul-18

Children's Services

5.47 The joint partnership is now in year three of the Five Year Forward View for Mental Health and Future in Mind and the local emotional wellbeing and mental health plans have resulted in additional resources being allocated across the referral and care pathways. The additional resource has been focused, to date, on adding capacity in the system. There has been a significant uplift in the number of referrals entering the system as a result of the new Single Point of Access model.

5.48 CCG investments, via the Better Care Fund, have been allocated to support the capacity issues in the single point of access, early intervention service. In addition, the CAMHs Transformation Plan investments have resulted in the early intervention being able to offer longer and more intense interventions for those young people with a need greater than can be met through early intervention, but whose needs are not such as to require specialist mental health provision.

5.49 Investment in a co-production programme to lead on the emotional wellbeing and mental health system and service transformation aims to involve communities, voluntary sector, providers and health and local authority commissioners in developing a transformed model of care to support the aims of keeping well and improving accessibility to the right service in the right place at the right time.

5.50 A joint programme to improve access to physical and mental health services for young offenders has recently been set up by the CCG and Bromley's Youth Offending service. Investments have been made to co-locate early intervention services at the front door and this will be supported by access to physical health services and specialist forensic CAMHs available through the YOS.

5.51 LB Bromley and CCG are also leading a programme to develop the joint funding protocols, policies and procedures for complex cases and out of area placements. The development of joint funding and commissioning approaches will allow for improved oversight on outcomes for children and young people placed out of Borough as well as identifying opportunities to repatriate children and young people closer to home where clinically appropriate.

5.52 Supported by partners and providers, and as a result of the community health contract re-procurement, the CCG will commission a single access point/no wrong door policy so that any young person needing physical, mental or emotional health care can go to one place for the care they need. It is anticipated that as a result of this approach along with the community health contract re-procurement that there will be a reduction in the number of presentations to A&E by children and young people with fewer admissions and when admitted, the length of stay will be reduced.

5.53 Work is also in progress with providers and the voluntary sector to implement best practice care and treatment for asthma, epilepsy, ADHD and diabetes using modelling from across the London area and aligning the referral and care pathways with Health London Partnership guidance on standards and transformation of out of hospital care.

5.54 The CCG has initiated the development of a personal health budget offer for young people with long term conditions to provide greater flexibility and control over their care. The vision is that this initiative will align with local authority personal budget policies and procedures to facilitate seamless provision and improved service experience by children, young people and their families.

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Local Change Programme 2 – Discharge Team

5.55 In 2015 partners from across the system came together to co-produce a response to the increasing number of patients with complex health and social care needs that required support to be discharged from the PRUH in a safe and timely way.

5.56 There have been many successes since the implementation of the Transfer of Care Bureau (ToCB) in October 2015 including;

- ✓ Key organisations and professionals have been brought together to work from a single place within the PRUH with additional GP, Continuing Health Care and out of borough capacity creating a specialist discharge function and single point of access to community services.

- ✓ Delayed Transfer of Care (DTOC) reduced significantly and patients are being transferred in a more timely way.

5.57 The ToCB, with single oversight of all complex discharges, provided a fresh insight into systemic challenges and issues in the transfer of patient care and identified growing areas of unmet demand across the system. As a result several out of hospital pathways have been streamlined and a major procurement of community health services has been undertaken to ensure a robust community infrastructure that is responsive to the changing needs in secondary care.

5.58 The new contract will be fully mobilised from December 2017 and brings together rehab (home, bed and neuro) and reablement alongside hospital in-reach and rapid response services accessed through a single point of access in the community. Rapid access to packages of care within 12 hours by care managers (and earlier when necessary), equipment delivered within 4 hours with major adaptations within 24 hours is now available with ring fenced step down accommodation available via the ToCB to support more timely discharge from hospital.

5.59 End of life pathways have been strengthened through proactive in-reach to identify and pull patients out of hospital and provide responsive, home based care and support for those in the last 12 months of life. Early outcomes from this work are showing a reducing in length of stay post medical optimisation from eight days to 1 day, reduction of readmissions and less people dying in hospital unnecessarily.

5.60 In addition further improvements across the acute hospital including the introduction of the SAFER bundle, fully functioning Multi Disciplinary Team (MDT) Board rounds and dedicated discharge transformation programme is continuing to improve patient flow and have a positive impact on reducing delayed transfer of care. The ToCB are fully integrated within MDT Board rounds at the front and back end of the hospital ensuring discharge planning commences from the point of admission.

DRAFT

5.61 Further work to strengthen hospital diversion is planned from September 2017 building on the success of discharge co-ordinators, a GP and care managers in front end departments. The co-ordinated team which will also benefit from a Community Matron and frailty nurse will work much earlier in the patient journey to ensure more people who do not require an acute intervention are diverted away from urgent and unplanned care and back to the community. MRT continues to provide a rapid response to those in crisis at home preventing the need for hospital attendance and possible admission.

5.62 The recruitment of a joint appointed Discharge Commissioner with responsibility for CCG and LA commissioning activity is showing positive results in developing co-ordinated, integrated out of hospital pathways that support both health and social care outcomes. The post has oversight of the whole hospital to home pathway to address potential blockages and ensuring on-going patient flow.

5.63 The post, alongside the solid foundations provided by transformation work to date will be key enablers to implementing the Eight High Impact Changes to further improve performance around delayed transfer of care.

6. Delivering Integrated Care – Future Direction

6.1 Bromley recognises the need to address the national conditions that come with Better Care Funding and is committed to utilise the fund to make longer term systematic changes to the overall structure of the health and care economy in the borough.

6.2 Our focus over the next 2 years is to further develop and embed our local integrated care networks as outlined in Section 5 above and to continue to implement our joint programmes with the aim of keeping people independent in their own homes where appropriate, thereby reducing the need for residential care and hospital admissions. Ensuring that we are maximising opportunities with the Third sector will be crucial.

6.3 Whilst Bromley has not put our local area forward for consideration for the first wave of BCF graduation, we are committed to working together towards a greater level of integration and we will continue to prepare for submission in a later wave.

6.4 To support this commitment we have already a number of joint funded posts in place and have recently agreed to appoint a joint Director of Integration to provide a key role for transformational change and to drive the delivery of key operational integration projects. We aim to have an interim post holder in place by mid-September.

6.5 Discussions are also progressing with regards to furthering joint working opportunities for example joint working with the Integrated Commissioning Unit.

6.6 Whilst many of the programmes will be long term for example the ICNs and the Transfer of Care, additional shorter term commissioning projects will evolve resulting in opportunities to explore the more efficient use of resources and the improved effectiveness of services.

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7. Better Care Fund Plan 2017/19

7.1 Our BCF plan for 2017-19 continues to be aligned with the new model of providing services, with funding to underpin the wider objectives to move care from an acute setting into the community.

7.2 *Table 2* below provides a summary of the BCF schemes for 2017-19.

Table 2. BCF Schemes and Funding for 2017-19

Commissioner	Scheme Name	2017/18 budget £'000	2018/19 budget £'000
LBB	Reablement Capacity	853	870
CCG	Winter Pressures Discharge (CCG)	646	659
LBB	Winter Pressures Discharge (LBB)	1,027	1,048
CCG	Integrated Care Record	433	441
CCG	Intermediate Care Cost Pressure	625	638
LBB	Community Equipment Cost Pressure	422	431
LBB	Dementia Universal Support Service	520	531
CCG	Dementia Diagnosis	620	632
LBB	Extra Care Housing Cost Pressure	418	427
CCG	Health Support into Care Homes/ECH	314	320
CCG	Self Management and Early Intervention (inc. Vol sector)	1,047	1,068
CCG	Carers Support - New Strategy	633	646
CCG	Risk against acute performance	1,347	1,374
CCG	Transfer of Care Bureau	611	623
LBB	Protection Social Care	8,977	9,156
LBB	Disabled Facilities Grants - CAPITAL	1,838	1,976
CCG	Carers Funding	527	538
CCG	Reablement Funds	952	971
LBB	Reablement Funds	315	321
	Total Recurrent Budget	**22,125**	**22,670**

7.3 Current and planned performance against metrics is provided within the BCF plan excel spreadsheet submitted alongside this narrative.

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8. National Conditions

CONDITION 1: Plans to be jointly agreed

8.1 Members of the Joint Integrated Commissioning Executive (JICE) continue to meet monthly to discuss and oversee integrated working and the Better Care Fund remains a standing item on the agenda. Officers from Bromley CCG and the Local Authority continue to build relationships and discuss options for how the fund can be best used to meet competing pressures of reduced resources across the local care and health system as a whole.

8.2 Plans, considered and drafted through JICE are then presented to the Health and Social Care Integration Governance Board (HSCIGB) which include decision makers from both commissioning organisations. Standing members include elected Councillors, CCG board members; clinical leads and the Chief Executive from both organisations (see governance section 10). This governance structure has allowed the organisations to have mature conversations about the funding available through the BCF and to set out this jointly agreed plan for how it will be jointly commissioned to meet the other national conditions.

8.3 **Disabled Facilities Grant** meetings between Housing and Social Services and the PRU hospital Discharge Bureau were held in February 2016 to identify how DFG funding could be used to improve health and wellbeing, reduce hospital admissions and keep residents safely in their own home. The principles were shared and discussed with the CCG through the JICE and then taken through each organisation's governance structures.

8.4 The following items have been implemented

- A Rapid Hospital Discharge bed moving service is in place and allows hospital staff to request works in the home to facilitate a timely discharge. Consideration is also being given to follow up works to reduce re-admissions e.g. minor works or repairs that put clients at risk and move beds back upstairs following reablement. Extending the scheme to allow access to prescription system for minor works to improve health and safety in the home accessible to Care Managers, OTs, GPs and District Nurses, Wheelchair Service and Carers is due to be trialled in phases.

- The Specialist Housing OT post in the Housing and Homelessness teams to link properties to the right disabled client has been trialled and is now confirmed as a full time post. This role includes matching clients to suitable properties, increasing and maintaining the stock of adapted properties in the social rented sector and advising on adaptations to provide sustainable and effective housing for long term use.

- An assessment of the current mandatory DFG process to identify blockages for major adaptations. This included an assessment of our DFG process by Foundations, the Government funded national body who oversee Home Improvement Agencies. As a result a fast track route is being trialled, the inclusion of an OT in the Home Improvement Agency and using a schedule of rates instead of a tender process are also being considered.

- Provision of fire misting systems and of fire retardant bedding for high risk clients unable to escape unaided in the event of a fire.

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8.5 The following items are under active consideration.

- Assistance with removal and relocation costs to help move clients to more suitable accommodation where a property cannot be appropriately adapted

- The use of discretionary grants for both adaptations and repairs (to deal with issues that put the client at risk) with minimal bureaucracy with consideration to remove the means test for works under £5000. The proposals are aimed at supporting works to prevent admissions or readmissions, to assist with accident prevention and to assist with the care of terminally ill patients. Proposals to accept direct referrals from a number of health care professionals are to be considered. Potentially charges will be recorded as a local land charge to assist with the recycling of funding.

- The introduction of grant funded rapid adaptations linked to and necessary for emergency housing provision to allow properties to be adapted in a timely fashion and keep clients close to their support network.

- Payment of client's contribution for mandatory grant, where hardship can be shown.

- Grants to remove adaptations and make good in private rented sector properties where the landlord would otherwise refuse permission for works to be carried out.

- To record NHS numbers on all grant applications in a searchable format, subject to clarification as to how this will be used to make the change appropriate.

- Housing Improvement team staff to be trained as trusted assessors and employment of an Occupational Therapist to work solely an adaptation work within the team.

- The annual payment of service agreements for lifting and hoisting equipment for safety and longevity reasons.

CONDITION 2: NHS contribution to social care is maintained in line with inflation

8.7 A considerable percentage of the fund has been set aside again in 2017/18 and for 2018/19 for the direct provision of social care.

8.8 Existing grants included in the fund that were originally from social care continue to be protected and are still fully accessible to social care services e.g. DoH Social Care Grant £4.49m.

8.9 Since the commencement of the BCF, the NHS contribution to social care has been increased in line with inflation as set out by NHS England. For 2017/18, this uplift was 1.8% as per the CCG allocation notifications.

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CONDITION 3: Agreement to invest in the NHS commissioned out of hospital services

8.10 In Bromley this requirement equates to £5.76m of the total fund. As the BCF plan (excel spreadsheet) demonstrates Bromley have exceeded that target with the CCG directly responsible for commissioning £6.41m of the fund.

8.11 The BCF plan for 2017-19 will continue direct investment in the following specific NHS commissioned out of hospital services.

- ✓ Winter pressures funding
- ✓ Dementia diagnosis and support
- ✓ Community equipment
- ✓ Intermediate care
- ✓ Health support into care homes
- ✓ Discharge team

CONDITION 4: Implementation of the High Impact Change Model

8.12 There has been significant work across the local system to align, develop and co-produce local plans to fully implement the eight High Impact Changes (HICs). Overseen by the A&E Delivery Board, plans look to build upon solid foundations already in place locally and to provide significant investment in order to establish and fully mobilise all eight changes.

8.13 Early Discharge Planning (HIC 1) is in place for planned procedures and all unplanned admissions are allocated an expected date of discharge from point of admission. Further work to ensure Expected Discharge Dates (EDDs) are challenging and appropriate and led by clinical optimisation is underway at the PRUH.

8.14 Implementation of the SAFER Bundle initiative has started with a programme of activity to identify, review and improve red/green days across the hospital by the senior management team (SMT) including twice weekly scrutiny of all patients with a current or imminent EDD and those Medical Stable For Transfer (line by line) as well as regular SMT and site management team input into Board Rounds to drive SAFER Bundle implementation. The multimillion pound IT investment programme due to be rolled out across the PRUH will provide robust systems to monitor patient flow (HIC 2) and allow demand and flow issues to be proactively managed.

8.15 The Transfer of Care Bureau (ToCB) is a well-established multidisciplinary discharge team (HIC 3) with further worked planned to enhance the role of the voluntary and community sector through the BCF funded Primary and Secondary Intervention Support Services (PSIS) including the Age UK ‘Meet and Greet Service’ which enables patients, without carers or family, to be transferred home safely.

8.16 Bromley’s philosophy is that ‘home is best’ and should be the first consideration for all hospital discharge with a range of commissioning activity to support this. For example the joint commissioning of community health services including rapid response, rehabilitation and reablement into a single point of access will provide more responsive community infrastructure to meet the needs of patients leaving the acute hospital and support more people to return home sooner for their long term care and support needs to be assessed.

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8.17 The Trusted assessor model which is used for health professionals at the front end of the hospital to restart packages of care is being rolled out to the back end of the hospital for patients whose care and support needs have not changed. In addition trusted assessor is being used to maximise the impact of ward based multi-disciplinary teams including rehab pathways to improve patient flow and continuity of care into the community.

8.18 Seven day working (HIC 5) is in place across the hospital with community health providers providing full services seven days per week. A reduced ToCB offer is available at the weekend and further work is required to ensure agencies are able to start and re-start packages of care, as well as access placements during evenings and weekends.

8.19 Recent implementation of trusted assessor (HIC 6) for acute therapists to access community rehab services and the roll out of restart of packages of care by any allied health professional is recuing unnecessary waste it in the system and improving timely patient transfer ensuring patients are in the right place, at the right time to meet their needs.

8.20 A localised discharge leaflet has been developed and is provided to all patients admitted to the hospital. A robust Choice protocol (HIC 7), shared across the local Acute Trusts, is in place with a fair and transparent escalation process. Patient and family engagement is done early to ensure individuals have the opportunity to fully consider their option while also ensuring a timely discharge form hospital. Care Home Select are commissioned via Kings Collage Hospital Trust to provide support, advice and guidance to self funders and are successful in brokering packages of care and placements in a timely way for this cohort of patients.

8.21 The red bag scheme has been rolled out across the whole of the borough to improve patient journey from care home to hospital and back again. Additional services are commissioned to support care homes including end of life care, Mobile Response Team (MRT) crisis response service and a Visiting Medical Officer (VMO) model. Further work to align existing activity to Enhanced Health in Care Homes (HIC 8) Guidance is underway with a Joint Care Home Strategy in development to provide a single vision and co-ordination of health and local authority resources to ensure a thriving and quality placement economy locally.

8.22 Going forward there are robust plans to further ensure all High Impact changes are realised fully locally. (See Section 13 – High Impact Change Areas).

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9. Performance against the National Metrics

9.1 Bromley is responding to the national metrics within the BCF. *Figure 9* below sets out the planned position for 2017/18 and improvement targets for 2018/19.

Figure 9: Metrics for Bromley

Metric	2016/17	2017/18 Plan	2018/19 Plan	Comments
Non-elective admissions (General and Acute)	26,856	26,353	26,518	The plan seeks to support the reduction of emergency admissions and stem growth against the 2016/17 outturn position for Bromley.
Admissions to residential and care homes	432.2 (per 100,000 population)	425.0 (per 100,000 population)	425.0 (per 100,000 population)	Analysis of 2016/17 performance has been undertaken and Bromley plan to maintain robust performance against this measure in 2017-19 by maintaining people at home with domiciliary care where appropriate
Effectiveness of Reablement	89.3%	90.1%	90.1%	Analysis of 2016/17 performance has been undertaken and Bromley plan to further improve performance against this metric in 2017-19 by commissioning enhanced reablement services
Delayed transfers of care*	6,435	5,299	4,722	Historic performance analysis shows deterioration in performance against this metric over the last year. Bromley is planning to improve performance in the number of delayed days in 2017-19 and plans are in place to support this across the health and social care system predominantly driven by the further development of the Transfer of Care Bureau

9.2 Over the last year Bromley has seen a decrease in emergency admissions at the local acute hospital, with 661 fewer admissions in 2016/17 than in 2015/16. This is, in part, due

to a change in the coding of Ambulatory Care Unit activity. In 2015/16 this activity was recorded as emergency admissions and it is now coded as outpatient activity. A number of initiatives are in place across the health economy to support a reduction in avoidable emergency admissions.

9.3 For admissions to residential/care homes and the effectiveness of reablement historic and 2015/16 performance has been assessed to ensure that ambitious but realistic targets are put in place for 2017-19. A significant level of investment is planned for 2017-19 to help keep people well in their own homes, which should positively influence performance against these targets but with an increasing aging population maintaining a steady state may be the achievable position.

10. Bromley's BCF Funding Principles

10.1. Local areas are encouraged to place more than the minimum requirement into the fund, but initially Bromley will stay with the minimum allocation. Bromley may however decide to vary and add to the fund in year if there is a good business case to do so and will do this under an amendment to our joint Section 75 agreement. The minimum requirement for Bromley as set out by NHS England stands at £22.125m

10.2 In summary the fund will continue to be used to create a shift in demand and supply from acute settings into community based services, reducing emergency hospital admissions and moving to a more proactive rather than reactive model of care.

10.3 Bromley have set out some funding principles for administration of the pooled fund between BCCG and LBB. These have been developed over the year and shared with the Health and Social Care Integration Board for their approval:

- ✓ The management of grants that pre-existed BCF and are now subsumed within it, as well as the on-going commitment to protect social care is protected and administered in exactly the same way as 2016/17.
- ✓ Those new additional revenue commitments that have come out of the BCF in 2016/17 are also protected for 2017/18.
- ✓ That any remaining uncommitted funds from 2016/17 are rolled over into the BCF for 2017/18 and used as one-off funds to 'pump prime' the system change required to deliver the local change programmes.
- ✓ That due to Local Authority funding the expectation is clear that although LBB support these local change programmes the LA cannot provide any additional funds to support the programmes. However they endorse the use of part of the BCF for this purpose as long as all existing commitments within the BCF and wider shared Section 75 are maintained.

10.4 The spending plan for the improved Better Care Fund (iBCF) funding for adult social care has been developed on the principle of investing the funding to create a sustainable adult social care system beyond 2020. The funding announced in November 2016 will be

invested in core social care services (£0m in 2017/18 and £2.014m in 2018/19). The additional IBCF announced in March 2017 (£4.184m in 2017/18 and £3.363m in 2018/19) will be invested in transformational projects that stabilise the social care market and support the High Impact Changes Model to reduce delayed discharges and reduce pressure on NHS services. It will also be invested in supporting and developing the provider market in the locality.

11. Funding Decisions and Risk Share

11.1 Refer to BCF planning template (tab 3) HWB Expenditure Plan detailing all schemes funded for 2017-19.

Care Act 2014

11.2 Total 2017/18 and 2018/19 funding is £0.6m relating to Support for Carers – New Strategy.

Reablement

11.3 Total 2017/18 funding is £2.118m and £2.161m for 2018/19

Carers breaks

11.4 Total 2017/18 and 2018/19 funding is £0.5m

Social Care

11.5 Total 2017/18 and 2018/19 funding is £9.0m. This consists of social care grant £4.5m and protecting social care £4.5m.

Improved Better Care Fund (iBCF)

11.6. It is confirmed that the IBCF will not be used to offset Minimum CCG contributions to the BCF. The IBCF will be invested in a number of schemes that are transformational and will ensure the sustainability of social care going forward.

11.6.1 In 2017/18 these investments will either be in pump priming revised services, dual running costs during pilots or other one off costs for schemes that support social care or reduce pressures on the NHS. Care has been taken in developing investment schemes for the IBCF that support the High Impact Changes Model. The relationship between the investment schemes and the High Impact Changes Model is summarised in *Table 3* below.

11.6.2 In addition a sum of money will be set aside to invest in an increase in residential nursing care in the Bromley locality.

Table 3. Investment schemes and the High Impact Change Model

DRAFT

IBCF Grant Condition	% of IBCF Invested in Grant Condition in 2017/18	Scheme Name	Supports High Impact Change Model
Meeting Adult Social Care Needs	62% (£2.599m)	Transformation of Social Care and Workforce Development	• 7 Day Services • Trusted Assessors • Focus on Choice
		Resources to Implement BCF and IBCF schemes	• Early Discharge Planning • Multi-disciplinary discharge Teams • Focus on Choice • Home First Discharge to Assess • Seven Day Services • Trusted assessors
		Transitioning from Children's Services to Adult Services	• Focus on Choice
		Public Health and Meeting Requirements of the JSNA	• Focus on Choice
		Investment in Additional Nursing Care facilities	• Enhancing health in Care Homes
Reducing Pressures on the NHS, including supporting more people to be discharged from hospital when ready	28% (£1.189m)	Placing Council Social Workers and Occupational Therapists into the Integrated Care Networks	• Early Discharge Planning • Multi-disciplinary discharge Teams
		Implementing Discharge to Assess in Extra Care Housing	• Home First / Discharge to Assess
Ensuring the Local Social Care Market is Supported	10% (£0.396m)	Investment in Mental Health Safeguarding	• Multi-disciplinary discharge Teams
		Investment in Increasing Uptake of Direct Payments	• Focus on Choice
		Developing and Supporting the wider provider marketplace	• Focus on Choice
		Investment into the 3rd Sector	• Focus on Choice
		Investment to Support Self Funders	• Focus on Choice

Risk Share

11.7 £1.347m has been allocated against risk share as advised in the BCF guidance to ensure some contingency to cover over performance in emergency admissions and not meeting the 1000 reduction to unplanned admissions. This is particularly important in Bromley as the planned reduction in emergency admissions was not delivered in 2016/17.

11.7.1 The contingency has been agreed and signed off by the CCG and the London Borough of Bromley and represents 27% of the risk. The outstanding £3.65m risk will be covered through the CCG's own contingencies and reserves. A key element of the MOU metrics is a performance fund dependant on the delivery of the emergency admissions reduction should the target not be met, this fund will be utilised to offset the risk set out above. The 2017/18 contract has been agreed with Kings College Hospital which includes an agreed activity profile including the QIPP reductions and an element of risk share on the overall targets. On this basis, we are assured that the contingency level is appropriate and the outstanding risk is covered.

11.7.2 The risks to providers in terms of a shift of acute spend being redirected into community services was explained to the HWB who fully support the direction of travel. It was explained that initial shifts in funding over the next year would be small but through building capacity and investing in the community services that these shifts from reactive to proactive care would accelerate over the next few years.

12. Programme Governance

12.1 The Local plan has now been agreed by both organisations executives and signed off collaboratively through the Health and Wellbeing Board.

12.2 The fund will be held by the Local Authority as in 2016/17 and the BCF will remain a standing item at the Joint Integrated Commissioning Executive (JICE) which meets monthly. Each organisation will give delegated powers to JICE to manage and oversee the day to day operations of the fund.

12.3 Increasingly the services paid for by the fund will be moved across into business as usual and subject to standard business processes and approvals, the only difference being that they continue to be funded through the BCF. The focus for JICE will be where BCF is funding new, redesigned or recommissioned services or projects that are brought in to deliver against the national conditions. Where these services or projects require procurement, reports will be taken back through the usual business processes in order to meet EU regulations and each organisations authorisation requirements.

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13. Additional relevant information

Document or information title	Synopsis and links
Joint Strategic Needs Assessment 2016	https://bromley.mylifeportal.co.uk/media/20397/final-report-jsna-2016.pdf
HWB Strategy	HWB Strategy 2012-2015
Bromley CCG Integrated Commissioning Plan 2014-2019	Bromley Integrated Plan 2014-19.pdf
Bromley's Out of Hospital Strategy 2015 – summary (full report available upon request)	The Bromley Out of Hospital Transformati
Commissioning Intentions feedback 2015	Feedback on our 2016.17 Commissioni
Bromley's Memorandum of Understanding with Providers for ICNs	Bromley Memorandum of Unde
Risk Log ICNs	RIsk Log at 20 April.pptx
Bromley Market Position Statement	Bromley Market Position Statement.pd
ICN operating model	ICN Operating Model - 15 December v1.ppt
High Impact Change Areas	201707 Hospitals to Home Response Deve

DRAFT

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**7th September 2017**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**Delayed Transfer of Care (DToC) Performance**
Contact Officer:	Jodie Adkin, Head of Discharge Commissioning Commissioning, LBB/BCCG Tel: 07803 496492 E-mail: Jodie.adkin@bromley.gov.uk
Chief Officer:	Ade Adetosoye, Deputy Chief Executive and Executive Director Education, Care and Health Services Angela Bhan, Chief Officer, Bromley CCG
Ward:	All

1. Summary

2. The NHS England Mandate for 2017-18 sets a target for reducing Delayed Transfers of Care (DToC) nationally to 3.5% of occupied bed days by September 2017. This equates to the NHS and Local Government working together so that, at a national level, delayed transfers of care are no more than 9.4 in every 100,000 adults (i.e. equivalent to a DToC rate of 3.5%).

The Integration and Better Care Fund Planning Requirement 2017-2019 required Health and Wellbeing Boards to submit a local DToC metric with expected reductions in both social care and NHS attributed delays alongside the first quarterly iBCF spending return.

The paper provides oversight of the submitted return and analysis of local performance in delayed transfer of care.

3. Reason for Report going to Health and Wellbeing Board

The report is for information and provides an overview of the submitted DToC target, for which the HWBB has oversight.

4. SPECIFIC ACTION REQUIRED BY HEALTH AND WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

It is advised that:

- The Health and Wellbeing Board receives regular reports on DToC performance locally and progress against plans to reduce delayed transfers.

- The Health and Wellbeing Board delegates responsibility for implementation and achievement of associated elements of the DToC target to:

    - Angela Bhan as the Chief Officer of Bromley CCG and Chair of the A&E Delivery Board for the achievement in reduction of NHS attributed delays

    - Ade Adetosoye as the Deputy Chief Executive and Executive Director Education, Care and Health Services for achievement of social care attributed delays.

Health & Wellbeing Strategy

1. Related priority: Delayed Transfer of Care

Financial

1. Cost of proposal: within existing budgets

2. Ongoing costs: within existing budgets

3. Total savings: Not Applicable:

4. Budget host organisation:

5. Source of funding:

6. Beneficiary/beneficiaries of any savings:

Supporting Public Health Outcome Indicators:

Yes, reducing mortality and morbidity by reducing unnecessary stays in hospital

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5. COMMENTARY

5.1 A target of 13.72 bed days per day has been submitted to NHSE, which is a 24% reduction on 16/17 out turn activity of 17.63 bed days per day equating to 3802 total delayed days from September to March 2018. This equates to 9 bed days per day (2488 delayed days) attributed to social care delays and 4.3 bed days/day (1130 delayed days) for NHS attributed delays and 0.4 attributed to both systems.

5.2 The original target given by NHSE suggested a 24% reduction on January – April 2017 performance (from 13.79 bed days/day to a target of 10.31 bed days/day). This does not take into account seasonal variations in performance and is significantly lower than the 2017/18 out turn figure of 17.63 delayed days/day. Based on 2017/18 out turn, the suggested target of 10.31 delayed days/day would require a 58% reduction.

5.3 There is also variation in published figures and those used by NHSE to come to the proposed target. London Borough of Bromley and Bromley CCG have therefore submitted a joint target of 13.40 bed days/day based on a 24% reduction given by NHSE but applied to the 17/18 out turn figure, and not the lower January – April 2017 figure. NHSE has yet to confirm acceptance of this proposal.

6 IMPACT ON VULNERABLE PEOPLE AND CHILDREN

The implementation of the Bromley Discharge to Assess (D2A) model will ensure vulnerable adults who have been acutely unwell but have on-going care and support needs, are appropriately assessed and supported in the right place at the right time to maximise recovery, independence and staying well in the community for longer. The D2A model will also reduce the risk of infection and deconditioning associated with prolonged hospital admission by reducing length of stay post medical optimisation.

7 FINANCIAL IMPLICATIONS

8 LEGAL IMPLICATIONS

The Government have mandated NHSE to agree Delayed transfer of Care Targets with local Health and Wellbeing Boards to come into effect from September 2017. The Integrated and Better Care Fund Planning Guidance requires HWBB to submit a DToC metric including NHS and social care attributed delay targets by July 2017.

9 IMPLICATIONS FOR OTHER GOVERNANCE ARRANGEMENTS, BOARDS AND PARTNERSHIP ARRANGEMENTS, INCLUDING ANY POLICY AND FINANCIAL CHANGES, REQUIRED TO PROCESS THE ITEM

Delegated responsibility for achieving the health associated DToC to the A&E Delivery Board, which will be overseen by the evolving joint commissioning arrangements being developed between London Borough of Bromley and Bromley CCG

10 COMMENT FROM THE DIRECTOR OF AUTHOR ORGANISATION

Reducing the level of Delayed Transfers of Care (DToCs) is challenging but clearly is an important area of joint working between health and social care services. Reducing the level of unnecessary hospital stays for vulnerable patients will have significant impact on maintaining independence and health

Non-Applicable Sections:	Financial Implications Supporting Public Health Outcome Indicators
Background Documents: (Access via Contact Officer)	[Title of document and date]

Glossary

A&E	Accident and Emergency
BCF/iBCF	Better Care Fund
CCG	Clinical Commissioning Group
D2A	Discharge to Assess
DToC	Delayed Transfer of Care
HWBB	Health and Well Being Board
LBB	London Borough of Bromley

Bromley Health and Wellbeing Board

Date: Thursday 7 September 2017

Report title: Proposal for a falls prevention expert task and finish group

Report author: Laura Austin Croft, Public Health Specialty Registrar

Chief Officer: Dr Nada Lemic, Director of Public Health

1. SUMMARY

1.1 Reducing the number of falls in older people is an important consideration for Bromley in light of the increasing proportion of older people in the borough. Falls cause a high amount of morbidity and mortality in older people in addition to early admissions to residential homes. They also result in a high level of emergency hospital admissions. Preventing falls can therefore potentially save hospital costs in addition to improving quality of life for older people.

1.2 Falls are generally not events in themselves. They are often associated with long term health conditions, for example related to the impacts of medication, and can be a sign of underlying health issues such as frailty[1]. They may also be associated with environmental risks. Fall prevention therefore requires a multifaceted approach.

1.2 This paper scopes a proposal for an expert task and finish group to investigate the numbers and types of falls affecting Bromley's older population, with the intention of producing a summary report with recommendations for action.

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

The Health and Well Being Board is asked to review the proposal and agree the approach set out.

3. INTRODUCTION

3.1 Routine data is not easily accessible at a borough level to help understand the extent of falls in the borough. The National Institute of Clinical Excellence (NICE) estimates that around a third of all people aged 65 years and over fall each year (estimated at 19,082 people in Bromley) increasing to half of those aged 80 and over in London (estimated at 8,577 people in Bromley[2]).

3.2 Data for the London region shows rising rates of falls in relation to indicators for emergency hospital admissions for the over 65 years old age

[1] Falls and fractures consensus statement, Public Health England (2017)
[2] Interim 2015-based demographic projections, long term migration scenario, GLA 2017 https://data.london.gov.uk/dataset/interim-2015-based-population-projections/resource/af57691d-fcbf-4839-8a6c-181c1dd2f9df

group and 65-79 years age group (with a stable rate for the over 80 years)[3]. The 2016 Bromley JSNA includes estimates from the RNIB on the number of older people falling owing to sight loss (estimated at around 9,487 people aged over 65 per year). It also draws attention to the risk of falls amongst people experiencing hearing loss.

4. PROPOSED EXPERT TASK AND FINISH GROUP

4.1 GROUP COMPOSITION

Chair: Professor Cameron Swift (previous Chair of the Falls Guideline Development Group at NICE) - to be approached

Membership (provisional):
Bromley Public Health Team
Bromley Clinical Commissioning Group (CCG)
Bromley Social Care team
Bromley Housing team
The Falls Clinic, Princess Royal University Hospital
London Ambulance Service representatives
Health watch
Bromley care home forum representative(s)
Age UK Bromley and Greenwich
Occupational Therapist representation
Safer Bromley Partnership representation
Public Health England National Falls Prevention Clinical Group

4.2 DRAFT ROLES FOR THE GROUP

1. Oversee falls epidemiology research for Bromley
This research will map the extent and type of falls in the borough through:

- Accessing and analysing relevant hospital indicators including emergency admissions, non-elective bed days, A&E attendances in addition to non-emergency related hospital stays. This will also examine injury type and level of severity (for example, type of fracture and subsequent length of hospital stay).

- Where possible map hospital admissions to areas of residence to understand if the impact of falls is felt by some groups of older people more than others (for example, in areas with higher levels of deprivation). In addition identify frequent location of falls if possible, for example the frequency at home, outside and in community institutions (hospital, nursing homes). To note, this information may be unavailable.

[3]Age-sex standardized rate of emergency hospital admissions for injuries due to falls in persons aged 65 years plus at 2,253 per 100,000 in London compared to the South East region at 2,137 per 100,000
http://fingertips.phe.org.uk/search/falls#page/0/gid/1/pat/15/par/E39000018/ati/6/are/E38000023

- Access any additional data that help understand falls in Bromley particularly in terms of falls taking place outside the hospital environment[4]. For example social care data, liaisons with emergency services, data from, the community alarm system, community pharmacists, care homes and Bromley's voluntary sector. Bromley's Extra Care Housing Schemes provides potential to monitor the frequency and type of falls.

- Explore any impact of seasonal changes on the number of falls in the borough, broken down by age group and gender.

2. Assess falls prevention work currently undertaken in the borough

- Undertake a literature review to summarise the current evidence base in terms of fall prevention.

- Carry out interviews with service providers working to reduce falls in the borough, including:
  - understanding routine identification of those most vulnerable to falling
  - home hazard assessment and improvement programmes
  - effective links to health promotion programmes for older people (such as physical activity and smoking reduction support).

- Engagement with older people groups and carers to ensure preventative activity is carried out in a meaningful way that is appropriate for the people it is targeted at.

3. Production of a summary report with recommendations for action

This report will be brought back to the Health and Well-being Board for discussion, including approaches to embedding the group's recommendations into service planning in Bromley. For example, through the care homes training programme and/ or integrated into the commissioning of preventative servicers with the third sector.

4.3 TIMESCALE

December to May 2017

To note: This timescale aligns with when there is public health specialist trainee support to coordinate this piece of work.

[4] It is estimated that around 5% of cases of a fall leads to fracture and hospitalisation. Falls and fractures consensus statement, Public Health England (2017)

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MAYOR OF LONDON

Better Health For All Londoners

CONSULTATION ON THE LONDON HEALTH INEQUALITIES STRATEGY

August 2017

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Contents

Foreword

I believe London is the greatest city in the world, but like any global city we are grappling with some major challenges. One of the most pressing is the stark health inequalities that still exist across our city.

Many Londoners enjoy some of the highest standards of living in the Western world. However, the reality is that when it comes to health and wellbeing, our city is still deeply divided. Too many Londoners are still suffering ill health because of social and economic exclusion.

Perhaps the most striking evidence of this is in how long Londoners can expect to live in good health. Healthy life expectancy rates vary enormously - not only across London, but from postcode to postcode and street to street within the same boroughs.

I am committed to doing all that I can to address these inequalities. My vision is for a healthier, fairer city, where nobody's health suffers simply because of who they are or where they live. It is unacceptable that your background, upbringing or financial circumstances can still determine the quality of your health. Improving the health of Londoners will also help them make the most of the opportunities here and reach their potential.

That's why, as London's Mayor, I am working with others to address this problem now. I want to reduce the health inequalities that exist between different groups, and explore ways to improve the physical and mental health of all Londoners. As set out in this strategy, City Hall will work to support early years development so that babies and young children have the best possible start in life. We will tackle poor air quality in the most polluted parts of our city. We will also aim for a reduction in childhood obesity over the next ten years. In addition, we will place more emphasis on improving Londoners' mental health.

I will also continue to champion our brilliant National Health Service and the interests of all its staff and patients, as I always have done. City Hall is committed to supporting the fantastic work our NHS doctors, nurses and others do treating Londoners. We will also encourage local healthcare providers to be ambitious in their own plans for reducing health inequalities and preventing ill-health.

We are also striving to create a fairer economy, a more integrated society and an environment that helps people stay fit and healthy. I strongly believe a city that does not value the health of all its citizens is one that will fail to achieve a prosperous future. By working together, we can help all Londoners, their families and communities, so that everyone can enjoy healthy, happy and fulfilling lives.

Sadiq Khan,
Mayor of London

Chapter 01
Executive Summary

This document is a consultation on a Health Inequalities Strategy for London.

It describes some of the main issues which lead to inequalities in the health of different groups of Londoners, and proposes a set of aims for reducing them. It explains what the Mayor sees as his role in meeting these aims. Finally, it invites others to get involved by giving their feedback and by pledging to do something to reduce health inequalities themselves.

The length of time that Londoners can expect to live in good health varies widely across the city. This is both unfair and avoidable. The proposed overall ambition of the strategy is to reduce this unfair variation while also improving the overall health of Londoners.

The causes of these differences are complicated. Even though there is much that the Mayor can do about them, he cannot act alone. The Mayor has identified his key ambitions for this strategy, but achieving any of them will need help from many others. This means that the final strategy will be supported by partnership work with people and organisations from across London, both within and beyond the public sector.

HEALTHY CHILDREN

The first aim of the strategy is for every London child to have a healthy start in life. Differences in the development of children and babies start from their very earliest days. This can affect their health and wellbeing throughout their lives. That means if we are to make London a healthier city, we need to start with babies and children.

The Mayor wants to support London's early years settings to surround children with environments that help them to play, eat, socialise and develop well. This will build on his existing successful Healthy Schools London programme.

The Mayor's key ambition is to launch a new health programme that will support London's early years settings. This will be twinned with his successful Healthy Schools London programme, ensuring London's children have healthy places in which to learn, play and develop.

HEALTHY MINDS

The second aim of the strategy is for all Londoners to share in a city with the best mental health in the world. Poor mental health is both a cause and a consequence of other inequalities. Rates of mental ill-health are higher among some disadvantaged groups. People with severe mental illness also have much lower life expectancy than the rest of the population. Stigma related to mental ill-health is also widespread, and far too many Londoners take their own lives every year. Many have not previously felt able to seek help.

The Mayor wants many more Londoners to feel comfortable talking about mental health. His aim is for fewer people to feel stigmatised and for people across the city to work together to reduce suicide.

The Mayor's key ambition is to inspire more Londoners to have mental health first aid training, and more London employers to support it.

HEALTHY PLACES

The third aim of the strategy will be for all Londoners to benefit from a society, environment and economy that promotes good mental and physical health. The places where we live, learn, work and play have a profound impact on our health and wellbeing. Too many parts of London have poor access to healthy, pleasant streets and green space. Poor air quality in London is more concentrated around schools with a higher proportion of children who receive free school meals. Meanwhile, social and economic inequalities mean that too few Londoners have access to good work, and too many Londoners struggle to afford a decent home.

The Mayor wants London to be a place where our surroundings and where we live support good health.

The Mayor's key ambition is to work towards London having the best air quality of any major global city.

HEALTHY COMMUNITIES

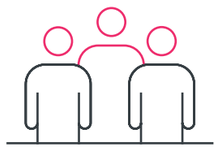
The fourth aim of the strategy is for London's diverse communities to be healthy and thriving. Communities that are better connected and engaged are more socially integrated. They are also healthier. The Mayor would like more people to have the power to act on the things that affect their health. He wants more people to have access to groups, places and networks that make their community a healthy place. One way to do this is through social prescribing, which is a way to refer people to community-based services.

Aiming to support healthy communities also means tackling discrimination and stigma, and supporting the people at risk of conditions such as TB and HIV.

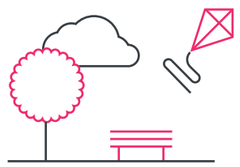
The Mayor's key ambition is to support the most disadvantaged Londoners to benefit from social prescribing to improve their health and wellbeing.

Ensuring London's children have healthy places in which to learn, play and develop

Inspire more Londoners to have mental health first aid training



Work towards London having the best air quality of any major global city



Support more Londoners to benefit from social prescribing

HEALTHY HABITS

The fifth and final aim of the strategy is to ensure that the healthy choice is the easy choice for all Londoners. The combination of smoking, excessive drinking, physical inactivity and an unhealthy diet is too common in some communities, leading to health problems. Reducing this inequality means making it easy for some communities in the most disadvantaged areas to eat well and be active. This can be achieved by ensuring all Londoners have access to healthy and affordable food and to the city's good quality green space and public spaces. It also means reducing smoking and harm from alcohol misuse.

The Mayor's key ambition for this strategic aim is to work with partners towards a reduction in childhood obesity rates and a reduction in the gap between the boroughs with the highest and lowest rates of child obesity.

Work with partners towards a reduction in childhood obesity rates.

Chapter 02 Introduction: a healthier, fairer city

The Mayor's vision is for a healthier, fairer city, where nobody's health suffers because of who they are or where they live.

We want to create a city where all Londoners have the best opportunity to live a healthy life.

Helping Londoners lead healthier lives will benefit London's economy. Indeed, London will never reach its full potential while so many Londoners are living with poor health.

It matters for public services like the NHS too. When we don't do enough to keep people healthy, it puts a huge strain on our health and social care system.

But above all, it matters to the people who call this city home. Cities that are more equal are happier, safer and healthier, so reducing London's health inequalities will make a difference to us all.

LONDON'S HEALTH

London has the potential to become the world's healthiest global city. The overall health and wellbeing of Londoners is improving. Over the last decade, there has been a fall in the rates of early death from cancer and heart, circulatory and lung diseases. Life expectancy for Londoners is now more than 80 years for men and more than 84 years for women.[1]

London is a vibrant, tolerant, open and a relatively healthy place, but we face challenges. Major environmental, social and economic changes are underway. Our population is growing, our working patterns are changing, and poverty - linked to housing costs, low pay and debt - is rising.

London also has the widest health inequalities in England. All Londoners deserve a fair opportunity to live a long life, and to be well enough to get the best out of life in London at any age. Currently, too many are missing out.

WHAT ARE HEALTH INEQUALITIES?

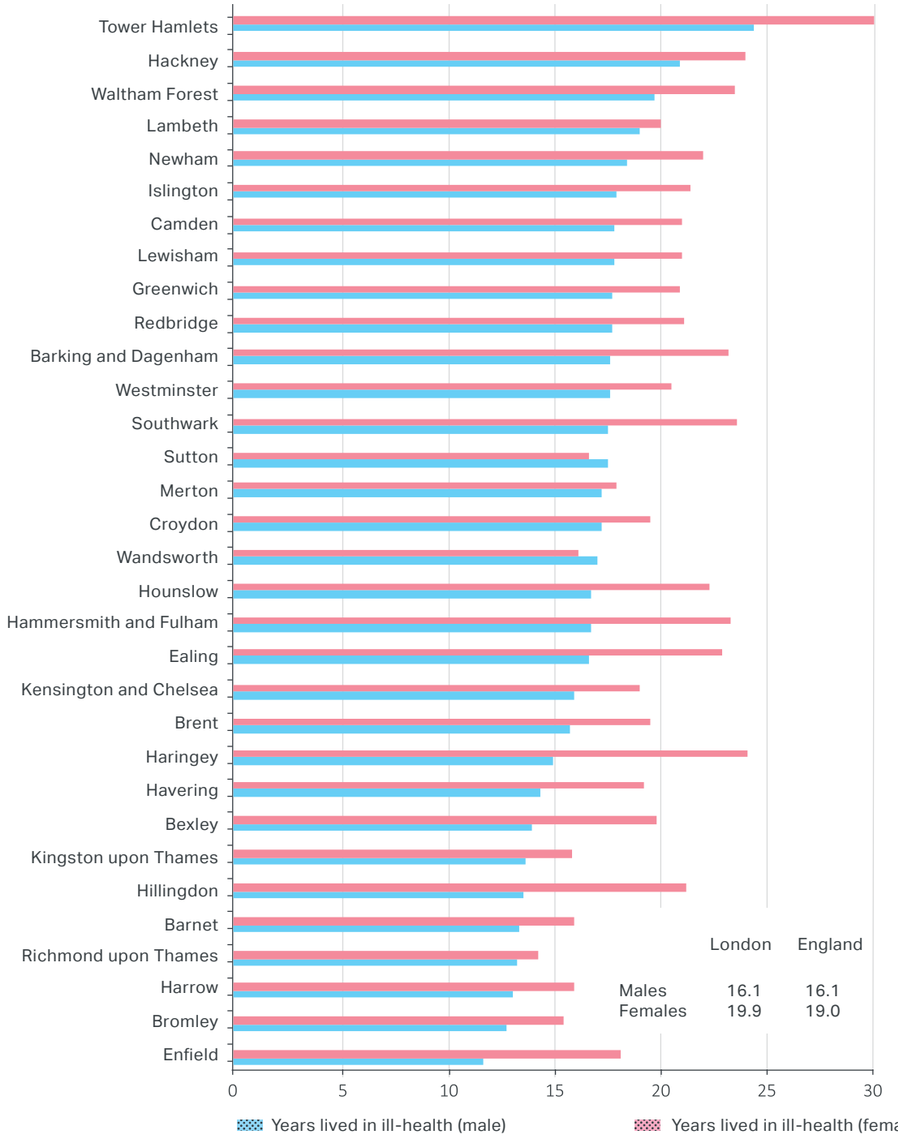
Health inequalities are systematic, avoidable and unfair differences in mental or physical health between groups of people. These differences affect how long people live in good health. They are mostly a result of differences in people's homes, education and childhood experiences, their environments, their jobs and employment prospects, their access to good public services and their habits.[2]

The rate of early deaths from preventable causes is twice as high in Tower Hamlets as it is in the nearby City of London.[3] But inequalities don't just lead to people dying early. They also unnecessarily undermine people's quality of life. People from some of London's deprived neighbourhoods are unnecessarily living with ill-health for years, or even decades. For example, women in Tower Hamlets can expect to spend 37 per cent of their lives in poor health – that's equivalent to 30 years.[4] Many of their health problems could be prevented.

But it isn't only deprived communities whose health suffers because of the inequalities in our city. There is a clear relationship between wealth and health which means that everyone but the very richest is likely to have some avoidable illness[5].

We know that cities with lower levels of inequality are also healthier overall. This means that if we focus on reducing inequalities, we will make London a healthier city as well as a fairer one.[6] It is why health inequalities cannot be seen in isolation. Improving Londoners' health will also be a result of how we tackle the housing crisis, and how we give people the skills they need to access well paid, stable employment.

Figure 1: Years of life lived in ill-health by borough, male and female



Reference: Public Health England, Public Health Outcomes Framework, calculated as the difference between life expectancy at birth indicator 0.1i and healthy life expectancy at birth indicator 0.1ii, 2013-15
Note: Calculated by taking Healthy Life Expectancy 2013-15 from Life expectancy at birth 2013-15

This consultation will inform a strategy for all Londoners, because all Londoners should have a fair opportunity for good health. However, it also recognises that some people and some communities need proportionately more help to improve their health because of their backgrounds and their experiences.

WHAT ARE WE TRYING TO CHANGE?

The final strategy will have succeeded if we see better overall health as well as less variation in how long different Londoners can expect to live in good health.[7] At present, healthy life expectancy varies between boroughs by more than 15 years for men and almost 19 years for women[8]. Variation between local neighbourhoods is even wider.

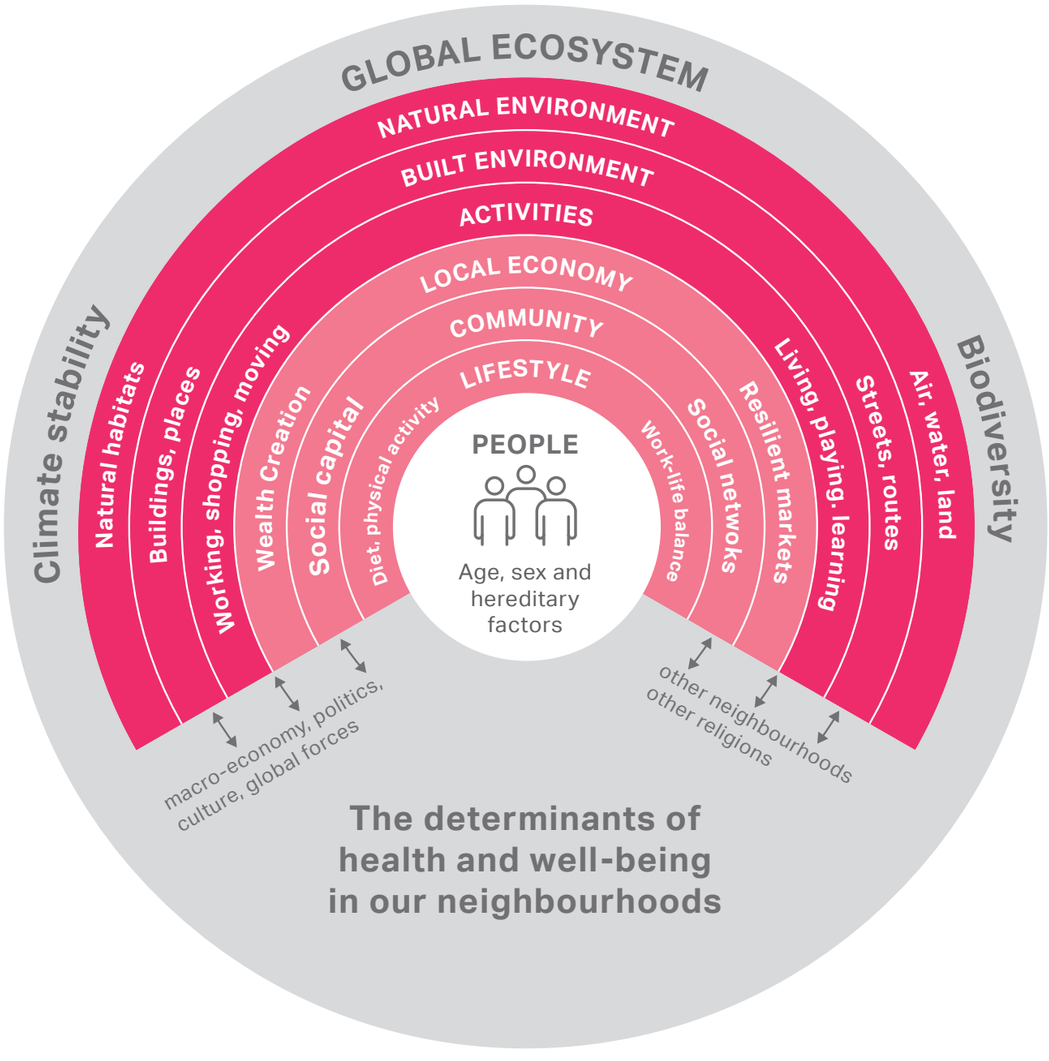
The overall ambition for the new Health Inequalities Strategy is to see healthy life expectancy as well as less variation in how long men and women and different Londoners can expect to live in good health.

WHAT THE MAYOR OF LONDON CAN DO

A City for All Londoners, published in October 2016, set out a broad and inclusive vision for London. It also explained the Mayor's overall ambition for a fairer city. The Mayor has a direct influence over some of the things which affect the health of Londoners. He will make the most of that role to reduce health inequalities.

Figure 2 shows that many things affect our health. For example, we know that a decent family income and good employment will support healthy development for young children. It will also increase access to good food, culture and exercise and support positive mental health. Meanwhile, those in poverty may face many different problems which combine to result in worse health. They are less likely to have a good diet and secure good quality housing, and are more likely to have problems accessing key public services.

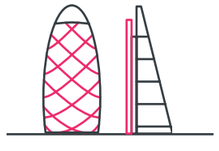
Figure 2: Social, economic and environmental influences on health and wellbeing



Source: Adapted from Dahlgren and Whitehead[9]

2 x

The rate of early deaths from preventable causes is twice as high in Tower Hamlets as it is in the City of London



Reference: Public Health England, Public Health Outcomes Framework, Mortality rate from causes considered preventable, indicator 4.03, 2013-15

"The overall ambition for the new Health Inequalities Strategy is to see healthy life expectancy as well as less variation in how long men and women and different Londoners can expect to live in good health."

The Mayor's responsibilities for planning, transport, housing, economic development, culture, policing and the environment mean he can make a difference to many of these things. New strategies and policies are in development at City Hall for all these areas, as well as for other key issues such as food, education and sport. This has given the Mayor a unique opportunity to think about how everything he does can affect the health of different groups of Londoners. Examples of how the Mayor plans to reduce health inequalities in all his work appear throughout this document.

There are similar opportunities for other organisations to do the same in their own planning. For example, the NHS and local councils are coming together to develop and put in place local Sustainability and Transformation Partnerships. These partnerships give them a chance to work together to address health inequalities and prevent ill-health.

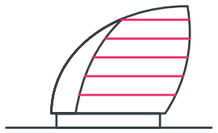
The Mayor is ensuring that health and health inequalities are systematically considered in the development of his new strategies. This relates to both mental and physical health.

The topics in this consultation involve and affect many different people and organisations. Work to reduce health inequalities is already happening in local neighbourhoods, boroughs, and across the city. A vital part of the Mayor's role is to work with those organisations and people, and speak out about their great efforts to reduce health inequalities.

Figure 3: The Mayor's role in reducing health inequalities

ENSURING ALL THE MAYOR'S WORK CONTRIBUTES

- Environment
- Planning
- Housing
- Transport
- Economic development
- Culture
- Policing



CHAMPIONING WORK FROM ACROSS LONDON

- Speaking out about health inequalities
- Challenging and championing the health sector to reduce inequalities
- Generating consensus from others as chair of the London Health Board

DIRECTING SUPPORT FROM CITY HALL

- Delivering City Hall's health programmes
- Consulting and engaging Londoners
- Reporting on actions and outcomes

WHAT OTHERS CAN DO

The Mayor has a legal responsibility to publish this strategy, but not to act alone. According to the GLA Act,[10] the Health Inequalities Strategy must:

a) identify any issues that appear to the Mayor to be major health issues where there are health inequalities between persons living in Greater London

b) identify those inequalities

c) specify priorities for reducing those inequalities

d) describe the role to be performed by any relevant body or person in terms of implementing the strategy

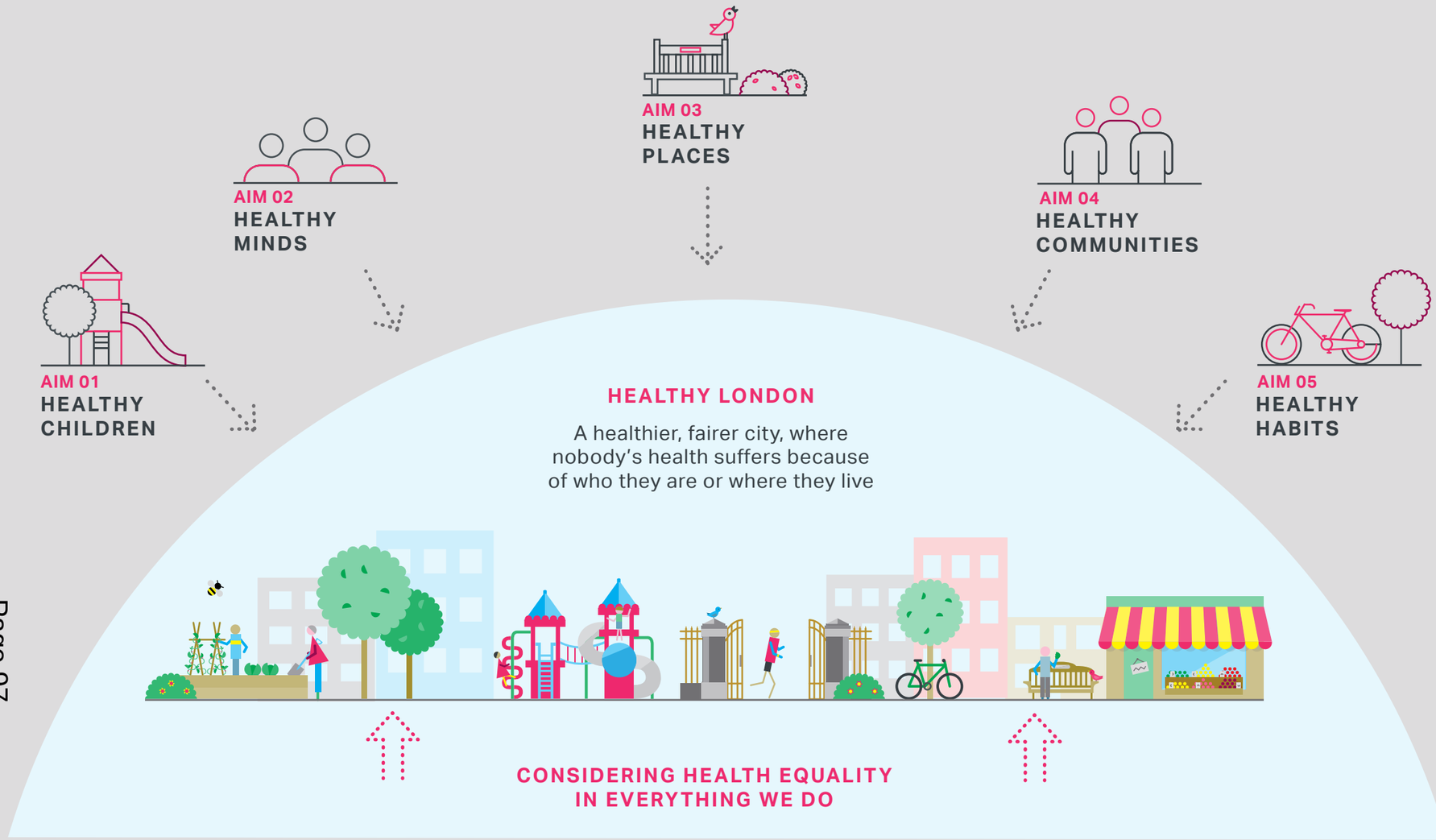
Reducing health inequalities needs the commitment, support and focus of many people and organisations across London. Here are the roles of some that are already having an impact:

- Local authorities, with the support of Public Health England take responsibility for prevention of ill-health, public health services and social care
- Schools and early years settings support London's children to learn, play, develop and live well
- Businesses and social enterprises can support their employees and customers to develop healthy habits
- The local voluntary and community sector supports and works with Londoners in their own neighbourhoods
- NHS organisations work together to commission and provide some of the world's best healthcare to Londoners

All these groups and organisations are doing important work. This consultation asks them – and others – what they see as their role, what could help them do more and what they could achieve by working in partnership. This will inform the final version of the strategy and help to more fully define the roles of relevant bodies in implementation.

But much of our health and wellbeing takes shape outside formal organisations. Our families, friends and homes all shape our health. We all have our own part to play in supporting ourselves and others to stay mentally and physically healthy. This might be through supporting friends, family and colleagues; through volunteering, or simply through how we lead our lives. That's why this consultation also invites Londoners to support a vision for a fairer, healthier city and tell us what it means to them.

Figure 4: Overview of strategy consultation



Chapter 03 About this consultation

This consultation explains what the Mayor is proposing to do to reduce health inequalities in the city. It invites London's local councils, NHS, other public-sector bodies, businesses, schools, voluntary and community groups and people to get involved, share their good work, and tell us what would help them to do even more.

PURPOSE OF THIS CONSULTATION

This consultation sets out five broad aims – for healthy children, healthy minds, healthy places, healthy communities and healthy habits.

These have been chosen after a review of the evidence and talking to Londoners, experts and stakeholders as the topics where inequalities are most relevant in London.

The Mayor and the London Health Board have developed these together and the Mayor is now consulting on them.[11] Health board members would like to see these five aims become shared priorities for London to work together to reduce health inequalities.

All five of the aims are reinforced by our main ambition to consider health inequalities in everything we do.

For each of these aims, we will seek to engage **all** Londoners, because health inequalities affect us all. However, there will be proportionately more focus for those who need the most help because of their backgrounds and experiences. This approach is known as 'proportionate universalism'.[12] It is the best way to reduce health inequalities between people in all parts of society.

The five aims reaffirm, build on and complement the ten shared ambitions for health in London which were agreed after the London Health Commission's Better Health for London report was published.[13] They also recognise the opportunities to go further and faster enabled by the 2015 London Health and Care Collaboration Agreement, London Health Devolution Agreement and forthcoming London Health and Care Devolution Memorandum of Understanding.[14]

The consultation sets out the Mayor's policies and proposals, and what he will do to meet the aims in his current term. These plans are an important starting point and set an ambitious agenda, but they aren't exhaustive. Much more than this will be needed to realise his vision for a healthier, fairer city.

This document asks what matters should be included and what issues should be taken into account to finalise the strategy. Your feedback will help to refine the aims and the Mayor's policies and proposals. It will ensure they have the greatest possible impact to improve health and reduce health inequalities.

But it also goes beyond a simple consultation. We don't just want to know what you think. We want to know how you can help. We want to know what you're already doing. We want to know what would help you do even more. And we want to know how the Mayor can support coordinated action across London.

HOW THIS CONSULTATION DOCUMENT WAS DEVELOPED

The aims, policies and proposals in this document have been shaped by evidence of the health inequalities issues affecting Londoners and what can be done about them. They have also been refined through early consultation with Londoners, community groups and others during the autumn of 2016, via the Mayor's consultation on A City for All Londoners.

The London Health Board agreed on the five aims based on this evidence and feedback. In deciding on these priorities, the board thought about:

- the extent of an issue's impact on gaps in healthy life expectancy
- the extent of the differences across London
- the strength of evidence that effective action could be taken.

The Mayor's plans outlined in this consultation are built on commitments made in his manifesto to get to grips with health inequality. He has pledged to improve air quality, to promote healthy habits to disadvantaged groups, to renew focus on prevention of TB and HIV, to reduce child obesity, to break down the stigma of mental illness and to coordinate efforts to reduce suicide rates. He has also promised to improve London's housing, environment and economy, all of which make an important difference to the health of Londoners.

The aims and policies proposed here have also been shaped by the interim recommendations of an Integrated Impact Assessment (IIA). This considered the potential impact of the strategy on London's economy, environment and community safety as well as its impact on health and equalities. The IIA report will also be published for comment during the consultation period.

The Mayor's priorities for reducing health inequalities are described by the objectives of this strategy. His policies and proposals are described within each objective.

These Mayoral policies and proposals are indicated in bold throughout this document.

THE FINAL STRATEGY

The final strategy will be published after we analyse the responses to this consultation document and the consultation on the Integrated Impact Assessment. It will set an ambition for the next ten years. This is deliberately a shorter timetable than some of the Mayor's other strategies. Ten years allows us to make ambitious long-term plans. It is also soon enough to be held accountable for immediate action to reduce health inequality. We will regularly take stock of progress and report on it in between.

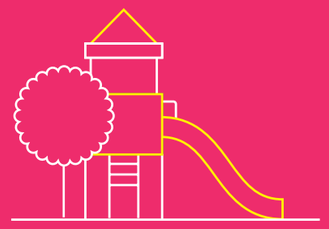
There will also be a delivery plan alongside the final strategy. This will be a separate document to the strategy itself and will be frequently refreshed over the strategy's ten-year lifetime. We will also publish indicators to be used to measure how London's health inequalities are changing.

The Health Inequalities Strategy will set out the Mayor's vision for a healthier, fairer city over the next ten years. It outlines in detail the Mayor's policies and proposals and what he will do in his current term, which he hopes will provide an important starting point to realising the longer term ambition. This will include any changes that have been made because of your feedback on this consultation document. It will also include examples of commitments that other organisations in London will make in support of the five aims, and detail how the Mayor will work with and support them. It will explain how roll-out of this strategy can be measured and overseen in partnership with the London Health Board.

Working with Public Health England, the Mayor will track London's progress in reducing health inequalities and report this via the London Health Board.

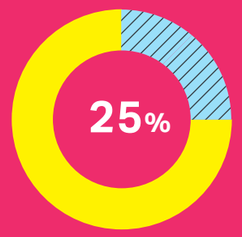
Chapter 04

AIM ONE



Healthy Children:

EVERY LONDON CHILD HAS A HEALTHY START IN LIFE

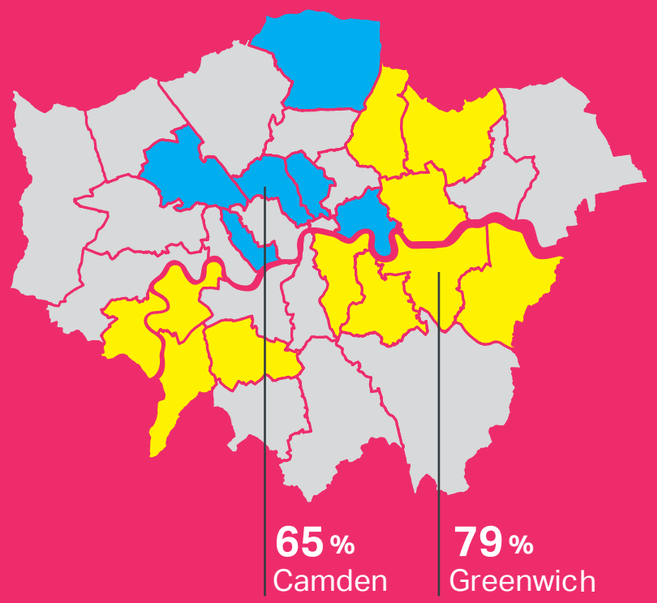


of 5 year-olds have tooth decay when they start school

There are wide variations between the proportion of children who are ready for school in London: 65 per cent in Camden compared to 79 per cent in Greenwich

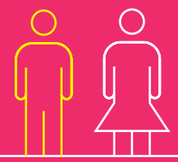
- Better than England
- Same as England
- Worse than England

of children in London aged 5 years do not achieve a good level of development



1.2 x

Girls are 1.2 times more likely to have a good level of development compared to boys



1.2 x

Pupils not eligible for free school meals are 1.2 times more likely to have a good level of development compared to those who are eligible

Babies born in Kensington and Chelsea are half as likely to have a low birth weight as those born in Redbridge

Low birth weight is associated with increased risk of

- Childhood mortality
- Developmental problems
- Poor health in later life

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Public Health England, Public Health Profiles – Fingertips online data tool, https://fingertips.phe.org.uk/. Date accessed: 15 June 2017

The Mayor wants every London child and young person to have a healthy start in life.

Poor physical and mental health in early years and childhood has been shown to have consequences that reach into adolescence and adulthood. By the time children are old enough to start school, inequality is already well entrenched. Poor health can limit a child's opportunities long before they are able to make decisions for themselves.

There are wide differences between London's diverse communities in key indicators of child health and wellbeing. These include childhood obesity rates, exposure to traumatic and stressful experiences, low birth weight, and oral health. Many of these are related to poverty, so tackling child poverty and other wider influences on child health are vitally important to reduce health inequalities. There is more information about the Mayor's work on this in the Healthy Places chapter.

A healthier, fairer city starts with excellent health for all children and young people. This will be achieved through support for fair and equal access to healthier, good quality, early education and childcare and laying the foundations for good lifelong health.

There are two objectives to help achieve the Mayor's vision:

1. London's babies have the best start to their life
2. Early years settings and schools support children and young people's health and wellbeing

OBJECTIVE 1.1:

London's babies have the best start to their life

The causes of poor health in young children can start even before they are born. Inequalities in pregnant women's incomes, housing, habits and access to effective healthcare and other services all have an impact. For some, this can mean that they don't reach health services until late in their pregnancy, which can lead to late diagnosis of health conditions and low birth weight. These can seriously limit a child's development and learning[15].

From birth, one of the best things we can do to address health inequalities is to support parents[16]. We must do all we can to help them to cope with the challenges of parenting. This includes supporting them to have their children vaccinated against preventable illness and helping them to keep themselves healthy. It also includes enabling them to understand a child's development goals and the potential health issues they might encounter. Together, these can all help parents to give their children a healthy start in life. Social prescribing may be one way to help this, and you can read more about it in the Healthy Communities chapter.

The NHS, along with London's boroughs and with the Mayor's support, will soon launch the Child Health Digital Hub. This includes an online version of the traditional Red Book given to all parents at the birth of their child. This helps parents and health professionals keep a track of screenings, vaccinations and the child's physical development. It will enable parents to have one complete and consistent view of the health of their children, no matter which agency they engage with or where in London they live.

The Child Health Digital Hub is for every family. But it will also help to reduce inequalities by helping us to better understand how children's health varies across London. The way we collect and understand child health data hasn't changed in over 20 years. Updating our approach will allow the NHS and London's boroughs to better plan services and target the right support where it is most needed across London as early as possible.

Making it easy for mothers who want to breastfeed is also vital to early life. Breastfeeding is not only good for the health and development of infants, it is also good for the health of mothers[17]. However, breastfeeding can be very difficult to start or sustain and there is wide variation across London in both the rates of breastfeeding initiation and the proportion of mothers who stop breastfeeding.[18] London needs to become a more welcoming city for breastfeeding. The London Healthy Workplace Charter is the Mayor's award scheme to help workplaces to be healthier environments. Through this, we will encourage businesses to ensure that flexible working practices and family friendly policies are in place, including policies supporting breastfeeding.

The Mayor will show his support for the launch of the Child Health Digital Hub, including the new e-Red Book, supporting parents to better understand the health of their children and how they are developing.

The Mayor will continue to encourage businesses to put in place flexible working practices and family friendly policies, including policies on breastfeeding through the London Healthy Workplace Charter.

City Hall will lead by example in supporting mothers who wish to breastfeed while visiting or working here.

OBJECTIVE 1.2:
Early years settings and schools support children and young people's health and wellbeing
Safe, healthy environments where all children can develop, learn and play are essential to give all of London's children a healthy start in life. We know that for children to develop healthy habits these must be a normal part of their environment. That means these habits must be practised by their role models and routinely part of their everyday lives, such as in childcare and in schools[19].

The Mayor wants London's children to have a healthy and happy start in life which continues as they go into education. He is now piloting a new Healthy Early Years Awards programme. This will provide a framework for good child health to London's 18,000 childcare settings to create healthy places where under-fives can play and learn. He will also help their parents and families to support good health and development.

The Mayor's Healthy Early Years London Awards programme will be open to all childcare settings registered with Department of Education, including childminders. The programme will encourage healthy eating and active play. It will also boost emotional wellbeing and support parenting. This new award will improve childcare, assure parents and help to reduce inequalities from the start through a universal but proportionate approach. It will be open to all, but we will also give particular attention to ensuring it reaches the places where it is most needed. This includes areas where child outcomes such as school readiness and breastfeeding are lowest. And we will monitor uptake to make sure we are reaching the children who are in the greatest need.

As London's children move from early years settings to schools, it will be important that they are still growing up in healthy environments. The Mayor will also continue his successful Healthy Schools London programme that supports children and young people to lead healthy, happy lives and achieve their full potential. Over 1,900 London schools are already signed up to the scheme. Each one has committed to promoting healthy eating, physical activity, emotional health and wellbeing and Personal Social Health Education (PSHE). The programme has been particularly successful in deprived areas and aims to continue to reduce health inequalities in this way.

"The Mayor's key ambition is to launch a new health programme that will support London's early years settings. "

Through the London Plan, the Mayor wants to ensure that London's schools are healthy places for all children and young people to learn, in terms of their design and location. For example, entrances to new schools will be safer and healthier if they are located away from busy roads and have traffic calming in place. He also wants safe walking and cycling routes to school. This will encourage children to be more physically active and reduce their exposure to poor air quality. In addition, he recognises the increasing pressure on land for development in London. That means he will encourage innovative design in new schools. This will ensure they are both high quality and offer the space children need to be healthy in an increasingly dense environment.

The Mayor's key ambition is to launch a new health programme that will support London's early years settings. This will be twinned with his successful Healthy Schools London programme, ensuring London's children have healthy places in which to learn, play and develop.

CONSULTATION QUESTIONS

Q 1

IS THERE MORE THAT THE MAYOR SHOULD DO TO REDUCE HEALTH INEQUALITIES FOR CHILDREN AND YOUNG PEOPLE?

london.gov.uk/talk-london/healthstrategy

Q 2

HOW CAN YOU HELP TO REDUCE HEALTH INEQUALITIES AMONG CHILDREN AND YOUNG PEOPLE?

london.gov.uk/talk-london/healthstrategy

Q 3

WHAT SHOULD BE OUR MEASURES OF SUCCESS AND LEVEL OF AMBITION FOR GIVING LONDON'S CHILDREN A HEALTHY START TO LIFE?

london.gov.uk/talk-london/healthstrategy

Chapter 05

AIM TWO

Healthy minds:

ALL LONDONERS SHARE IN A CITY WITH THE BEST MENTAL HEALTH IN THE WORLD

Approx. 1 in 4

people in the UK will experience a mental health problem each year

£26 billion

Economic and social impact of mental ill- health every year

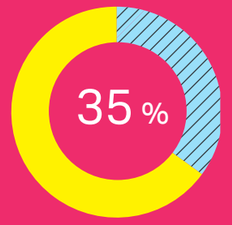
33% increase

London's suicide rate has increased from 7.8 per 100,000 people in 2014, to 10.4 per 100,000 in 2015

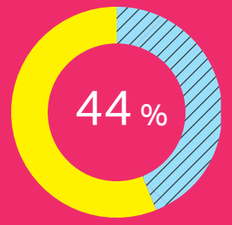
15-25 years

People with severe and prolonged mental illness in London are at risk of dying on average 15 to 25 years earlier than other people

of children and young people living in the capital aged between 5 and 16 experience some form of mental ill-health



The risk among males in skilled trades was 35 per cent higher than the male national average



Men working in the lowest-skilled occupations had a 44 per cent higher risk of suicide than the male national average

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Suicides in the UK: 2015 registrations ONS December 2016
Office for National Statistics: Suicide by occupation, England: 2011 to 2015, March 2017

In London, more than two million people will experience some form of mental ill-health every year[20]. Almost ten per cent of young Londoners aged between five and 16 experience some form of mental ill-health[21]. The wider impacts of mental ill-health cost us over £26bn a year[22].

Mental ill-health is both a cause and consequence of inequality[23]. Certain groups in society may be particularly at risk of experiencing mental health issues. This includes households living in poverty, people with chronic health conditions, minority groups, and people exposed to violence or abuse[24]. Accompanying discrimination due to ethnicity, cultural background or sexuality can also worsen mental ill-health[25].

People with mental health issues have their own set of risks. These include a higher likelihood of experiencing disability, stigma and discrimination, social exclusion and poverty[26]. Rates of smoking and alcohol misuse are also higher among people with mental ill-health than the average population. People with severe and prolonged mental illness in London are also likely to die on average 15 to 25 years earlier than other people[27].

The Mayor's vision is to create a healthier, fairer city. He wants London's public, private and voluntary and community sectors and communities to work together to prevent mental ill-health. He also wants to ensure that those with mental illness have the support they need to thrive.

There are five objectives to help achieve this:

1. Mental health becomes everybody's business across London. Londoners act to maintain good mental health of themselves, their families, friends, neighbours and colleagues.
2. There is parity of esteem between mental and physical health
3. London's diverse populations no longer experience stigma associated with mental ill-health, and levels of general awareness about mental health increase
4. London's employees are mentally healthy
5. Londoners feel able to talk about suicide and can find out where they can get help.

OBJECTIVE 2.1:
Mental health becomes everybody's business across London. Londoners act to maintain good mental health of themselves, their families, friends, neighbours and colleagues.
One of the main ways in which the Mayor is supporting better mental health more directly is through personally championing the new Thrive LDN programme.

Thrive LDN is a city-wide movement focusing on mental health and communities. It will aim to educate, equip and empower all Londoners to lead healthier, happier lives, bringing the city together to join around a collective purpose for mental wellbeing in London. As well as identifying 'once for London' actions – things that we can do more efficiently by working together across the whole city - Thrive LDN will use collaborative action with local communities to make changes at a local level.

Maintaining good mental health and prevention of mental ill-health are at the heart of Thrive LDN. This means taking action for everyone, but it also means supporting specific groups of people who are at higher risk of developing mental health issues[28] [29]. Some people have both more risk factors for mental health issues and less opportunity to protect their mental health. Poverty increases the risk of mental health issues and can be both a cause and a consequence of mental ill-health[30]. We need to understand how problems that build up in people's lives can contribute to mental ill-health.

To reduce mental health inequalities, we need to support these people. We also need the help of all Londoners and all of London's communities and community groups, as well as organisations like schools, hospitals and businesses. Only by working together can we act early to prevent mental health issues and find opportunities to promote positive health for all of London. The best changes for a community come from the community itself[31].

The Mayor will provide political leadership for Thrive LDN and support the plans developed by the partnership where there is a case for the Mayor to act.

OBJECTIVE 2.2:
There is parity of esteem between mental and physical health
For too long, mental health has been taken less seriously than physical health. Much work is being done to redress the balance and create parity of esteem, and it is important that this continues.

People with mental illness are less likely to receive treatment than anyone else in the health and social care system. Just a quarter of people with mental health problems receive treatment compared to, for example, 92 per cent of people with diabetes and over 75 per cent of those with heart disease.[32] We must address these inequalities in access to treatment and services. As such, the Mayor welcomes the work underway through the Mental Health Five Year Forward View.[33]

"Only by working together can we act early to prevent mental health issues and find opportunities to promote positive health for all of London."

Parity of esteem might also help people with mental ill-health to have better access to other services, including those which improve their physical health. The links between smoking, alcohol, substance misuse and mental health are both interlinked and complex. The link between smoking and premature death is well established. In England, 41 per cent of adults with a serious mental illness are smokers which is more than twice the rate of the general population (17 per cent)[34]. People with mental health conditions are just as likely as the general population to want to quit smoking but are not getting the support they need. An estimated 44 per cent of community mental health patients have reported problem drug use or harmful alcohol use in the previous year[35].

The Mayor of London does not have a role in providing these services so cannot directly ensure mental and physical health have parity of esteem in care and treatment. However, he is taking action to demonstrate his commitment to parity of esteem for mental and physical health throughout this strategy consultation document. This is being done through direct consideration of mental ill-health and its root causes and explicitly focusing on reducing inequalities in both mental and physical health. You can read more about how the Mayor is addressing some of the underlying causes of mental ill-health in the Healthy Places and Healthy Communities chapters.

The Mayor is also directly embedding mental health improvement as a core part of all his health programmes, supporting good mental health for children through his Healthy Schools and Early Years programmes and for workers through the London Healthy Workplace Charter. He is also supporting safe and mentally healthy communities through the Police and Crime Plan.

The Mayor will consider mental health and mental health inequalities at the same time as physical health inequalities throughout his work, and will challenge others to do the same.

The Mayor chairs the London Health Board partnership. In this role, he advocates for Londoners to have proper access to mental health services and a move towards parity of esteem between physical and mental health illness.

OBJECTIVE 2.3:
London's diverse populations no longer experience stigma associated with mental ill-health, and levels of general awareness and understanding about mental health increase

Awareness of mental health is improving. However, we recognise that as a city we could improve our understanding of mental health. Nearly nine out of ten people with mental ill-health say that stigma and discrimination have a negative effect on their lives.[36] We need to build on the work of initiatives like Time to Change[37]. This is a movement led by Mind and Rethink that aims to change how people think and act about mental health.

People experience a range of inequalities because of mental ill-health, but certain groups are disproportionately affected. People from lesbian, gay, bi-sexual and transgender + (LGBT+) communities, some black and Asian and minority ethnic (BAME) communities, deaf and disabled people (including people with learning disabilities) amongst others, have higher rates of mental health issues[38]. Inequalities doubly affect people within these groups. People can experience multiple barriers and discrimination both because of their identity and because of their mental ill-health. This discrimination can worsen mental health issues, potentially increasing stigma still further.

By both improving awareness and looking to combat stigma around mental health, we can make London a better city for all. The Mayor wants all of London to talk about mental health, to combat and prevent stigma. We want to improve Londoners' knowledge to enable individuals and communities to empower themselves and support each other.

The Mayor will campaign to reduce the stigma and discrimination associated with mental health issues. He will also promote good mental health and raise general awareness at City Hall, though social marketing and across other policy areas.

The Mayor commits to sign the Time to Change pledge and encourages other organisations to do so.

OBJECTIVE 2.4:
London's workplaces are mentally healthy

There is a clear link between a personal sense of wellbeing, job satisfaction and productivity. In 2016, mental health issues - including stress, depression, anxiety and more serious conditions such as manic depression and schizophrenia - resulted in 15.8 million UK working days being lost [39].

Mental ill-health remains the commonest reason for exclusion from the workforce. Nine out of ten people believe that disclosure of either a past or present mental health issue would damage their career[40]. There is already much being done to help get people with mental health issues into work.

Because of stigma and discrimination, people with mental ill-health often struggle to find and secure employment. Only ten to 16 per cent of people with a mental health condition, excluding depression, are in employment. This is despite 85 per cent wanting to work[41]. Schemes like 'individual placement and support' can help people with mental health issues into work and support both them and the employer to keep them in work.

"The Mayor's key ambition is to inspire more Londoners to have mental health first aid training, and more London employers to support it."

In addition, we want to take practical steps to give Londoners the tools to have a greater understanding of mental health issues at work. That way they can help others and have a greater insight into their own mental health.

People need to know how to recognise the signs of mental health issues and have the knowledge to help themselves or find the right help, and support others. In the workplace, training programmes like mental health first aid increase awareness and provide practical tools. They can also increase the confidence of managers and colleagues to spot signs and symptoms early.

Mental health is one of the key themes in the Mayor's London Healthy Workplace Charter, which you can read about in the Healthy Places chapter. Employers are encouraged to develop mental health strategies. This includes training employees to raise mental health awareness and reduce stigma, and training line managers to support people with a mental health condition. The aim is to create supportive workplaces where all employees can flourish. The Charter links to a wide range of resources including Time to Change, Business in the Community and others that offer practical support to employers of all sizes and sectors.

The Mayor will introduce mental health first aid training, or equivalent, for City Hall staff. He will also encourage Transport for London, the Metropolitan Police, London Fire Brigade and others to build on work they have already started.

The Mayor will champion effective schemes to recruit and retain people with mental ill-health.

The Mayor will support London's employers to create workplaces that are more mentally healthy through the Healthy Workplace Charter.

The Mayor's key ambition is to inspire more Londoners to have mental health first aid training and more London employers to support it.

OBJECTIVE 2.5:

Londoners can talk about suicide and find out where they can get help.

In England, a person dies from suicide every 107 minutes[42], equivalent to three times the number of deaths resulting from road traffic collisions. In London, every week, more than 14 Londoners choose to end their own lives. Many more have attempted to end their lives by suicide. Some 310,000 adults in London have attempted suicide in their lifetime and a further 283,000 people have thought about suicide – one in ten adults[43]. London's suicide rate has increased from 7.8 per 100,000 people in 2014, to 10.4 per 100,000 in 2015.[44]

Suicide disproportionately affects some groups of people and communities, for example men are three times more likely than women to take their own lives[45]. Nationally suicide is the largest cause of death in men aged 15-49[46]. The risk of suicide among low-skilled male labourers, particularly those working in construction roles, is three times higher than the male national average[47]. In London suicide is concentrated mainly in inner London boroughs. With only two exceptions, every borough in inner London has a higher suicide rate than the London average. Men working in the lowest-skilled occupations had a 44 per cent higher risk of suicide than the male national average; the risk among males in skilled trades was 35 per cent higher[48].

There is also a strong association between alcohol misuse and suicide. The National Confidential Inquiry into suicide and homicide by people with mental illness found that there was a history of alcohol misuse in 45 per cent of suicides among the patient population during period 2002 to 2011[49].

It is with the knowledge that each of these tragic events is preventable that London sets a guiding aspiration to become a 'zero suicide city'. As a first step, the aim is to meet the national target of a 10 per cent reduction in the number of suicides.

There is much good work already happening. This includes local authorities' suicide prevention and reduction plans, the work of TfL and Network Rail reducing suicides on the transport network, and the work of City of London, the Samaritans, and RNLI in reducing suicides in the River Thames.

Thrive LDN is working to help London become a city that has a better understanding of suicide. We aim to help someone who might be feeling suicidal and support families, friends, colleagues and communities affected. We want all Londoners to feel able to talk about suicide and seek help. To reduce suicide deaths in London, we need to work in partnership. This includes ensuring that there is accurate and timely data in relation to suicide so that we can understand and respond to changes in trends.

The Mayor with partners will support the Thrive LDN movement to establish a long-term shared vision for a zero-suicide city, and campaign to raise awareness about suicide.

CONSULTATION QUESTIONS

Q 4

IS THERE MORE THAT THE MAYOR SHOULD DO TO MAKE SURE ALL LONDONERS CAN HAVE THE BEST MENTAL HEALTH AND REDUCE MENTAL HEALTH INEQUALITIES?

london.gov.uk/talk-london/healthstrategy

Q 5

HOW CAN YOU HELP TO REDUCE MENTAL HEALTH INEQUALITIES?

london.gov.uk/talk-london/healthstrategy

Q6

HOW CAN WE MEASURE THE IMPACT OF WHAT WE'RE DOING TO REDUCE INEQUALITIES IN MENTAL HEALTH?

london.gov.uk/talk-london/healthstrategy

Chapter 06

AIM THREE

Healthy places:

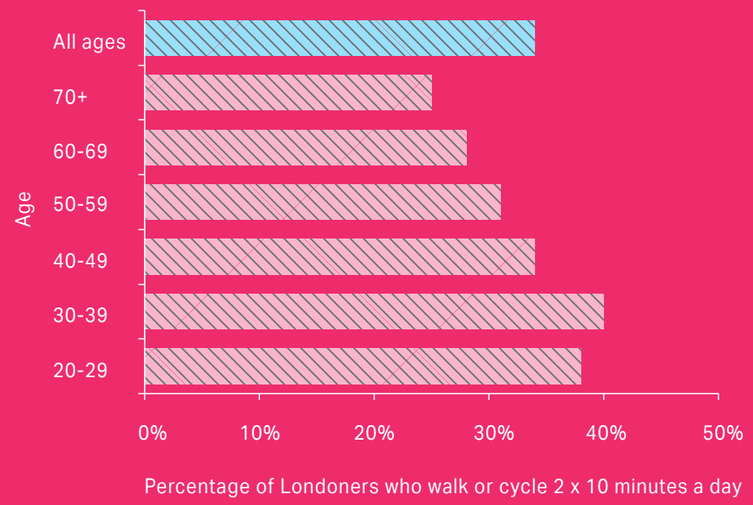
ALL LONDONERS BENEFIT FROM A SOCIETY, ENVIRONMENT AND ECONOMY THAT PROMOTES GOOD MENTAL AND PHYSICAL HEALTH

4 in 5 schools

in the most deprived communities are located in areas of poor air quality

1 in 4

privately rented homes do not meet the Decent Homes standard



Approx. 89,000

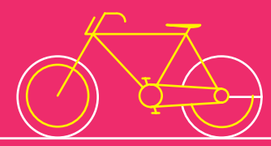
children, were living in temporary accommodation at the end of 2016

47 years old

Rough sleepers experience some of the poorest health, on average they die at age 47

only 34%

of adults in London walk or cycle for 20 minutes or more on a given day. This decreases by age.



of London's households are affected by fuel poverty

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Department for Communities and Local Government (DCLG). Statutory homelessness and prevention and relief live tables (worksheet 775_London): type of temporary accommodation, https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness, 2017
Reference: Crisis. Homelessness: A silent killer. December 2016.

All Londoners deserve a fair opportunity to live in good health. The biggest influence on our health, and on health inequalities between different groups, is the conditions in which we are born, grow, live, work and age. There are stark inequalities in these conditions between Londoners. The circumstances in which we live are often linked: for example, having a low income makes it more difficult to access quality housing. There is also a disturbing cyclical relationship with poor health. For example, people with severe mental illness are less likely to get secure work, which reinforces other inequalities. Multiple disadvantage is closely linked to poor physical and mental health.

Addressing underlying inequalities in our social, economic and physical environment will have the greatest impact on health and health inequalities in the long term.[50] It is also an area in which the Mayor has substantial powers. It is therefore a key aim of this strategy and there are seven objectives to help achieve this:

1. London's air quality improves
2. Health inequalities are reduced through planning and making our streets healthier
3. London is a greener city where all Londoners have access to good quality green space
4. The negative impact of poverty and income inequality on health is addressed
5. London's workplaces support more Londoners into healthy, well paid and secure jobs
6. Housing quality and affordability improves
7. Homelessness and rough sleeping in London is tackled

OBJECTIVE 3.1:

London's air quality improves

Poor air quality has been associated with many health problems including lung and heart diseases.[51] It affects the health of all Londoners but some parts of the city and certain groups are affected more than others. People in the lowest socioeconomic groups are more likely to be exposed to poor air quality [52] and that exposure is more likely to result in poor health[53]. Of the more than 400 London primary schools located in areas of poor air quality four-fifths were schools in the most deprived communities.[54]

London now meets nationally set legal limits for most pollutants and we have seen a reduction in some. However, two - NO_2 and particulate matter - remain a concern. London is failing to meet the legal limit for NO_2, which is primarily a transport related pollutant. Levels of particulate matter should also be reduced as this is damaging to health at any level.

The Mayor aims for London to have the best air quality of any major world city. This would reduce the exposure of Londoners to harmful levels of pollution, especially in more deprived areas. Improving air quality directly protects health and reducing inequalities in air quality by reducing car use can reduce related health inequalities. It can also make streets more accessible and welcoming, giving people a chance to mix socially and be more active. The Mayor's draft Environment Strategy outlines how air quality could be improved.

The Mayor proposes to deliver the following objectives of his London Environment Strategy in order to reduce health inequalities arising from poor air quality:

- **Reduce exposure of Londoners to harmful pollution across London – especially at priority locations like schools – and tackle health inequality**
- **Achieve legal compliance with EU and UK limits for all air pollutants as soon as possible, including by mobilising action by the London boroughs, Government and other partners.**
- **Establish and achieve new, tighter air quality targets for a cleaner London by transitioning to a zero emission London by 2050, meeting all World Health Organisation health-based guidelines**

The Mayor's key ambition is to work towards London having the best air quality of any major global city.

"The Mayor's key ambition is to work towards London having the best air quality of any major global city"

OBJECTIVE 3.2:
Health inequalities are reduced through good planning and making our streets healthier

Streets make up 80 per cent of public space in London. The Mayor wants to make streets welcoming and accessible for all. This will encourage people to walk and cycle and take part in their local community. It can also reduce inequalities caused by air and noise pollution, road injuries and social isolation.

Physical activity has strong benefits to physical and mental health, for example reducing risk of heart disease and cancers, helping depression and anxiety and increasing mental wellbeing. Only 58 per cent of adults and three in ten children aged 5-15 in London meet minimum activity levels needed for good health. Children under five are amongst the most inactive groups. There are stark inequalities in physical activity too. For example, older people and disabled people are more likely to be inactive.

Sport and leisure activities can also improve health and give social benefits. However low income and disability can be a barrier to these. We know that building activity into the daily routine is the best way to stay active throughout life. Many more Londoners could be more active every day by walking or cycling as part of their journeys or using streets for leisure and outdoor play. To enable this, we must make walking, cycling and public transport the most attractive transport options. We must also create street environments that are inviting spaces to use. Only 34 per cent of adults in London walk or cycle for 20 minutes on a given day.

By taking the Healthy Streets Approach, the Mayor and Transport for London aim to make London a more attractive place to walk, cycle and use public transport rather than drive. This is particularly important for older people, the very young, disabled people and people living on lower incomes, who disproportionately feel the negative impacts of living in a car-dependent city.

The Healthy Streets Approach makes positive changes to our street environments against ten Healthy Streets Indicators (see diagram 5 and 6). To reduce inequalities, it must prioritise streets that currently pose the greatest health threats in terms of noise, air pollution and road danger. Each year there are around 30,000 casualties on London's roads, of which in 2015 just over 2,000 led to serious injury, and 136 resulted in a death (TfL, Casualties in Greater London during 2015). Improving performance against the indicators will help to reduce health inequalities as well as improve health and wellbeing for everyone.

Figures 5 and 6:
The Healthy Streets Approach & How the 10 indicators of a Healthy Street relate to health inequalities

Source: Lucy Saunders

People feel safe – Women, older people, and residents of deprived areas are more likely to feel unsafe on the street

Things to see and do – Streets need to be engaging places with a mix of uses so that people can access the services they need easily. People who live in low density, car oriented environments travel less actively and tend to spend more money on travel

People feel relaxed – Busy, cluttered, dirty streets without enough space for walking, cycling and spending time on are intimidating and stressful. These streets are more commonly found in deprived areas and particularly affect children, disabled and older people

Clean air – Poor air quality most affects those who live, learn or work near busy streets; or are more vulnerable because of their age or existing medical conditions

Pedestrians from all walks of life – Environments that are not welcoming and accessible for everyone create inequalities in activity levels and social interaction and can exclude disabled people, children, BAME groups and older people

Easy to cross – The effect of busy streets being difficult or impossible to cross on foot or by bicycle is more likely to affect people living in deprived areas, disabled people and their carers, children and older people

Shade and shelter – Older people are particularly vulnerable to excess heat, as are people with heart, respiratory and other serious health problems

Places to stop and rest – Older people, people with injuries and mobility impairments and those accompanying young children, all rely on places to stop and rest. Without places to stop and rest these groups can become socially isolated

Not too noisy – Socially disadvantaged people are more likely to live in noisy environments near busy streets

People choose to walk, cycle and use public transport – older people, children and car owners, are less likely to travel actively enough to get the activity they need to stay healthy.

Source: Lucy Saunders

The London Plan is the Mayor's overall development strategy for London. London Plan policies must be considered when planning decisions are taken in any part of London.

The London Plan will play a key role in delivering the Healthy Streets Approach by promoting mixed use development. It will also promote higher density development in sites with good transport connectivity so that people have the things that they need within walking or cycling distance, or can easily access them by public transport.

New developments and their surroundings can make a big difference to the health of the people who live and work in an area by changing the local environment. These changes can be positive or negative. That's why it's important to make sure health and health inequalities are considered when development proposals are being prepared and assessed.

The Mayor is due to consult on a new London Plan later in 2017. The new London Plan will strengthen the consideration of the impact of planning on health and health inequalities.

The Mayor's aim is, by 2041, for all Londoners to do at least the 20 minutes of active travel they need to stay healthy each day. This is reflected in his Transport Strategy.

The Mayor will strengthen the impact of the planning process on health and health inequalities through the new London Plan and agree appropriate outcome measures.

The Mayor will promote a built environment which enables all Londoners to participate in community life on their streets.

OBJECTIVE 3.3:
London is a greener city where all Londoners have access to good quality green space

There are big inequalities in both the availability and use of quality green space in different communities and different parts of London. Living in greener places is associated with a range of positive health outcomes, from a longer life in older people to improved mental and physical health.[55] [56] There is also evidence that greener neighbourhoods may reduce the impact of deprivation on health. The differences in health between wealthier and poorer people appear smaller in places with the greenest environments.[57]

Public parks and green spaces need to be maintained and improved to be places that provide opportunities for a wide variety of informal recreation and play. They should also be designed to be part of safe and secure walking and cycling routes to and from schools, public transport hubs and high streets.[58]

Greening, such as trees, planting, green roofs and green walls provides shade and shelter, things to see and do, makes places less noisy and helps people to feel more relaxed. Other benefits include cleaning the air, reducing flooding, cooling the city (with related health benefits) and providing people with access to green space and nature close to where they live and work.

The Mayor wants to ensure that London's green spaces and other features such as street trees, planting, green roofs and walls are planned, designed and managed as an integrated green infrastructure. This approach will maximise the health benefits of a greener city.

The Mayor will protect London's green spaces and ensure that all Londoners have access to good quality green space.

The Mayor will encourage the creation of a network of green infrastructure that is designed and managed to minimise inequalities in physical and mental health.

OBJECTIVE 3.4:

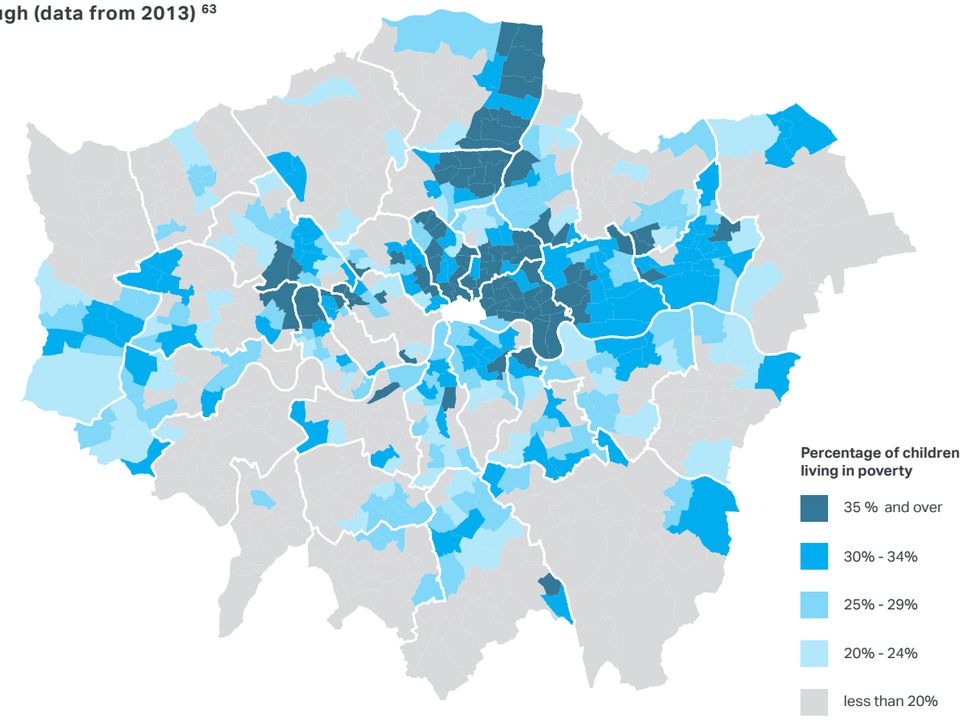
The negative impact of poverty and income inequality on health is addressed

Economic fairness is one of the best ways to reduce health inequalities. This is because poverty and low living standards have such a strong impact on the main influences of health.[59] Poverty can worsen health through material deprivation. It means people can't afford the elements of a basic healthy standard of living, including decent quality, affordable housing, nutritious food, or fuel for heating. The negative impact on health can be deepened through psychological factors. These include stress and isolation arising from a lack of control,[60] and inability to afford to take part in social activities.[61] Unemployment is linked with many poor mental and physical health outcomes.[62]

The Mayor wants to improve the city's social integration and reduce income inequality. To lead this work, he has established an economic fairness programme at City Hall. This includes promoting the London Living Wage to London's employers. Reducing the number of Londoners on low pay and in poverty will have a positive impact on their wealth and prosperity. It will also improve Londoners' mental and physical health and wellbeing.

Fuel poverty is also a problem of inequality. It is defined as not being able to pay to keep your home lit and warm without cutting back on essentials such as food. Fuel poverty is increasing, and now affects more than ten per cent of London's households. Londoners are experiencing falling average incomes. This is coupled with increasing housing costs, poor energy efficiency of homes and more recently, increasing energy prices. It has both short- and long-term negative impacts on the health of the most disadvantaged communities in society.

Figure 7: Children in poverty using HMRC measure by borough (data from 2013) [63]



Fuel poverty is an issue for low income groups living in the social rented sector or the private rented sector, where rising rent has squeezed tenants' incomes. Measures to address fuel poverty include ensuring households get all the benefits to which they are entitled and the best fuel deals. Importantly, it includes the promotion of a reasonable wage too. The Mayor is also currently working to improve the energy efficiency of existing homes and to ensure new housing stock is energy efficient.

The Mayor will do all in his power to contribute towards addressing the causes and effects of poverty in London

The Mayor will work to reduce income inequality through his economic fairness programme

The Mayor will work with partners to reduce the impact of fuel poverty on vulnerable Londoners through the Mayor's Fuel Poverty Action Plan.

OBJECTIVE 3.5:
London's workplaces support more Londoners into healthy, well paid and secure jobs

A secure and well-paid job is a route out of poverty for both adults and their children.

There is strong evidence that being in work can be good for physical and mental health and wellbeing. But it is not enough to aim simply for 'employment for all'; the health benefits of work also depend on the quality of the job. 'Good work' is being healthy, safe and secure. It means offering individuals some influence over how their work is done. In addition, it provides flexibility in working hours and the pace of work. It also offers appropriate rewards and a sense of self-worth for employees.

To address inequalities in London it is important to help the poorest and most disadvantaged groups who are least likely to be in good quality employment. Supporting more people into well-paid work is an important first step towards reducing inequality.

The Mayor believes all those that want to work, and who can, should have access to a job where they are fairly paid and treated, feel valued, and are able to progress. Evidence shows that employees earning the London Living Wage have significantly higher psychological wellbeing on average than

those who do not, regardless of their social class. This offers benefits to both worker and employer.[64] The Mayor wants London to become a 'Living Wage City', where as a minimum everyone is paid a wage that reflects the cost of living here. The Mayor has led by example and adopted the London Living Wage for the GLA group. Businesses need to play their part by signing up to the Living Wage and the Mayor's new Good Work Standard by pledging to adopt model standards of employment and working practices.

In London, most people living in poverty are in a working family. As employment has increased so has the number of people in a working family in poverty - from 700,000 to 1.2 million in the last decade, an increase of 70 per cent.
(data from 2013/14 compared with 2003/4)[65]

The London Healthy Workplace Charter is a voluntary employer accreditation process that supports and rewards employers for investing in workplace health and wellbeing. To achieve accreditation, employers meet standards which helps them create and develop healthier workplaces. For example, to improve mental health, employers are encouraged to offer training and awareness-raising relating to mental health and stigma and to create supportive workplaces. Employers of every size and sector have signed up. Now, the Mayor wants to target employers within traditionally low paid sectors, such as hospitality, retail and social care, to sign up. This will help maximise the programme's benefits to reduce health inequalities as well as improving health.

To date, more than 160 organisations have been accredited to the Charter, benefiting more than 300,000 employees.

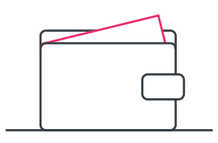
People with poor health or disabilities can be disadvantaged in the labour market. This perpetuates the cycle of poor health and low income. Through London's European Social Fund (ESF), the Mayor is supporting programmes to help specific groups who are unemployed or in low paid jobs into sustainable work. This includes people with physical and mental health conditions and disabilities. In addition, after sustained lobbying, the Autumn Statement 2016 announced that the Work and Health Programme is being devolved to London. It is an opportunity for greater involvement in the design of future work programmes. This will help align employment services with other locally run services such as housing, health, debt advice and childcare to reduce an individual's barriers to work. The devolved programme will link with London's European Social Fund to assist the long-term unemployed and those with health conditions or disabilities find work in London.

The Mayor will encourage employers to sign up to the London Living Wage through his Good Work Standard. He will also continue to work with the new Living Wage Commission to ensure the London Living Wage rate reflects the real costs of living in London.

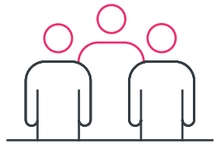
The Mayor will urge employers, particularly those within traditionally low paid sectors, to sign up to the London Healthy Workplace Charter, so that they can develop and maintain healthier workplaces.

The Mayor will use the devolved Work and Health programme to assist long term unemployed, those with health conditions or disabilities to get work.

In London, most people living in poverty are in a working family.



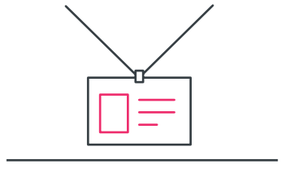
increase in working families living in poverty



Healthy Workplace Charter badge

300,000

employees in 160 organisations are benefitting from working for 'healthy employers'



OBJECTIVE 3.6:
Housing quality and affordability improves

Affordable good quality housing
Decent, affordable housing protects both our physical and our mental health throughout our lives. However, the housing crisis in London in which too many good quality homes are out of the reach of Londoners has worsened health inequalities.

Due to the failure of supply to keep up with demand, the cost of owning or privately renting a home in London is high. Housing costs are a major factor in creating poverty in London. Poverty and low income have a major impact on health and wellbeing.[66]

The cost of housing and the insufficient supply of family-sized affordable homes contributes to overcrowding. This affects eight per cent of households in London[67].

Overcrowding brings risks to mental health such as stress, anxiety, violence and abuse, as well as physical risks of injuries from falls or burns and infectious diseases.[68] It most affects poor, young families and children from BAME backgrounds. Lack of affordable housing is also a cause of people being homeless, living in poor accommodation or moving from their communities and social support.

Many older or disabled Londoners are living in homes that do not meet their needs. Where possible and appropriate, people should be enabled to remain in their own homes.[69] This may require adaptations or support in the home. Other people may need to move to more accessible dwellings or specialist or supported housing where they can live independently as part of their community.[70] Living in housing where there is insufficient support or accessibility can impact negatively on health and wellbeing.

Lack of affordable housing can also contribute to homelessness. It leads to people moving from their communities and social support or living in poor accommodation.

To address these issues the Mayor has made building more genuinely affordable homes for Londoners to rent or buy a priority. He will ensure that new homes are designed to meet the needs of London's diverse population. He is also ensuring that new developments include homes which are wheelchair user dwellings or accessible or adaptable dwellings.

By 2021, the Mayor will invest £3.15bn in starting 90,000 new affordable homes for Londoners to rent and buy. This will include supported and specialist housing. He will also seek to introduce a new planning policy in the London Plan to increase the proportion of all new homes that are genuinely affordable.

Improving the private rented sector
The health impacts of poor quality housing are wide-ranging. They include illnesses related to damp, cold, mould and noise, as well as excess winter deaths from cold, and injuries resulting from hazards to health and safety. Almost one in five adults in poor housing in England have poor mental health, and improvements to housing result in corresponding reductions in anxiety and depression.[71]

Just under one in five homes do not meet the Decent Homes standard. While this is an improvement on previous years, it is still too many. Some of the worst housing conditions are found in the private rented sector. The proportion not meeting the Decent Homes Standard remains highest in this sector at just under one in four[72] so it is a real concern.

The mental health of people living in private rented accommodation, particularly those in low income groups, may be affected by the insecurity of their tenancies[73] [74] . As rents have risen and the help available through the welfare system has decreased, some private sector tenants who claim Housing Benefit appear to have moved to areas with lower rents.[75] Such moves, can take people away from existing jobs and sources of employment, disrupt children's education and remove people from social support networks, to the detriment of their health and wellbeing.

High rents, growing competition as Londoners who would previously have bought homes continue to rent, welfare reform and insecure tenancies are a toxic combination. It is low income and disadvantaged Londoners who often face the greatest barriers to securing decent private rented homes. As well as increased affordable housing and actions to address income inequality, it is important to improve the quality of private rented sector housing. Local authorities can use their enforcement powers to address the worst conditions in the private rented sector. The introduction of licensing schemes can also help improve the quality of accommodation in this sector.

The Mayor will work with boroughs and partners to tackle criminal landlords and letting agents and support boroughs that wish to set up licensing schemes to help raise standards.

OBJECTIVE 3.7:
Homelessness and rough sleeping are addressed
There has been a sharp increase in statutory homelessness in recent years. This has coincided with an even bigger rise in the proportion of homeless households caused by the ending of their private rented sector tenancy.[76] A growing proportion of homeless households who seek help from local authorities are ending up in temporary accommodation: about 54,000 households, including almost 89,000 children[77]. This is a big concern.

About a third of households in temporary accommodation are living away from their local area[78]. This can worsen the social, economic and environmental influences of poor health[79]. A small but growing proportion of homeless households spend time in cramped bed and breakfast accommodation[80] where, for example, they may struggle to prepare healthy food[81] or be at risk of injury.

The unaffordability of housing is a major cause of homelessness. Increasing London's supply of affordable housing is crucial to dealing with the root causes of homelessness, as is wider work to reduce poverty. However, this will take time and the Mayor is committed to helping those at the sharp end of London's housing crisis now, including rough sleepers.

Factors such as relationship breakdown and domestic abuse can also trigger homelessness. Physical and mental ill-health can contribute to people ending up on the streets, prolong the time they spend there and be worsened yet further by their living conditions. Almost three-quarters of those who sleep rough have support needs related to their mental health and/or substance misuse[82].

Rough sleepers experience some of the poorest health outcomes and die on average at the age of 47[83]. They are at higher risk of TB and are also far more likely to be victims of violence and abuse than the general population[84].

Addressing rough sleeping is challenging. Many rough sleepers have complex needs, many are mobile and many have no connection with any one London borough. The majority are non-UK nationals[85] with very limited accommodation options unless they are in work.

The Mayor sees this rise in rough sleeping in London as a growing source of shame to the city. To support rough sleepers off the street and ensure they do not return requires close partnership working. As one example, he will work with the NHS to better understand the problem of people being discharged from hospital to the street and develop solutions to it.

The Mayor will fund accommodation that can be used for homeless households through the 2016-21 Affordable Homes Programme, including hostels and refuges, and accommodation for those ready to move on from them. He will also work with boroughs to support close collaboration in their efforts to secure private rented sector accommodation for homeless households.

The Mayor will commission and develop pan-London services to help target particular groups of rough sleepers. This will mean that City Hall and borough-commissioned services can together ensure there is a route off the streets for every rough sleeper. He will lead and develop his 'No Nights Sleeping Rough' taskforce in identifying and pursuing new approaches to tackling rough sleeping in London.

CONSULTATION QUESTIONS

Q 7

IS THERE MORE THAT THE MAYOR SHOULD DO TO MAKE LONDON'S SOCIETY, ENVIRONMENT AND ECONOMY BETTER FOR HEALTH AND REDUCE HEALTH INEQUALITIES?

london.gov.uk/talk-london/healthstrategy

Q 8

HOW CAN YOU HELP TO REDUCE INEQUALITIES IN THE ENVIRONMENTAL, SOCIAL AND ECONOMIC CAUSES OF ILL-HEALTH?

london.gov.uk/talk-london/healthstrategy

Q 9

WHAT SHOULD BE OUR MEASURES OF SUCCESS AND LEVEL OF AMBITION FOR CREATING A HEALTHY ENVIRONMENT, SOCIETY AND ECONOMY?

london.gov.uk/talk-london/healthstrategy

Chapter 07

AIM FOUR

Healthy communities:

LONDON'S DIVERSE COMMUNITIES ARE HEALTHY AND THRIVING

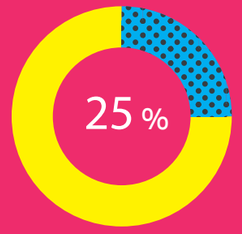
3.5 million

Londoners formally volunteer each year

1 in 3

people feel they can influence decisions that affect their local area

of patients visit their GP for social rather than medical problems



increased risk of dying due to loneliness

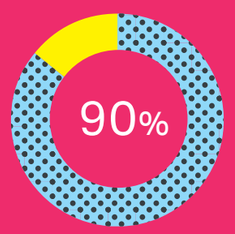
By 2020

90%

of all people living with HIV will know their HIV status

90%

of all people with diagnosed HIV infection will receive sustained antiretroviral therapy



of all people receiving antiretroviral therapy will have viral suppression

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Cabinet Office, Community Life Survey 2015/16

UNAIDS, 2016 - 2021 Strategy: On the Fast-Track to end AIDS, 2015

Our vision is for a healthier, fairer London. This is also a vision for a city in which the places that people live and the social networks they build do not unfairly reduce life expectancy or quality of life. We want London's neighbourhoods to create opportunities for all Londoners to support one another. We want to make places where people are experts in understanding their local strengths and needs. They can help to shape public services and create environments that support good mental and physical health. Aiming to support healthy communities also means tackling discrimination and stigma, and supporting the people at risk of conditions such as TB and HIV.

There are seven objectives to help achieve this:

1. It is easy for all Londoners to participate in community life.
2. All Londoners have necessary skills, knowledge and confidence to understand how to improve their health
3. Health is improved through a community and place based approach
4. Social prescribing becomes a routine part of community support across London
5. People and communities are supported to prevent HIV and reduce the stigma surrounding it
6. There is a reduction in TB cases among London's most vulnerable people
7. London's communities feel safe and are united against hatred in whatever form it takes.

OBJECTIVE 4.1:

It is easy for all Londoners to participate in community life

By taking part in community life, people can improve their health and gain a sense of personal control over their lives. This helps them to develop personal skills, self-confidence and the ability to deal with life's challenges at all ages. Healthy and thriving communities are those where people from different backgrounds can develop meaningful relationships. They are places where neighbours look out for each other. They are also places where people have a voice in decision-making about their area and the services within it.

Many Londoners already give their time freely for the benefit of others, either volunteering through organisations, or informally helping neighbours and friends. Volunteering is an important part of community life that can improve the health and social outcomes of volunteers and those receiving support where that is the case.[86] There is a huge range of volunteering activity in London. It includes everything from being a school governor, or teaching kids to read, to supporting somebody affected by dementia or a person living with HIV.

Those who have the most to gain from volunteering are often the people who are not always able to take part[87]. That's why we must do all we can to remove the physical, social and financial barriers to volunteering, particularly for disadvantaged groups.

Opportunities to participate, improve health and reduce inequalities

1. Sport
Sport London aims to get more than a million Londoners more active. Playing sport can improve the physical health and mental health of Londoners. Evidence is growing both of sport's health benefits and how it can improve social integration, by bringing different people together.[88] We must ensure more equal access to opportunities so all London's communities have the chance to play sport. Additionally, we must use the opportunities of London's major sporting events to inspire Londoners to become physically active.

2. Culture
There is also a growing body of evidence showing the value of the arts and creativity in improving mental and physical health. Cultural activities can also help people to manage long-term conditions, maintain social connections and build new skills and networks. The Mayor's Culture Strategy will seek to secure London's cultural venues, networks, institutions and the infrastructure necessary to support core culture and community arts programmes for Londoners. Taking part in culture is a great way to improve their mental and physical health.

3. Local decision making in planning
The best way to create healthy environments and provide better services is for professionals, service users and local people to work together. That way their joint expertise can inform both development and design.

Communities should be engaged in local planning. Developers should also be encouraged to engage with communities at the pre-application stage, when there is more opportunity to influence proposals. This can offer communities a genuine voice. Community input can help to create or change places in ways that can improve health, such as access to good quality housing, or green and open space. Community-led projects, the use of Community Rights and the preparation of Neighbourhood Plans provide opportunities for communities to shape and enable growth in their areas. It can also help build up a local understanding and appreciation of the balancing of issues that often needs to happen.

4. Local decision making in healthcare
There is a commitment to active involvement in health in the NHS Five Year Forward View. It views the 'NHS as a social movement', where patient and community engagement are essential to improving the NHS.[89] NHS organisations and local authorities are coming together to develop and roll-out local Sustainability and Transformation Plans that cover all aspects of health spending. These also focus on better integration with social care and other local authority services. We need to ensure

that future health and care in London best addresses health inequalities and prevents ill-health. As such, these plans should be developed with local communities through continuous engagement, including with marginalised groups.

Better services can often be created by involving professionals, service users and local communities as equals. This can ensure that their joint expertise can inform service development. It means people's voices must be heard, valued, discussed and acted upon. Where services have been developed collaboratively, the same groups may also be best placed to then run the service they designed together.

Many disadvantaged groups lack or are denied resources, rights, and services that allow them to participate. This prevents people from making the decisions that influence their lives and health. The Mayor's work on community engagement will help more Londoners to have a voice. In doing this, it is important to address inequalities in voice and power, and build relationships with those who are underrepresented in civic life.

This is particularly important for people who experience stigma and discrimination. This can cause significant social and material disadvantage and has a profound effect on health. Individual people can have many different social identities, and don't fit neatly into boxes. They may also experience multiple types of stigma and discrimination. We need to respect the differences between people and give everyone the chance to succeed in life by listening to the needs and concerns of all London's diverse groups.

There are also some basic things we need to get right in the local environment to give people the most opportunity to participate. Good quality social infrastructure such as for play, education, sport and faith, can improve physical and mental health. It can also strengthen communities and ensure that all Londoners can benefit from the opportunities in our city. The transport system is an important part of this. We need to give families with young children, older people and disabled people a better experience when they move around London. A more accessible public transport system will enable new trips to be made by all Londoners, helping create a more inclusive city.

"The Mayor will seek to improve health and wellbeing outcomes by embedding them in his culture strategy and relevant work programmes."

Too many people are socially excluded because of physical, organisational and attitudinal barriers. We must give people opportunities to shape the decisions that influence their lives and health. This will help us to remove these preventable barriers.

The Mayor will work with community groups to improve access to volunteering programmes so more Londoners can enjoy the health benefits of being an active citizen.

The Mayor aims to publish a new sport strategy and launch a new sport programme, 'Sport Unites', in 2018. He will also promote physical activity and sport to all Londoners through his health programmes.

The Mayor will seek to improve health and wellbeing outcomes by embedding them in his culture strategy and relevant work programmes.

The Mayor, through TfL and the boroughs, will seek to enhance London's streets and public transport network. His aim is to make the transport system navigable and accessible to all. This will enable all Londoners, including disabled and older people to travel spontaneously and independently.

The Mayor will implement his Diversity and Inclusion Strategy, currently under consultation. He will also set up a social integration team to lead a London-wide programme of activity and build social integration into City Hall's work.

OBJECTIVE 4.2:

All Londoners have the necessary skills, knowledge and confidence to improve health

Being able to access, understand, evaluate and use health information is strongly connected to health inequalities. It is at least as strong a predictor of health as income, employment status, education and racial or ethnic group.[90] More and more health information is available online. To prevent a digital divide, we must do more to equip all communities with digital and online skills. Given the opportunities to improve skills and knowledge digitally, it is important that more Londoners can access the internet. Gypsy and Traveller communities, older people and disabled people are less likely to have access to information or help for their health problems. To reduce this inequality, we need tailored health promotion material and interventions, and a well-trained, sensitive workforce.

Community-led approaches, such as using social networks to improve skills and knowledge, can help target harder to reach groups. This includes people from lower socioeconomic backgrounds and people from some migrant and ethnic minority groups. These groups are less likely to have access to health information, particularly from formal sources. This is best provided in the places where people spend most of their time and feel most comfortable. Up to 20 million people including postal workers, bar staff and hairdressers have contact with others through their work. This also offers an opportunity to promote health messages and support others. We want to improve the ability of Londoners to help manage their own wellbeing by helping others to support each other.

The Mayor will explore how he can help Londoners to increase their skills, knowledge and confidence in managing their own health and supporting others to do the same

OBJECTIVE 4.3:
Health is improved through a community and place-based approach
The Mayor's Healthy Early Years, Healthy Schools and Healthy Workplace Charter programmes are developing a London-wide approach to improving health in specific settings. Together, they can help to improve mental and physical health and wellbeing in places where people spend large parts of their daily lives. This approach is inclusive, bringing everybody in that place together to protect and promote health.

There are also effective models through which communities can shape a place-based approach to health in their neighbourhoods. Many communities are already working together to understand and solve problems. This includes making the best use of local assets, whether parks and green spaces, local businesses, faith organisations, or community spirit. There are also great examples of community development work with children and young people to improve health. The net result is strong and thriving communities. This may explain why some deprived areas seem to have better health than others.[91] We need to understand and learn from the success of these places.

The Mayor will work together with local health and care organisations, service users and local communities to design a programme that supports local neighbourhoods to act on the issues that matter most to them.

OBJECTIVE 4.4:
Social prescribing becomes a routine part of community support across London
Around 20 per cent of patients consult their GP for what could be seen primarily as social rather than medical problems. Social prescribing is a way for people to get support that they need but that doctors and nurses aren't easily able to give. This includes local community activities like walking groups, as well as help with getting a job, housing and debt management. Help with these issues is often available through local authorities, charities and local voluntary sector organisations.

Social prescribing takes place in both primary and acute care, and can also happen outside the NHS through organisations like housing associations. There are many ways to link a person to their social prescription. This is often done through a coordinator, who helps people to understand and decide what social or community activity might work for them and improve their health. Social prescribing can help to empower people and strengthen communities by ensuring that all Londoners have a genuine

"The Mayor's key ambition is to support the most disadvantaged Londoners to benefit from social prescribing to improve their health and wellbeing"

voice in developing these services and designing their own social prescriptions.

Social prescribing can also catalyse the local voluntary and community sector and support social integration.[92] For social prescribing to be routine across the city we will need to support and sustain the voluntary and community sector. The sector is faced with huge challenges due to the fall in public sector investment and the growing demand and complexity in the needs of service users. Partnerships between the NHS, local authority and the community and voluntary sector can strengthen community-based capacity and widen availability of local assets.

We need a sustainable way of funding the community and voluntary sector for these organisations to be able to support community health. Small and medium sized organisations must not be excluded from providing services. In order to get the best value for money from public spending, commissioners should also consider further use of the Social Value Act 2012. This requires public sector commissioners – including local authorities and health sector bodies – to consider economic, social and environmental wellbeing in their work.

The public as well the private sector can also make their skills, resources and networks available to support voluntary sector and community organisations. Also, as community groups can find it hard to find premises, local facilities can be used in more joined-up ways. This could include buildings with shared purposes such as leisure and sport facilities with health services. London Fire Brigade have identified fire stations as community assets. Potential uses of these include memory clinics for those living with dementia, stop smoking clinics, or for mental health services to support children and young people.

The Mayor will champion social prescribing programmes in London. He will champion the work of NHS GPs and other frontline healthcare professionals to help people of all ages find social, emotional or practical solutions to improve their health and wellbeing.

The Mayor's key ambition is to support the most disadvantaged Londoners to benefit from social prescribing to improve their health and wellbeing

OBJECTIVE 4.5:
People and communities are supported to prevent HIV and reduce the stigma surrounding it

Some of London's major public health challenges disproportionately affect some groups and communities and reinforce existing inequalities. This consultation document focuses on two of these challenges: HIV and tuberculosis.

HIV prevalence is more than twice as high in London as it is in England. Two in five people with HIV in the UK live in London.[93] HIV disproportionately affects some minority communities, particularly men who have sex with men, transgender people and black Africans.[94]

People living with HIV very commonly report social stigma, or anxiety, and two in five Londoners living with HIV are afraid that their HIV status will lead to different treatment from their GP.[95] Social inclusion is an important part of the Mayor's overall vision for London. Part of his role in reducing health inequalities is to challenge stigma related to having an HIV diagnosis.

This will not only help people who have been living with HIV for a long time, but also those at risk of HIV. Fear of stigma can also be a barrier to early diagnosis. With HIV, early diagnosis is vital. This is because it leads to better outcomes for the person being diagnosed. It is also because early diagnosis and effective treatment for HIV reduces the chances of it being passed on to other people. This is also a major inequalities issue: there is wide variation in the rate of late diagnosis among London's boroughs and demographic groups. In 2015, black African people were more than twice as likely as white people to be diagnosed late.[96]

This means that a fresh focus on sexual health education and on reducing risks will be an important step to reducing health inequalities for Londoners. The upcoming PrEP Impact trial is funded by NHS England and will be delivered by St Stephen's Clinical Research in partnership with PHE. It will be investigating how to implement prevention through HIV Pre-Exposure Prophylaxis (PrEP) and provides a new opportunity to look at wider HIV prevention strategies in the capital.

Prevention of HIV is led by London's boroughs, who are already collaborating on the successful Do It London campaign, under the leadership of the London HIV Prevention programme. The Mayor's role is to support and promote this work, helping to raise its profile where possible.

There are also opportunities to use the profile of City Hall to challenge HIV stigma and to promote international learning and collaboration to reduce the impact of HIV in London. The UNAIDS Fast Track Cities initiative may be one way to help bring HIV under control. Fast Track Cities is a collaborative programme through which London's health and public health systems could together agree to work towards international targets for HIV prevention and treatment.

The Mayor will challenge the stigma associated with HIV and will support collaborative work to support HIV prevention and treatment in London. This also includes supporting London's health and public health systems to explore the Fast Track Cities approach.

OBJECTIVE 4.6:
There is a reduction in TB cases among London's most vulnerable people
London accounts for 40 per cent of TB cases in England and has among the highest TB rates of any European capital city.[97] Significant progress has been made in reducing the number of new TB cases. This positive trend continues, supported by access to screening, early diagnosis and new technologies. However, there are many complex issues affecting the remaining population at risk.

The transmission of TB is facilitated by overcrowding and poor living conditions. Social risk groups such as current or former prisoners, rough sleepers, people with drug and alcohol misuse problems, refugees and asylum seekers make up an increasing proportion of people affected by TB. Those with social risk factors are twice as likely to have infectious TB, and twice as likely to die.[98]

Commitments made in earlier sections of this strategy will make a big difference to some of the factors that worsen TB in London. In particular, better housing, less rough sleeping, and empowering Londoners could help prevent the spread of TB, as could the improved use of community assets to break down stigma. However, the work of the London TB Control Board continues to be vital.

The Mayor will continue to support the work of the London TB Control Board to address the increasingly complex issues associated with TB in London

OBJECTIVE 4.7:
London's communities feel safe and are united against hatred in whatever form it takes.
The Mayor is working to ensure that London is a safe and healthy city for all Londoners. Feeling safe and secure in your community is the foundation of a great place to live. Without it people can be prevented from thriving and staying healthy both mentally and physically. Safe neighbourhoods are places that enable people to walk and cycle, work and do business, enjoy London's vibrant and diverse culture and history and spend time with friends and family. However, many Londoners do not experience this safety.

The British model of policing is based on trust and confidence between the public and the police. We know this varies significantly between communities, with confidence levels lower for black Londoners. There are many complex reasons for this, some of which are historical, but the Mayor seeks to address them as part of his vision for London. Community policing can play an important role in reducing levels of antisocial behaviour and crime that harms some neighbourhoods. It can help build relationships with local people and voluntary and community organisations. Reducing crime, increasing safety and diverting people at risk of offending into more positive activities, helps to strengthen, connect and empower individuals and communities.

Following the EU referendum and the recent terrorist incidents in Westminster, Manchester, London Bridge and Finsbury Park, there has been a marked increase in reported race, religious, disability and LGBT related hate crimes across London. Hate crime doesn't only harm its direct victims. It also victimises whole communities and erodes the sense of inclusion, solidarity and belonging that are London's most precious assets. It has never been more important for us to unite against both terror and hatred in whatever form it takes.

The Mayor will work through MOPAC and with the Metropolitan Police Service, the Crown Prosecution Service, Local Authorities and LFEPA to create a safer and healthier city as described in the Police and Crime Plan 2017-2021.

CONSULTATION QUESTIONS

Q 10

IS THERE MORE THAT THE MAYOR SHOULD DO TO HELP LONDON'S DIVERSE COMMUNITIES BECOME HEALTHY AND THRIVING?

london.gov.uk/talk-london/healthstrategy

Q 11

HOW CAN YOU HELP TO SUPPORT THRIVING COMMUNITIES?

london.gov.uk/talk-london/healthstrategy

Q 12

WHAT SHOULD BE OUR MEASURES OF SUCCESS AND LEVEL OF AMBITION FOR CREATING HEALTHY AND THRIVING COMMUNITIES?

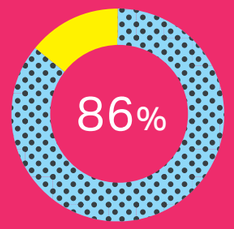
london.gov.uk/talk-london/healthstrategy

Chapter 08

AIM FIVE

Healthy habits:

THE HEALTHY CHOICE IS THE EASY CHOICE FOR ALL LONDONERS



of Londoners feel tackling childhood obesity should be a top or high priority

23%

of London children in year 6 are obese.

10 -11 year olds

London has the highest rate of obesity for 10-11 year olds in England compared to other regions.

1.7 x

smoking is more than 1.7 times as common among people in the most deprived communities as it is among people in the least deprived communities

50%

differences in tobacco use account for around 50 per cent of the inequalities in health found between social groups in London

2 x

the hospital admission rate for alcohol related conditions is 2 times higher in Islington than in Kingston Upon Thames

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Becoming the world's healthiest global city means creating a city where it is easy to be healthy. It means creating an environment that reduces child obesity through healthier food and regular physical activity. A healthier city will also help prevent and reduce smoking, alcohol and substance misuse.

There are two objectives to help achieve this:

1. Childhood obesity falls and there is a reduction in the gap between the boroughs with the highest and lowest rates of child obesity
2. Smoking, alcohol and substance misuse are reduced among all Londoners, especially young people

OBJECTIVE 5.1:
Childhood obesity falls and there is a reduction in the gap between the boroughs with the highest and lowest rates of child obesity

Childhood obesity is linked to the onset of a range of long term health conditions. It is also linked to poor educational attainment, and a drop in how happy and confident children and young people feel.

London has a higher proportion of children who are overweight than any other region in England. At the age of 4-5, one in five London children are overweight or obese. By the time they reach age 10-11, the rate is more than one in three children[99]. Further, there are big differences across London, with the most deprived children in reception year and year 6 twice as likely to be obese as least deprived children.

What causes London's children and young people to become overweight or obese is a complex mix of issues. These include the community they live in, the wider built environment, individual habits and biology, and the food system[100]. To address this tough problem, we need to look at all the contributing factors together. Simply focusing on one aspect will have limited impact on what causes London's children and young people to be overweight or obese.

Evidence shows that our buying and eating behaviour is automatic and unthinking, prompted by what has been marketed to us and by having food around us[101]. In our current environment the default options – in food, drink, and in terms of physical activity – are too often the unhealthy ones. Large portions of foods that are high in calories, fat and sugar are prominent, cheap and now much more readily available, leading more families to develop unhealthy diets[102].

An unhealthy food system in London impacts both adults and children's food choices. Eating too much food that is high in sugar, salt and fat increases the risk of obesity, type 2 diabetes, tooth extractions, cancer, heart attacks and strokes[103].

We must increase the accessibility and affordability of healthy food for Londoners to take home and make into meals. We must also reduce the prominence of unhealthy food in some of the most deprived areas of London. We need to act across the food system to make it easier for all Londoners to make and afford healthier food choices. This means transforming supply chains, and the built and retail environment to make the healthy choice the easy choice. These and a wide range of other interventions will be covered in more detail in the Mayor's London Food Strategy, set to be published in 2018.

Developing an integrated food policy also means recognising the rise of food poverty and the use of food banks. It must also recognise the high prevalence of mental health conditions which relate to an unhealthy relationship with food.

Physical activity is vitally important to health. We will work to increase regular physical activity by implementing the Healthy Streets Approach to make the built environment safe and welcoming for children and parents to play, walk and cycle. There is more information about this in the Healthy Places chapter.

The Healthy Schools London programme described in the Healthy Children chapter supports healthy eating and physical activity in schools. It does this by promoting active travel to school (walking, cycling or scooting) and opportunities for active play through playground buddies, training support staff in active play and zoning playgrounds. It also ensures that all food and drink in school is healthy including in packed lunches and food served after school or at events. Students are encouraged to bring in a water bottle and drink regularly throughout the day. Finally, it creates dining room environments that support healthy choices and encourage children to drink water.

The Mayor's key ambition for this strategic aim is to work with partners towards a reduction in childhood obesity rates and a reduction in the gap between the boroughs with the highest and lowest rates of child obesity.

The Mayor will work in partnership across London to roll-out the priorities of his new London Food Strategy.

The Mayor will show leadership on this issue by convening and leading London-wide action to reduce child obesity.

The Mayor will investigate the introduction of a policy in the new London Plan which seeks to limit the development of new hot food takeaways around schools.

OBJECTIVE 5.2:
Smoking, alcohol and drug misuse are reduced among all Londoners, especially young people

London's biggest killer, smoking, continues to directly cause the premature death of over 8,000 people per year. It contributes to four out of the five most common health conditions that kill Londoners[104]. Smoking is also a major inequalities issue. It is more than 1.5 times as common in the most deprived ten per cent of people in England as it is among the least deprived ten per cent.[105]

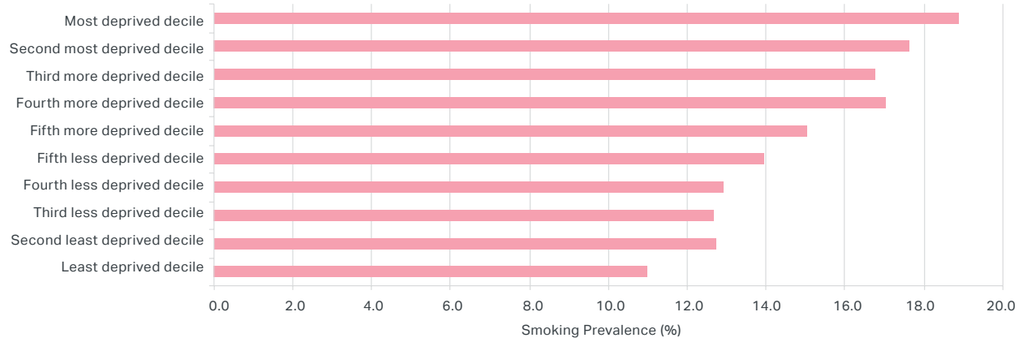
Whilst there has been a steady reduction in smoking overall, particularly since the emergence of e-cigarettes, rates remain relatively high in deprived areas[106]. We also know from other global cities, such as New York, that we must continue to work to make smoking a rarity in London and support those who want to quit. Otherwise, rates are likely to increase.

"The Mayor's key ambition for this strategic aim is to work with partners towards a reduction in childhood obesity rates and a reduction in the gap between the boroughs with the highest and lowest rates of child obesity."

Illicit and counterfeit tobacco also contribute significantly to health inequalities. Illicit tobacco can be more accessible and affordable to children and young people because it is often sold cheaply, illegally and in the form of single cigarettes rather than larger packs.

This is helping to establish a new generation of smokers in deprived areas, further entrenching ill-health. The link between illicit tobacco and children and young people starting smoking is concerning. It is encouraging that London boroughs are already working together to address it.

Figure 8: Smoking rates by socioeconomic group in England



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Public Health England, Public Health Outcomes Framework, Smoking Prevalence in Adults, 2016

Deprived communities also experience the worst concentrations of alcohol and drug misuse in terms of both health and crime. Those communities are likely to experience five to seven times the amount of alcohol-related harm, despite their average consumption being lower[107]. Too much alcohol is linked to a whole range of physical and mental health problems. Alcohol misuse not only affects the individual drinker but also their families, dependents and communities[108]. Violent crimes (especially domestic violence) and sex offences are both heavily linked to alcohol.

London's boroughs lead on reducing the number of people who smoke and misuse alcohol. Effective cooperation between local authorities, health agencies and law enforcement can play a big part in reducing these harms to Londoners and reduce the impact on the future chances of children. The London Healthy Workplace Charter also supports employers to encourage and signpost their staff to a variety of smoking cessation and alcohol services if they choose to make a change.

There is also potential to boost Londoners' health and encourage healthier alcohol use through a more varied night time economy that's active right across the city. The night time economy is a fantastic part of London's cultural and economic offer. We want to ensure it is vibrant and healthy, economically diverse and accessible. That way it will provide opportunities for all Londoners.

The Mayor will support partnership work across the city to help reduce the uptake of smoking and harmful drinking among Londoners, especially among young people.

CONSULTATION QUESTIONS

Q 13

IS THERE MORE THAT THE MAYOR SHOULD DO TO HELP TO REDUCE HEALTH INEQUALITIES AS WELL AS IMPROVE OVERALL HEALTH IN WORK TO SUPPORT LONDONERS' HEALTHY LIVES AND HABITS?

london.gov.uk/talk-london/healthstrategy

Q 14

WHAT CAN YOU DO TO HELP ALL LONDONERS TO DEVELOP HEALTHY HABITS? WHAT IS PREVENTING YOU FROM DOING MORE AND WHAT WOULD HELP YOU?

london.gov.uk/talk-london/healthstrategy

Q 15

WHAT SHOULD BE OUR MEASURES OF SUCCESS AND LEVEL OF AMBITION FOR HELPING MORE LONDONERS TO DEVELOP HEALTHY HABITS?

london.gov.uk/talk-london/healthstrategy

Chapter 09
Get involved

All Londoners are invited to share views about the ideas in this consultation document. We want to know what you think is most important to your own health and what would help reduce health inequalities where you live. You can join in a series of conversations about physical and mental health via Talk London throughout the summer: **www.london.gov.uk/talk-london/healthstrategy**

This document is a formal consultation on the matters to be included and the issues to be accounted for in the development of the London Health Inequalities Strategy. Consultation on this document is open from 23 August to 30 November 2017.

Formal responses to the consultation by organisations should be submitted via the questionnaire on the Draft Mayor's Health Inequalities Strategy page at **www.london.gov.uk/health-strategy**

For more inforamtion please contact the Health Inequalities Strategy Team at **healthinequalities@london.gov.uk**

Glossary A – Z

A

Active citizenship
means people getting involved in their local communities and democracy at all levels. This covers a range of activity, including representative participation (e.g. voting and political representation), charitable participation (e.g. volunteering and donating); associational participation (e.g. membership in community organisations like tenants' organisations, or charities); and challenging participation (e.g. protesting; lobbying). Active citizenship also includes communities, service users and service providers coming together as equals to ensure that their joint expertise can inform the development and design of local services.

Active travel
refers to forms of transportation that require people to be physically active, most commonly walking and cycling but also scooting, skating and skateboarding. Because most public transport travel requires some active travel as part of the journey this is also usually considered to be a form of active travel

Acute care is
when a patient receives active but short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. It usually implies hospital-based treatment.

Affordable Homes Programme
is the Mayor's programme for funding the delivery of new affordable homes in London. The current programme, Homes for Londoners: Affordable Homes Programme 2016-21 will use £3.15bn of investment to deliver 90,000 affordable housing starts by March 2021.

Air pollution
refers to substances in the air that harm human health, welfare, plant or animal life. Most pollution in London is caused by road transport and domestic and commercial heating systems.

Air quality
refers to whether levels of air pollutants are relatively high or low and usually includes a consideration of those pollutants that are included in the UK Air Quality Standards Regulations 2010 (e.g. particulate matter, lead, nitrogen dioxide)

B

BAME
stands for black, Asian and minority ethnic groups

Better Health for London report
is the final report of the independent London Health Commission published in 2014.

C

Child Health Digital Hub
The new Child Health Digital Hub aims to transform child health information services allowing better monitoring of every child's health and providing access to information for all those that are involved in the child's care, where appropriate, to ensure that all children get the best possible start in life.

Child obesity
is a condition in which a child has an abnormally high amount of body fat. It is measured by comparing a child's Body Mass Index (BMI) with the population average, taking into account the child's age, sex and height.

Communities
are groups of Londoners who identify with each other or share something in common, such as living in the same area or having a common cultural background.

Community Rights
A Community Right to Build Order is a form of Neighbourhood Development Order that can be used to grant planning permission for small scale development for community benefit on a specific site or sites in a neighbourhood area.

D

DCLG
is the government Department for Communities and Local Government

Decent Homes Standard
was introduced by the Government in 2004. It is made up of four criteria that a home must meet in order to reach the standard, as follows:

- meet the Housing Health and Safety Rating System (HHSRS) minimum safety standards for housing;
- be in a reasonable state of repair;
- have reasonably modern facilities and services; and
- have efficient heating and effective insulation.

While there is no statutory requirement for all homes to meet this standard, its introduction was accompanied by a Government-funded programme of investment aimed at improving council and housing association homes to bring them all up to it.

Determinants of health
are people's homes, education and childhood experiences, their environments, their jobs and employment prospects, their access to good public services and their habits, all of which have an effect on their general health and life expectancy.

Disability
as defined by the Equality Act 2010, is a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on a person's ability to do normal daily activities The social model of disability defines disability as the effect of the barriers, discrimination and disadvantages faced by disabled people, not the impact of their specific impairment.

Disadvantaged groups
are groups of people that experience a higher risk of poverty, social exclusion, discrimination and violence than the general population. Disadvantaged groups include, but are not limited to, ethnic minorities, migrants, people with disabilities, isolated elderly people and children. Their vulnerability to discrimination and marginalisation is a result of social, cultural, economic and political conditions and not a quality inherent to certain groups of people.

Diversity
is about recognising, respecting and valuing a wide set of differences and understanding that the opportunities we get are impacted by characteristics beyond those protected by legislation like class, family background, political views, union membership etc.

Diversity and Inclusion Strategy
is the Mayor's strategy to set out the evidence base, objectives and approach to delivering the Mayor's vision for a city where all Londoners are able to reap the rewards of growth, play active roles in their communities, and have the opportunities they need to fulfil their potential.

E

Early years
is the period from a baby's birth through to the age of five.

Early years settings
are establishments which offer provision to the 0-5 age group; ie childminders, crèches, nurseries, children's centres, nursery schools and schools with nurseries.

Economic fairness
is one where opportunity is shared and every Londoner can flourish, whatever their background; where people do not face discrimination or disadvantage as a result of characteristics such as age, ethnicity, gender, religion, sexual orientation or socio-economic background; where there is no destitution or persistent poverty; and where the economic gaps between Londoners are not so great that they entrench unfairness and deprivation by making it impossible for opportunity to be shared.

Educational attainment
refers to the grade or level a student achieves; this differs from 'progress' in that it does not factor in the student's starting point.

F

Food system
is a catch-all term for the way food works for Londoners and businesses. It includes the contribution of food businesses to London's economy, the role of the built food environment which Londoners experience (eg lack of access to healthy food, widely visible unhealthy advertising), and the contribution of food to Londoners' health, amongst many other things.

Frontline healthcare professional
is an individual who provides a routine and essential service in a healthcare setting. It covers a range of professions including but not limited to doctors, nurses, physiotherapists, dentists, paramedics and occupational therapists.

Fuel poverty
is when a household's fuel costs to heat and power the home adequately are above average (the national median level) and if they were to spend that amount, they would be left with a residual income below the official poverty line. It is caused by the combination of three factors: low incomes; the poor energy efficiency of homes; and high energy prices.

G

Good Work Standard
is the Mayor's vision for a new compact, or agreement, with London's employers. It aims to promote fair pay, excellent working conditions, diversity and inclusion, good work-life balance, health and wellbeing, opportunities for professional development and lifelong learning, and employee voice and representation in London's workplaces.

GP
stands for general practitioner, a medically qualified doctor who provides a primary care service from general practice. Also referred to as 'family doctor' (see 'primary care' below)

Green infrastructure
is a network of green spaces - and features such as street trees and green roofs – that is planned, designed and managed to deliver a range of benefits. These include mitigating flooding, cooling the urban environment and enhancing biodiversity and ecological resilience, as well as providing more attractive places for people.

Greening
is the improvement of the appearance, function and wildlife value of the urban environment through soft landscaping.

Green roof
is planting on roofs or walls to provide climate change adaptation, amenity, food-growing and recreational benefits.

Green space
is areas of vegetated land, such as parks, gardens, cemeteries, allotments and sports fields, which may or may not be publicly accessible. Together, these spaces help to form London's green infrastructure space network.

H

Healthy Early Years London
is an awards scheme funded by the Mayor of London that supports and recognises early years setting achievements in child health, wellbeing and readiness for school.

Healthy habits
are the regular routines that make up healthy lifestyle. Consistently eating a healthy diet, exercising and getting enough sleep are all examples of healthy habits.

Health inequalities
are avoidable and unfair differences in mental or physical health between groups of people. These differences affect how long people live in good health and are partly or entirely a result of differences in people's homes, their environments, their jobs and employment prospects, their access to good public services or their habits.

Healthy life expectancy
is an estimate of how many years a person might be expected to live in a 'healthy' state. It is a key summary measure of a population's health.

Healthy Schools London (HSL)
is an awards scheme funded by the Mayor of London that supports and recognises school achievements in pupil health and wellbeing. HSL focuses on the whole child and gives schools a framework for their activity with pupils, staff and the wider community. HSL promotes a whole school approach across four themes: healthy eating, physical activity, emotional health & wellbeing and Personal Social Health Education (PSHE). www.healthyschools.london.gov.uk/

Healthy Streets
is the Mayor and TfL's approach to prioritising people and their health in decision-making to create a healthy, inclusive and safe city for all. The approach is based on ten Healthy Streets indicators for making London a more attractive place to walk, cycle and use public transport, and reducing the dominance of motorised traffic.

HIV (human immunodeficiency virus)
is a virus that damages the cells in your immune system and weakens your ability to fight everyday infections and disease.

HIV Pre-Exposure Prophylaxis (PrEP)
is a course of HIV drugs taken before sex to reduce the risk of getting HIV.

I

Illicit tobacco
is smuggled, bootlegged or counterfeit tobacco, sold cheaply and tax-free and often linked to large-scale organised crime.

Income inequality
refers to the gap between those with the highest and those with the lowest incomes. There are different measures to assess income inequalities and how they change over time. One example is the '90/10' ratio which is calculated by dividing the average (median) income of the top 20 per cent of incomes by the average income of the bottom 20 per cent. The higher the number, the greater the gap between those with the highest incomes and those with the lowest incomes.

L

LFEPA
stands for London Fire and Emergency Planning Authority. Its seventeen members are appointed by the Mayor and it is part of the GLA group.

LGBT+
stands for Lesbian, Gay, Bisexual and Transgender. The plus demonstrates the inclusion of all identities that make up the LGBT community including the continuing ways people define themselves.

Life expectancy
is an estimate of how many years a person might be expected to live.

Living Wage Commission
is a forum set up in January 2016 to oversee the calculation of the living wage rates in London and the UK.

London Food Strategy
will set out how London can enhance our health, increase pleasure from eating, enrich experience of London's cultural diversity and ensure a more sustainable future.

London Health and Care Devolution Memorandum of Understanding
is the commitment by central government and national bodies to work with London partners to explore the transfer of powers, decision-making and resources closer to local populations. December 2015. Available at: https://www.gov.uk/government/publications/london-health-devolution-agreement/london-health-devolution-agreement

London Health Board
is a non-statutory partnership. It is chaired by the Mayor of London, and involves representatives of London's boroughs, NHS Trusts and Clinical Commissioning Groups, as well as Public Health England and NHS England.

London Health Commission
was an independent inquiry established in September 2013 by the Mayor of London. Chaired by Professor the Lord Darzi, the Commission examined how London's health and healthcare can be improved for the benefit of the population.

London Health Devolution Agreement
is the commitment by London partners to work more closely together to support those who live and work in London to lead healthier independent lives, prevent ill-health, and to make the best use of health and care assets. December 2015. Available at: https://www.london.gov.uk/sites/default/files/london_health_and_care_collaboration_agreement_dec_2015_signed.pdf

London Healthy Workplace Charter
is the Mayor's free accreditation scheme which supports and rewards employers for investing in workplace health and wellbeing. It provides a series of standards for workplaces to meet in order to guide them into creating healthier workplaces. It is supported by London boroughs and Public Health England (London). www.london.gov.uk/healthyworkplace

Londoners
are permanent and temporary residents of London and, where also applicable, commuters from outside London, visitors and tourists.

London Plan
is the Mayor's spatial development strategy for London.

London TB Control Board
is a multi-agency group which provides strategic oversight and direction to the control, commissioning, quality assurance and performance management of TB services across London.

Long term conditions
are health conditions for which there is currently no cure, and which are managed with drugs and other treatment, for example: diabetes, chronic obstructive pulmonary disease, arthritis and high blood pressure.

Low income
(or more accurately relative low income) is having a household income lower than 60% of the average (median) household income (note this covers all forms of income – wages, benefits, dividends etc).

M

Mayor's Culture Strategy
is the Mayor's plan to secure London's cultural venues, institutions and the infrastructure necessary to support core culture and community arts programmes.

Mayor's Fuel Poverty Action Plan
was first announced at Mayor's Question Time in October 2016. While not a London-specific problem, fuel poverty has been increasing in London as a result of falling incomes, rising housing costs, and increasing income inequality. The plan identifies stakeholders that have a role to play in tackling fuel poverty with

the Mayor's effort focused on targeting existing Mayoral programmes towards the fuel poor and supporting boroughs to increase enforcement of housing standards.

Mental health first aid
is a range of training packages for non-expert members of the public that builds knowledge of mental health conditions and how to spot signs and symptoms. It is a similar approach to (physical) first aid and increases the confidence to intervene and direct to specialist support as required.

Mental ill-health
covers a very wide spectrum of health issues from the worries and grief we all experience as part of everyday life to the most bleak, suicidal depression or complete loss of touch with everyday reality.

MOPAC
stands for the Mayor's Office for Policing and Crime. It is the strategic oversight body responsible for developing the Mayor's Police and Crime Plan and making sure it is delivered.

N

Nitrogen dioxide (NO_2)
is a gas formed by combustion, identified as an air pollutant harmful to human health. The legal limit values measure concentrations of NO_2 in the air.

Neighbourhood Plans
are prepared by a Parish Council or Neighbourhood Forum for a particular neighbourhood area. They can set out policies in relation to the development and use of land in the whole or any part of a particular neighbourhood area specified in the plan.

O

Older people
refers to people over 50, but also recognises that those above retirement age and those over 70 may have particular requirements that need to be addressed.

Overcrowding
refers to situations in which more people are living in a home than it can comfortably and safety accommodate. There are a number of different definitions are used for different purposes. Some are based on the number, age and relationship of the people occupying a home in relation to the number of rooms available and others on the relationship to the size of the rooms available. Where specific statistics on overcrowding are cited, the source cited will identify the specific definition used.

Overweight
refers to people with a Body Mass Index (weight in relation to height) which is higher than is considered healthy.

P

Parity of esteem
aims to ensure that mental health is valued as equal to physical health. It requires both forms of ill-health to be treated with the same level of urgency and given an equal status by policy makers and statutory bodies.

Physical activity
is any movement of the body's muscles and skeleton that burns energy

Police and Crime Plan
is how the Mayor sets out how the police, community safety partners and other criminal justice agencies will work together to reduce crime. See also MOPAC.

Poverty
is when a person's resources (mainly their material resources) are not sufficient to meet their minimum needs (including social participation)

Premature death
refers to death that occurs before the average age of death in a certain population.

Prevalence
is a statistical concept referring to the number of cases of a disease that are present in a particular population at a given time, for example the number of people who have lung cancer, or who smoke, who are obese.

Prevention
in the context of this health inequalities strategy is the work we do to stop people from getting ill. Prevention can be more cost-effective and better for reducing health inequalities than focusing on treatment of ill-health.

Primary care is
healthcare provided in the community for people making an initial approach to a medical practitioner or clinic for advice or treatment. Services are provided by general practitioners (see GP above) as well as practice nurses and other general practice staff.

Private rented sector
A housing tenure consisting of homes owned and rented out by landlords to tenants, normally by private individuals or organisations. It differs from the social rented sector in that there is no restriction on the rent that can be charged and less security of tenure for tenants.

Proportionate universalism
is an approach to tackling health inequalities. There is a social gradient in health which means that the lower a person's social position, the worse his or her health. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of this social gradient in health, actions must be for everyone, but with a scale and intensity that is proportionate to the level of disadvantage.

Public health
is the science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society.

Public Health England (PHE)
is an executive agency of the Department of Health. It exists to protect and improve the nation's health and wellbeing, and reduce health inequalities.

R

The RNLI
is a charity providing 24-hour lifeboat search and rescue service, seasonal lifeguards, water safety education and initiatives, and flood rescue response

Rough sleeping
is where people are bedded down or preparing to bed down in the open air, or in (parts of) buildings or other space not designed for habitation – for example, in stairwells, stations, or cars.

S

Service user
is a person who is using or has used a health and/or care service. Because of their direct experiences their unique insight into what works can be used to improve services.

Social inclusion
means removing barriers and taking steps to create equality, harness diversity and produce safe, welcoming communities and cultures that encourage innovative and fresh ways of thinking and allow people to speak up, especially to suggest where things could be done better.

Social integration
is about how we all live together. It is about building strong communities where all Londoners can lead interconnected lives and play an active part in their city and the decisions that affect them. We know this can only be achieved by working to overcome structural barriers and inequalities, whilst recognising the important role interaction and participation play in overcoming these.

Social isolation
is a state of complete or near-complete lack of contact between an individual and society. It differs from loneliness, which reflects a temporary lack of contact with other people.

Social marketing
brings concepts and approaches from commercial marketing into activities aimed at changing or maintaining people's behaviour for the benefit of individuals and society as a whole. It is guided by ethical principles and aims to deliver social change programmes that are effective, efficient, equitable and sustainable.

Social prescribing
is a way of linking people to sources of support within the community. It is mainly used by GPs, nurses and other health care professionals to refer people to a range of non-clinical services and activities in the community to address people's social, financial or emotional needs.

Statutory homelessness
refers to cases where households lose or are threatened with losing their homes and receive assistance from local authorities under the legislation on homelessness. This legislation stipulates that local authorities are obliged to ensure that households who meet certain criteria have accommodation available to them. It is important to note that local authorities may provide accommodation for households facing or experiencing homelessness outside the scope of this legislation.

Substance misuse
is where a drug or alcohol is used in a way harmful to an individual's physical or mental health, or that causes problems with their ability to study, work or maintain good relations with friends, family or community. In some cases specialist/medical help will be required to help with recovery.

Supply chain
is a network between a company and its suppliers to produce and distribute a specific product. The supply chain also represents the steps it takes to get the product or service to the customer.

Sustainability and Transformation Plan (STP)
refers to the plans the NHS is currently developing which set out the future of health and care services within a particular geography. There are five STPs in London.

T

TB
(tuberculosis) (respiratory) is a bacterial infection spread through inhaling tiny droplets from the coughs or sneezes of an infected person.

Thrive LDN
is a citywide movement to improve the mental wellbeing of all Londoners that aims to energise and mobilise Londoners to think, talk and act more about mental wellbeing. Through this intention, it will offer people the opportunity to coproduce thriving communities with London's public, private and charitable sectors.

Time to Change
is a national campaign led by Mind and Rethink that is challenging the stigma and discrimination experienced by people with mental health issues. The campaign is building a movement of people to change how we think and act about mental health problems. Find out more at https://www.time-to-change.org.uk/

Transport Strategy
is the Mayor's 25 year plan for London's transport system. This plan guides Transport for London and London boroughs in their transport policies and investments.

U

UNAIDS
is the Joint United Nations Programme on HIV/AIDS

W

Wellbeing
is a state of being where people can realise their potential, cope with the normal stresses of life, work productively and fruitfully and are able to make a contribution to their community

World Health Organisation (WHO)
is an organisation whose goal is to build a better, healthier future for people all over the world. Working through offices in more than 150 countries, WHO staff work with governments and other partners to ensure the highest attainable level of health for everyone.

Z

Zero suicide city
is a concept developed in the USA founded on the belief that suicide deaths for individuals under care within health and behavioural health systems are preventable. Zero Suicide relies on a system-wide approach to improve outcomes and close gaps rather than on the heroic efforts of individual practitioners. It requires the engagement of the broader community, especially suicide attempt survivors, family members, policymakers, and researchers.

Footnotes

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SUMMARY OF CONSULTATION QUESTIONS

Healthy children

1. Is there more that the Mayor should do to reduce health inequalities for children and young people?

2. How can you help to reduce health inequalities among children and young people?

3. What should be our measures of success and level of ambition for giving London's children a healthy start to life?

Healthy minds

4. Is there more that the Mayor should do to make sure all Londoners can have the best mental health and reduce mental health inequalities?

5. How can you help to reduce mental health inequalities?

6. How can we measure the impact of what we're doing to reduce inequalities in mental health?

Healthy place

7. Is there more that the Mayor should do to make London's society, environment and economy better for health and reduce health inequalities?

8. How can you help to reduce inequalities in the environmental, social and economic causes of ill-health?

9. What should be our measures of success and level of ambition for creating a healthy environment, society and economy?

Healthy communities

10. Is there more that the Mayor should do to help London's diverse communities become healthy and thriving?

11. How can you help to support thriving communities?

12. What should be our measures of success and level of ambition for creating healthy and thriving communities?

Healthy habits

13. Is there more that the Mayor should do to help to reduce health inequalities as well as improve overall health in work to support Londoners' healthy lives and habits?

14. What can you do to help all Londoners to develop healthy habits? What is preventing you from doing more and what would help you?

15. What should be our measures of success and level of ambition for helping more Londoners to develop healthy habits?

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London Borough of Bromley

PART ONE - PUBLIC

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**7th September 2017**
Report Title:	**2016/17 Winter Review**
Contact Officer:	*Michael Maynard, Urgent Care Lead, Bromley CCG* *Tel:* 01689 866636 Email: m.maynard@nhs.net
Chief Officer:	Ade Adetosoye, Deputy Chief Executive and Executive Director Education, Care and Health Services Angela Bhan, Chief Officer, Bromley CCG
Ward:	All

1. SUMMARY

This report highlights

- *The performance of the Urgent Care System in winter 2016/17*
- *The winter schemes identified to help manage surge and lack of capacity*
- *An evaluation of each scheme and lessons learnt*
- *Schemes carried forward to continue to support the system*

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

This paper is going to the Health and Wellbeing Board for information.

3. SPECIFIC ACTION REQUIRED BY HEALTH & WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

This report is to note progress

Health & Wellbeing Strategy

1. Related priority: Not applicable

Financial

1. Cost of proposal: £610k was already signed off as part of the winter funding

2. Ongoing costs: N/A

3. Total savings (if applicable): N/A

4. Budget host organisation: CCG

5. Source of funding:

6. Beneficiary/beneficiaries of any savings:

Supporting Public Health Outcome Indicator(s)

Yes, through better preventive care for people with complex needs, reducing length of stay in hospital and thereby promoting independence

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4. COMMENTARY

N/A

5. FINANCIAL IMPLICATIONS

No new finances are required

6. LEGAL IMPLICATIONS

N/A

7. IMPLICATIONS FOR OTHER GOVERNANCE ARRANGEMENTS, BOARDS AND PARTNERSHIP ARRANGEMENTS, INCLUDING ANY POLICY AND FINANCIAL CHANGES, REQUIRED TO PROGRESS THE ITEM

N/A

8. COMMENT FROM THE DIRECTOR OF AUTHOR ORGANISATION

This report shows that there has been a significant improvement in A&E performance over recent months, which has been the result of an improved system wide approach. The impact of strengthened joint working between London Borough of Bromley and Bromley CCG has clearly shown benefits. New schemes and development of existing schemes over the coming months should put Bromley in a good position to ensure improved quality of urgent and emergency care for our residents.

Non-Applicable Sections:	[List non-applicable sections here]
Background Documents: (Access via Contact Officer)	[Title of document and date]

Glossary

A&E	Accident and Emergency
CCG	Clinical Commissioning Group
CD	Community Matron
ED	Emergency Department
HWBB	Health and Well Being Board
KCH	Kings College Hospital
KPI	Key Performance Indicators
LBB	London Borough of Bromley
MRT	Medical Response Team (rapid response and out of hours GP services)
PRUH	Princess Royal University Hospital

RSV	Respiratory Syncytial Virus
TBC	To be confirmed
TOC	Transfer of Care
UCC	Urgent Care Centre

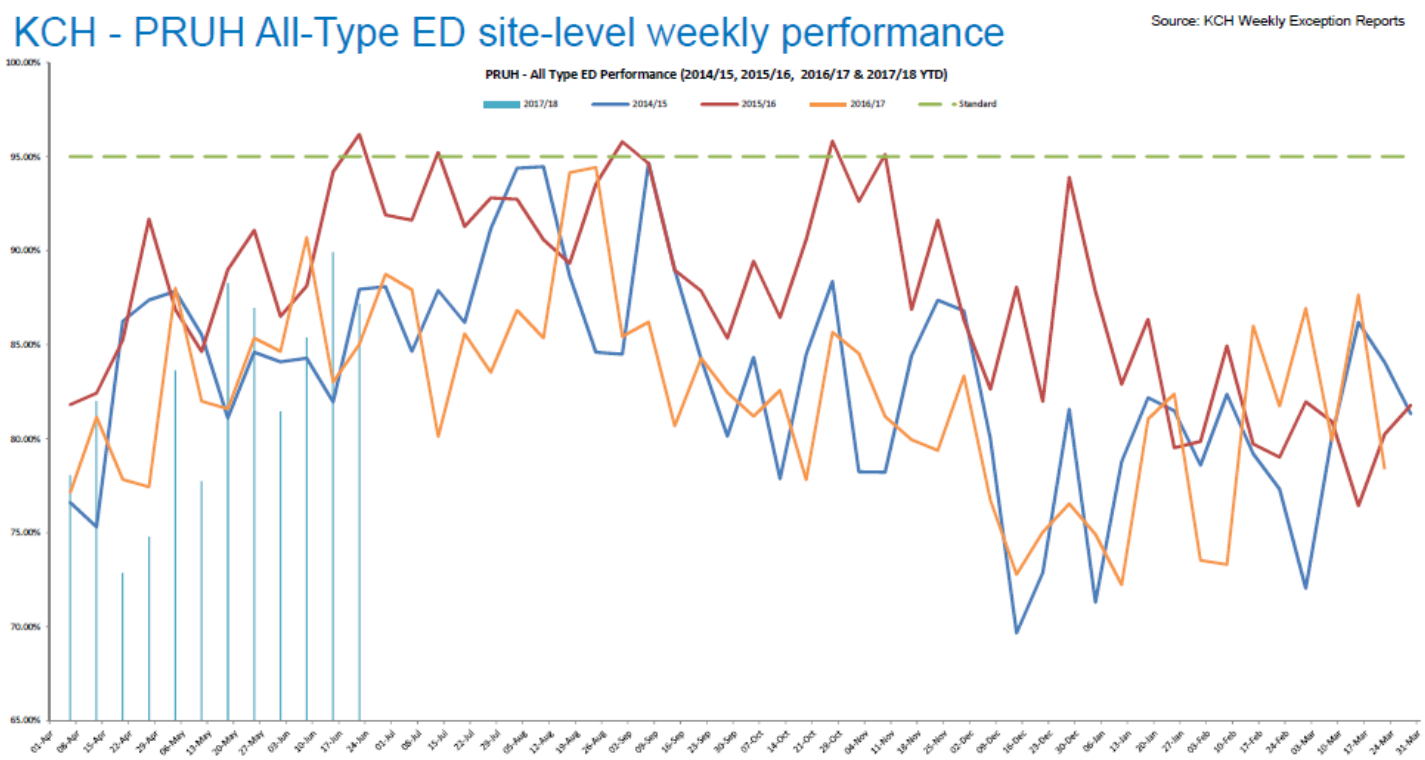
Overview

This highlight report follows the interim report presented to the Health and Wellbeing Board in on the 2nd February 2017, it provides:

- The performance of the Urgent Care System in winter 2016/17
- The winter schemes identified to help manage surge and lack of capacity
- An evaluation of each scheme and lessons learnt
- Schemes being carried forward to continue to support the system

1. Performance of the system

The graph below highlights the performance of the A&E 4 hour target for over the 16/17 winter and Q1 of this financial year with comparisons of the same period for the last 2 years



The orange line shows the performance against the 95% standard dipped dramatically against previous years from Aug 2016, hitting its lowest period in December before starting to recover.

As already known to the Health and Well Being Board, there are a number of reasons for the poor performance. It should be noted that performance has significantly improved over the late spring and summer months this year and, as a system, urgent care services in Bromley (particularly the PRUH) has developed the ability to recover more quickly than in previous years.

Reasons for sporadic performance include:

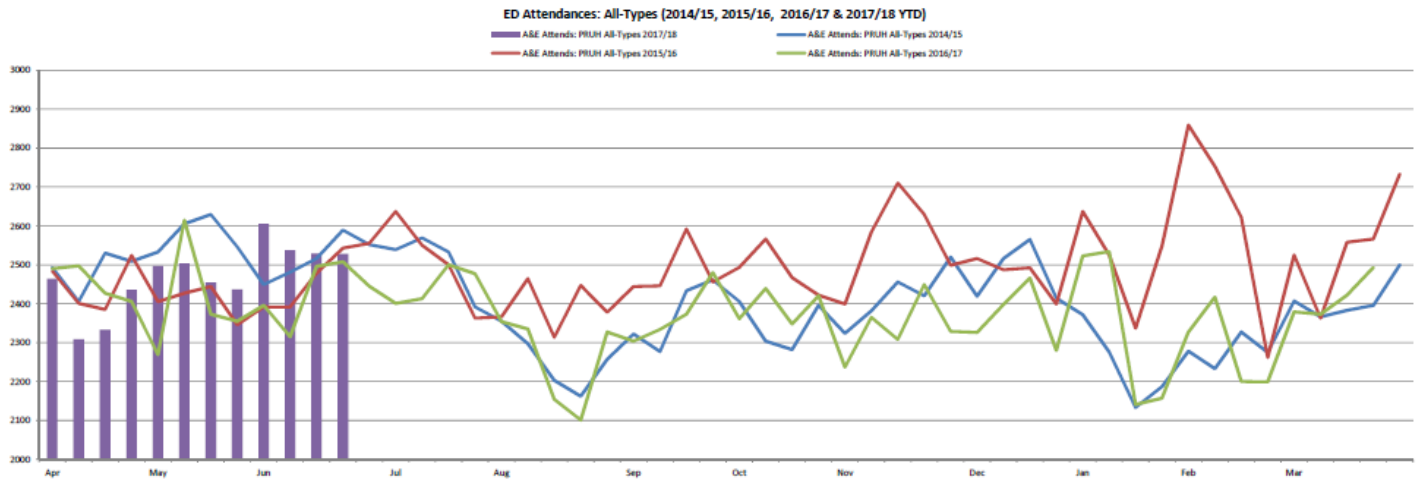
1. Demographics and infectious disease
   - Increasing age and frailty of parts of the Bromley population
   - A winter that has been particularly cold at times, with icy and (more recently) foggy conditions
   - Circulating viruses – we are seeing more cases of influenza A and also respiratory syncytial virus (RSV), as well as flu like illness caused by other viruses.
   - Increase in numbers and proportion of ambulances and 'blue light' ambulances coming to the PRUH (an indirect marker of increased acuity of patients)

2. Poor flow of patients through the urgent and emergency care system, as manifested by large numbers of patients identified as delayed transfers of care prior to Christmas week:

   - Difficulties in placing packages of care due to lack of capacity in the domiciliary care market, especially over the Christmas and New Year period
   - Availability of care and nursing home places for social care and continuing health care patients as well as for self-funders
   - Particular delays for patients in the PRUH who are the responsibility of other boroughs

3. Factors internal to the hospital
   - Staff vacancies and challenges in recruiting locum staff
   - Process issues in being able to move patients from A&E to the wards (usually because beds not available or not available early enough in the day, resulting in patients waiting longer to be seen in A&E)
   - Outbreak of norovirus at the start of winter, with ongoing associated problems.

The following graph is an updated position on the attendances of patients to the PRUH in comparison to previous years



Attendances have remained at or lower than previous years, though the 'demand' has been harder to anticipate as has been the acuity of the patients. This has been further impacted on by the outbreak of Norovirus at the beginning of winter.

2. Winter Schemes and Intervention

In preparation for winter and taking into consideration the lessons learnt from last year, the following winter schemes were implemented to help manage the surge and capacity issues.

Scheme	Description	Provider
In-reach (Medical Response Team)	A scheme that places an Advance Nurse Practitioner in the front of the PRUH to extract patients that have attended inappropriately	Bromley Healthcare
Patient Champion	A staff member working in the UCC dedicated to redirecting patients back into primary care	Greenbrooks
Community Matron in the PRUH	A matron to work as part of the Transfer of Care Bureau to help expedite patient discharge back into community services	Bromley Healthcare
GP in the PRUH	A GP working in the Transfer of Care Bureau to help expedite patients back into community services and primary care	GP Alliance
Additional Primary Care Hub appointments	An increase of additional primary care hub appointments	GP Alliance
Dressings Service	An additional dressing service 3 days a week to help manage post op dressings (located in the primary care hubs)	GP Alliance
Social Worker	An additional Social Worker at the front door to help manage social care issues	London Borough of Bromley (through the Transfer of Care Bureau)
Discharge Co-ordinator	Additional capacity in the Transfer of Care Bureau	Transfer of Care Bureau
Rapid Response	An Alternative Care Pathway focusing on care homes to help avoid ambulance callouts and ED attendances	Bromley Healthcare
Day and Night Sitting	A day and night sitting service to help patients settle at home	Age Concern

Other interventions have included:

- The purchasing of additional packages of care
- The provision of additional social care beds
- Direct booking into the primary care hubs (111, UCC and MRT)
- Additional funding for care home assessments
- Flexing of criteria for community rehab beds
- Platinum calls and meetings with the system (twice weekly)
- Additional Acute beds as part of the frailty pathway (in Orpington Hospital)
- Increased capacity for psychiatric liaison service

3. Scheme Evaluations

Scheme Name	**MRT Inreach**

Scheme Description	To provide a community Inreach service at the front end to identify and 'pull' patients back into community services as early as possible and avoid patients being admitted into 'back end' bed provision
KPI agreed	• 2 Discharges a day • Identify discharge blockages • Number of tracked patients handed over to community matron
Summary of impact	November 2016 – March 2017 In reach were referred 880 patients of which 653 (74%) were accepted and discharged back to the community with MRT the services. 107 patients that were tracked converted to discharges A further deep dive was conducted on 50 patients and found a 32% readmission rate within 6 weeks and of the 32%, 43% were readmitted within a week.
Recommendations/lessons learnt	1) Strengthened links with the developing frailty pathway as the patients who can benefit from the service are mostly frail and elderly 2) Increased multi-disciplinary approach at weekends/Bank Holidays 3) Intensive 'myth busting' of perceptions amongst acute clinical staff of what MRT can manage in the community. This is improving with time and experience but a more timely introduction of the service could be achieved by co-ordinated awareness raising sessions prior to the service commencing and conducting case by case reviews/discussions at a senior/advanced level
Scheme Name	**Community Matron**
Scheme Description	To provide a Community Matron (CM) In-reach service for 'back end' wards in the PRUH. To work with TOC GP/KCH MDT colleagues to identify pts who can be safely transferred to community health services and provide clinical challenge
KPI agreed	• Facilitate 2 discharges per day • Educate/raise awareness of community health services in Bromley • Be a reference point for KCH staff to contact for advice
Summary of impact	The service expedited and supported the discharge of 81 patients. A total of 181 assessments/advice offered – this excludes ad-hoc conversations
Recommendations/lessons learnt	• Continue with regular meetings with the PRUH discharge team colleagues to build on recent In reach education to continue communicating best practices for a safe and timely discharge process • Regular attendance on the ward to support discharge into community and smooth the discharge and patient flow by direct liaison with the team • Consider 7 day presence • Intensive 'myth busting' of perceptions amongst acute clinical staff of what community health teams such as MRT can manage in the community.
Scheme Name	**Rapid Response for care homes**
Scheme Description	The service provided rapid medical response and assistance for cases which were urgent but could be treated in the community, helping care homes and extra care housing to cope quickly and efficiently without having to call an ambulance or wait for a GP
KPI agreed	N/A
Summary of impact	The service started in January but struggled to recruit members of staff and therefore became fully operational throughout March and April. 16 patients were seen from 8 care homes. The conditions referred were: • Chesty cough: 3 occasions • Recurrent chest infection: 3 occasions • Confused: 2 occasions • Generally unwell and could not reach GP: 2 occasions • Swollen ankle • Ongoing rash • Constipation • Blocked catheter

	• Pressure sore • Leg ulcer
Recommendations/lessons learnt	1) The scheme was started late (at the height of winter) and it struggled to attract staff 2) As it was only a pilot, homes were reluctant to change their way of working for such a short period of time 3) The scheme overlapped significantly with another care home scheme implemented through the 111 services. This meant there were potentially conflicting messages issues, with homes naturally choosing to rely on the permanent national service that they used throughout the year. 4) Engaging and communicating with homes and key decision makers proved challenging, better communication links was needed

Scheme Name	**Day and Night Sitting Service**
Scheme Description	The Age UK Bromley & Greenwich Sitting Service was designed to support older people returning home post discharge from hospital or a rehabilitation unit for the vital 24-48 hour period whilst they settle and assimilate to their home environment especially after lengthy hospital stays.
KPI agreed	N/A
Summary of impact	The service did not see any patients in its duration because of limited referrals. Issues identified: • The service could only receive referrals from hospital staff and not families/ carers or self-referrals from patients • It took some time subsequent to going live with the service, for the exact hospital departments and locations who were to refer to be decided • When multidisciplinary professionals from wards at the PRUH did call and leave messages to make a referral it was almost impossible to get in contact with them to complete the process, and they were unable to respond or get back in touch to fully instigate the referral • There was a referral for one client mid-way in to the contract however the patient then needed to stay in hospital longer and transfer to a rehabilitation unit, thus postponing the referral • When staff did attend for the singular referral they had felt relatively disempowered because no personal care element was in place. When the client required certain support in the toilet or bathroom they were very limited as to how they could assist. Staff also raised issues regarding the domiciliary carers who were meant to provide personal care and administration of medication but failed to do so- this was relayed to the client's next of kin via Age UK Bromley & Greenwich. For ongoing practical support the service also allocated their Hospital Aftercare 6 week package of support for companionship and confidence building subsequent to the sitting time allocated.
Recommendations	• Broadening the range of who can refer for the service, i.e. not hospital staff only • Having a dedicated Coordinator who could be based at the PRUH and indeed travel between the acute, Orpington and Lauriston House rehabilitation unit to manage discharge home with the Sitting service in place. • To have a personal care element introduced and an element of handover to domiciliary or enablement agencies who would be continuing care of the client • To instil a reporting system liaising with the Hospital social work teams to report any issues related to the client care or service deficiencies so that these can be addressed in a timely manner adhering to best practice and relieving some burden from the patient and their family members, thus

	minimising the need for further deterioration in health and wellbeing and readmission.

Scheme Name	Patient Champion
Scheme Description	An administrator located within the Urgent Care Centre to redirect patients attending the UCC inappropriately, and to provide awareness to patients of other services in Bromley
KPI agreed	5% patients redirected
Summary of impact	From Jan-March the patient champion redirected 76 patients from the PRUH and Beckenham Beacon
Recommendations	To continue with the scheme for the next financial year, with a greater emphasis on redirection from the PRUH

Scheme Name	GP in Transfer of Care Bureau
Scheme Description	A team of GPs located in the Transfer of Care Bureau to help expedite discharges
KPI agreed	2 patients per day
Summary of impact	During the four month period over 109 patients were seen and the notes of a further 180 patients reviewed and advice given. The GP's initially focussed their time and attention on the wards, reviewing patients with delayed discharges, however this proved of little effect therefore attention was moved to the front of the hospital to avoid admission.
Recommendations/lessons learnt	To continue with the scheme and utilise the GP at the front of the hospital indefinitely for a range of functions. Benefits and lessons learnt included: • the ability of the GPs to do outpatient referrals, order bloods and other tests, arrange GP appointments and visits on discharge, arrange District nurse and community appointments, prescribe medication, liaise with the community pharmacy, speak with families, GP's and other professionals involved in the care of the patient, recommend the patients for addition to the practice admissions avoidance register and for MDT meetings.
Scheme Name	**Dressings Clinic**
	(i) Nurse dressing clinics for patients requiring suture removal or post op wound care
KPI agreed	N/A
Summary of impact	The clinics was originally set up to alleviate the pressure on UCC's to provide dressings, however minimal referrals was made, the decision was taken to expand provision to general practise. Once the restriction in referrals and type of referral was lifted, practices started to use the service. The scheme operated at 64% utilisation
Recommendations/lessons learnt	This scheme was ended in March as it's moved away from its original intention.
Scheme Name	Additional Primary Care Hub Appointments
Scheme Description	To provide additional appointments by opening a 3rd primary care hub (crown meadow)
KPI agreed	N/A
Summary of Impact	The third hub has been successful since its inception and now forms part of the regular hub contract. Utilisation has always been high. The appointments reserved for the UCC were underutilised. Between 1/12/16-31/3/17 only 294 appointments were used. However appointments were made available to the MRT. They utilised a further 691 and continue to book patients into the hubs when they are open instead of sending them to UCC
Recommendations/Lessons Learnt	Continue with the provision of the third hub

Winter 2016/17 Summary

The performance graph at the beginning of the report highlights an improvement against the 95% 4 hour A&E target from Mid-December onwards. This time period correlates with the majority of winter schemes being in full operation and supporting the system as planned. This is further evidenced by the dip in attendance at the same period, as many of the schemes centred on admission avoidance.

At the end of March when the majority of schemes were scheduled to end, the decision was taken to extend the following services to continue supporting the urgent care system:

- In-reach MRT
- GP in Transfer of Care Bureau
- Third primary care hub
- Patient Champion in the UCC

Winter Schemes 2017/18

Learning from the previous winter became critical when identifying what initiatives were required to support this winter. The earlier graph highlighted activity over the last few years has relatively remained the same therefore enabling a more accurate forecast of demand for this winter.

After evaluating the supporting data and consulting the wider Urgent Care System, the following initiatives have been proposed for this winter

Scheme Name	**Front door team**
Scheme Description	A multi-disciplinary admission avoidance team at the front door of the PRUH to help redirect patients back into the community - consisting of the GP (role used last year), a social worker, community matron (used last year) and discharge coordinator
KPI agreed	Tbc
Summary of potential impact	Will run from October 17 to March 18 and provide primary care working with secondary care

Scheme Name	**Patient Champion extension**
Scheme Description	Providing an additional patient champion and ensure the service operates 7 days a week
KPI agreed	Tbc
Summary of potential impact	Increased redirection of patients back into the community
Scheme Name	**Patient Champion**
Scheme Description	A multi-disciplinary admission avoidance team at the front door of the PRUH to help redirect patients back into the community - consisting of the GP (role used last year), a social worker, community matron (used last year) and discharge coordinator
KPI agreed	Tbc
Summary of potential impact	Will run from October 17 to March 18 and provide primary care working with secondary care
Scheme Name	**HCA**
Scheme Description	Provide additional administrative support to each UCC
KPI agreed	Tbc
Summary of potential impact	Provide additional capacity
Scheme Name	**GP Uplift**
Scheme Description	An agreed uplift to enable a fully staffed rota between Christmas and New Year in the UCC
KPI agreed	Tbc
Summary of potential impact	Greater capacity

Scheme Name	**St Christopher's**
Scheme Description	A member of St Christopher's working in the Transfer of Care Team to help identify appropriate patients for their end of life pathway
KPI agreed	Tbc
Summary of potential impact	Will run from October 17 to March 18

Scheme Name	Communication
Scheme Description	A communication campaign focusing on self-care messages and directing patients to the most appropriate service
KPI agreed	Tbc
Summary of potential impact	Patients receiving the right care in the right place

In addition to the schemes identified other measures will be adopted to further support the system, this includes:

- Purchasing of additional packages of care
- Additional Primary Care Hub appointments
- Direct booking into Primary Care Hubs
- Revision of escalation processes between providers
- Discharge to Assess pilot supported through existing schemes and specifically identified 10 discharge to assess beds.
- Further development of the Transfer of Care Bureau, including new management and operating arrangements
- Links between urgent and emergency care (and reactive approaches) will be strengthened by further improvements in the Integrated Care Networks operating model (which has traditionally been focussed on proactive care)

Ongoing Governance and development 2017/18

It is clear that the improved joint working between London Borough of Bromley and Bromley CCG in recent months has improved and further developed the initiatives aimed at ensuring that patients flow through the hospital and urgent care system much better than previously. Joint appointments between LBB and the CCG are supporting the new approach.

The winter schemes will be directly managed through the Bromley A&E Delivery Board and will overseen by the evolving joint commissioning arrangements being developed between the commissioning organisations.

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CSD17073 **London Borough of Bromley**

Decision Maker:	**HEALTH AND WELL BEING BOARD**
Date:	**September 7th 2017**
Decision Type:	Non Urgent Non-Executive Non-Key
Title:	**Health and Wellbeing Board Matters Arising and Work Programme**
Contact Officer:	Stephen Wood, Democratic Services Officer Tel: 0208 313 4316 E-mail Stephen.wood@bromley.gov.uk
Chief Officer:	Mark Bowen, Director of Corporate Services
Ward:	N/A

1. Reason for report

1.1 Board Members are asked to review the Health and Wellbeing Board's current Work Programme and to consider progress on matters arising from previous meetings of the Board.

1.2 The Action List (Matters Arising) and Glossary of Terms are attached.

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2. RECOMMENDATION

2.1 The Board is asked to review its Work Programme and progress on matters arising from previous meetings.

2.2 The Board is asked to consider what items (if any) need to be removed from "Outstanding Items for Possible Consideration".

2.3 The Board is encouraged to suggest new items for the Work Programme and for the next meeting.

Non-Applicable Sections:	Policy/Financial/Legal/Personnel
Background Documents:	Previous matters arising reports and minutes of meetings.

Corporate Policy

1. Policy Status: Existing Policy:

2. BBB Priority: Excellent Council; Supporting our Children and Young People; Supporting Independence; Healthy Bromley

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Financial

1. Cost of proposal: No Cost for providing this report

2. Ongoing costs: N/A

3. Budget head/performance centre: Democratic Services

4. Total current budget for this head: **£335,590**

5. Source of funding: 2017/18 revenue budget

Staff

1. Number of staff (current and additional): There are 8 posts (6.87 FTE) in the Democratic Services Team

2. If from existing staff resources, number of staff hours: Maintaining the Board's work programme takes less than an hour per meeting

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Legal

1. Legal Requirement: Matters Arising and the Work Programme should be actioned in accordance with statutory obligations.

2. Call-in: Not Applicable

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): This report is intended primarily for Members of the Health and Well Being Board.

Ward Councillor Views

1. Have Ward Councillors been asked for comments? No

2. Summary of Ward Councillors comments: N/A

3. COMMENTARY

3.1 The Matters Arising table is attached at **Appendix 1.** This report updates Members on matters arising from previous meetings which are ongoing.

3.2 The current Work Programme is attached as **Appendix 2.** The Work Programme is fluid and evolving. Meetings are scheduled so that generally speaking they will be held approximately two weeks after CCG Board meetings which will facilitate more current feedback from the CCG to the HWB.

In approving the Work Programme members of the Board will need to be satisfied that priority issues are being addressed, in line with the priorities set out in the Board's Health and Wellbeing Strategy and Terms of Reference which were approved by Council in April 2013.

3.3 For Information, **Appendix 3** shows dates of Meetings and report deadline dates.

3.5 For Information, **Appendix 4** outlines the Constitution of the Health and Well Being Board.

3.6 **Appendix 5** is the updated Glossary.

APPENDIX 1

Health and Wellbeing Board

Matters Arising/Action List

Agenda Item	Action	Officer	Notes	Status
Minute 65 02/06/16 **HWB Strategy**	Resolved that the issue of Falls be discussed at a future meeting.	**Nada Lemic** **Laura Austin Croft**	A short scoping paper for an expert task and finish group on Falls will be submitted to the September meeting. To be followed by a more definitive proposal for the meeting at the end of November. Recommendations from the task and finish group will then be considered at the meeting in March 2018.	**First Stage Complete** **Rest of the Project is ongoing.**
Minute 102 01/12/16 **Healthwatch Inequalities Report**	Resolved that the report be noted, and that an update on the development of the Homelessness Strategy be brought back to a future Board meeting	**Sara Bowrey**	The Homelessness Strategy update has been assigned to the September meeting. An update at the September meeting will be provided by either Sara Bowrey (Director of Housing) or Tracey Wilson.	**Completed**
Minute 113 02/02/2017 **Presentation from the Local Pharmaceutical Committee**	Resolved that a letter be drafted from the HWB to NHS England to highlight the problems faced by local pharmacies in exiting commercial leases and to request support in dealing with these issues.	**Jackie Goad**	The letter has been drafted and sent out.	**Completed**
Minute 120 02/02/17 Performance Against the Winter Plan	It was resolved that a further update on performance against the Winter Plan be provided to the Board in March if possible.	**Michael Maynard/Dr Bhan**	This item has been allocated to the HWB agenda for September. The update should include information and lessons learned, and the plans for the winter of 2017/2018	**Completed**

Minute 121 02/02/17 Phlebotomy Update	It was resolved enquiries be made to see if a phlebotomy clinic could be hosted at Bromley Civic Centre.	**Jackie Goad/Jackie Peake**	Short term interim sites are no longer needed. The CCG however has contacted LBB property department about the possibility of using the old Town Hall in the future.	**Ongoing**
Minute 136 30/03/17 CAMHS Transformation Plan	It was agreed that an update on the CAMHS Transformation Plan be provided to the HWB in 2018.	**Daniel Taegtmeyer**	This has been added to the Work Programme for 2017/2018. The Board has to decide at which meeting the update will be provided.	**Ongoing**
Minute 137 30/03/17 Social Isolation Action Plan	It was resolved that an update on the Action Plan be provided prior to the awareness campaign in the Autumn.	**Denise Mantell**	This has been allocated to the agenda for September 2017 as planned.	**Completed**
Minute 138 30/03/17 Phlebotomy Update	It was resolved that an update be provided in 6 months.	**Dr Bhan**	This has been allocated as an item for the September meeting.	**Completed**
Minute 140 30/03/17 BCF Performance Update	The issues around the cost of delayed transfers of care to be looked at in the June meeting.	**Dr Bhan**	As the June meeting was cancelled, this has been allocated to the September meeting.	**Completed**
Minute 144 30/03/17 PNA	Resolved that a draft PNA would be presented to the HWB in September.	**Dr Lemic/Dr Marossy**	Assigned to the November agenda.	**Ongoing**

Appendix 2

HEALTH AND WELLBEING BOARD
WORK PROGRAMME 2015/16

Title	Notes
Health and Wellbeing Board—7th September 2017	
Update report on the Social Isolation Action Plan	Denise Mantell/Alicia Munday
Phlebotomy Update	Dr Bhan
Work Programme and Matters Arising	Steve Wood
Primary Care Commissioning Update	Dr Bhan or Dr Parson
PNA Update	Vanessa Lane/Nada Lemic
Update on the IRIS Project from Victim Support.	Rachel Nicholas/Bob Parker
Update on the Homelessness Strategy	Sara Bowrey or Tracey Wilson
Scoping Paper for a Falls Task and Finish Group	Dr Lemic/Laura Austin Croft
Update Report on Delayed Transfers of Care	Jodie Atkins--CCG
Improved Better Care Fund Report	Phil Stevens-IBCF Project Manager
BCF Plan (Report) 2017-2019	Jackie Goad
Update report on Performance against the Winter Plan	Michael Maynard (CCG)
Mental Health Sub Group Update (tbc)	Harvey Guntrip
London Health Inequalities Strategy	London Mayor
Emerging Issues	The Board.
Health and Wellbeing Board—30th November 2017	
Presentation from Nash College. (Moved from September)	Steven McDermott
Draft PNA	Dr Lemic/Vanessa Lane
Work Programme and Matters Arising	Kerry Nicholls
BSCB Annual Report	Jim Gamble/Joanna Gambhir
Vulnerable Adolescent Strategy.	Jim Gamble
Report on School Nursing.	Jenny Selway
CCG Community Health Contract.	CCG-Contact Jackie Peake
Draft JSNA Update	Nada Lemic
Public Health Programme Paper	Nada Lemic
Clinical Governance Programme Report	Nada Lemic
Immunisation and Screening Programme	Public Health England/Dr lemic
Update on Care Homes (TBC)	Alicia Munday
Dementia Update	TBC
Update on Bromley Community and Engagement Network	Folake Segun (Healthwatch)
Disabilities Facilities Grant	Alicia Munday-deferred from September
Health and Wellbeing Board---1st February 2018	
Update Paper on Falls Task and Finish Group-definitive decision taken on falls Task and Finish Group.	Dr Lemic/Laura Austin Croft
Report on School Nursing (TBC-November/February)	Jenny Selway
Work Programme and Matters Arising	Kerry Nicholls
PNA Report	Dr Lemic/Vanessa Lane
Primary Care Commissioning Update	Dr Bhan or Dr Parson

Outstanding Items for Possible Consideration:
Obesity and Promoting Exercise
Update from Bromley Third Sector Enterprise/Community Links

Healthwatch Project to Explore Sexual Health and Gender Identity
Update on CAMHS Transformation Plan in 2018
Elective Orthopaedic Centres
Implementation of Personal Health Budgets
Developing a System Wide Mental Health Strategy/Mental Health Act
Improvements in Services for Dementia Suffers
Recommendations from the Falls Task and Finish Group- Dr Lemic/Laura Austin Croft
HWB Strategy

Appendix 3

Dates of Meetings and Report Deadline Dates

The Agenda for meetings MUST be published five clear days before the meeting. Agendas are only dispatched on a Tuesday.

Report Deadlines are the final date by which the report can be submitted to Democratic Services. Report Authors will need to ensure that their report has been signed off by the relevant chief officers before submission.

Date of Meeting	**Report Deadline**	**Agenda Published**
7th September 2017	August 25th 5.00pm.	August 30th 2017
30th November 2017	November 20th 5.00pm	November 22nd 2017
1st February 2018	January 22nd 5.00pm	January 24th 2018
29th March 2018	March 19th 5.00pm	March 21st 2018

A link to the agenda is emailed to the Board on the publication date. Hard copies are available on request.

Questions
Questions from members of the public to the meeting will be referred directly to the relevant policy development and scrutiny (PDS) committee of the Council, or to other meetings as appropriate, at the next available opportunity unless they relate directly to the work of the Board.

A list of the questions and answers will be appended to the corresponding minutes.

Minutes
The minutes are drafted as soon as possible after the meeting has finished. They are then sent to officers for checking. Once any amendments have been made, they are sent to the Chairman, and once he has cleared them, they are sent, in draft format, to Members of the board. Please note that this process can take up to two weeks.

The draft minutes are then incorporated on the agenda for the following meeting and are confirmed.

London Borough of Bromley

Constitution

Health & Wellbeing Board

(11 Elected Members, including one representative from each of the two Opposition Parties; the two statutory Chief Officers (without voting rights); two representatives from the Clinical Commissioning Group (with voting rights); a Health Watch representative (with voting rights) and a representative from the Voluntary Sector (with voting rights). The Chairman of the Board will be an Elected Member appointed by the Leader. The quorum is one-third of Members of the Board providing that elected Members represent at least one half of those present. Substitution is permitted. Other members without voting rights can be co-opted as necessary.

1. Providing borough-wide strategic leadership to public health, health commissioning and adults and children's social care commissioning, acting as a focal point for determining and agreeing health and wellbeing outcomes and resolving any related conflicts.

2. Commissioning and publishing the Joint Strategic Needs Assessment (JSNA) under the Health and Social Care Act.

3. Commissioning and publishing a Joint Health & Wellbeing Strategy (JHWS) – a high level strategic plan that identifies, from the JSNA and the national outcomes frameworks, needs and priority outcomes across the local population, which it will expect to see, reflected in local commissioning plans.

4. Receiving the annual CCG commissioning plan for comment, with the reserved powers to refer the CCG commissioning plan to the NHS Commissioning Board should it not address sufficiently the priorities given by the JSNA.

5. Holding to account all areas of the Council, and other stakeholders as appropriate, to ensure their annual plans reflect the priorities identified within the JSNA.

6. Supporting joint commissioning and pooled budget arrangements where it is agreed by the Board that this is appropriate.

7. Promoting integration and joint working in health and social care across the borough.

8. Involving users and the public, including to communicate and explain the JHWS to local organisations and residents.

9. Monitor the outcomes and goals set out in the JHWS and use its authority to ensure that the public health, health commissioning and adults and children's commissioning and delivery plans of member organisations accurately reflect the Strategy and are integrated across the Borough.

10. Undertaking and overseeing mandatory duties on behalf of the Secretary of State for Health and given to Health and Wellbeing Boards as required by Parliament.

11. Other such functions as may be delegated to the Board by the Council or Executive as appropriate.

Appendix 5

GLOSSARY:

Glossary of Abbreviations – Health & Wellbeing Board

Acute Treatment Unit	(ATU)
Antiretroviral therapy	(ART)
Any Qualified Provider	(AQP)
Autistic Spectrum Disorders	(ASD)
Behaviour, Attitude, Skills and Knowledge	(BASK)
Better Care Fund	(BCF)
Black African	(BA)
Body Mass Index	(BMI)
British HIV Association	(BHIVA)
Bromley Clinical Commissioning Group	(BCCG)
Bromley Safeguarding Children Board	(BSCB)
Cardiovascular Disease	(CVD)
Care Programme Approach	(CPA)
Care Quality Commission	(CQC)
Children & Adolescent Mental Health Service	(CAMHS)
Child Sexual Exploitation	(CSE)
Chlamydia Testing Activity Dataset	(CTAD)
Clinical Commissioning Group	(CCG)
Clinical Decision Unit	(CDU)
Clinical Executive Group	(CEG)
Clinical Leadership Groups	(CLG)
Common Assessment Framework	(CAF)
Community Learning Disability Team	(CLDT)
Community Psychological Services	(CPS)
Delayed Transfer of Care	(DTOC)
Director of Adult Social Services	(DASS)
Director of Children's Services	(DCS)
Disability Discrimination Act 1995	(DDA)
Dispensing Appliance Contractors	(DAC)
Emergency Hormonal Contraception	(EHC)
Essential Small Pharmacy Local Pharmaceutical Services	(ESPLPS)
Female Genital Mutilation	(FGM)
Florence – telehealth system using SMS messaging	(FLO)

Health & Wellbeing Board	(HWB)
Health & Wellbeing Strategy	(HWS)
Health of the Nation Outcome Scales	(HoNOS)
Hypertension Action Group	(HAG)
Improved Better Care Fund	(IBCF)
Improving Access to Psychological Therapies programme	(IAPT)
Improvement Assessment Framework	(IAF)
In Depth Review	(IDR)
Integrated Care Network	(ICN)
Integration Transformation Fund	(ITF)
Intensive Support Unit	(ISU)
Joint Health & Wellbeing Strategy	(JHWS)
Joint Integrated Commissioning Executive	(JICE)
Joint Strategic Needs Assessment	(JSNA)
Kings College Hospital	(KCH)
Local Medical Committee	(LMC)
Local Pharmaceutical Committee	(LPC)
Local Pharmaceutical Services	(LPS)
Local Safeguarding Children's Boards	(LSCB)
Long Acting Reversible Contraception	(LARC)
Mental Health Champion	(MHC)
Multi Agency Planning	(MAP)
Medicines Adherence Support Service	(MASS)
Medicines Adherence Support Team	(MAST)
Medium Super Output Areas	(MSOAs)
Men infected through sex with men	(MSM)
Mother to child transmission	(MTCT)
Multi-Agency Safeguarding Hubs	(MASH)
Multi-Agency Sexual Exploitation	(MASE)
National Chlamydia Screening Programme	(NCSP)
National Institute for Clinical Excellence	(NICE)
Nicotine Replacement Therapies	(NRT)
National Reporting and Learning Service	(NRLS)
Nucleic acid amplification tests	(NATTS)
Patient Liaison Officer	(PLO)
People living with HIV	(PLHIV)

Pharmaceutical Needs Assessment	(PNA)
Policy Development & Scrutiny committee	(PDS)
Primary Care Trust	(PCT)
Princess Royal University Hospital	(PRUH)
Proactive Management of Integrated Services for the Elderly	(ProMISE)
Public Health England	(PHE)
Public Health Outcome Framework	(PHOF)
Quality and Outcomes Framework	(QOF)
Quality, Innovation, Productivity and Prevention programme	(QIPP)
Queen Mary's, Sidcup	(QMS)
Secure Treatment Unit	(STU)
Serious Case Review	(SCR)
Sex and Relationship Education	(SRE)
Sexually transmitted infections	(STIs)
South London Healthcare Trust	(SLHT)
Special Educational Needs	(SEN)
Summary Care Record	(SCR)
Supported Improvement Adviser	(SIA)
Sustainability and Transformation Plans	(STP)
Tailored Dispensing Service	(TDS)
Unitary Tract Infections	(UTI)
Urgent Care Centre	(UCC)
Voluntary Sector Strategic network	(VSSN)
Winterbourne View Joint Improvement Programme	(WVJIP)