Health & Wellbeing Board

28th April 2016

Quarterly Director of Public Health Report – Lambeth and Southwark (January – March 2016)

Wards: All

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Report summary

This report is a quarterly report of the Joint Director of Public Health to the Lambeth & Southwark Health and Wellbeing Boards and the Lambeth & Southwark clinical commissioning groups.

Finance summary

None arising from this report.

Recommendations

1. To note the Director of Public Health Report covering the period January to March 2016.
1. **Context**

1.1 This is an update report for information only.

1.2 This report covers the following work streams:

- Lambeth and Southwark Public Health Team
- Teenage conceptions
- SH:24
- Bowel Screening
- Zika virus
- Tuberculosis
- Avoidable deaths in Lambeth and Southwark
- Southwark Free Swim & Gym Programme

2. **Proposals and Reasons**

2.1 **Introduction**

2.2 **Introduction from Ruth Wallis**

*Lambeth & Southwark Director of Public Health*

This is my last quarterly report as Joint Director of Public Health for Lambeth and Southwark. The joint Lambeth and Southwark Public Health Team is being reorganised into two borough based teams and these will be effective at some point during the next quarter April – June 2016.

I initiated these quarterly reports as a way to regularly update partners both on the work of the Department and on issues of public health concern. The purpose was to ensure partners gained insight into our remit to promote and protect the public’s health, and into the breadth and depth of work the Department is leading on or supporting partners to achieve those aims.

The new department came together from two different settings and staff applied themselves wholeheartedly to improving the health and wellbeing of the Lambeth and Southwark population. The team has much to be proud of. There have been significant reductions in teenage pregnancy, infant mortality, and in cardiovascular deaths in both boroughs. The team have led or supported programmes to tackle deep seated issues affecting the public’s health including child obesity, violence, latent Tuberculosis infection, mental wellbeing, and illegal tobacco. They have worked closely with council and other colleagues to successfully influence decisions on alcohol and fast food outlets, and to improve understanding of the health impacts of regeneration programmes. Staff have led major service redesign and innovation, for instance the development of an award
winning web based sexual health service (SH:24) and community based solutions to promote access to healthy, affordable food. Life expectancy has increased and there is a reduced gap in life expectancy between both boroughs and the rest of the country.

It is a tough environment to make progress and there has been considerable learning which staff will seek to apply in their new roles. Importantly the two new teams expect to continue to collaborate on a range of strategic areas and keep to the principle that ‘the health of the people is the highest law’.

It has been a huge privilege to work on behalf of the populations of Lambeth and Southwark. I am extremely grateful for the excellent and hard work of my team, and for the collaboration and support of colleagues from both councils and CCGs over the last three years. Not everyone in the team will be staying on and I particularly want to thank these staff and wish them well in the future; I am sure their experience will stand them in good stead. I am also confident that both new teams will continue to provide a high quality public health service on behalf of our local populations and communities.

Ruth Wallis

2.3 Contents of this quarter’s report

This quarter there are summaries on; the Lambeth and Southwark Public Health Team, teenage conceptions, SH: 24, bowel screening, Zika virus, Tuberculosis, avoidable deaths in Lambeth and Southwark and the Southwark Free Swim & Gym Programme.

Comments and suggestions are welcome. Please contact PHadmin@southwark.gov.uk

2.4 Reorganisation of Lambeth & Southwark Public Health Team

As noted in Ruth’s introduction this is the last quarterly report of the Joint Director of Public Health for Lambeth and Southwark. The reorganisation of the shared public health department
to two separate borough based teams is due to take effect during the coming quarter April - May 2016. Since the last report (Oct –Dec 2015) a consultation has been completed and two new structures agreed. The process of aligning staff to roles in line with their interests and needs of the organisations is in progress with the aim of having two separate teams from early May. A second consultation will then be held for the new Lambeth team regarding their transfer of employment from Southwark to Lambeth Council. This phase should be complete during June-July at which point the Lambeth team will relocate to premises in Lambeth.

To manage the process with minimal disruption to the existing work programme the public health team have been actively identifying and taking action on risks, and developing handover plans. Staff are preparing interim business plans for May – Sept 2016. Discussions on new memoranda of understanding for both Clinical Commissioning Groups with their new Public Health Department are to start imminently.

As part of the new arrangements it is likely that a number of areas will be retained as joint. For instance;

- In the last year the Public Health Department has agreed with both councils to take on additional duties with respect to the Child Death Overview Panel (CDOP) which now runs across both boroughs. Subject to resource it makes sense to continue this.

- Individual Funding Requests (IFRs) is the process by which non commissioned or non NICE approved services are requested by individuals. The process is guided by a policy agreed across south east London CCGs. Public Health provide specialist advice and makes recommendations to the panel. This will continue to be provided by one public health consultant on behalf of both CCGs

- Much of the public health sexual health and sexual health commissioning has been successfully led and coordinated across Lambeth Southwark and Lewisham since the days of the LSL Health Authority. There is as much if not more reason to continue to collaborate and share expertise and capacity in this area.

- Other elements of the strategic health protection responsibilities of public health are also likely to be shared due to the specialist expertise of individual consultants and other staff

As part of the changes needed in health protection, especially the increasing priority for CCGs of preventing antimicrobial resistance (AMR) and promoting infection prevention and control (IPC), and the changing commissioning responsibilities of CCGs, the public health department is recommending CCGs review their arrangements. This is particularly in relation to primary care staff and premises and care provided to people at home. Public Health will continue to
provide strategic leadership, advice and coordination of AMR and IPC work on behalf of partners in line with their core role.

2.5 Teenage Conceptions

The under 18 years conception numbers and rates for 2014 were released by the Office of National Statistics (ONS) in March 2016. The England rate continues to decline and at 22.8 conceptions per 1000 girls (aged 15-17), is a reduction of 6.2% from 2013. For girls aged 13-15 there was a reduction to 4.4 per 1000 conceptions. Since 1998, the England under-18 rate has declined by 51%.

2.5.1 Lambeth

In Lambeth the 2014 rate is 33.8 per 1,000 girls aged 15-17 (or 142 conceptions), representing an overall decline of 60.4% since the 1998 baseline. 66.2% of these conceptions were aborted. This conception rate is an increase of 36.8% compared to the 2013 rate (24.7 per 1,000 girls). This is the first increase in Lambeth’s conception rate in just over a decade. Lambeth is now the Inner London Authority with the highest under-18 conception rate.

The 2012-2014 conception rate for girls aged 13-15 years was 6.7 per 1,000 (or 85 conceptions), a decline of 5.6% since 2011-2013. 76.5% of these conceptions were aborted.

2.5.2 Southwark

In Southwark the 2014 rate is 27.4 per 1,000 girls aged 15-17 (or 110 conceptions), representing an overall decline of 68.6% since the 1998 baseline. 72.7% of these conceptions were terminated. This conception rate is a reduction of 10.5% compared to the 2013 figure of 30.6 per 1,000 girls aged 15-17 years. Southwark is now the Inner London Authority with the third highest under-18 conception rate.

The 2012-2014 conception rate for girls aged 13-15 years was 4.8 (59 conceptions) per 1,000; a decline of 22.6% since 2011-2013. 72.9% of these conceptions were aborted.

2.5.3 Next steps

Both boroughs have high teenage conception rates compared to the national figure. The rise in Lambeth’s rate is of additional concern. The Local Government Association & Public Health England report Good progress but more to do earlier in 2016 reminds local areas that teenage pregnancy is both a cause and consequence of health and education inequalities. It outlines the ten factors for effective local action such as strategic leadership, youth friendly sexual health
services, sex and relationships education, targeted prevention for young people at higher risk (such as Looked After Children) and support for parents. Both boroughs should ensure that these ten effective factors are being implemented.

2.6 SH: 24

High rates of sexually transmitted infection (STI) in Lambeth and Southwark have lead to long waiting times and overcrowding in clinics. SH:24 works in partnership with the NHS to provide a digital solution to this problem. The organisation is revolutionising sexual health services by promoting self management using telephone and internet technologies to deliver services remotely – improving access, offering early access to treatment and thereby reducing the risk of transmission. In an area of significant public health risk SH:24 offers an easy to access sexual health service without the stigma of attending a genito-urinary medicine clinic that is both efficient and lower cost.

The online STI testing part of SH:24 was launched to Lambeth and Southwark residents in March 2015. Since then the service has delivered over 10,000 testing kits 74% of which have been returned; much higher than comparable services and 24% higher than initially predicted.

To free up capacity in clinics the model relies on encouraging people who may have been exposed to risk of an STI but have no symptoms to use the online service. 94% of people using the service to date state they do not have symptoms and 80% of them have visited a clinic in the past. Half of these have done so in the last year.

Use of SH:24 is also strong amongst high risk and, or more marginalised groups: 25% of people are from black and ethnic minority groups, 14% are men who have sex with men and 30% are under 25 years. The SH:24 diagnostic rate is 11% (compared with 12-14% in clinics). Together with its rapid results service (24-72 hours) this is helping to detect STIs quickly and reduce transmission of infection which is a crucial aspect of any sexual health service.

SH:24 continues to develop including with good input from people using the services. In February a live web chat service was launched, opening another channel of communication between service users and the SH:24 sexual health nurse. The website now has series of pages with comprehensive information on contraceptive options to help people make decisions before they come to clinic.

A treatment service for people who test positive for Chlamydia will be launched in April 2016 followed by a contraceptive service in July. This will extend the opportunity for people to self manage and help to transform the way people use sex and reproductive health services in
Lambeth and Southwark. Feedback suggests that this approach is also empowering for people who need these services. Given the efficiency of the model and its rapid take-up by local people SH:24 is also likely to make an important contribution to local Sustainability and Transformation Plans. This is a truly ground breaking model as Lambeth and Southwark are the first area to develop such a service in England. SH:24 will be launching in four areas outside London in April 2016.

2.7 Improving Bowel Screening Uptake

2.7.1 Introduction

Bowel cancer is the third most common cancer in the UK and the second leading cause of cancer deaths. Regular bowel cancer screening has been shown to reduce deaths from the disease by 25\%\(^1\).

The effectiveness of any screening programme is dependent on uptake – or the percentage of people eligible to be screened who participate in the programme. Lambeth and Southwark have low uptake of bowel cancer screening compared to the rest of the country (39.1\% and 38.9\% respectively compared to the England average of 55.4\%)\(^2\) and when compared to the national target of 60\%.

Screening uptake is lower in men, socially deprived groups and BME groups, especially in Asian Muslims. These groups also have worse outcomes from bowel cancer\(^3\).

2.7.2 How the bowel screening programme works

All men and women between the ages of 60-74 years registered with a GP are invited to participate every two years. People receive a letter telling them about the bowel screening programme. This is followed one week later by a bowel cancer screening kit. People place a small sample of their ‘poo’ on three successive days onto the special kit and send it to a processing centre where it is examined for traces of blood. Participants and their GPs will receive a letter notifying them of their results.

\(^1\) Logan et al, 2011. Outcomes of the Bowel Cancer Screening Programme in England after the first million tests (downloaded from gut.bmj.com on July 7, 2014)

\(^2\) 2014 CCG data from the NCIN Cancer Commissioning Toolkit, practice profiles: [https://www.cancertoolkit.co.uk/Profiles/PracticePublic/Filters](https://www.cancertoolkit.co.uk/Profiles/PracticePublic/Filters)

2.7.3 Why this is important in Lambeth and Southwark

- Lambeth has a high incidence (rate of new cases) and Southwark has a high death rate from bowel cancer
- Lambeth and Southwark have one of the lowest uptake of bowel cancer screening in London; two thirds of people in Lambeth & Southwark who are sent a bowel screening kit do not return it

Table 1: New cases and deaths from bowel cancer, and uptake of screening in Lambeth, Southwark, London and England

<table>
<thead>
<tr>
<th></th>
<th>Incidence (new cases) per 100,000 of bowel cancer (2012-14 pooled, DSR - directly age-standardised rates)</th>
<th>Mortality (deaths) per 100,000 (2012-14 pooled, DSR)</th>
<th>Uptake of bowel screening (2013-14, 60 - 69 year olds)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lambeth</td>
<td>78.82</td>
<td>28.99</td>
<td>39.1%</td>
</tr>
<tr>
<td>Southwark</td>
<td>72.02</td>
<td>30.92</td>
<td>38.9%</td>
</tr>
<tr>
<td>London</td>
<td>69.15</td>
<td>26.31</td>
<td>n/a</td>
</tr>
<tr>
<td>England</td>
<td>77.23</td>
<td>28.41</td>
<td>55.4%</td>
</tr>
</tbody>
</table>

* Source: HSCIC portal; ** Source: PHE National GP Profiles

2.7.4 Improving bowel cancer screening in Southwark

An initial review over six months where Public Health followed up receipt of the screening kit with a telephone call to check a) whether the person had in fact received the screening kit and b) they understood how to use it, showed that of 1205 people issued with a kit, it was possible to contact only 335. As a result of this contact, a further 82 people returned the kit (or 7% of the original cohort and 24% of those contacted).

A subsequent pilot funded by GSTT charity involves local practices and aims to embed the national bowel cancer screening programme and follow up in primary care. Ten practices were initially recruited from Southwark to participate. Staff from the Public Heath department visited each practice to train practice staff in the bowel screening programme processes, how to use the test kit, overcoming barriers to participating in bowel screening, and about the intervention

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4 Three practices dropped out during the project
itself. Practices were provided with a comprehensive information pack, sample test kits and health promotion materials to assist them in the intervention.

Trained practice staff contacted all patients by telephone who had not returned their test kit within a set time. Practice staff were expected to discuss all aspects of bowel screening in depth with the patient and to provide practical advice. The practice then followed up all patients involved in the project with a letter, once again endorsing the programme and providing information about how to order a new test kit. Expected outcomes included an improved uptake rate among patients contacted and greater knowledge among practice staff about the national bowel cancer screening programme.

Initial results show that overall, 12.5% of patients ordered and returned a test kit following a discussion with their practice.

<table>
<thead>
<tr>
<th>Practice</th>
<th>Number of patients contacted</th>
<th>Number of patients returning test kit following contact</th>
<th>Percentage of patients returning test kit following contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>40</td>
<td>7</td>
<td>17.5%</td>
</tr>
<tr>
<td>2</td>
<td>105</td>
<td>17</td>
<td>16.2%</td>
</tr>
<tr>
<td>3</td>
<td>21</td>
<td>6</td>
<td>28.6%</td>
</tr>
<tr>
<td>4</td>
<td>118</td>
<td>12</td>
<td>11.1%</td>
</tr>
<tr>
<td>5</td>
<td>64</td>
<td>8</td>
<td>12.5%</td>
</tr>
<tr>
<td>6</td>
<td>115</td>
<td>12</td>
<td>11.4%</td>
</tr>
</tbody>
</table>
2.7.5 Next steps

An additional 12.5% of those contacted by the practice who had failed to return their kit initially – subsequently returned their test kit following the intervention.

A final report, with all the learning and good practice, will be shared with both Lambeth and Southwark CCGs and practices. Although further work is needed to understand what other interventions might support participation in the programme there are opportunities to roll out the learning to date and to consider how best to include this approach in GP Federation and CCG plans for improving population health.

2.8 Zika Virus Briefing – 17th March 2016:

Adapted from PHE Zika Virus Guidance: https://www.gov.uk/guidance/zika-virus

2.8.1 Quick links to more information:

- Latest travel advice for patients: NaTHNaC
- Patient information: NHS Choices

2.8.2 What is Zika Virus?
• Zika is a virus carried by mosquitoes.
• The symptoms are usually minimal and may include a mild, short (up to 7 days) febrile illness with symptoms similar to Dengue.
• Serious complications are rare. Guillain-Barré syndrome can occur and although the link between with these illnesses has yet to be proven there is accumulating evidence.
• There is also increasing evidence to suggest an association link between the Zika virus outbreak in Brazil and the increase in babies born there with ‘microcephaly’ (abnormally small brain size and accompanying disability) and other congenital abnormalities.

2.8.3 Where does Zika virus occur?
• Before 2015 Zika was found in small numbers in parts of Africa, Southeast Asia and some Pacific Islands.
• In May 2015 locally acquired Zika was reported in Brazil and as of March 2016, countries across Central and South America have local active Zika transmission.
• Further cases are expected in previously unaffected countries, particularly in south and central America and the Caribbean, where the mosquito species that transmits the virus is present.
• Zika does not naturally occur in the UK because our climate is not warm enough to enable the mosquitoes that carry Zika virus to breed here. However, as of 16 March 2016, a total of 12 cases have been diagnosed in UK travelers.

2.8.4 How is Zika Virus spread?
• People can be infected after being bitten by a mosquito carrying the virus.
• If a person acquires Zika abroad and becomes ill on their return to the UK, any public health risk to the wider population is negligible.
• There is also some evidence of sexual transmission and transmission from mother to foetus via the placenta.

2.8.5 Zika Virus and Pregnancy
• Due to the possible association with congenital malformations, travellers who are pregnant or planning to become pregnant should postpone non-essential travel to areas with active Zika transmission.
• If a pregnant woman must travel they are advised to take scrupulous measures to avoid being bitten by mosquitoes both during the day and at night i.e. covering exposed skin, wearing shoes outdoors and applying repellents that contain diethyltoluamide (DEET).
• If a woman has travelled to an area with Zika virus, she is advised to avoid becoming
pregnant for 28 days after returning to the UK.

2.8.6 Zika Virus and Sexual Transmission

- There is evidence of sexual transmission though the risk is thought to be very low.
- If a woman’s partner has travelled to a country with active Zika virus transmission, condom use is advised:
  - If no symptoms whilst abroad or in the two weeks after leaving the affected country: for 28 days.
  - If symptoms of Zika during that period: for 6 months following resolution of symptoms.
  - If female partner of a male traveller is pregnant, condom use for the duration of the pregnancy is advised.

2.8.7 How can Zika virus be prevented, diagnosed & treated?

- There is no vaccine to prevent Zika infection.
- To reduce the risk of infection all travellers should take precautions to avoid being bitten by mosquitoes during the day and at night.
- Health professionals can consider Zika virus infection among the differential diagnoses of patients with fever returning from south and central America, the Caribbean, Africa, south and south east Asia and the Pacific region.
- Diagnostic testing is indicated for patients:
  - who have travelled to or arrived from an area with active Zika virus transmission and
  - within 2 weeks of return to the UK, has two or more symptoms suggestive of acute Zika virus infection at the time of assessment
- Clinicians testing for suspected cases of Zika virus infection should liaise with their local diagnostic library and samples need to be sent to PHE’s Rare and Imported Pathogens Laboratory (RIPL).
- There is no drug treatment available to treat Zika virus infection and the management is supportive with symptom relief.


Guidance is being updated regularly as more information on the outbreak becomes available.
2.9 Latent Tuberculosis screening and treatment pilot

Tuberculosis (TB) rates in England remain high and are associated with significant ill health, death and associated costs. In England in 2013, 3 out of 4 people identified with TB were born abroad, most due to reactivation of latent TB infection (LTBI) (ie infection that they had many years previously).

LTBI can be diagnosed by a single, validated blood test (interferon gamma release assay (IGRA)), and is usually treated with antibiotics to prevent active TB disease in the future. LTBI testing and treatment (‘LTBI screening’) of new entrants to England is supported by the National Institute of Health and Care Excellence (NICE).

The incidence of Tuberculosis has decreased over the past 10 years across Lambeth, Southwark and Lewisham (Public Health England, 2014), but these boroughs still have among the highest numbers of new tuberculosis cases a year in England (see table 3) and all 3 boroughs fulfil the criteria for introducing targeted latent TB screening and treatment in line with the Collaborative Strategy for England published in January 2015 (PHE, NHS England, 2015).

Table 3: New cases of TB in Lambeth, Lewisham and Southwark 2012-14

<table>
<thead>
<tr>
<th>Area</th>
<th>TB incidence (3 year average 2012-14)/100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>13.5</td>
</tr>
<tr>
<td>London</td>
<td>35.4</td>
</tr>
<tr>
<td>Lambeth</td>
<td>26.6</td>
</tr>
<tr>
<td>Lewisham</td>
<td>25.9</td>
</tr>
<tr>
<td>Southwark</td>
<td>31.7</td>
</tr>
</tbody>
</table>

Data from (Public Health Profiles, PHE, 2015)

LSL CCGs have now received confirmation of additional funding to implement Latent Tuberculosis testing and treatment in migrant populations.

Who should be tested for LTBI? Individuals aged 16 to 35 years, who have entered the UK from a high incidence country (≥150/100,000 persons) or from sub Saharan Africa within the last five years, and have been previously living in that high incidence country for six months or longer. This is expected to require about 668 tests for LTBI in Lambeth and 802 in Southwark.
LSL CCGs have adopted a step by step approach. A pilot phase is starting in April 2016 involving general practices with high numbers of TB notifications and, or which are located in areas of relatively high concentration of residents born in countries that have high TB incidence.

The Public Health team contributed to the development of the proposal and the funding request, estimated demand for testing, and reviewed good practice for ensuring good uptake of testing. The team will also provide guidance on monitoring indicators and coordinate the evaluation of the pilot phase.

3. **Avoidable Deaths in Lambeth and Southwark**

The Public Health Team have produced two new factsheets on “avoidable deaths” one for Lambeth and one for Southwark. These provide a detailed analysis of both the preventable and amenable components of avoidable deaths together, looking at both sexes separately, as well as a very detailed breakdown by specific causes and by geography and deprivation.

These are part of the JSNA series of factsheets and can be found here:

Southwark:  [www.southwark.gov.uk/jsna](http://www.southwark.gov.uk/jsna); Lambeth:  [www.lambeth.gov.uk/jsna](http://www.lambeth.gov.uk/jsna)

**Avoidable** deaths are from causes that are considered avoidable if timely, effective treatment and good quality healthcare, or public health interventions such as vaccination programmes are provided and improvements to lifestyle are made. **Avoidable** mortality has two components. The Office for National Statistics (ONS) defines these as **Amenable** and **Preventable**:

A death is **preventable** if, in the light of understanding of the determinants of health at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be **avoided by public health interventions** e.g. vaccination programmes, health improvement activities such as smoking cessation.
A death is **amenable** (treatable) if, in the light of medical knowledge and technology at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be **avoided through good quality healthcare.**

*In other words a death is deemed preventable if one or more population health interventions could prevent it, and amenable if there is a treatment for it. The total of these two types of deaths is the avoidable deaths for an area.*

A higher percentage of deaths occurring in Lambeth (29%) and Southwark (30%) were avoidable compared to England and Wales (23%). Men are more likely to die from avoidable causes than women in both Lambeth and Southwark but also in England.

In Lambeth age standardised the total of **amenable and preventable death rates have fallen at a faster pace** than the rates for amenable only or preventable only deaths. Amenable and preventable death rates fell by **34%** between 2006-2008 and 2012-2014 from 98.5 to 65.1 per 100,000. Amenable only deaths also decreased significantly by **29%** from 56.6 to 40.0 per 100,000 in the same period. The decrease in preventable only deaths was smaller at **19%**, from 164.6 to 133.1 per 100,000 population.

In Southwark the combined amenable and preventable death rate fell by **26%** from 90.4 to 67.2 per 100,000 in 2006-08 to 2012-14. As for Lambeth the age standardised **amenable death rates have fallen more** than preventable deaths; by **30%** from 52.6 to 37.0 per 100,000. The decrease in preventable deaths was much smaller at **12%**, from 150.5 to 133.1 per 100,000 population.

The main broad causes of **avoidable deaths** are cancers, cardiovascular diseases, respiratory diseases, injuries and drugs and alcohol related deaths. The two graphs show the decline in both boroughs has been fastest for cardiovascular disease and to a lesser degree cancers. More detailed analysis of specific causes shows that the main causes of avoidable deaths remains ischaemic heart disease and lung cancer.
3.1 Inequalities in avoidable deaths
Despite overall reductions in avoidable deaths in both boroughs, the proportion of avoidable deaths is much higher in deprived populations compared with people living in the least deprived parts of Lambeth and Southwark.

**Lambeth SII for Mortality from Causes Considered Avoidable, 2006 to 2014**  
Slope Index of Inequality = 183.71 (95% confidence Interval: 133.99 to 233.44)

People living in Lambeth's most deprived areas experience a higher rate of avoidable mortality than those living in the least deprived areas.

Points on the graph represent Lambeth’s Lower Super Output Areas  
DSRs per 100,000 population by LSOAs  
Source: PCMD, Index of Multiple Deprivation 2015

**Southwark SII for Mortality from Causes Considered Avoidable, 2006 to 2014**  
Slope Index of Inequality = 195.75 (95% confidence Interval: 152.73 to 238.77)

People living in Southwark’s most deprived areas experience a higher rate of avoidable mortality than those living in the least deprived areas.

Points on the graph represent Southwark’s Lower Super Output Areas  
DSRs per 100,000 population by LSOAs  
Source: PCMD, Index of Multiple Deprivation 2015
### 3.2 Priorities for action to reduce avoidable deaths

The National Institute for Health and Clinical (NICE) Excellence recommends that health and wellbeing partnerships take *whole systems approaches* to reducing avoidable deaths (see figure).

<table>
<thead>
<tr>
<th>Adoption of a population-wide approach to tackling premature mortality through:</th>
</tr>
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<tbody>
<tr>
<td>• Sustaining effective partnerships across all key stakeholders</td>
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<tr>
<td>• Using local intelligence and tools to engage with local communities</td>
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<tr>
<td>• Supporting local communities to adopt healthy lifestyles</td>
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<tr>
<td>• Developing integrated population-wide programmes that address health inequalities &amp; improve access with robust monitoring and evaluation</td>
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<tr>
<td>• Ensuring prevention, early detection and effective treatment of infectious and long term conditions that lead to premature mortality</td>
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<tr>
<td>• Evaluating programmes and share learning on local innovations</td>
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<table>
<thead>
<tr>
<th>Considering wider determinants by:</th>
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<tbody>
<tr>
<td>• Helping people back into work</td>
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<tr>
<td>• Working with schools</td>
</tr>
<tr>
<td>• Awareness raising e.g. community programmes to improve diet</td>
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<table>
<thead>
<tr>
<th>Commissioning services to prevent premature mortality:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Stop smoking services</td>
</tr>
<tr>
<td>• Brief interventions for smoking and alcohol</td>
</tr>
<tr>
<td>• Health Checks</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Developing policies to prevent premature mortality through:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Use of procurement opportunities to influence healthy lifestyle choices [e.g. catering contracts, licensing policies]</td>
</tr>
<tr>
<td>• Creating, protecting and managing safe spaces for physical activity that are accessible by foot or bicycle. Also consider active transport policies</td>
</tr>
<tr>
<td>• Ensuring leisure and other services are affordable, culturally acceptable and accessible to all</td>
</tr>
<tr>
<td>• Encouraging local organisations to become exemplars of healthy lifestyles</td>
</tr>
</tbody>
</table>

NICE has a set of evidence based guidance on the main risk factors for avoidable deaths (preventable and amenable). Health and Wellbeing Boards and commissioners should check that these are local priorities, and ensure providers are taking sufficient action.
3.3 Southwark Free Swim and Gym (FSG) pilot scheme

3.3.1 Introduction

In May 2014 Southwark Council wanted to improve access to physical activity opportunities as part of their Fairer Future promises (promise number 2).

“We will make it easier to be healthier with free swimming and gyms for all residents and doubling the number of NHS health checks.”

The Public Health team did substantial preparatory work looking at good practice and other evidence to attempt to ensure that the people most in need of the opportunity were able to benefit especially if they were less likely to take up the offer. In January 2015 the FSG project was initiated and rolled out as a phased approach.

3.3.2 18s and under and over 60s – early launch

- The FSG registration for 18 and under and over 60 years was launched in March 2015.
- From May 2015, FSG was available for the following groups:
  - 18s and under free swim - all day Friday; afternoons from 2pm and 6pm on Saturday and Sunday
  - 16 to 18 years free gym - all day Friday; afternoons from 2pm until 6pm on Saturday and Sunday
  - 14 to 16 years free youth gym sessions – at selected times on Friday evenings Saturday and Sunday afternoons
  - Free ‘Silver Sessions’ – access to over 60s sessions all week (Silver sessions include swimming, gym use and specific classes such as aerobics and circuits)
3.3.3 Registrations up to and including December 2015 show that:

18 years and under
- Approximately 12% (over 7,000) of people 18 years and under in Southwark registered
- 9.2% of the female population in this age group registered compared with 8.3% of males.
- Of the total registrations marginally more male than females registered (M = 51%, F = 49%)
- There were higher BME registrations (73%) compared to the proportion from BME background in that population as a whole (64%)

Over 60s
- Approximately 5% (over 1,700) of over 60s in Southwark registered
- 5.5% of the female population in this age group registered compared with 4.2% of males
- Of the total registrations more females than males registered (M = 40%, F = 60%)
- There were higher BME registrations (41%) compared to the proportion from a BME background in that population as a whole (27%)

3.3.4 Attendances to and including December 2015 show that:

18 years and under
- Of the total attendances more males (63%) than females attended (35%).
- There was higher BME attendance (75%) compared to the proportion from BME background in that population (64%)

Over 60s
- More female (74%) than males (26%) attended
- There was higher BME attendances (67%) compared to the proportion from BME background in that population (27%)

3.3.5 Next phases

The FSG health offer:
- Free swim and gym for health referral schemes; from late April 2016
- Free access at The Castle Centre; all of the time for people with disabilities (pilot from April 2016)
- Free access at all centres, all of the time, for people with disabilities from July 2016;

The FSG offer for all residents from July 2016:
- Free access to gym and swimming for all residents; all day Friday, afternoons on Saturday and Sunday until close

The FSG offer for all Southwark Council staff from July 2016:
- Free access to gym and swimming for Southwark Council staff; all day Friday, afternoons on Saturday and Sunday until close
3.3.6 Health offer from April 2016

People who are least likely to be active require additional motivation and support to increase their activity levels. People who are less active are also more likely to be of unhealthy weight or have poorer health or long term health conditions. Evaluations show that brief interventions by health professionals do increase physical activity levels so the FSG offer is to be enhanced for specific health schemes:

- Physical activity on referral including Kickstart, Active boost (exercise on referral) and Cardiactive (cardiac rehabilitation phase 4)
- NHS Health Checks Programme
- Healthy Weight Programme.

This will start from late April 2016 leading up to the introduction of the general offer in July 2016. The health offer involves:

- Free Exercise on Referral and Cardiac Rehabilitation: the charge of £1.60 per session will cease for Southwark residents
- Clients using the Kickstart scheme will have a free 3 month FSG passport for anytime use (currently £20 per month reduced tariff)
- Clients referred through the NHS Health Checks / Health Improvement Motivational Hub for leisure centre based activity will have a free 3 month FSG passport for anytime use (currently £20 per month reduced tariff)
- Participants in the Healthy Weight Programme will receive two free public swimming sessions per week for one child and one adult whilst registered on the programme between Monday-Thursday at any Southwark leisure centre with a swimming pool. All young people taking part will also be eligible for the pilot offer and in July 2016 will be incorporated into the general scheme.

4. Finance

4.1 No direct financial implications result from this report.

5. Legal and Democracy
5.1 There are no legal implications.

6. Consultation and co-production
6.1 Not applicable.

7. Risk management
7.1 Not applicable.

8. Equalities impact assessment
8.1 Not applicable.

9. Community safety
9.1 Not applicable.

10. Organisational implications
10.1 Not applicable.

11. Timetable for implementation
11.1 Not applicable.

### Audit trail

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<td>Dr Sarah Corlett and Jin Lim</td>
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<td>13/08/16</td>
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<td>Cabinet Member: Health &amp; Wellbeing</td>
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### Report history

<p>| Original discussion with Cabinet Member | N/A |
| Report deadline | |
| Date final report sent | 13/04/2016 |
| Report no. | 222/16-17 |</p>
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**Appendices**

1. Logan et al, 2011. Outcomes of the Bowel Cancer Screening Programme in England after the first million tests (downloaded from gut.bmj.com on July 7, 2014)

2. 2014 CCG data from the NCIN Cancer Commissioning Toolkit, practice profiles: [https://www.cancertoolkit.co.uk/Profiles/PracticePublic/Filters](https://www.cancertoolkit.co.uk/Profiles/PracticePublic/Filters)
