LAMBETH TOGETHER STRATEGIC BOARD

Date and Time: **Wednesday 26 May 2021 1.00 pm**

Venue: **Microsoft Teams meeting - hosted by SEL CCG Click here to join the meeting**

BOARD MEMBERS:

Councillor Danny Adilypour	-	Cabinet Member for Health and Social Care (job-share)
Dr Dianne Aitken	-	GP and Assistant Chair NHS SEL CCG, clinical lead for Lambeth Neighbourhood & Wellbeing Delivery Alliance
Sarah Austin	-	Director Integrated Care, GSTT
Fiona Connolly	-	Executive Director of Adult Social Care
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Natalie Creary	-	Programme Delivery Director, Black Thrive
Councillor Edward Davie	-	Cabinet Member for Children and Young People
Councillor Jim Dickson	-	Cabinet Member for Health and Social Care (job-share)
Andrew Eyres	-	Strategic Director, Integrated Health & Care
Therese Fletcher	-	Managing Director, GP Federations
Sue Gallagher	-	Lay Member
Graham Gardiner	-	Age UK Lambeth
Kate Gregory	-	King's college Hospital Foundation Trust
Sandra Jones	-	Lambeth Patient Participation Group Network
Merlin Joseph	-	Strategic Director of Children's Services
Sadru Kheraj	-	GP & Primary Care Network Clinical Director
Adrian MacLachlan	-	GP and Governing Body Member NHS

SEL CCG, clinical lead for Lambeth

FURTHER INFORMATION

If you require any further information or have any queries please contact: Cheryl Smith, lamccg.lbsat@nhs.net

ATTACHMENTS

0_Agenda Lambeth Together Strategic Board

Minutes of previous meeting

4. Draft emerging ambitions_Help-shape-our-new-strategy

5a GSTT Presentation for Lambeth Together Strategic group

5b Lambeth Together - CYP Mental and Emotional Health

6a_Gov review proposals

6b Lambeth Integrated Assurance Cover

6bLTSB Lambeth Integrated Assurance Report

7a Section 75 Cover Sheet

7b s75 Deed of Variation SEL transfer April 2020

9a SEL CCG cover sheet_M12_Finance Report

9b South East London Finance Report M12

9c SEL H1 Financial Plans

9d APH cover sheet M12_Finance Report

9e Adults & Public Health Finance Report

10a LTSB Planning Update

10b Adults and Health Business Plan 2021-22

10c LTSB Planning Update

11a Risk Register Cover sheet

11b Lambeth snapshot - May 2021 (003)

11c Risk Register May 2021

12a Reforming the MHA - cover sheet

12b -MHA review AMT 210420

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Agenda Item 1

Lambeth Together Strategic Board

Wednesday, 26 May 2021 1.00 – 5.00
Microsoft Teams meeting

AGENDA

Agenda Item No. and Time	Agenda Item Reference and Title	Attachment / Supporting Information	Agenda Item Lead
1:00pm	**Public Forum**		
60 mins	Introductions **Brief notices – Covid -19 response** Questions from the public Please click below to join the Public Forum Click here to join the meeting		Cllr Jim Dickson RuthHutt/ Andrew Eyres Cllr Jim Dickson
	Meeting in Public		
2:00	**Part A**		
1. **2.** **3.**	**Introductions** Welcome, Introductions and apologies **Declarations of Interest** Members are asked to declare any interests on items included in this agenda **Minutes of the Meetings 20 March 2021**	Enc	Andrew Eyres
4. 2:10	**South London and Maudsley (SLAM) NHS Trust** • To receive and consider a presentation: 'Developing our Strategy'	Presentation	James Lowell
5. 2:40	**Children and Young People Alliance** Early Years workstream: Maternity programme and priority update and the 5X More Campaign	Presentation	Nina Khazaezadeh (GSTT) Clotilde Abe (MVP Chair)

Agenda Item No. and Time	Agenda Item Reference and Title	Attachment / Supporting Information	Agenda Item Lead
3:00	Children and Young People's Mental Health and Emotional Wellbeing: Programme of Current and Future Delivery	Presentation	Dan Stoten
3:40 5 mins	**COMFORT BREAK**		
6. 3:45	**Lambeth Together – Developing our partnership working arrangements**		
6a.	• **Governance review and Assurance Arrangements** To receive and consider next steps and recommendations.	Enc	Andrew Eyres, Tom Barrett, Brian Reynolds
6b. 3:55	• **Lambeth Together & Integrated Health and Care Assurance Report** To receive for information and consideration	Enc	Andrew Parker
6c. 4:05	• **Update from Equalities, Diversity and Inclusion Working Group** Including reflections on Board development session	None	Di Aitken
4:15	**PART B**		
7.	**Section 75** • To note chairs action	Enc	Jane Bowie
8. 4:20	**South East London CCG Quality Report – Lambeth** • To receive for information	Enc	Dr Di Aitken
9. 4:30	**Finance Report** • To receive for information	Enc	Edward Odoi Pete Hesketh
10. 4:40	**Integrated Health and Care Business Plan 2021/22 and NHS Planning Guidance** • To receive for information	Enc	Andrew Parker, Brian Reynolds

Agenda Item No. and Time	Agenda Item Reference and Title	Attachment / Supporting Information	Agenda Item Lead
11. 4:45	**SELCCG – Lambeth Borough Risk Register** • To receive for information	Enc	Cheryl Smith
12. 4:50	**LWNA/SLaM MHA consultation response** • To receive for information	Enc	Jane Bowie
13. 4:55	**AOB/Date of Next Meeting/Close** Date of next meeting - 21 July 2021 1.00 – 5.00		Adrian McLachlan

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Prior to the official meeting of the Board an update on Covid was provided by the Director of Public Health and the members of the public were invited to ask questions. This session can be viewed here https://bit.ly/32NW2RL

Lambeth Together Strategic Board

Wednesday 24 March 2021 1.00– 3.30

Microsoft Teams Meeting

Members

Cabinet Member for Health and Social Care (job-share)	Cllrs Danny Adilypour and Cllr Jim Dickson
GP Assistant Chair NHS SEL CCG, (clinical lead Neighbourhood & Wellbeing Delivery Alliance)	Dr Di Aitken
Executive Director of Adult Social Care	Fiona Connolly
Cabinet Member for Children and Young People	Cllr Ed Davie
Strategic Director, Integrated Health & Care NHS SE London CCG (Lambeth) and Lambeth Council	Andrew Eyres
Managing Director, GP Federation	Therese Fletcher
Borough Lay Member	Sue Gallagher
CEO Age, UK Lambeth	Graham Gardiner
Director Integrated Care, GSTT	Paran Govender (substitute)
Director of Public Health	Ruth Hutt
Healthwatch Lambeth Chief Executive	Catherine Pearson
GP & Chair, Lambeth Local Medical Committee	Dr Penelope Jarrett
Lambeth Patient Participation Group Network	Sandra Jones
PCN Clinical Director and GP Clinical Cabinet representative	Dr Sadru Kheraj
GP Governing Body Member NHS SEL CCG (clinical lead Lambeth Living Well Network Alliance)	Dr Adrian Macachlan
GP Borough Clinical lead ,clinical lead Children and Young People Alliance)	Dr Raj Mitra

In attendance

Programme Lead, Lambeth Together	Tom Barrett
Democratic Services Officer, Lambeth Council	Adrian Bentley
Director of Integrated Commissioning (Adults), Lambeth CCG and Lambeth Council	Jane Bowie
Programme Director, Lambeth Together (Neighbourhood and Delivery Alliance	Amanda Coyle

Head of Communications & Engagement, NHS SEL CCG (Lambeth)	Catherine Flynn
AD Finance, NHS SEL CCG (Lambeth)	Edward Odoi
Director of Primary Care & Transformation, NHS SEL CCG (Lambeth)	Andrew Parker
AD Health and Care Planning and Intelligence, NHS SEL CCG (Lambeth)	Brian Reynolds
Assistant Director Children, Young People, Maternity and CAMHs Commissioning	Dan Stoten
Deputy Director, Lambeth Living Well Network Alliance	Guy Swindle

Apologies (members only)

Director Integrated Care, GSTT	Sarah Austin
Programme Director, Black Thrive	Natalie Creary
Strategic Director Children's Services, Lambeth Council	Merlin Joseph
King's College Hospital Foundation Trust Executive lead rep	Kate Gregory
South London and the Maudsley NHS Foundation Trust rep	TBC

1. Welcome, introductions and apologies

Andrew Eyres, Strategic Director, Integrated Health & Care, Lambeth Council and NHS South East London CCG (Lambeth), welcomed attendees to the meeting.

Apologies were received from Heather Gilmour, Merlin Joseph, Sarah Austin, and Sabrina Phillips.

2. Declarations of Interest

There were none.

3. Minutes of the meeting of 20 January 2021

The minutes of 20 January 2021 were agreed as an accurate record.

4. System Story – Age UK Lambeth – The Way Ahead

Graham Gardiner, Chief Executive of Age UK Lambeth presented. He noted that the work of Age UK had changed dramatically though the Covid period. In talking about the work Age UK had been involved in over the previous year he noted:

- Though usually Age UK Lambeth would have contact with around 17,000 people a year, that number had risen to 55,000 people over the previous year.
- Covid had produced a number of difficulties although working from home proved not be the challenge expected. It did however cause an issue in terms of staff working from home and dealing with difficult issues and ways of dealing with this pressure had been explored.
- Covid had led to an opportunity to ensure that services were relevant. Jobs had evolved and expanded.
- 5000 phone calls had taken place in one month.
- Key safes were being used so that carers could get easy access to properties.
- The My Neighbour service had started with 142 befriending relationships. This had moved to Phone Friends and at the peak had 800 volunteers, with 800 connections. At the present time this number was 696.
- The My Social service had run 1200 events since the start of lockdown. These had included online exercise classes, discussion groups and cooking classes.
- Over 2500 Isolation bags, which contained items such as jigsaws and puzzles had been given out. This had been made possible thanks to a single donation.
- Birthday cakes had been delivered to the most elderly residents.
- At Christmas over 250 meals had been delivered to isolated neighbours.
- All of the above was possible due to working in partnership with others.

The Vision of Age UK was to work closely with residents where they live by working with neighbourhood teams, both collaboratively and in partnership. These Neighbourhood teams would be enabled to respond locally to arising needs.

The My Neighbourhood teams contained neighbourhood workers, link workers, a handy fixer, gardeners, cleaners and volunteers. A new Neighbourhood Support Worker role had been created. Commissioners had been supportive of this change.

Graham provided the contact details for Age UK and asked to hear how people could work together.

Neighbourhood and Wellbeing Delivery Alliance

Amanda Coyle, Director of the Neighbourhood and Delivery Alliance, and Dr Di Aitken, Clinical Lead for the Alliance, presented this item.

The programme sought to help Lambeth residents live healthy lives for longer. Efforts were focused on making it easier for those with the poorest health outcomes to access health and care services. Programme priorities spanned the full life course of adult Lambeth residents. Prevention through the creation of thriving communities was a focus.

The Medicine and Clinical Pathway Group would ensure that there were evidence based clinical pathways for people with long term conditions. It would ensure that medicines provided were high value, safe and effective. The workstream would form a link with the South East London Integrated care system, where there was an integrated medicines recommendations body.

The outpatients workstream was in place and the first focus will be on chronic pain and multiple long term conditions.

The work with Care Homes over the pandemic had resulted in increased coordination across the 42 care homes in Lambeth. The Alliance wanted to work with that, looking at, for example, increased digital accessibility of care records and consistency across evidence-based programmes.

The Alliance would build on the progress in end of life care that had been developed over the pandemic.

Programmes would be very data centric. There would be an emphasis on communicating the work that was being done.

The Loneliness Test and Learn project was working with the Primary Care Networks (PCN) to allow access to data sources. It was based in three wards, Tulse Hill, Herne Hill and Thurlow Park.

Loneliness was recognised as being harmful to health and had increased since Covid. Attempts were being made to reduce social isolation. Programmes would be targeted at those who lived alone, were 65 years or older with multiple long term conditions or those at risk of frailty.

Details of the website were provided and Amanda welcomed those that would like to be involved to get in touch.

The Chair thanked Amanda and Di for their presentation and asked for questions and comments from the Board. In reply to questions it was noted:

- The Alliance was a very small team and were always on the look out for ways to scale up projects.
- There had been fantastic examples of community development and great structures, such as Project Smith, Community Connectors, and Street Connectors existed. Bringing all of these assets together with people that needed those services required systematic change.
- Housing was recognised as one of the wider determinants of health and had was considered in more detail in some of the other Alliance priorities. Lambeth Council were trying to improve joint working between health and social care and other workstreams that deal with housing provision and maintenance.
- Di was examining the care planning data. She would come back to the group with an update on care planning progress at the next meeting.
- The model that Thriving Stockwell had in place was not capable of being rolled out across the whole borough as it was population specific. Attempts were though being made to look at what was working and see where that could be used in other areas that needed support. Part of the Councils role would be in facilitation connectivity.
- Housing for key workers was important and should be brought into discussions.

- Age UK funding was in place for a further four years. The priority for signposting services produces a challenge for the voluntary sector. There was a need to ensure that funding for this did not undermine funding for the services themselves.
- It was noted that the Council had invested £500m in improving the social housing stock. There was though more that could be done. It was worth engaging with housing colleagues and it was suggested that a further discussion on this would be useful.

The Chair thanked people for their comments.

RESOLVED

The updates were noted.

Dr Adrian MacLachlan took over as Chair for the final two items.

5. Integration and innovation: Working Together to improve health and social care for all

Andrew Eyres presented information on the White Paper proposing the further development to integrated care systems.

In November 2020 NHS England published an engagement document on integrating care with two options. The preferred option involved establishing ICSs as statutory organisations. Lambeth Council and South East London submitted formal submissions and this was influenced by the work being done by Lambeth together. NHS E&I had thereafter made recommendations to parliament.

The White paper proposals were grouped under the following themes:, working together and supporting integration, reducing bureaucracy, enhancing public confidence and accountability and additional proposals relating to social care, public health, quality and safety. The Key issues of system reform was not addressed in the White Paper.

There would be three duties placed on health bodies in securing: better health and wellbeing for everyone, better quality of health care for individuals, and sustainable use of all NHS resources. This would imply that organisations should think about the system as a whole, rather than their own financial positions. There would be a shift away from a transactional system towards a focus on collaboration.

The importance of Place was set out in the document, reinforcing much of the work that had been done in South East London and Lambeth.

A national NHS body would be established to have oversight of the whole of the NHS. The role of the Secretary of State would change and would carry increased power.

The statutory entity of NHS Trust would remain.

The overall direction of travel remained consistent, with the move to establish integrated working in SE London and Lambeth. The strong emphasis on Place-based integration, including across the NHS and local authorities was welcomed. There was a desire to fully engage with the areas of proposed focus across South East London. Social care and public health remained outside of the current white paper and detailed consideration of the enabling of changes within scope would be needed.

Comments were received as follows

It was suggested that the White Paper was light on detail and that the gaps around public health and social care was inadequate. It was commented that the structure looked very top down and may not lead to increased accountability.

It was responded that the White Paper was not trying to describe everything about integrated care systems. It proposed the changes to the law that would be required to lead to that. It was expected that there would be a lot more to come in terms of how ICSs would operate. Many of the things noted were within the gift of Lambeth Together and could be taken forward. Such documents as this would not inform the behaviours that needed to be taken on as a partnership. The strength of our the local arrangements had been demonstrated and it was a case of making best use of the resources.

RESOLVED

The update was noted.

6. **Lambeth Together Programme Highlight report**

Due to time constraints this item was not discussed in detail.

Andrew Parker asked that any comments on the report come back to him or Tom Barrett.

The Chair thanked members of the Public and Board members. The next meeting would take place on Wednesday 26 May.

South London and Maudsley Quality Programme
Delivering services that are safe, effective, compassionate and high-quality.

Listening into Action

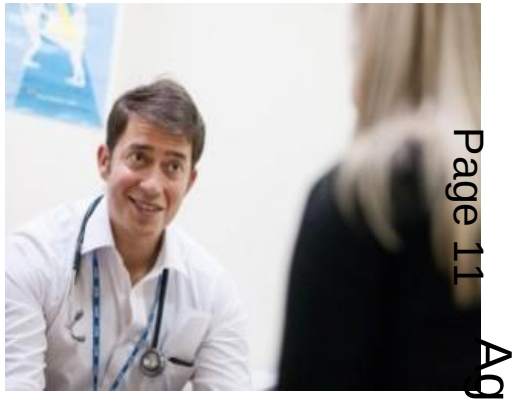
NHS South London and Maudsley NHS Foundation Trust

DRAFT

Be the Change beyond Changing Lives: Help shape our new strategy April – June 2021 engagement

DRAFT




Draft in progress – updated emerging ambitions (May 2021) v2

KING'S HEALTH PARTNERS
An Academic Health Sciences Centre for London
Pioneering better health for all

Be the Change beyond Changing Lives

Help shape our emerging strategy – get involved!

- This is a presentation to share some of the draft ambitions and ideas that have been developed so far around our emerging strategy.

- We're calling the 12 week staff engagement programme *Be the Change beyond Changing Lives*. This runs from April to the end of June

- We really want your views to help shape our emerging strategy.

- There are lots of ways for you to get involved and you can find out more on Maud and in this presentation – so keep reading.

No small ambition – we are aiming to be the best mental health trust in the country by 2026.

- We are deeply ambitious for people experiencing mental ill health.
- Our vision sees South London and Maudsley NHS Foundation Trust offering each and every person outstanding treatment and support to enable their recovery and to live a fulfilling life.
- We will build on the commitments set out in the NHS Long Term Plan, the Advancing Mental Health Equalities strategy, and on our existing work pioneering new models of care to take our ambitions one step further.
- We are beginning to see greater investment in mental health to correct years of underfunding, in tandem with a positive shift in societal attitudes to mental health which will strengthen our work to speak up against stigma.
- This backdrop presents a hugely exciting opportunity for us, those we care for, and our local communities and partners. Together, we believe we can be outstanding.
- To help us get there, we are developing a small number of big ambitions for the next five years, and we need your help.

Working with staff, patients, partners and local communities to build this together

Worked with 100+ leaders, stakeholders, governors across the Trust as well as with partners to identify a small number of key ambitions for the organisation to 2026

Set of draft headline ambitions and proposed areas of focus for wider engagement with staff, service users, carers and our partners to enable further refinement over the summer

The change required is as much about how we do things, as what we do

We know we can’t achieve our ambitions alone. Working in partnership with our NHS, council and voluntary community sector partners is central to our vision.

Plan for formal launch w/c 27 September 2021

Our emerging five strategic ambitions so far – May 2021

1. Best place for outstanding mental health care
2. Partner in prevention
3. Catalyst for change
4. Building a culture of trust
5. An effective and sustainable organisation

Overview of emerging strategic ambitions

1 Best place for outstanding mental health care (1 of 2)

Ambition One

Children and young people, adults, and older adults who we serve in our highly diverse communities will experience the best standard of mental health care and will be treated with kindness, compassion, dignity and respect.

Outstanding care	Supporting more people to recover and to live a positive, meaningful and fulfilling life in community settings
	Ensuring that people who are experiencing mental ill-health can access the support they need from us, when they need it, and in an inclusive and person-centred way – whether that's online or in person
	Taking an individualised approach to recovery for each person who uses our services, and which ultimately supports them to achieve the goals that matter to them.
	Increasing uptake of the physical health interventions which evidence shows contribute to closing the 15-20 mortality gap for those with severe mental illness.
	Minimising our use of detention under the Mental Health Act.
	Significantly reducing our use restrictive practices, including restraint, with an ambition of eliminating all prone restraint, working closely with partners such as the Police.
	Adopting a 'Zero-Suicide' ambition and approach.

1 Best place for outstanding mental health care (2 of 2)

Ambition One

Children and young people, adults, and older adults who we serve in our highly diverse communities will experience the best standard of mental health care and will be treated with kindness, compassion, dignity and respect.

Improving the way we deliver	Co-production of services such that we are working collaboratively with all people who use our services and their families
	Ensuring we put quality and equity at the heart of everything we do
	Building on our most successful partnerships with NHS, local authority, education and community organisations across all four Boroughs
	Workforce planning, recruitment and retention so that we have both the right skill mix and number of staff, who collaboratively deliver outstanding care.
	Data-driven services to help us continually improvement and harnessing the potential of digital innovations to improve the way we deliver services
	Upgrading and replacing our most outdated hospital estate and the creation of modern therapeutic facilities

2 Partner in prevention

Ambition two

We will be recognised nationally and internationally for our pioneering work in driving research into the prevention of mental illness, promoting early intervention and early access for those in our communities at higher risk of mental illness, and for supporting people living with mental health conditions to stay well.

Improving the way we deliver	Successful partnerships with other NHS, statutory and voluntary sector players to drive the improvement of mental and physical health outcomes across our local population. This will include influencing the wider determinants of health, including housing, employment, education, and the strength of our communities.
	Working with our partners to radically transform our understanding of the needs, and the planning and delivery of interventions, for 0-25 years. Our ambition will be to fundamentally affect life course and opportunity for the better, and ensure young people are equipped to manage their mental health in the future.
	Improving the health of our local population and tackling inequalities by taking a lead in designing and commissioning services which respond to the needs of our local populations, building on the successes of the South London Partnership.
Pioneering research	Taking a lead role, with our academic partners, in research into the prevention of mental ill-health and ensuring the translation of evidence-based interventions into practice in our local health and care system.
Investing in Prevention and Early Intervention	Increased investment in our community services to maximise the benefits of mental health promotion, prevention and early intervention, working with our local health and care partnerships to provide earlier access to therapeutic care and preventing avoidable deterioration of ill-health.

3 Catalyst for Change

Ambition three

Jointly with the Institute of Psychiatry, Psychology & Neuroscience and our other research partners, we will be a prominent and authoritative voice in the growing national and global conversation about how we improve mental health and combat harmful stigma.

Leading Global Research	Further enhancing our position as the leading centre of innovation and education globally with all our staff feeling ownership and pride in our research.
	Engaging more local people with serious mental illness in our clinical trials and ensuring the benefits of research apply equitably across our diverse communities.
Research with Delivery	Research opportunities will be offered alongside routine clinical practice, leading to faster translation and adoption and better mental health outcomes in our local and specialist services.
	Bringing together research and clinical care for children and young people in our new Pears Maudsley Centre, a beacon of excellence with clinicians and academics working together to redefine how we care for growing minds and supporting transition between services at the right time.
Ambassador for Outstanding Policy & Practice	Using our own organisational journey to advocate at the highest levels nationally and internationally for modern mental health services based on evidenced interventions for prevention and recovery.
	Further UK-wide and international adoption of our leading models of care and evidenced-based innovations

4 Building a culture of trust

Ambition four

Our organisation will be viewed by its employees and communities as transparent, responsive, decent and fair.

Leading anti-racism in mental health	Demonstrable restorative and equitable action against the structural racism that affects society, including all mental health services, and which we have a special responsibility as a Trust serving and employing significant Black, Asian and Minority Ethnic communities, to eliminate.
	In line with the Advancing Mental Health Equalities strategy, embed the Patient and Care Race Equality Framework at scale, to improve the way we deliver mental health services so that the experience, access and outcomes for our Black, Asian, and Minority Ethnic communities improve.
A Different Name	Based on feedback from our local communities, the inappropriate acronym 'SLaM' will have been replaced by a name which more appropriately reflects the strengths of the Maudsley 'brand', sending a clear signal that we are serious about listening to our communities and embracing change.
Our Core Values	Involving the people who use our services to co-produce and embed a core set of values across the organisation to enable people to be clear on the standards we will hold ourselves to.

5 An effective and sustainable organisation (1/2)

Ambition five

We will transform the conditions for all our staff to give their best and contribute fully to the achievement of our ambitions.

Continual Learning	A culture of learning and improvement to encourage a more reflective approach to adverse incidents and to ensure we learn from the experience of our service users, carers and families.
	Using innovative and creative approaches to reshape our workforce, both in terms of the right numbers and mix of staff, peer support and volunteers, and widening access to good quality employment opportunities for our local communities.
	Equipping all our staff and managers with the skills they need to feel supported and confident in delivering outstanding care.
Valuing our Staff	Aiming for all staff to feel valued and to regard us as a great place to work.
	Making it easier for people to do the right things and take initiative by simplifying how we make decisions at all levels.
	Championing equality, diversity & inclusion, taking the necessary steps to support all our staff to fulfil their potential.

5 An effective and sustainable organisation (2 of 2)

Ambition five

We will transform the conditions for all our staff to give their best and contribute fully to the achievement of our ambitions.

Confident, Capable & Diverse Leadership	Investing heavily in the leadership capabilities and behaviours at all levels that will drive the transformation of the organisation.
	Ensuring that leadership at all levels, including the Trust Board, reflects the diversity of our communities.
Realising the Full Value of our Investment	Establishing new income streams for our local and national services by making use of the creativity and expertise of our staff
	Better use of our estate including using our buildings and spaces to support our local communities, for example, through the creation of affordable housing schemes for local residents
	Delivering financially sustainable and outstanding quality care by living within our means, and recognising the potential for wider societal benefit of our purchasing choices, for example, benefits to local business by buying locally.
Environmental Sustainability	Taking significant steps towards 'net zero' carbon emissions and be making a positive contribution to the environment through better use of technology, estates, medical devices, and consumables.

So what next?

How to get involved and shape our strategy

We will be holding a number of engagement events up to the end of June. This includes:

- A strategy event in each borough, co-developed with partners and local stakeholders that brings together service users, carers, communities and partners.
- A number of targeted events for key groups
- A strategy engagement survey

If you would like more information in the meantime please email Lucy Canning, Associate Director of Strategy, on Lucy.Canning@slam.nhs.uk

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MATERNITY SERVICES PRIORITIES & FIVEXMORE CAMPAIGN

Nina Khazaezadeh Head of Midwifery- Guy's &St. Thomas NHS FT

Clotilde Abe-Founder of Prosperity's

Key priorities

Women's experience:

Staff experience

Continue to meet the National Ambition

2015-17

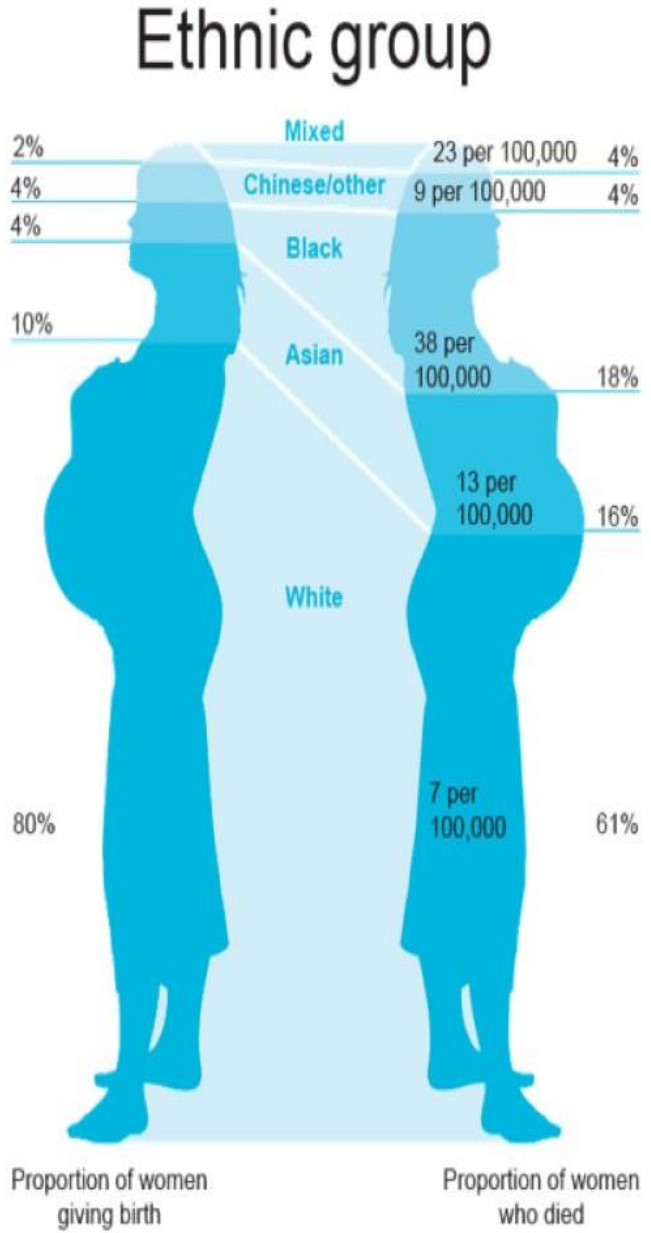
9.2 per 100,000 maternities

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Inequalities

Black and Asian women have a higher risk of dying in pregnancy

White women		7/100,000
Asian women	2x	13/100,000
Mixed ethnicity women	3x	23/100,000
Black women	5x	38/100,000



FIVEXMORE

Tackling health inequalities in maternity

WHAT IS FIVE X MORE?

Five x More is a grassroots campaign committed to highlighting and changing Black women's Maternal outcomes in the UK

WHO ARE WE?

Tinuke - Founder of Mums and Tea

Clo - Founder of Prosperitys

WHAT DO WE DO

EMPOWER

We empower mothers with our 6 recommendations and by offering 100 Black women free access to digital hypnobirthing courses

AMPLIFY

We amplify the voices of Black women and allow them to speak out about their experiences, good or bad, so others can learn from it

EDUCATE

We have teamed up with the RCOG to give five steps for health professionals

We give talks to university students

RAISE AWARENESS

We have our #fivexmore selfie on social media to keep the conversations going and continue to raise awareness of this issue.

We are also the creators of the UKs first Black maternal health awareness week

LOBBY

Our petition gained over 187,000 signatures in June 2020. Debated on Monday 19th April.
We have a MP letter writing campaign and have submitted written evidence to the Maternity Safety Enquiry.
Back in December of 2020 we gave oral evidence in parliament which you can watch back via Parliament TV

ISSUES FOR BLACK WOMEN

MYTHS

We have different shaped spines
We have different shaped pelvises
We can handle more pain
Our bodies do the "Black girl thing" in labour

STEREOTYPES

Strong Black woman
Loud and angry Black woman
We have loads of children

NOT BEING LISTENED TO

This is a trending and recurring theme amongst many Black women we speak to

COVID

Black pregnant women are eight times more likely to be admitted to hospital with COVID-19

MENTAL HEALTH

In the UK depression and anxiety are most prevalent among black women,

NOT BEING GIVEN RIGHT INFOMATION

Maternity safey inquiry consultation results

"I am here to listen"

6 STEPS FOR BLACK PREGNANT WOMEN

Speak up

Find an advocate

Seek a second opinion

Trust your gut

Do your research

Document everything

POSITIVE QUOTES FROM BLACK MOTHERS

Your campaign gave me confidence to speak out if i felt the tiniest of things were not ok. I had a lovely experience 4th c-section

‘These stories give me hope’ Black women need to hear positive birth stories and be empowered to speak up for themselves

Your campaign has empowered me honestly and for that I will be forever grateful for

“I was originally told ‘no’ to a pool birth, but with the help and support of Five X more steps I was able to have a water birth during the COVID pandemic and was able to advocate for myself especially as a black woman! So much so, I was approached by a midwife before being discharged asking how I knew what to ask and who to speak to because many women do not know how to advocate for themselves and believe they can not challenge health providers. Reality is, I didn’t know my rights until Five X More informed and encouraged me.

5 STEPS FOR HEALTH PROFESSIONALS

Our partnership with the RCOG gives you five steps you can take as health professionals to help reduce these disparities and improve outcomes for Black women.

Listen

Remove any barriers to communication

Check you are providing clear information

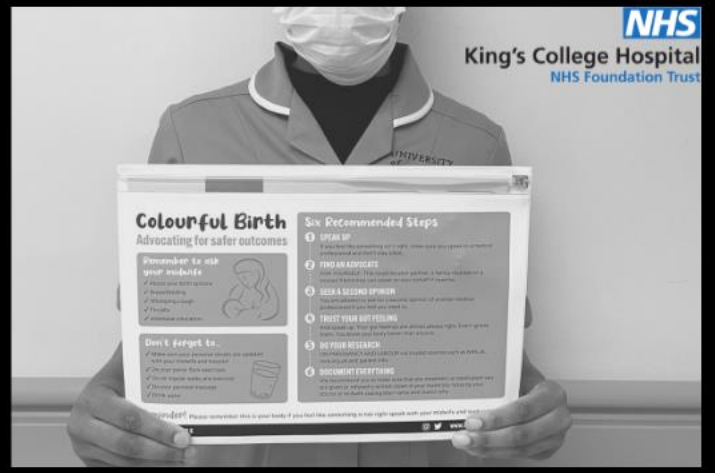
Provide access to detailed documentation

Be a champion

Do You Know Your RIGHTS?

AIMS

Maternity Wallets



Black Maternity Experience Survey

FIVEXMORE

THANK YOU FOR LISTENING

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Email: fivexmore@gmail.com

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NHS
South East London
Clinical Commissioning Group

Lambeth

Children and Young People Alliance

Children and Young People's Mental Health and Emotional Wellbeing

Programme of Current and Future Delivery

Lambeth Together Strategic Board

26th May 2021

Mental Health and Emotional Wellbeing Needs Assessment

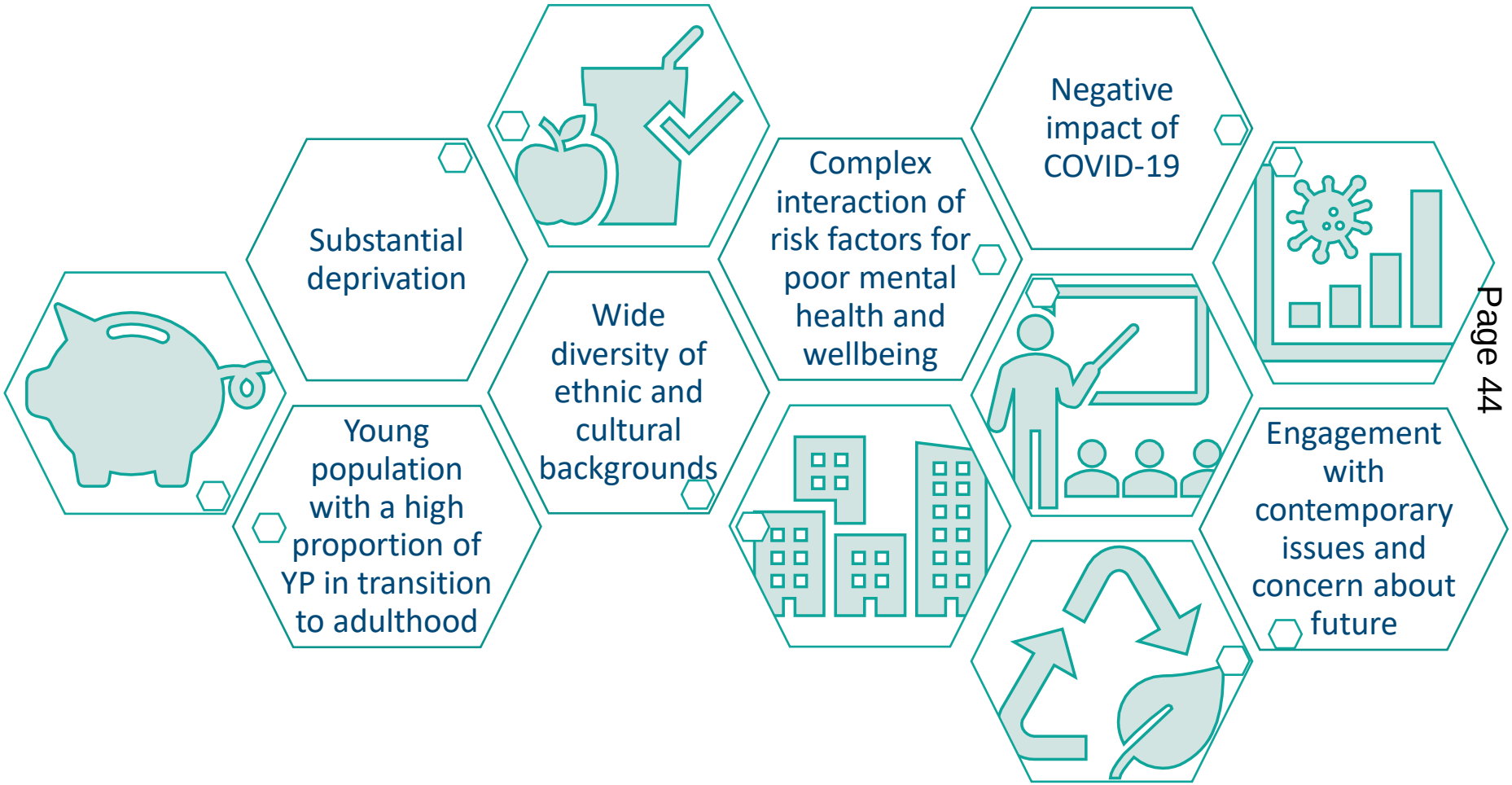
- Aim to understand current level of mental health and wellbeing need and factors that promote resilience in children and young people and scope:
  - Inequality in condition, outcome, and service access
  - Local provision available
  - Determinants that affect mental health and wellbeing

- Task and Finish Group established to advise and guide development

- Eight-week, borough-wide consultation and engagement to commence from early June 2021

- Lead to development of clear commissioning priorities and future investment plan

Overarching Themes: Needs Assessment



Key Findings: Needs Assessment

Determinants of Mental Health and Wellbeing

- Prevalence of child obesity at reception (10.4%) and year 6 (23.8%) higher than regional and national levels
- Roughly 36% of CYP n Lambeth lived in food poverty in 2019 – prior to pandemic (31% nationally)
- High proportion of under 16s in low income families (23.4% vs 18.8%), high uptake of free school meals (24.6% vs 23.1%), high level domestic abuse incidents (32.9%), and lone parent households (10.4%)
- High proportions of children in need due to parental disability (17.7 vs 14.0) or dysfunction (129.7 vs 97.9 per 10,000)
- Significantly high proportion of 16-17 year olds that are NEET (7.9% compared to 4.2% and 5.5%)
- 18% of primary school and 25% of secondary school pupils use internet to chat to people they don't know
- Rate of violent offences and hospital admissions for violence is higher than London average and is reported to be a significant worry by YP

CYP with SEND

- High proportion of CLA with EHCPs (33.5% compared to 27.2% nationally) and children in need with EHCPs (27.4% compared to 21.6%, respectively)
- Higher proportion of pupils with EHCPs and receiving SEN support that national levels (4.7% and 13.7%, compared to 3.3% and 12.1%
- Speech, language, and communication needs are much higher in Lambeth (29.7% vs 21.9%) and is the most common SEN followed by social, emotional, and mental health (17.3%) and Autism (14.9%)

Key Findings: Needs Assessment

Mental Health and Wellbeing

Rate of hospital admissions due to mental illness higher than regional and national

Among those receiving free school meals, the risks of mental health problems were around 30% higher than in those not receiving free school meals

Similar levels of conduct (6.0%) and hyperkinetic (1.7%) disorders and SEMH (2.7%) to regional and national levels

49% of CAMHS patients diagnosed with neurodevelopmental conditions; 50% YP attending Well Centre presented with depression

Kooth reporting increase in YP expressing suicidal thoughts, self-harm, and worries about family relationships

Roughly 1 in 5 adolescents reported mental health problems in Lambeth and Southwark

Key Priorities: Needs Assessment

General

- Collect further data on mental health and wellbeing, particularly to understand inequalities
- Promote inclusion and diversity in the mental health workforce
- Enhance parenting support programmes

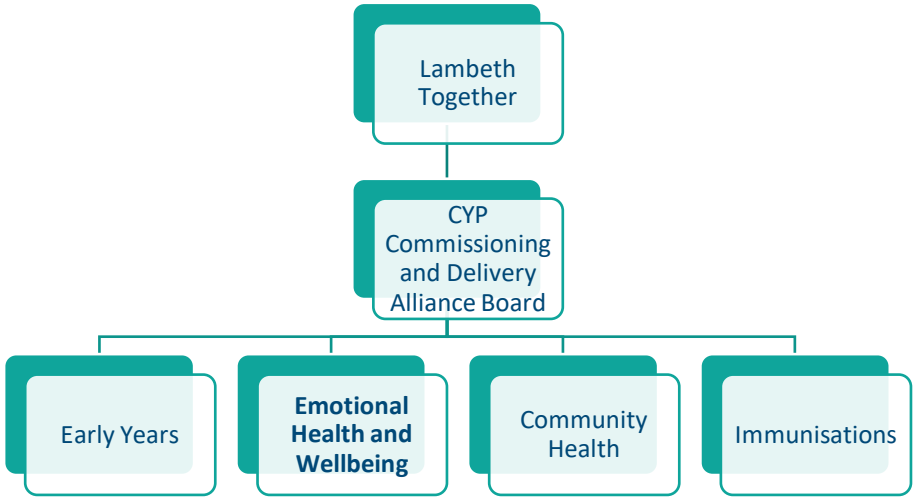
Determinants

- Promote healthy living with a focus on physical activity and nutrition
- Support efforts to reduce and prevent food poverty
- Increased support to families with children in need
- Increased support to young carers and children that are looked after placed out of area
- Support and expand mental health capacity and capability in schools

CAMHS

- Invest on preventive services and early intervention to stem the increase in need for high-tier services
- Create an online referral platform that links CAMHS with other CYP services that support mental health and wellbeing to facilitate direct and cross-referrals
- Better data collection on ethnicity, prevalence and incidence of conditions, and outcomes of interventions
- Review mental health support services available for neurodevelopmental conditions

Emotional Health and Wellbeing Alliance Board



- Aim to establish Children and Young People's Emotional Health and Wellbeing Programme Board
- Responsible for developing robust mental health offer for CYP following on from needs assessment
- Maintaining oversight over mental health agenda
- Ensuring delivery against programme plan

Mental Health and Wellbeing Panel

- Establishing quarterly CYP mental health and wellbeing panel
  - Terms of Reference
  - Referral form
  - CAMHS involvement
- Social Care Team and Service Managers to present high need cases
- Enable better forward planning to meet anticipated mental health need
- £50,000 budget set aside for spot purchasing mental health services
- Expected that majority of cases will relate to out of borough/CLA placements

General Updates

- Exploring options for capital funding to enable CAMHS to move into St. Johns Angell Town School

- Additional funding approved with GSTT for additional capacity to support backlog of ASD assessments

- Proposal for additional capacity to identify and address specialist needs of UASC is under consideration

- Service booklet listing Lambeth mental health and emotional wellbeing providers due for completion

CAMHS Update

- Service reporting increasing complexity, high acuity cases
- Seeing 50% increase in A&E admissions for mental health; predominantly children and young people rather than adults
- Average waiting times for assessment and treatment are now increasing:
  - Assessment time – 18.79 weeks
  - Treatment time – 27.33 weeks
  - Currently 34 CYP waiting for 52 weeks or more for assessment
- Work to recruit staff has been unsuccessful; significant challenges in recruitment owing to small pool of practitioners
- CAMHS staff are under immense pressure given the historic unmet need
  - Significant new investment is a huge opportunity and requires workforce innovations as traditional roles can be hard to recruit to
  - Staff wellbeing and support are CAMHs priorities to increase retention
  - the new balance between face to face and remote working continues to be evaluated to ensure it does not become another stressor

CAMHS Update

- 2020/21 Activity Data

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Referrals	62	69	100	122	76	153	151	171	141	111	120	201
Contacts	426	413	517	628	452	672	794	845	688	796	816	818
A&E contacts: - New - Existing	4 17	1 6	7 25	12 12	3 19	15 12	8 28	14 45	13 19	11 11	9 19	20 11

- 20/21 Caseload Data

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Caseload	1662	1569	1593	1602	1580	1634	1633	1641	1641	1652	1408	1419
Asian	5%	4.4%	7.9%	2.1%	5.9%	4.5%	2.6%	2.7%	6.2%		1.6%	3.6%
Black	20%	47.8%	42.1%	41.7%	32.4%	29.2%	30.8%	28.4%	24.6%	33.9%	24.6%	27.7%
Mixed Race	5%	4.4%	13.2%	14.6%	17.7%	9%	10.3%	9.5%	10.8%	8.9%	21.3%	12.1%
White	55%	30.4%	26.3%	31.3%	35.3%	34.9%	35.9%	24.3%	32.3%	32.1%	21.3%	26.5%
Other	15%	13%	10.5%	10.3%	8.7%	22.4%	20.4%	35.1%	26.1%	25.1%	31.2%	30.1%

Mental Health Support Teams in Schools

- As of January 2021, Mental Health Support Team members are in place and have begun training
- Following Expression of Interest process, eight schools have been selected to participate in the first wave
- First phase of work with selected schools has begun – local needs assessment and audit of provision; service establishment in each school
- Referrals to MHSTs will begin in April
- Plans to introduce a blended model of provision after Easter break
- Further six schools have been identified and will benefit from MHST support from summer 2021
- Over 8,000 children and young people expected to benefit from MHST support in year one

North Hub	Central Hub
Lilian Baylis Technology School (Host School)	**St. John's Angell Town (Host School)**
Jubilee Primary School	Holy Trinity School
Allan Edwards Primary School	Woodmansterne Primary and Secondary School
Walnut Tree Walk Primary School	La Retraite Secondary School

Small Grants: Emotional Wellbeing

- Small Grants programme to test different models of improving wellbeing and building resilience in Lambeth CYP

- Successful providers include:

Provider	Service
Mosaic LGBTQ+	Enhancing digital service offer to reach more LGBTQ+ young people and increase range of engagement opportunities
Safer London	Specialist worker to deliver 1:1 emotional support for CYP who are at risk of permanent exclusion, with a focus on additional learning needs
Big Kid	Delivery of Breaking Barriers Leadership Programme in Lambeth schools for pupils at risk of exclusion; focus on inequalities

Ongoing Priority Areas

- Equitable, responsive access to mental health services by black and other minority ethnic groups

- Response to the Learning Disability and Autism Programme:
  - Case management
  - Care, Education, and Treatment Reviews

- Improving transition pathway for young people aged 16-25 years

Report to: Lambeth Together Strategic Board

26 May 2021

Report Title	Lambeth Together - Developing our governance and assurance arrangements
Authors	Andrew Parker - Director of Primary Care and Transformation. SEL CCG. Tom Barrett – Lambeth Together Programme Lead Brian Reynolds – Associate Director Health and Care Planning and Intelligence
Summary	The purpose of this paper is to update the Strategic Board on the outcomes arising from the recent review of our governance and to seek approval for a number of recommendations to take forward over the coming months .
Recommendation(s)	The Lambeth Together Strategic Board is asked to; 1. Agree the priorities and ways of working for the Strategic board (see paragraph 2) and note that further priorities for partnership development, including our work to address inequalities, will be identified over the coming period 2. Agree to establish a process to review and confirm the Lambeth Together pledge and this be brought back to a future Strategic Board for approval. 3. Agree that the number of VCS providers represented as Members on the Strategic Board be increased from 1 to 3 and that each Delivery Alliance identify one VCS Provider representative. 4. Confirmation be sought from partner Foundation Trusts and the Clinical Cabinet that they have the appropriate representation at the Strategic Board, within the Executive Group and Delivery Alliances 5. Ask each Delivery Alliance to review their membership to ensure appropriate clinical input 6. Agree that further consideration be given to inclusion of pharmacy and/or other primary care practitioners in Lambeth Together arrangements

	7. Agree to take forward additional work to further develop our Lambeth Together overall approach to community and citizen engagement; • Developing our overall approach to engagement and co production, both Lambeth-wide and within our Delivery Alliances • Citizen/community representation within our governance fora • Relationship with existing SEL engagement assurance committee members and future ICS arrangements 8. Agree the Lambeth Together arrangements for performance review and assurance reporting as set out at paragraph 5

Lambeth Together : Developing our governance and assurance arrangements

1.0 Executive Summary

Over the past three months, system partners have helped to inform the Lambeth Together governance and assurance reviews. The current structure of Lambeth Together governance is at Annex A. Below, we have summarised the outcomes of the reviews across the following broad themes:

- Purpose and focus of the Board and ways of working
- Membership
- Working with our communities
- Structure
- Assurance
- Executive arrangements

2.0 Purpose and focus of the Strategic Board and ways of working

Four clear areas of purpose and focus for the Strategic Board have emerged from discussions as part of the governance review. These are:

- Refreshing the draft 2020 pledge. Changes will include embedding greater focus on equalities, diversity and inclusion and a clearer statement on how the partnership will hold itself to the pledge. The Lambeth Together pledge was developed in 2017 and was being reviewed in 2020 (see annex B) immediately prior to the emergence of Covid-19. The purpose of the pledge was to provide the means through which Lambeth Together partners could reaffirm their commitment to each other and clearly set out the programme's purpose, values, behaviours and objectives.

- Developing system leadership (partnership development). This will include developing our system-wide organisational/partnership development requirements with a particular focus on how the Board can support the transition from single organisation activity to a more integrated/alliance-based approach and the practical support required to develop the enabling factors to support more integrated working

- Focus on equalities, diversity and inclusion. This will include embedding the activity of the Equalities, diversity and inclusion working group focussing on data, workforce, recruitment and retention activity (anchor institutions within a wider system) and establishing a set of common targets across the partnership

- Visioning and determining our approach within a future ICS. This will include a clear process for engaging the Strategic Board in discussions on the positioning of Lambeth Together in our future place-based and ICS system

Strategic Board - Ways of Working

The following approaches for the Strategic Board emerged from discussions as part of the governance review:

- To maintain a strategic focus, informed by evidence, transparency, learning from what we and others do and open to new opportunities
- To sustain the public forum as a key point of visible public accountability and engagement
- To have a Forward Plan of deep-dive sessions focussed on the strategic direction of our Delivery Alliances, Recovery and Enabler Programmes.
- To be informed by enhanced assurance work – with oversight of the programme outcomes, incl. around inequalities.

Recommendations

1. Agree the priorities and ways of working for the Strategic board (see paragraph 2 above) and note that further priorities for partnership development, including our work to address inequalities, will be identified over coming period

2. Agree to establish a process to review and confirm the Lambeth Together pledge and this be brought back to a future Strategic Board for approval.

3.0 Strategic Board Membership

Lambeth Together has always strived to ensure that all parts of the system are well represented in discussions balanced against the need to ensure an effective leadership model.

The current membership of the Strategic Board is provided in Annex C. It is recognised that there have been a number of role and personal changes over the past fifteen months and it is important that member partners reconfirm their representation.

It has previously been acknowledged that it would be helpful to enhance the role played by third sector providers within our partnership and the need to further review the voice of the community. Through the governance review there were a number of discussions on how to expand the scope of the third sector provider voice and to reconfirm membership of statutory provider and clinical leads.

The ICS are developing an approach to clinical and professional leadership in SEL. They've produced an interim report on the work done so far and the findings and recommendations were strongly supported by OHSEL ICS Executive and is moving into the next phase to progress this work.

Under the Integrating Care White paper proposals local systems are expected to play a bigger role in working with primary care providers beyond general practice, including community pharmacy, dentistry and optometry. It is recommended we consider how we might involve local providers with Lambeth Together building on a positive history of joint working.

Recommendations

1. Agree that the number of VCS providers represented as Members on the Strategic Board be increased from 1 to 3 and that each Delivery Alliance identify one VCS Provider representative.

2. Confirmation be sought from partner Foundation Trusts and the Clinical Cabinet that they have the appropriate representation at the Strategic Board, within the Executive Group and Delivery Alliances

3. Ask each Delivery Alliance review their membership to ensure appropriate clinical input

4. Agree that further consideration be given to inclusion of pharmacy and/or other primary care practitioners in Lambeth Together arrangements

4.0 Working with our Communities

Through the governance review there was considerable discussion about how engagement and coproduction work could be taken forward across the programme continuing conversations that were taking place at the beginning of the pandemic and aligning with other work taking place in this space (including with the Health and Wellbeing Board, Healthwatch and Black Thrive). Individual Delivery Alliances have also started to develop approaches to engaging and involving citizens in their work. (e.g. LWNA; Loneliness test-and-learn).At the centre of this would be the aim to develop a model that enables genuine community voice and coproduction opportunities.

A Lambeth Together communications and engagement group is in place, however, the focus of that group has largely been on coordinating communications activities linked to our Covid -19 response. Recent innovations led by the group have included establishing an engagement fund for alliances to bid into through an existing Lambeth Together budget.

Recommendation

Agree to take forward additional work to further develop our Lambeth Together overall approach to community and citizen engagement;

- Developing our overall approach to engagement and co production, both Lambeth-wide and within our Delivery Alliances
- Citizen/community representation within our governance fora
- Relationship with existing SEL engagement assurance committee members and future ICS arrangements

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Annex A

5.0 Lambeth Together Assurance arrangements

Over the last six months we have been developing our new assurance arrangements. Following individual conversations and a dedicated workshop we have started to produce a new bi-monthly integrated assurance report and have previously supported the establishment of a new Lambeth Together Assurance Group. The Assurance Group will begin to meet from July and will overview performance and assurance issues and report to the Lambeth Together Strategic Board.

Lambeth Together Assurance Group:

This new group will provide a regular forum for the consistent receipt and review of assurance and performance matters on behalf of the Lambeth Together Strategic Board and will review progress against Delivery Alliance key priorities. It provides dedicated time on oversight on behalf of the Strategic Board, and opportunities to consider issues that are overarching or cover multiple elements. This Group does not replace but supports the accountability of the Strategic Board and of our individual Delivery Alliances.

The Assurance Group will meet bi-monthly at least ten working days before the Lambeth Together Strategic Board and will report directly into the Lambeth Together Strategic Board. It will use the developing bi-monthly Integrated Assurance Report as its main agenda item and will draw upon other material from the respective alliance and programme boards on matters related to assurance of performance, activity, finance, risk and quality as necessary.

It recognises that risks are inherent with transformation and programmes, and are best managed within those areas, and will pull through key risks, and link through to further risks as relevant.

The proposed Membership of the Group is set out below and it draws upon a subset of Strategic Board, Executive Group and Delivery Alliance Members and will have a non-officer chair and deputy chair.

Local Authority	CCG	LA and CCG	Provider	Lambeth Together

Job Role	Name
Non-Executive LTSB member, and chair of this group, SEL CCG	Sue Gallagher
A LBL elected cabinet lead / Chair of Health & Wellbeing Board, and deputy chair of this group	Edward Davie or Jim Dickson or Danny Adilypour
A clinical Lead, and deputy chair of this group, SEL CCG	Dr Adrian McLachlan, or Dr Raj Mitra, or Dr Di Aitken
Strategic Director, Integrated Health & Care, LBL/CCG	Andrew Eyres
Director Primary Care and Transformation, CCG	Andrew Parker
Director for Childrens Commissioning, LBL/CCG	Abi Onaboye
Director for Adults Commissioning LBL/CCG	Jane Bowie
Director Public Health,	Ruth Hutt

Annex A

Executive Director of Deputy Director Adults Social Care, LBL	Fiona Connolly,
TBC, GSTT	TBC – Paran Govender, Sarah Austin
TBC, KCH	TBC – Kate Gregory, other
TBC, SLaM / LLWNA	TBC – Sabrina Philips, Guy Swindle
TBC, Primary Care	TBC – Therese Fletcher, George Verghese
Associate Director Finance, SEL CCG	Edward Odoi
Associate Director Finance, LBL	Pete Hesketh
Associate Director Health & Care Planning & Intelligence, SEL CCG	Brian Reynolds
Associate Director Programme, Lambeth Together	Tom Barrett
Director Neighbourhood and Wellbeing Delivery Alliance, Lambeth Together	Amanda Coyle

Lambeth Together- integrated health and care assurance report:

This report aims to provide in a single coordinated assurance framework visibility for both Lambeth Together and Lambeth's integrated health and care arrangements. The report is structured with key outcomes and themes essential to providing assurance that our programmes and activities are delivering against agreed objectives and outcomes, including reducing health inequalities and will be developed over time:

- Lambeth Together programme highlight reports and associated alliance dashboards as these develop
- Integrated health and care assurance: covering the SEL CCG and Lambeth Council delegated responsibilities to our boroughs integrated health and care arrangements. This includes:
    - Adult Social Care and Older Persons
    - Public Health
    - Childrens Commissioning
    - Primary and Community Care
    - Medicines Management and Long Term Conditions
    - Integrated Commissioning for Adults
    - Adults Mental Health
- Quality matters
- Risks identified not covered elsewhere in programme highlight reports
- Finance for Lambeth Together and Lambeth's integrated health and care arrangements.

This report is not intended to be duplicative or create any unnecessary additional reporting or assurance work, but to bring together in a coordinated fashion, using a single framework,

the breadth of assurance materials that exist so the Board and assurance group has oversight of our delivery within Lambeth.

As well as developing over time to ensure it has the right focus on health outcomes including equalities measures. The report will also serve to report against our progress against the Lambeth integrated health and care business plan 2021/22, and emerging NHS planning requirements.

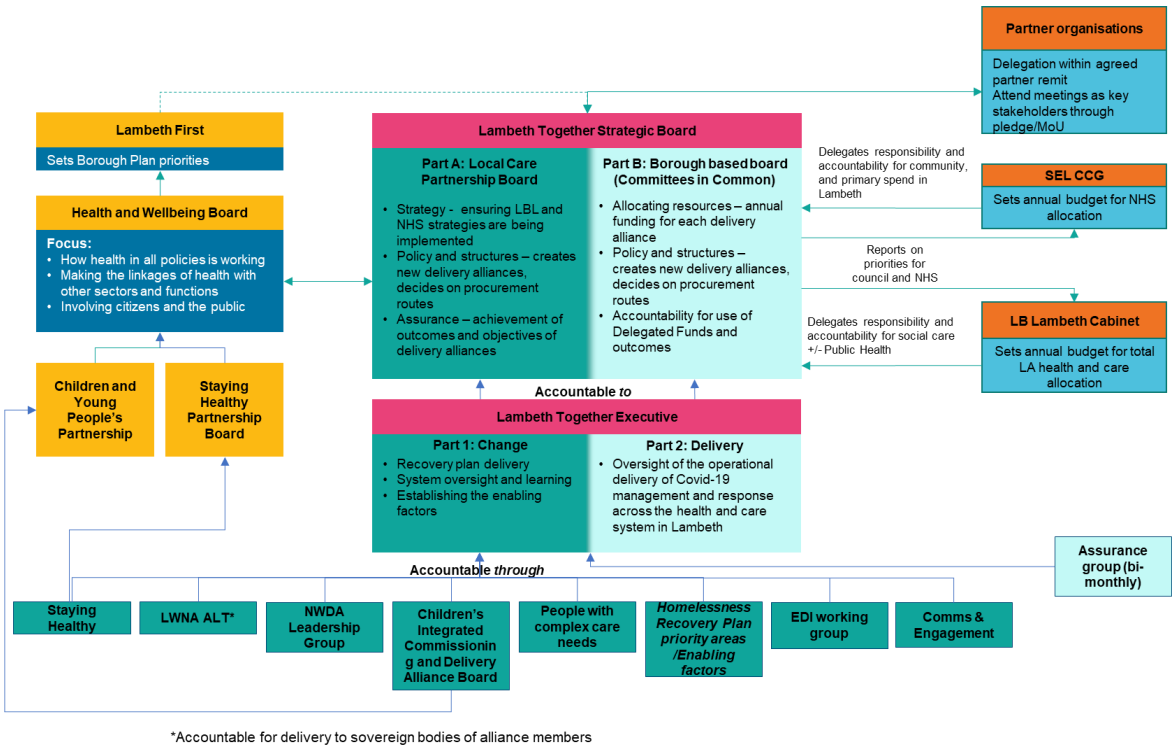
Recommendation

Agree the Lambeth Together proposed arrangements for performance review and assurance reporting

Annex A

Lambeth Together structure as is

The structure of Lambeth Together is extensive and relatively complex, due to the nature of the collaborative work across multiple organisations and programmes. The following diagram sets out the structure as-is:



*Accountable for delivery to sovereign bodies of alliance members

Any significant changes should be held until further details regarding the legislative ICS changes occur. However, the position of new groups, subgroups or work package groups can be planned, to ensure reporting processes and communication lines are in place from the outset.

Lambeth Together meetings were reorganised during phase one of Covid and subsequently the former Lambeth Together Executive and Covid Borough Response Groups merged in October 2020. As the system moves out of recovery and into a new position the focus of the partnership is shifting from covid response to delivery of recovery plans and progressing alliance work. These meetings will continue weekly

Annex B

Refreshing the Pledge

Mission/Vision:

We will work together using one, integrated health and care budget, because only by working as a single team will we truly deliver transformative health and care for all who need it in Lambeth

We want Lambeth to be a place where:

- Health and social care outcomes are improved for all of our communities, regardless of background or lived experience
- People are able to reach their potential, feel valued, are safe from harm and have positive choices about their health and social care
- We strongly celebrate our rich diversity and our communities' voices are heard

Values: (*what* LT believes in)

- Putting people first, always, and striving to provide the best care possible
- Being honest and plain speaking, and fair and clear in what we do
- Working together, collaboratively, in partnership
- Respecting difference and celebrating diversity

Strategic Objectives/Goals (*what* we need to *do* to achieve the Vision)

- We will bring health and care partners together across Lambeth, working across boundaries and geographies.

- Whoever we work for, we will operate as 'One Lambeth' team, with our people clear about their roles, whether they be in health and social care, the voluntary and community sector or working in statutory services or other partners.

- We will make sure service users are the centre of our focus – we will empower them and give them voice, with and through co-production. We will listen to their voices and act on what they say.

- We will develop services that are centred around their neighbourhoods, not the organisations who provide them, by combining forces in Delivery Alliances that are grounded in those places.

- We will work under one health and care budget, with combined systems, working collectively through a culture which is open and honest, where challenge is welcomed.

- We will have a single leadership team and key functions.

Behaviours (*What* we expect of our people) - The Lambeth Together Way

- Whichever provider or practise our people work within, our staff recognise they are part of a collective whole, where individual strengths are critical to success
- Our people embrace feedback and learn from it, sharing learning when we know it will make a difference, building relationships based on trust
- Our people are accountable, share power and enable diverse voices to be heard

Current Membership Lambeth Together Strategic Board

Title	Membership status
Strategic Director, Integrated Health & Care NHS SE London CCG (Lambeth) and Lambeth Council	SEL CCG (Lambeth) & Council Part A&B Voting
GP Assistant Chair NHS SEL CCG, (clinical lead Neighbourhood & Wellbeing Delivery Alliance)	SEL CCG (Lambeth) Part A&B Voting
GP Governing Body Member NHS SEL CCG (clinical lead Lambeth Living Well Network Alliance)	SEL CCG (Lambeth) Part A&B Voting
GP Borough Clinical lead ,clinical lead Children and Young People Alliance)	SEL CCG (Lambeth) Part A&B Voting
Borough Lay Member	SEL CCG (Lambeth) Part A&B Voting
Cabinet Member for Children and Young People	Council Part A&B voting
Cabinet Member for Health and Social Care (job-share)	Council Part A&B voting
Strategic Director of Children's Services	Council Part A& B voting
Director of Public Health	Council Part A& B voting
Executive Director of Adult Social Care	Council Part A& B voting
Programme Director, Thrive	Lambeth Thrive Part A Voting
Director Integrated Care,	GSTFT Part A Voting
King's College Hospital Foundation Trust Executive lead rep – tbc	KCH Part A Voting
South London and the Maudsley NHS Foundation Trust rep - Interim Chief Operating Officer??	SLAM Part A Voting
Lambeth Patient Participation Group Network	Tbc Part A Voting
PCN Clinical Director and GP Clinical Cabinet representative	Lambeth PCNs Part A Voting
Managing Director, GP Federation	GP Federation Part A Voting
Chair Lambeth Local Medical Committee	LMC Part A Voting
CEO Age, UK Lambeth	Age Uk Lambeth Part A Voting
Programme Director - Lambeth Together (Neighbourhood & Wellbeing Delivery Alliance)	Part A (Non Voting)
Alliance Directors, Lambeth Living Well Network Alliance	Part A (Non Voting)

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Report to: Lambeth Together Strategic Board

May 2021

Report Title	Lambeth Together & Integrated Health and Care Assurance Report
Authors	Andrew Parker - Director of Primary Care and Transformation. Brian Reynolds – Associate Director Health & Care Planning and Intelligence Tom Barrett – Programme Lead, Lambeth together
Summary	The purpose of this paper is to provide, in one place, an integrated picture for assurance purposes of both our Lambeth together delivery alliances and programmes of work, and our Lambeth integrated health and care arrangements. This report has been developed over recent months, and will be further adapted and updated during the course of the year, as a consequence of Lambeth together developments, reporting against the integrated health and care business plan, and other changes within SEL CCG and ICS as necessary. The report will also be adapted to reflect the additional time and focus offered by the new Assurance group being established, which will sit beneath and report to the Lambeth Together Strategic Board and will strengthen our assurance oversight arrangements from early July. This report includes updates against key performance measures for each of the place based integrated health and care commissioning areas.
Recommendation(s)	The Strategic Board is asked to receive for information and consideration: • The latest version of the Lambeth integrated assurance report providing an update on progress against both our Lambeth together programmes, and our Lambeth integrated health and care commissioning areas.

Lambeth together & Integrated Health and Care

Assurance Report May 2021

Lambeth Together Strategic Board 26 May 2021

Contents

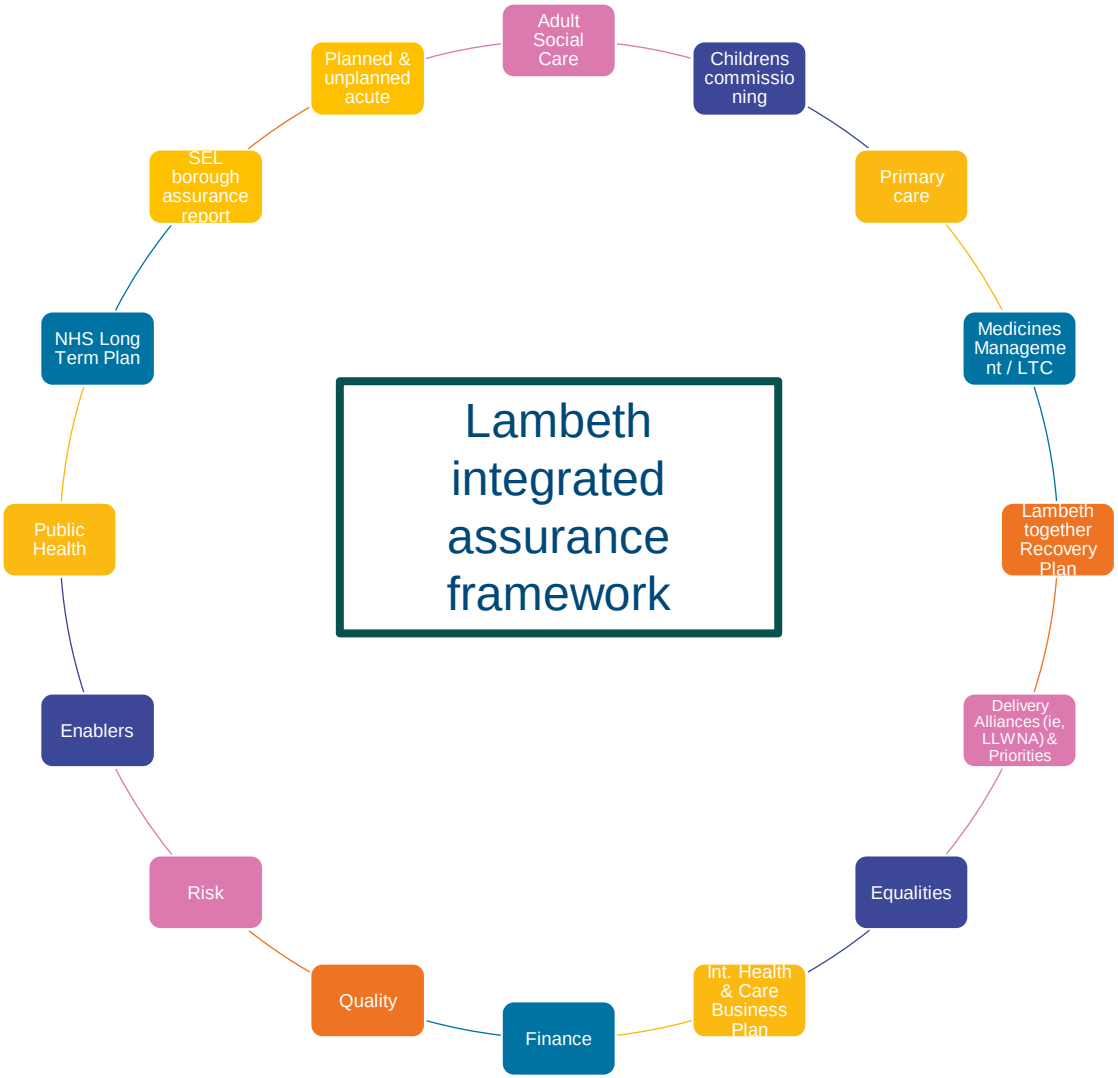
1. Executive summary

1.1 Introduction

- This report provides in one place an integrated summary of assurance across **Lambeth together** and **Lambeth integrated health and care** arrangements.
- This report does not seek to duplicate, but to draw upon existing assurance, performance or quality reporting arrangements, such as those within alliance and programmes boards
- This report's format and flow is structured along the lines of the LTSB, with a focus on **Lambeth Together delivery alliance and programmes**, and a focus on **Lambeth's integrated health and care responsibilities**.
- The report will be adapted over time, particularly in relation to the **development of equalities and outcome measures**. It will also reflect any changes to SEL CCG priorities, key policy changes and the development of the NHS planning guidance for 2021/22, and will also seek to report on progress against our programmes and the new integrated health and care business plan for 2021/22
- **A new assurance group** reporting directly to the Lambeth Together Strategic Board is being established, and will meet bi-monthly from early July. This will provided dedicated oversight and assurance on behalf of the board. Further details on these arrangements are described in the 'Lambeth Together governance and assurance review' paper, also presented at the LTSB meeting on 26 May 2021.

1.2 Source material:

- An extensive range of material exists to provide assurance for Lambeth together and Lambeth's integrated health and care arrangements. These are used to update each section of this integrated report.
- As such, there is some variety in the number and look of assurance measures, and the period to which it relates, although every effort is made to use the most current and visual information available.



2. Lambeth together programme highlights

2.1 Lambeth Together Programme Highlights

Director / lead	Andrew Parker, Director of Primary Care Development
Management Lead	Tom Barrett, Programme Lead, Lambeth together
Data source / period	Bi-monthly programme highlight reports x 7 / Enabler reports, May 2021 Lambeth Together Recovery Plan available here: https://lambethtogether.net/lambeth-together-draft-borough-covid-19-recovery-plan/

Lambeth Together alliance and programme summary highlight reports are enclosed in the following pages. These reports are produced every other month and provide a summary of key developments for each Lambeth together area, covering both the delivery alliances (highlighted with a red box) and key recovery plan priority programmes and supporting and enabling workstreams.

- Programme and recovery plan status
- Activity milestones and deliverables, including the Lambeth Living Well Network Alliance dashboard in section 2.3
- Enabling factors
- Alliance/recovery plan priority risks
- Alliance/recovery plan priority issues

Lambeth Together programme and borough recovery plan highlight report

This report represents the continued evolution and development of a structured approach to providing oversight, assurance and awareness of the range of transformation and delivery activity being undertaken in the integrated (i.e. delivered by multiple rather than single players) health and care system in Lambeth.

SRO	Andrew Eyres	**Programme Lead**	Tom Barrett	**Period**	March – April 2021	**Overall status**
Vision	**To improve health and wellbeing and reduce inequality for people in Lambeth**					Delivery across the alliance and recovery plan priorities has been good despite Covid-19 pressures and clear plans are in place for activity in the next period
Programme Description	Lambeth Together is a partnership of NHS, Council and voluntary sector organisations working together with local people and stakeholders to help our residents maintain their health and wellbeing and provide more joined up local health and care. This is a programme for the delivery of the covid-19 borough recovery plan, a range of delivery alliances (Living Well Network Alliance, Neighbourhood and Wellbeing Delivery Alliance, Children and Young People) and putting in place the enabling factors for an integrated approach to health and care at borough-level.					

Programme/recovery plan status 1/2

Programme/ Alliance	Overall RAG		DoT	Commentary
	Last Period	This Period	↑→↓	
Programme management	A	A	→	Work is continuing to bring together the previous Lambeth Together Alliance-focussed programme management and the delivery of the borough recovery with implications for the reporting and assurance framework. The governance review has been completed and reports to LTSB in May alongside the assurance review. Resource in the last period has been reprioritised to supporting the vaccination uptake programme.
Living Well Network Alliance	A	G	↑	Following an awayday, the Alliance is updating its Business Plan, reinvigorating its approach to Staying Well and addressing 21/21 finance position with a view to launching a Culturally Appropriate Peer Support and Advocacy (CAPSA) service and Staying Well. Alliance Workforce Development Programme now coming to the end, with System Leadership, Mentoring and Compassionate Leadership programmes delivered, Compassionate Care, Compassionate Champions and Equalities workshops due by the end of June.
Neighbourhood and Wellbeing Delivery Alliance	A	A	→	The response to Covid-19 and vaccination roll out has impacted the progress of NWDA's workstreams during Q3 & Q4 due to stretched capacity, reduced resource and workforce redeployment..However, workstreams have now started to resume with the EOLC project team holding a "Management Planning Workshop" and a refresh partner meeting. Outpatients workstream held a 'kick off' meeting to identify priority areas, data requirements and next steps. Prevention workstream (Thriving Communities) - Health Well being hubs is progressing in line with the project plan including innovative ideas such as a mobile health & Wellbeing hub

Red box denotes Delivery Alliance

↑	Better RAG than previous period	G	No deviation, plan is on track
→	Same RAG as previous period	A	Deviation is likely. Mitigation is being planned to remain on track
↓	Worse RAG than previous period	R	Deviation has occurred. Mitigation not planned or insufficient.

Lambeth Together highlight report – continued

Programme/recovery plan status 2/2

Programme/ Alliance	Overall RAG		DoT	Commentary
	Last Period	This Period	↑→↓	
Children and Young People	G	G	→	Establishment of the Children and Young People's integrated commissioning and delivery alliance board and associated workstreams. We are in the formation stages of this work at present with some of the workstreams further along than others.
Learning disabilities and autism and people with continuing complex needs	-	-		Learning Disability and Autism related complex need: programme is working with individuals, families and system partners to keep people safe through the current second and any future wave off Covid transmission: minimise any disproportionate impact of Covid on people on this population cohort; maximise as far as possible opportunities to realise their potential by promoting independence, participation and engagement with supportive services and the wider community.
Staying Healthy	A	A	→	The Staying Healthy commissioned services include weight management, stop smoking, and NHS Health Checks programmes. These services were paused during the first wave of Covid-19 but are now remobilised with a remote or digital offer. The stop smoking pharmacy service and NHS Health checks have now remobilised with a remote/digital offer but activity is yet to reach the same levels as previous years' performance. The weight management service has been able to recover lost ground by re-engaging those who had previously just started the programme and/or those who were put on the waiting list due to COVID.
Sexual Health	R	A	→	Due to the impact of Covid, any service improvement plans in Quarter 4 will have to be temporarily suspended. Sexual health services will focus on seeing extremely vulnerable patients and those with emergency needs.
Homelessness	-	-		Excellent progress to reduce rough sleeping within Lambeth; the vast majority of rough sleepers have now been supported into longer term housing. The vaccination programme across the hostel provision has now been completed. Additional grant funding through the RSI Year 4, to be announced shortly, enabling us to secure additional bed spaces to protect vulnerable rough sleepers and a pilot a Housing First provision. However eviction ban ends at the end of May, and the furlough ends in September 2021, which likely to increase homelessness; work is already underway to mitigate the impact
Assurance				'Assurance' is an integral part of Lambeth Together. To develop, and have in place integrated health and care assurance arrangements that provides insight and oversight of the Lambeth health and care agenda, including performance, finance, risk and quality.
Equalities, diversity and inclusion				Lambeth Together Equalities Group was formed to check and critique the health system in Lambeth. The group meets monthly and recently delivered a Board-level EDI development programme. Task and finish work is under development focussing on system-wide recruitment and retention and data.
Communication and engagement	A	A	→	Communications and engagement as and when required with Lambeth Together, both within key stakeholders and the wider public

↑	Better RAG than previous period	G	No deviation, plan is on track
→	Same RAG as previous period	A	Deviation is likely. Mitigation is being planned to remain on track
↓	Worse RAG than previous period	R	Deviation has occurred. Mitigation not planned or insufficient.

Lambeth Together highlight report – continued

Activity, milestones and deliverables 1/3

Programme	Activities, milestones and deliverables achieved this period	Activities, milestones and deliverables not completed	Activities, milestones and deliverables for next period
Programme management	• LTSB and LTEG supported • Governance review completed	• Develop approach to risk (c/f assurance) • Determine approach to delivery on enabling opportunities • Support to EDI group task and finish work	• Develop approach to risk (c/f assurance) • Determine approach to delivery on enabling opportunities • Support to EDI group task and finish work
Living Well Network Alliance	• Alliance Workforce Development Programme – all six System Leadership sessions having been delivered by the Leadership Academy, along with the Mentoring Programme and Compassionate Leadership • Staying Well prototypes continue • The SPA held its second listening event for service users and carers in March, which we have now increased frequency to monthly • The Alliance submitted a response to the MHA White Paper		• Compassionate Care and Compassionate Champions workshops in May • Staying Well evaluation of prototypes and next steps • Agree way forward for CAPSA and Peer Support • Set up group to implement Transformation Fund roles • Implement PCN MH Practitioner roles
Neighbourhood and Wellbeing Delivery Alliance	NWDA Leadership Group membership EDI review complete amended with added disability and resident representation **End of Life Care:** Outcome measures suggested. Data beginning to be collated related to outcome measures; Vision in final draft stage; Mgmt team planning workshop arranged to agree short, mid and long term objectives / next steps. **Prevention:** Programme Priorities paper proposed; Six areas agreed with Board; **Outpatients (Chronic pain):** Chronic Pain kick off meeting held; Priority areas and membership identified **Quality of Care Homes:** Next steps agreed incl Safe Steps app to be embedded into workstream & agreement to recruit to extensivist role **Loneliness Test & Learn:** Collation of learnings & associated methodology for Test & Learn projects; Evaluation completed for User Needs Analysis; Engagement Events held with residents and voluntary sector organisations; Outcome measures finalised. Next steps for project outlined; Breaking Barriers Project to understand the link between loneliness & unemployment / young BAME people rolled out	**Outpatients (Chronic pain)** • SRO to be agreed • Data to be collated. **Quality of Care Homes** • Workstream meeting still to take place: postponed Jan – Apr due to second wave of Covid-19. • Outcome measures to be established	**End of Life Care:** Outcome measures a KPIs agreed; Objectives finalised; T&F groups to resume incl. Data collated **Prevention (H&WB Hub programme)**: Prevention Thriving Stockwell report; Business Cases for priority areas in development (Gypsy Hill, Food Poverty / Insecurity and H&WB bus) **Outpatients / Chronic Pain:** Discussion re integration of 3 workstreams to share framework and project model; SRO to be agreed **Quality of Care Homes:** Look to recruit extensivist role; Arrange MDT-style meetings **Loneliness Test & Learn**: Primary care roll out of local interventions and next steps; Cohort data to be reviewed and baseline surveys to be held; Breaking Barriers stakeholder interviews underway

Red box denotes Delivery Alliance

Lambeth Together highlight report – continued

Activity, milestones and deliverables 2/3

Programme	Activities, milestones and deliverables achieved this period	Activities, milestones and deliverables not completed	Activities, milestones and deliverables for next period
Children and Young People	• TORs are finalised for board and 3x workstream • Community Health Chairs agreed – representatives from Evelina and Primary Care will lead this. • Emotional health and wellbeing needs assessment work, which will inform the delivery, is in final draft and will be discussed at meeting on 26 May. • Discussions with key stakeholders regarding emotional health and wellbeing – including Cllrs, Lead GPs and Black Thrive.		• Establish emotional health and wellbeing and Community Health workstream meetings – aim by June 2021. • Meet with community health chairs to scope out logistics, meeting rhythm. • Programme work to get the Early years group on track.
Learning disabilities and autism and people with continuing complex needs	• Worked with partners and providers to adapt our community service provision to ensure it is Covid-secure to maintain access for users and carers as far as possible guidance • Over 80% of people with LD living in residential care received first vaccination dose	• Ongoing work with SEL CCG to deliver Transforming Care Programme to ensure continued transfer of patients from long stay institutional to community settings • Implementation of local action plan to improve performance re LD Healthchecks including better use if digital systems and information sharing across health and care	• Ongoing - Intensive MDT approach to facilitating those who are due for discharge by 31/03/2021 • Ongoing - Work with two key providers that are creating new opportunities in care market for those transitioning from hospital setting • Webinar for GP practice staff on encouraging attendance at annual health checks – led by LD Nurse
Staying healthy			• Plan for recommendations from PHE report on inequalities • Review of health improvement programmes and Covid impact • Understand how best to deliver services to those not able, or not comfortable to access online platforms
Sexual health	• Online STI testing extended to symptomatic residents who are low risk, therefore not seen in clinic. • E-service now includes hormonal contraception • LSL Covid Impact Analysis for Sexual Health services, focusing on vulnerable groups and access points	• London-wide audit of sexual health clinic access during lockdown	• LSL Syphilis and Gonorrhoea Needs Assessment • NHS trust contract extensions • Citizen and patient engagement

Red box denotes Delivery Alliance

Lambeth Together highlight report – continued

Activity, milestones and deliverables 3/3

Programme	Activities, milestones and deliverables achieved this period	Activities, milestones and deliverables not completed	Activities, milestones and deliverables for next period
Homelessness and rough sleepers	• Vaccination programme for all hostel residents and rough sleepers has been completed with everyone who wanted a vaccine offered one. Engagement continues with those who have previously refused or did not attend appointments. • Good take up overall with estimated 60% of pathway vaccinated. Continuing to work with providers to engage frontline hostel staff who had previously refused the vaccine. • Pathway Manager post appointed to in Young Persons Pathway		• Rough Sleeping Initiative funding to be announced by week ending 14/05/21. Awaiting decision on extra posts and funding applied for • Two Rough Sleeper Accommodation Programme funded schemes mobilised providing 25 extra beds for Rough Sleepers. Housing First Programme launched for 10 Rough Sleepers • Bid for funding for Accommodation for Offenders submitted • Moving forward with recommissioning of Young Persons Supported Housing Pathway following Needs Assessment and Options Appraisal. Pathway Manager appointed and interviews scheduled for Project Officer and Bidding Officer. • Care Leavers Protocol established between Housing and Children's Social Care
Communication and engagement	• Promotion of Covid-19 vaccine and updated information • Political stakeholder briefings • Produced films, case studies & stories featuring local people, health & care staff to encourage vaccine uptake • Analysis, sharing and learning from Vaccine Survey • Information sessions and engagement events held with faith groups, vcs groups and community networkers • Support to inform and engage specific groups • Support to NWDA comms and engagement • Refresh of NWDA area on LT website and support to produce more public-facing content • Sharing of news and campaigns relating to alliances • Increasing Lambeth Together followers on Twitter • Increasing visits to Lambeth Together website as result of news stories and refreshed content	• None	• Continued activity to support vaccine uptake including • Support to pop-ups (LVS, mobile) • Vaccine news stories to LT and LBL websites and local media • Lambeth Talk summer edition – young people and the vaccine • Bitesize Bulletin weekly to political stakeholders, LTSB delivery partners • Launch of ICS vaccine facts resources and activity – radio, billboards, media, digital • Communications and engagement support to resumption/revisiting of LT Recovery Plan (alongside above)
Equality, Diversity and Inclusion	• Had first meeting, developed TOR, shared equalities plans and proposed training • Agreed focus on delivery of Board development programme, recruitment and data	• Development of response to BAME Covid impact report (Fenton Recommendations)	• Collate evaluation of EDI training providers from equalities group using survey response data • Develop a shared measurement tool • Establish recruitment and data working groups
Assurance	• Workshop held regarding finding a single framework • Further development of integrated assurance report	• Development of a sub committee or similar	• Completion of governance for assurance agenda

Enabling factors

Enabling Factor (see here for more detail)	What are the implications for programme activity across the range of enabling factors?
System leadership Driving improvement, innovation and transformation of services	• LT Executive group provides good opportunity for regular discussion and progression of the programme. Governance review has flagged system leadership development requirement once membership and engagement approach has been settled, utilising local care partnership funding from SEL CCG. The EDI working group has delivered the first of its Board development sessions. Resourcing of alliance (e.g. data and communications activity) or system-level (e.g. EDI group and population health management task and finish groups) activity continues to be a challenge and will require system leadership.
Asset-based places Engaging communities to support integrated health and social care	• Engaging with communities is a priority across Lambeth Together alliances (all), working groups (particularly equalities and communications and engagement) and within existing services/VCS (e.g. link workers/social prescribing) which brings with it risks of duplication and demand for rationalisation/understanding of activity across the system. • Understanding of the wider (system-wide) map of physical assets/estate is a demand arising at both borough-wide and ward-levels. As part of the Health and Wellbeing Hubs project work is underway alongside Thriving Stockwell to develop a local health and wellbeing asset and opportunity map.

Population approach incl. data and information sharing
Identifying and managing the health and care risks of the local population
	• Population health management working group is underway (programme lead: Amanda Coyle) and has agreed outputs. Next steps include:
	  • Explore wider senior management clarity of PHM approach including access to partner resources
	  • Continued engagement with PCN Clinical leads – Clinical cabinet discussion in the autumn
	  • Convene follow-up groups in May (reconvene full group 17 June) to drive clarity on the data assets & impact of PHM through exemplar projects
	  • Wider engagement with the NHSE/CCG, GSTT, KCH, SLaM to leverage PHM resource

Integrated workforce Health and social care professionals collaborating to provide care and support to individuals	• Integrated workforces are in place across alliance areas (e.g. CYPHP, Living Well Centres) and improving understanding and links across frontline workers is key priority within the council's emerging neighbourhood working programme. Workforce development has been identified as potential area of collaboration with local academic institutions.
Innovation, technology and digital Developing new ways of doing things and addressing digital exclusion	• Challenges also in relation to digital inclusion [opportunities to work more closely with the council on digital inclusion project?]
Joint commissioning Health and social care organisations collaborating and sharing responsibility for integrated care services	• Joint commissioning is core business of the Lambeth health and care system already albeit with different levels of maturity in different areas. There is strong engagement in Lambeth Together across the system. While joint commissioning is strong there remain opportunities to develop more mature joint corporate/enabling functions and better working across non-core health and care parts of the system (e.g. children's social care, education, housing).

Lambeth Together highlight report – continued

Alliance/recovery plan priority risks 1/2

RISKS		Impact			
Likelihood		Minor (1)	Significant (2)	Serious (4)	Major (8)
	Very Likely (4)	4	8	16	32
	Likely (3)	3	6	12	24
	Unlikely (2)	2	4	8	16
	Very Unlikely (1)	1	2	4	8

Summary of Top Risks

Risks where assurance is weakest – risk score is after mitigation

Lead	Prog.	Area	Risk Description	Risk Score	Actions / Assurance
DO	LDA & PCCN	Demand	People with challenging behaviour who are due for discharge in 2020/21 after being sectioned experience delays to discharge – main risk is provider market unable to accommodate their support	16	Work closely with key providers that will be providing support to a number of people due to be discharged to ensure they are safe and well resourced. Consider use of Community Discharge Grant for individuals that will benefit
AC/ DS/ SP	NWDA/ CYP/ LWNA	Workforce	Covid & continuing competing pressures for partners and stakeholders	12	
AC	NWDA	Workforce	Gap in diversity on Leadership Group board – no representation from disability groups	**12**	Leadership Group members finalised and agreed among partners with full representation including DASL.
JA	EDI	Operational	Kevin Fenton recommendation report not completed	12	Need to enable all members of the group to access the report.
BR	Assurance	Workforce	Impact of COVID and the de-scaling of governance arrangements reduces availability of representation to discuss and establish sub-committee, or equivalent assurance arrangement	**6**	Delivery alliance boards and other associated groups continue to meet to review issues such as performance, finance, and quality.

Alliance/recovery plan priority risks 2/2

RISKS		Impact			
Likelihood		Minor (1)	Significant (2)	Serious (4)	Major (8)
	Very Likely (4)	4	8	16	32
	Likely (3)	3	6	12	24
	Unlikely (2)	2	4	8	16
	Very Unlikely (1)	1	2	4	8

Summary of Top Risks

Risks where assurance is weakest – risk score is after mitigation

Lead	Prog.	Area	Risk Description	Risk Score	Actions / Assurance
SP	LWNA	Finance	Recovery Plan fails to deliver required savings leaving a significant cost pressure for the Alliance	12	Assurance Group driving plan. Programme Manager in place. Additional roles identified to help deliver savings in complex placements and transforming care. Procurement of block placements framework agreement increases ability to reduce contract values. £482k net placement savings in 2020/21 (equivalent to c.£750k in a full year).
SP	LWNA	Finance	Budget pressures lead to service closures and/or possible risk to the Alliance	12	Delivering savings in placements, identifying new savings and exploring what a break even budget would look like. All to be monitored by AMT, F&P and ALT on a monthly basis.
SP	LWNA	Finance	Failure to agree new risk share	12	Ongoing work in AMT, F&P and ALT to identify cohorts to track to represent a contained risk share
SP	LWNA	Finance	We fail to find savings to meet the estimated Lambeth revenue pressure from Douglas Bennett House.	12	A workshop with key clinical stakeholders has been held to discuss how this financial gap would be filled, which provisionally identified £5m of savings – although when probabilities were applied this left a gap of c. £0.5m. The Finance and Performance Group will be reviewing DBH proposed savings in more detail.

Lambeth Together highlight report – continued

Alliance/recovery plan priority issues

Issue severity	Description	Issue Severity	Description
Critical	Issue will stop project progress.	Medium	Issue impacts the project, but could be mitigated to avoid an impact on budget, schedule or scope.
High	Issue will likely impact budget, schedule or scope.	Low	Issue is low impact and/or low effort to resolve.

Summary of Top Issues					
Ref	**Prog.**	**Area**	**Issue Description**	**Impact**	**Actions**
1	LDA & PCCN	Demand	Potential to exacerbate health inequalities - re prevalence of key long term physical and mental health conditions due to 'missed' opportunities to prevention, identification and early intervention through uptake of LD health screens.	Med.	Action plan currently being developed for full roll out during Q4 2020-21 to include communication and engagement with population cohort; quality improvement programme and support with General Practice and health partners; action to improve data capture including interface between primary and secondary care.
2	LDA & PCCN	Demand	JCVI advice now recommends covid vaccination for all people aged 16+ on the LD GP register	Med.	GP led roll out of vaccinations to those on the LD register has begun. Community and family engagement will be ramped up
3	Staying Healthy	Operational	Reduced activity and capacity at pharmacy stop smoking service	Med.	Specialist service engaging additional clients
	Staying Healthy	Operational	Reduced number of NHS Health Checks	High	Alternative methods of service provision (e.g. telephone consultation) and targeted services for most vulnerable population.
7	Staying Healthy	Operational	CQC and HMIP thematic inspection of community-based drug treatment and recovery work with probation service users	High	Public Health working closely with commissioned substance misuse services and other stakeholders to prepare, including briefing packs, review of needs date, etc.
8	Sexual Health	Demand	Increased rate of syphilis and gonorrhoea diagnoses locally, with increased gap between Lambeth and London averages	High	LSL Syphilis and Gonorrhea Needs Assessment to understand population groups most affected and identify best practice interventions.
9	Sexual Health	Operational	HIV Prevention and Sexual Health promotion outreach work to MSM paused during Covid restrictions	Medium	Online targeted work and provision of condoms through home delivery

Lambeth Together highlight report – continued

Strategic/system risks and issues (work in progress)

		Impact			
Likelihood		Minor (1)	Significant (2)	Serious (4)	Major (8)
	Very Likely (4)	4	8	16	32
	Likely (3)	3	6	12	24
	Unlikely (2)	2	4	8	16
	Very Unlikely (1)	1	2	4	8

Draft Top Programme Risks (where assurance is weakest)			
Ref	**Risk Description**	**Risk Score**	**Actions / Assurance**
	The financial position of one or more partners, or one or more alliance, results in an inability to deliver programme outcomes		[needs completing]
	Organisational change and churn threatens the development of relationships, trust and leadership in the system		[needs completing]
	System leadership is not focussed and short-term demands are prioritised over Lambeth Together work		[needs completing]
	Failure to effectively engage including with Lambeth's diverse communities		[needs completing]
	Covid-19 results in the redirection of resource away from Lambeth Together activity		[needs completing]

Issue severity	Description	Issue Severity	Description
Critical	Issue will stop programme progress.	Medium	Issue impacts the programme, but could be mitigated to avoid an impact on budget, schedule or scope.
High	Issue will likely impact budget, schedule or scope.	Low	Issue is low impact and/or low effort to resolve.

Top Programme Issues			
Ref	**Issue Description**	**Impact**	**Actions**
	Workstream resourcing		

2.2 Equalities indicators

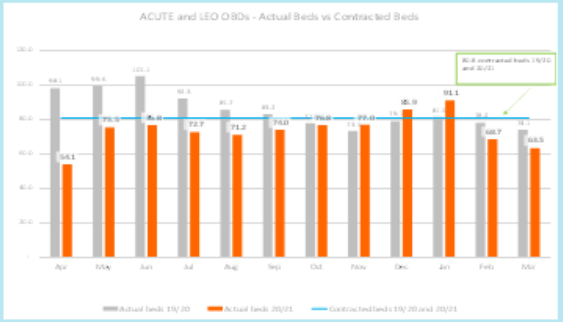
Equalities

- Reducing equalities is fundamental to our ways of working and ambitions as described within Lambeth Togethers work, delivery alliances, Recovery Plan and programme approaches.
- There are a number of key equalities indicators already included within this report, for instance Severe Mental Illness health checks, Adults with Learning Disabilities health checks, and public health indicators, but the equalities and diversity group and each alliance and programme area will also be considering what existing or new indicators need to be developed that would help inform this report and its assurance.
- The Lambeth Together Equalities Diversity and Inclusion programme is also considering how data and indicators can support the EDI programme and delivery alliances through the development of a shared measurement tool, and the establishment of recruitment and data working groups.

2.3 Alliance Dashboard Highlights

Director / lead	**Sabrina Philips, Alliance Director, Lambeth Living Well Network Alliance**
Management Lead	Guy Swindle, Deputy Director, Lambeth Living Well Network Alliance
Data source / period	Lambeth Living Well Network Alliance Performance Dashboard, Month 12 March 2021

In-patient Beds (Acute)



Key Indicators	Target	Actual
Number of beds used in month	80.8	63.5
Number of private occupied bed days (OBDs) used in month	0	116
Number discharged with length of stay >100 days/ >200 days	n/a	4/1

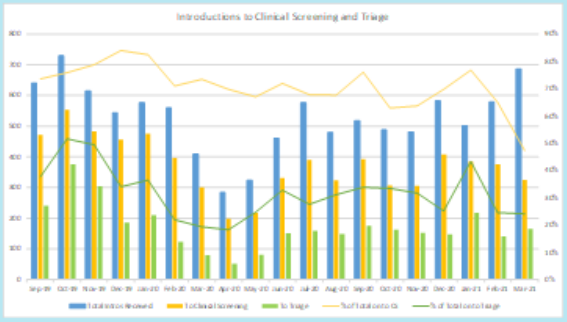
Narrative: Another decrease in Acute OBDs in M12 (Lambeth CCG registered patients only). There were 116 acute private overspill OBDs in M12, this was by far the highest level seen in 20/21. 9 long-stay patients were discharged this month.

Crisis Pathway

Key Indicators	Number
St Thomas A&E Referrals	334
AMHP referrals	160
AMHP assessments	118
AMHP detentions	98

Narrative: A&E Liaison numbers increased by 63 in M12 and were at the higest level since November last year. There were 28 more AMHP referrals in M12, and 28 more assessments. Detentions increased by 22 this month.

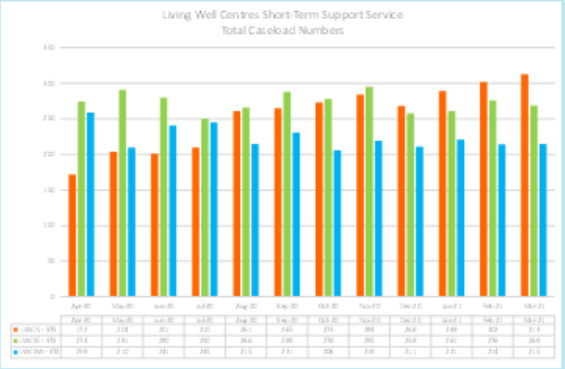
Single Point of Access



Key Indicators	M7	M8	M9	M10	M11	M12
Number awaiting admin screening	93	171	180	88	141	334
Admin screened, not clinically screened	14	6	53	11	90	43
Clinically screened, not yet triaged	39	45	24	64	47	48
Total number awaiting referral	146	222	257	163	278	425

Narrative: In M12 SPA introductions were highest since Oct-19 averaging 30/day. Admin backlog down to 237 @ 17-Apr-21 with support from clinical screeners and other overtime, hence downturn in % clinically screened.

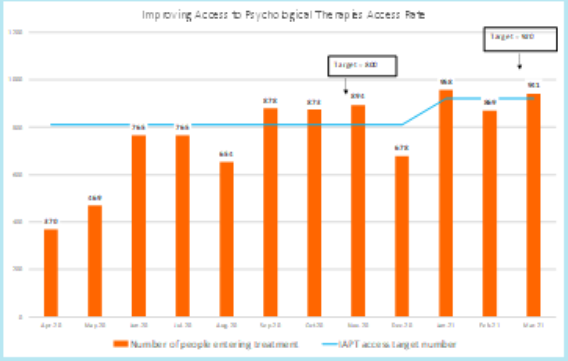
Living Well Centre Activity



Key Indicators	Last Mth	This Mth
Short Term Support – Total Referrals	175	217
Short Term Support – Total Caseloads	793	797
Focused Support – Total Referrals	52	38
Focused Support – Total Caseloads	959	950

Narrative: 42 more Short Term Support (STS) referrals in M12, 14 fewer Focused Support (FS) referrals. Small changes to caseload levels in both teams this month.

IAPT



Key Indicators	Target	Actual
Access Rate	920	941
Recovery Rate	50%	55%

Narrative: Monthly access recovered in M12 surpassed target, following a fall M11. Note M11 target does not account for there being fewer working days in the month. In daily terms M11 access was higher, at 43.5/day against the 41/day of M12. Recovery rate in M12 was 59% (against target of 50%) sustaining the high rate of recovery seen in M11 .

Finance and Risk

Alliance Member	Cost Item	Total £000s
SLAM	Pick up of SLAM overspend	0
Council	Pick up of Council overspend	1,632
	Total amount picked up	**1,632**

Main overspend areas (>£100k over budget)	M12 Year End Overspend £000s	Change from M11 ↑ = worse ↓ = better £000s
Complex Placements (SLAM - IPSA)	1,458	↓ 8
Residential Care (LBL) – £174k additional temp. Covid budget	919	↓ 193
Nursing Care (LBL) – actual income less than forecast	406	↑ 64
Low Intensity Team (SLaM)	281	↓ 9
SLAM residential and supported living placements	270	↓ 21
Community Support (LBL) – £5k additional temp. Covid budget plus one-off income	176	↓ 198
Lambeth Home Treatment Team (SLaM)	174	↑ 39
Single Point of Access	142	NEW
Community Forensic Team (SLaM)	124	↑ 5

Key Risks

- **Finance Pressures** – savings plan and risk share being agreed
- **Covid-19** - contingency plans in place to keep services open
- **SPA Backlogs** – staff issues have led to increased backlogs
- **DBH** – Alliance implications if SLAM fails to find savings to meet increased costs of Douglas Bennett House

2.3 Alliance Dashboard Highlights - continued

The other delivery alliances will continue to report progress against key activities and priority areas through the Lambeth Together Programme Highlight Reports in section 2.2. Over time, as with the LWNA, the other delivery alliance will be developing outcome monitoring dashboards and these will be included here in section 2.3.

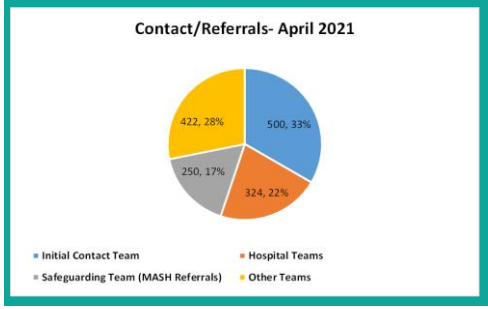
3. Integrated Health and Care assurance summary

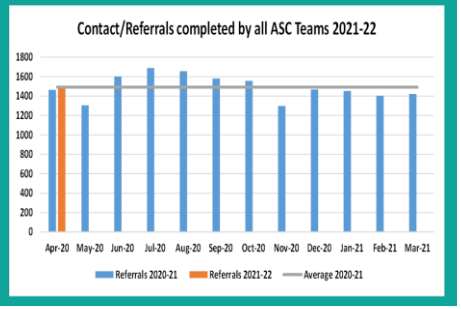
3.1 Adult Social Care

Director / lead	**Fiona Connolly, Executive Director Adult Social Care**
Management Lead	Richard Outram, Deputy Director Adult Social Care
Data source / period	Mellissa Murphy, Service Improvement Lead – Adults and Health, London Borough of Lambeth. April 2021

Overall Contact/Referrals completed by all teams

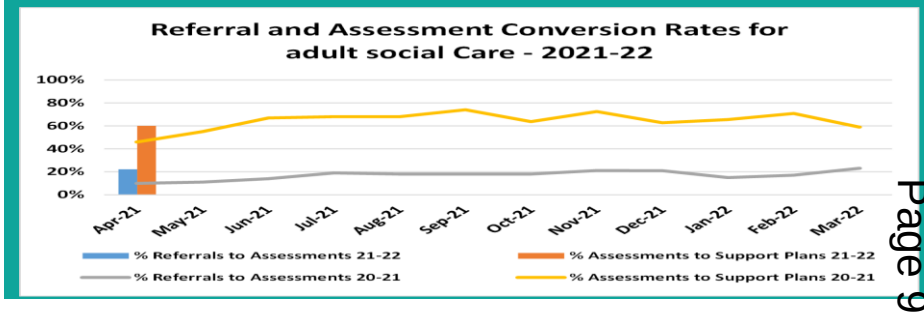
- A total of 1,496 Contact/referrals in April.
- Increase of 73 (5%) from previous month.
- 299 (14%) were raised as Safeguarding Concerns. This is a 4% decrease from the previous month





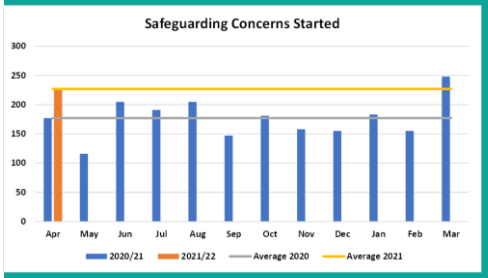
Overall Contact/Referral and Assessment Conversion Rates

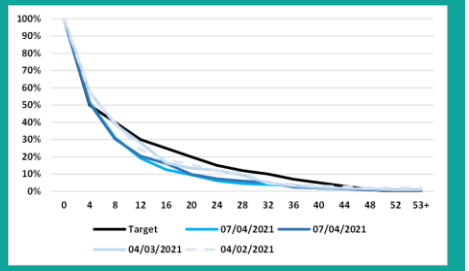
- Conversion rates from contact-referrals to assessments has decreased in April from 23% to 22%.
- Conversion rates for Assessments to support plans have increased from 59% to 60% in April.



Safeguarding Information

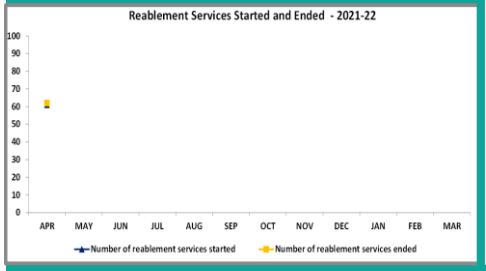
- The number of cases started in April have decreased from the previous month but still remains significantly above the same period in the previous year.
- There are 3 (1%) open safeguarding cases for 12 months or more.

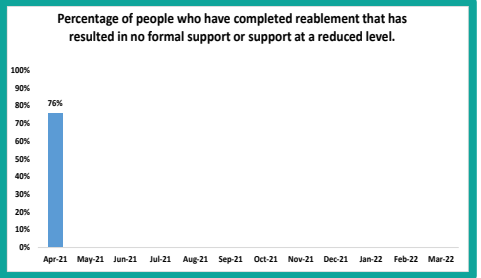




Reablement

- The numbers of reablement services provided in April have increased and returned to similar activity levels before the Covid-19 pandemic.
- The outcome of people completing reablement at a reduced level or no support was 76% in April. This is a slight decrease from the previous month.

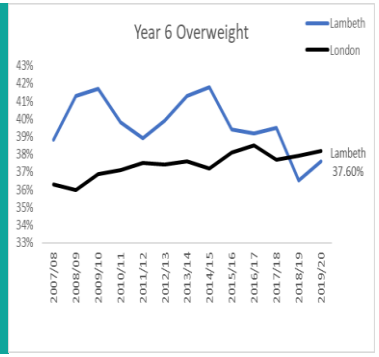




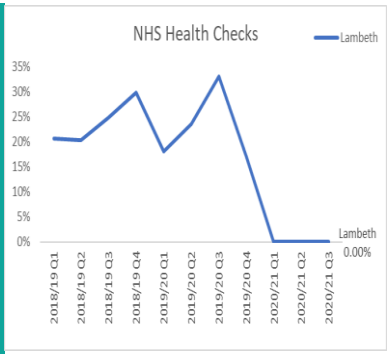
3.2 Public Health

Director / lead	Ruth Hutt, Director of Public Health
Management Lead	Ruth Hutt, Director of Public Health
Data source / period	Vince Wakfer Head of Business and Performance Public Health Data: Fingertips and Service Monitoring

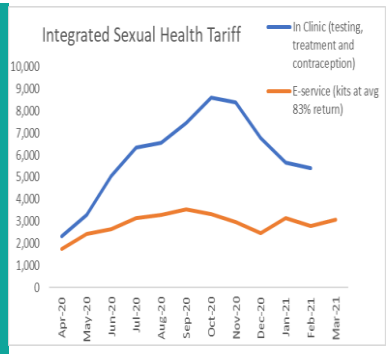
Year 6: prevalence of overweight
For 2020/21, national data collection has been impacted by the Covid pandemic. Services have continued virtually, and are currently in process of undertaking 2021/22 NCMP for 10% of Lambeth schools. This lower participation, due to Covid, may impact on data quality for future reporting.



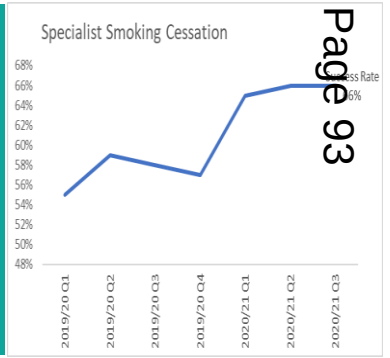
NHS Health Checks
NHS Health Checks were severely impacted by COVID19 but remobilisation and alternative arrangements were developed. All possible activity to focus on high CVD and diabetes risk, and targeted at BAME, with opportunistic HC by telephone or video call where capacity allows.



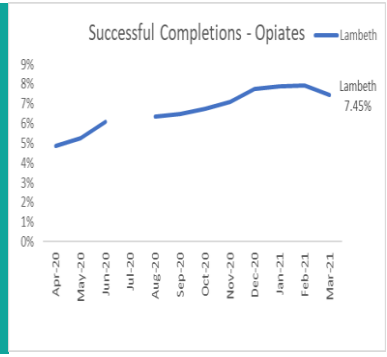
In Clinic and E-Service STI Testing & Treatment and Contraception
STI testing has increased since introduction of SHL e-service in Jan 2018. Online STI tests now available to symptomatic people due to Covid, with likely even higher rates of STI testing in 2021. As always, our local sexual health services at GSTT and KCH also test for STIs.



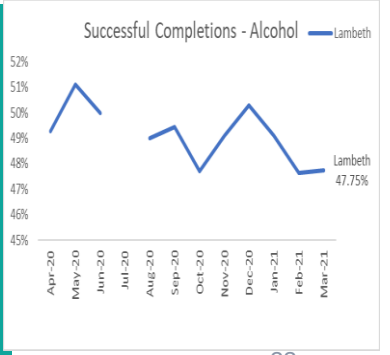
Success Rate at Smoking Cessation Services
Stop Smoking services were paused during first wave of COVID-19 but have now resumed via a remote (telephone) or digital (online) service. Increasing numbers of smokers looking to quit are accessing our digital stop smoking services and quit rates remain very high.



Successful completion of drug (opiate) treatment
The Lambeth Drug & Alcohol Treatment consortium also operate an open-door policy to clients, allowing for the exit and re-entry to treatment programmes. Throughout 2020-21, the consortium have continued to facilitate the provision of community based treatment and support via Lorraine Hewitt House, and preserved service user access to opioid substitution treatments and needle exchange via Pharmacy and GP Shared Care.



Successful completion of alcohol treatment
Alcohol treatment completions remain better than the regional and national average. According to the Global Drug Survey, 48% of people increased their drinking during lockdown. In addition to preserving access to community based treatment and support programmes throughout lockdown, in 2020-21 Lambeth's digital site Drink Coach saw 3,355 users complete an audit to assess their current level of alcohol consumption and receive brief advice, a 114% increase on the previous year.



3.2 Public Health (Covid)

Director / lead	Ruth Hutt, Director of Public Health
Management Lead	Ruth Hutt, Director of Public Health
Data source / period	Data: Local Contact Tracing

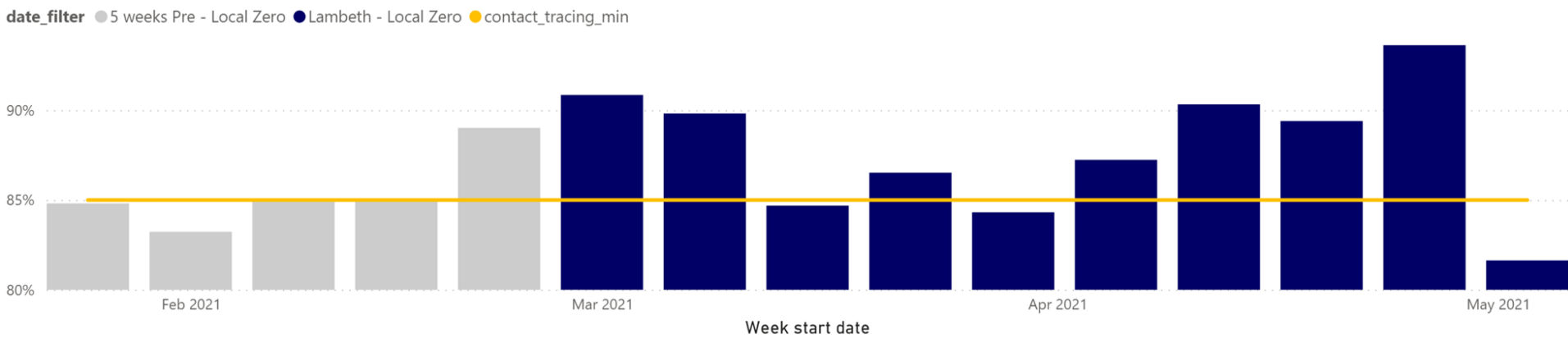
Covid Contact Tracing

- 49 cases received in this week (ending 14th May), this is the slight increase on cases from previous week but remains low
- Trend to a lower completion rate has continued but a single case makes this difference due to small numbers
- The caseload included 5 international travellers, 2 remain open at the advice of Intl travellers team - both had a door knock, 2 completed including a VUI at LCRC request, 1 was reached but not completed.
- Three cases reached but not completed 2 confirmed that they were self-isolating, and one was part of household where the spouse who had also tested positive did complete. One was uncooperative.
- There have been 10 referrals to specialist team this week (25% of actionable), This often assists in informing local situations and enables Specialist team to advise schools, workplaces or neighbouring DPH informed if the case attends an out of borough school.
    - There have been 3 referrals of cases to the Stay Home Safely service during this week
    - Anecdotally, age range of cases decreasing, few elderly in our caseload - one this week (85yrs) thought due to prior infection

01 03 2021 - 02 May 2021

772	3.36
Total	Contacts per case
0 Uncontactable	91 Failed
88%	
cases_completed_%	

Number of CTAS cases



3.3 Childrens Commissioning

Director / lead	**Abi Onaboye, Director of Children's Commissioning and Community Safety**
Management Lead	Dan Stoten, Integrated Associate Director - Children's Commissioning
Data source / period	SLaM 4 boroughs Community Performance Report March 2021, Lambeth Council Pentana May 2021, SEL Borough Based Report May 2021

Overweight and obese children Year 6

- Lambeth's performance is similar to the London average, although data quality across other London areas has been poor. Services have continued virtually, and are currently in process of undertaking 2021/22 National Child Measurement Programme for 10% of Lambeth schools. This lower participation is a result of Covid pandemic. Data (February 2021) indicates Lambeth's rate has risen to 37.6% in 2019/20 from 36.5% in 2018/19.

Mental Health

- Average waiting time for CYP to access first CAMHs assessment appointment Service within the Trust (Face to Face, Video, Phone)

- Average wait time for second appointment (treatment)

Eating Disorder Service

- Referrals received (includes all referrals received by SLaM from referring GP (in borough) and includes referrals which were rejected when reviewed by the service.

2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4	2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4
14	9	17	14	13	14	31	19

Childhood immunisations in primary care

- The borough performance has in Quarter 3 2020/21 across a number of the six-in-one vaccination rates (compared with the London average)
  - Children receiving DTaP/IPV/Hib % at 12 months: 83.8% (London average 85.8%)
  - Children receiving DTaP/IPV/Hib % at 24 months: 90.5% (89.9%)
  - Children receiving DTaP/IPV/Hib % at 5 years: 89.3% (91.4%)

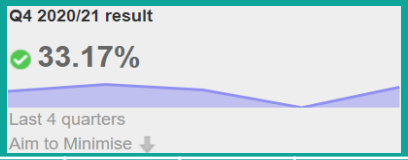
- MMR performance for Quarter 3 2020/21 (compared with the London average).
  - Children receiving MMR1 at 24 months: 78.7% (82.3% London)
  - Children receiving MMR1 at 5 years: 86.1% (88.8%)
  - Children receiving MMR2 at 5 years: 77.9% (74.1%)

Maternity

- There is typically a delay in the service provider (Evelina London) gathering this data and figures for recent months Jan– Mar are slightly lower as a result. A refresh will be requested mid year. It is anticipated that the annual figure will show a slight increase. Prevalence of breast-feeding at 6-8 weeks from birth: 2020/21 73% against target of 70%, and 69.3% in 2019/20.

Domestic Violence

- The proportion of cases heard at MARAC which were repeat cases has increased to 33% in Q4 2020/21 from 23% in Q3. SafeLives sets the best practice national repeat target at 28-40%: this recognises that nationally, victims of domestic abuse will experience multiple incidents before finding safety – accordingly our target is set at 34% and in Q4 we returned to within this target range.



2018/19 Q4	2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4	2020/21 Q1	2020/21 Q2	2020/21 Q3
33.33%	35.51%	29.45%	30.56%	31.06%	34.44%	31.47%	22.65%

3.4 Primary and Community Care

Director / lead	Andrew Parker, Director of Primary Care Development
Management Lead	Garry Money, Associate Director Primary and Community Care
Data source / period	NHS South East London CCG non-acute performance report April 2021

Learning Disability and Autism

- The learning disabilities (LD) health check scheme is one of several GP enhanced services in the Quality and Outcomes Framework (QOF). Enhanced services are voluntary reward programmes covering primary medical services; one of their main aims is to reduce the burden on secondary care services.
- The NHS Long Term Plan states that the Learning Disability Annual Health Check target for 2020/21 is 67%. Lambeth has historically performed higher than this, and at year end the Latest figures, after adjustments, show Lambeth has achieved a target of 78% which exceeded the 2019/20 achievement of 71%.
- Against the backdrop of the everchanging challenges of the past year as a result of the pandemic this is good news for Practices and for people with learning disabilities.
- Planning is currently underway to ensure we maintain this momentum for 2021/22 in tandem with ongoing activity to maximise uptake of Covid-19 vaccination amongst patients on GP clinical LD register.

Covid Vaccinations – primary care

- Primary Care LVS and pop-up clinic sites have contributed greatly to the successful borough Covid-19 vaccination delivery programme. Snapshot figures using NIMS Dashboard data as at 04 May indicates that over 121k vaccinations have been administered by Lambeth PCNs.
- Work is continuing via the dedicated Lambeth Vaccine Hesitancy Group on a wide range of initiatives to increase uptake across the boroughs diverse population e.g. mobile units, grassroots community champions, and targeted work with vulnerable patient groups such as those living with Severe Mental Illness, Homelessness or Learning Difficulties.

CQC Ratings – May 2021

- Of the 41 Practices within Lambeth, CQC has rated them as
  - 38 overall rated Good
  - 2 overall rated Requires Improvement
  - 1 is brand new and yet to be rated.
- As a result of the pandemic CQC have not been carrying out any inspections (whether on site or virtually) over the last year. However, CQC is now beginning to resume site inspections and will be prioritising inspecting the 'Requires Improvement' GP practices.
- Further detail is available online at Care Quality Commission (cqc.org.uk)

Flu

- Outturn figures for 2020/21 are still begin finalised and are expected by early June, and will be included once approved. The latest reported figures against the main categories are:
  - 65 years and over: 64.7%
  - Aged 16-65 and at risk: 41.9%
  - All pregnant women: 38.4%
  - Children 2years old: 44.2%
  - Children 3 years old: 45.9%
- The targets were previously 55% but ambitions were increased nationally to 75% across all eligible groups

- As some of the primary care measures are included elsewhere ie, SMI physical health checks contained within the Adult Mental Health chapter, these are not duplicated here.
- Over time indicators will be reviewed, for instance to develop measures related to outcomes, equalities and to staff wellbeing.

3.5 Medicines Management / Long Term Conditions

Director / lead	Jane Bowie, Director of Integrated Commissioning (Adults)
Management Lead	Vanessa Burgess, Chief Pharmacist, Associate Director Integrated Commissioning (Long Term Conditions)
Data source / period	Medicines Management (Lambeth), NHS South East London CCG non-acute performance report May 2021

Medicines Management schemes

- Reporting on this is currently in development, and will include:
  - Providing updates by way of data reporting via primary care information against key metrics for medicines optimisation, LTC optimisation, anticipatory care and relevant parts of the premium specification.
  - Written updates for any exceptions.
  - Narrative on broader system developments, eg. Pharmacy workforce planning, community pharmacy integration, digital solutions for prescribing and medicines.

- This will be coordinated together with what needs to be reported via the Alliance, as well as Lambeth Together board.

3.6 Planned and Unplanne Care

Director / lead	**Jane Bowie, Director of Integrated Commissioning (Adults)**
Management Lead	Jo Keats, Associate Director, Planned and Unplanned Care
Data source / period	NHS South East London CCG Performance and Assurance Reports. Link to report if available:

Cancer / early Diagnosis

- There is a significant lag on cancer screening reporting so we do not yet know the impact COVID has had on screening performance. According to the latest available data from February 2020, Lambeth is not meeting the screening targets for bowel, breast and cervical screening and is also the worst performing borough in all areas apart from Cervical Cancer Coverage (25-49 cohort.
- SEL boroughs are supporting the implementation of both national and local programmes to increase uptake rates, however securing sufficient practice and patient engagement was a challenge, even before COVID.
- SEL Cancer Alliance have a pilot to increase uptake of referrals for lung
- Cancer National Screening pathways Improving uptake locally for breast, cervical and bowel FIT screening. Supporting PCNs/practices to increase uptake through education sessions and providing information on support tools and guidance.
- Cancer support to PCNs/practices to understand and implement the Cancer Early Diagnosis DES and QOF providing education sessions, guidance and support tools to ensure systems such as safety netting, patient support are in place.
- The cancer screening programmes continue to be supported to increase uptake with media campaigns and a YouTube video has been developed for breast screening.
- Education and training sessions have been provided for practices and PCNS by the Macmillan GP and CRUK facilitator .
- Lambeth have submitted three Cancer Business proposals to the SELCA Cancer Business Planning funding. Outcome is TBC.

NHS continuing healthcare

- The borough is required to ensure no more than 15% of CHC assessments take place in an acute setting. Currently Lambeth for Quarter 4 2020.21 ,like all boroughs in SEL had zero assessments taking place in an acute setting which is very positive.

Out of Hospital Plan

- Transformation of services due to impact of Covid-19, in ensuring shielded patients and Covid-19 positive patients receive the appropriate clinical care. Working collaboratively with PCNs, Lambeth GP Federations, GSTT (Acute & Community) and KCH DH.

Healthy Weight Tier 3 Programme

- The HWP Tier 3 monthly meetings commenced 26 April 2021
- The scheme has adapted to triage patients and offer a range of activities such as virtual group work and 121 work.
- Lambeth data for April 2020-February 2021 accepted 311 referrals and rejected 108. 262 are booked for group sessions and 140 patients are on the waiting list.

Referral management

- Consultant Connect – Consultant Connect SDEC service went live Sept 2020.
- 31 Lambeth practices have used the service and there have been 388 referrals to the service over the last 12 months (May 2020 to May 2021. This also includes the Acute Medicine line which was set up middle May 2020. This provides a direct line to the team to provide advice which is why the number of calls has increased.

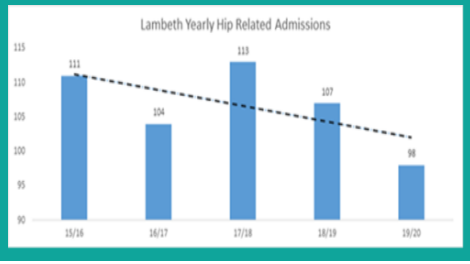
Urgent and Emergency Care

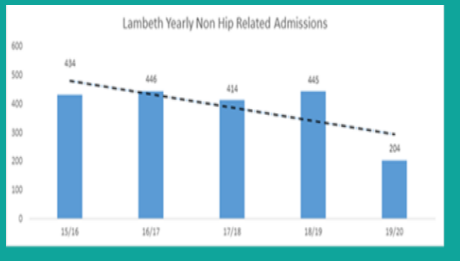
- Lambeth and Southwark Urgent & Emergency Care Board co chaired by the Hospital Trust and CCG ensures mutual accountability focusing in Urgent & Emergency Care, to share best practice, mutual aid as well as monitor A&E performance and leading on recovery
- The Lambeth and Southwark Urgent & Emergency Care Board oversees;
  - System planning and discharge process
  - Winter Planning and Winter Resilience
  - Winter Assurance
  - Deployment of Winter Monies

Injuries from falls in people aged 65 and over

Injuries from falls in people aged 65 and over

- In Quarter 2 2019/20, Lambeth is not achieving the sex-age standardised rate of emergency hospital admissions with a rate of 2,380 per 100,000 compared to the national position of 2,059.
- Introduction and roll out of early intervention and prevention of falls via the large scale exercise programme, developed during Southwark and Lambeth Integrated Care (SLIC) programme – essential to this is the service provides direct access for residents as doesn't need to be via physiotherapy.





Commissioned services for independent sector

- Insert key message here.

3.6 Planned and Unplanned Care – continued

Director / lead	Jane Bowie, Director of Integrated Commissioning (Adults)
Management Lead	Jo Keats, Associate Director, Planned and Unplanned Care
Data source / period	NHS South East London CCG Performance and Assurance Reports. Link to report if available:

Personal Health Budgets

- SEL provided 2,068 PHBs in 2020/21 which was below the annual target of 2,463. Progress to implement a number of initiatives to improve performance in 2020/21 were delayed due to the COVID-19 pandemic but these will be implemented at the start of 2021/22.
- Lambeth achieved 396 against a target of 467.
- The SEL PHB lead is supporting boroughs to implement the personalisation agenda and expand their PHB provision with an on-going focus on wheelchair users and mental health service users. SEL will also be exploring ways of expanding provision for people with learning disabilities through the care treatment review process.
- The personal wheelchair budgets offer will be restarted across SEL and more PHBs for mental health service users will be introduced through the South London Partnership.

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Number of PHBs at month 12 2020/21							
Year end target – 2021	338	483	419	467	386	370	2,463
Cumulative year end actuals - 2021	371	481	520	396	85	215	2,068

Adults Learning Disability / Transforming Care (LDA) Programme

- Continue to progress vaccine and Annual Health Check uptake in line with drive to reduce health inequalities. Improve synergies between the AHC and vaccination programmes and ensure operational streamlining
- LDA Programme - Currently 18 adult inpatients with 11 due for discharge within 6 months. LDA Manager recruited and now in post with focus on preventing admission. Ongoing provider development including scoping enhanced care and support
- Coburg Crescent, new development of supportive living, respite and day service due to open November 2021
- Initial planning to assess potential scope for Learning Disability and Complex Needs partnership to be instigated over the coming months.

3.7 Adults Mental Health

Director / lead	Jane Bowie, Director of Integrated Commissioning (Adults)
Management Lead	David Orekoya, Associate Director Integrated Commissioning-Mental Health
Data source / period	NHS South East London non-acute Performance Report, April 2021.

SMI Physical Health Checks

- The NHS has committed to ensuring 60% of people on the SMI register receive a full and comprehensive physical health check.
- Lambeth reported a performance of 23.3% in Quarter 3 2020/21. As with other boroughs in SEL CCG this is significantly below the 60% target. Achievement of the target for 2020/21 remains high risk.
- The Covid-19 pandemic has had a negative impact on the ability of primary care to deliver physical health checks for people with serious mental illness. Recent guidance from NHSE/I reiterated the importance of improving performance and London region is developing a schedule of supporting measures to assist primary care in making improvements against the standard.
- will actively engage with the regional work and this should lead to a collective approach to managing SMI physical health checks across SEL and improved performance. Additional funding has been secured to implement improvement plans.

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Proportion of people on the SMI register receiving a comprehensive physical health check in the last 12 months (Q3 2020/21) – target 60%							
% patients receiving check	27.6%	10.7%	14.3%	23.3%	19.1%	33.3%	21.7%
Trend since last quarter	+8.1%	-0.1%	-2.7%	-0.9%	-3.9%	+2.9%	-0.3%

Improved Access to Psychological Therapies

- Lambeth has traditionally performed very well across the range of IAPT measures. 2019/20:

	Standard	Lambeth
		h 2020
IAPT Access Rate - rolling three months	5.50%	5.64%
IAPT Recovery Rate - rolling three months	50%	57.0%
IAPT Waiting Times 6 Weeks	75%	95.0%
IAPT Waiting Times 18 Weeks	95%	100%

- From April 2020 some providers are no longer using the old CCG codes which means borough level performance data is not available. The SEL IAPT Performance Team have arranged monthly performance meetings with providers, which monitor improvements against agreed plans. As of Jan 2021 Lambeth had the highest recovery rate of 55.9% in SEL.

IAPT 2nd appointment waits

- The current IAPT waiting time standards measure waiting times from diagnosis to starting treatment (i.e. first treatment) and mandate that 75% of patients start treatment within 6 weeks and 95% within 18 weeks.
- As at January 2021 Lambeth remains the top performer at 93% in SEL.

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
First to Second Treatment within 90 days Rolling 3 months (January 2021)							
Current month	85.4%	64.6%	86.2%	93.0%	78.9%	83.3%	84.1%
Trend since last month	↑	↓	↑	↓	↓	↓	↔

4. Quality summary

4.1 Quality highlights

Director / lead	Leads for the 7 priority areas, lead providers & commissioners
Management Lead	Cheryl Smith, each of the leads for the 7 priority areas, lead commissioners
Data source / period	SEL Quality Report, Highlight reports x 7 / Enabler reports. Link to reports if available:

Summary

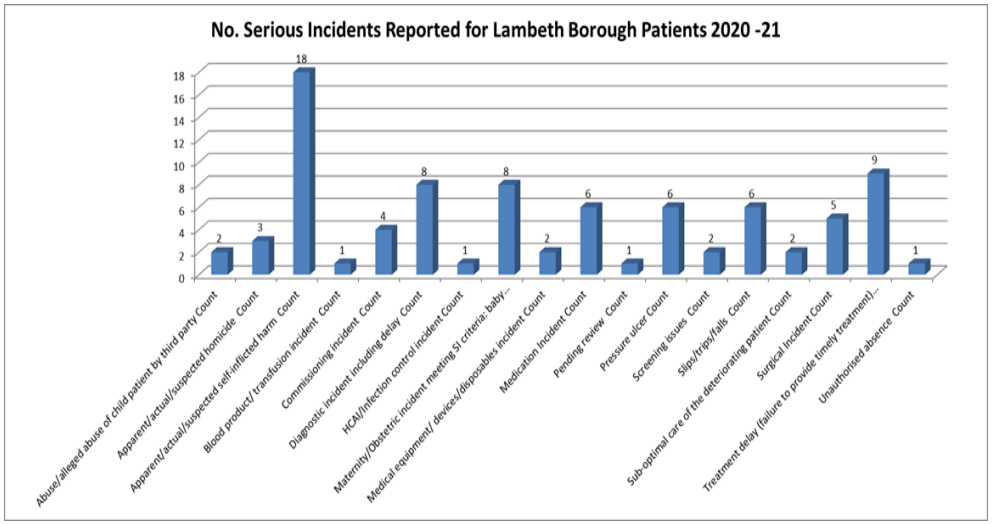
- Also included in papers for the LTSB 26 May meeting is a brief quality report for Lambeth. That report provides a summary of what was presented to the Quality and Safety Sub Committee on 15 April 2021.
- The Quality Assurance and Quality Improvement functions of the CCG have been significantly scaled back during the Covid pandemic and from January 2021 will be reduced further as staff are redeployed to support the pandemic response. The Quality Team has prioritised the Quality Alerts and Serious Incident systems and these will continue to operate in the weeks ahead. All other quality assurance functions have been stood down, although a small team has been retained to respond to emerging quality crises.
- A small group within Lambeth met in late-February to review the quality inputs that can be used to bring through headlines into this report, and it was agreed to conduct a mapping exercise of the meetings and networks and to meet again to discuss.

Quality alerts

- At present, each Borough collects and collates alerts differently with some using a reporting system and some excel spreadsheets.
- The SEL is in the process of implementing Datix IQ which will ensure all data is collected in a systematic way and assist on reporting and monitoring.
- The data also demonstrates the disparity in the level of engagement across the SEL by GPs.
- The Quality team will be undertaking an exercise to improve Primary Care engagement with the launch of Datix.
- These will be summarised and included here for Lambeth in future iterations.

Serious Incidents

- Weekly reports are in place.
- An Annual Report for Serious Incidents showed that there had been no reduction in the number of Serious Incidents reported during the pandemic.
- During 2020/21 the CCG was informed of 85 Serious Incidents affecting Lambeth patients (13% of the total). A count of Serious Incidents by type in Lambeth in 2020/21 and for April 2021 is shown below.
- The four most frequently reported Serious Incidents for Lambeth in 2020/21 were:
  - Apparent/actual/suspected self harm (18)
  - Treatment delays (9)
  - Maternity (8) and Diagnostic delays (8)



5. Risks summary

5.1 Risks highlights

Director / lead	leads for the 7 priority areas, lead commissioners
Management Lead	Cheryl Smith, Tom Barrett, each of the leads for the 7 priority areas, lead commissioners
Data source / period	SEL BAF, Highlight reports x 7 / Enabler reports. Link to reports if available:

Datix
- Training ongoing for Risk Owners and Sponsors
- Working with the Datix team to improve the content of available reports

Lambeth Risk Register
- Risk register finalised and forms part of the Lambeth Together Strategic Board papers
- First round of reviews are almost complete

Risk Forum
- The last Risk Forum was held in March. Items discussed at this meeting included:
    - Quality of reports available
    - Risks for possible escalation
    - Possible removal of IT risk from Lambeth Risk Register (South East London Risk Register contains very similar risk)

6. Finance summary

6.1 Finance highlights

Director / lead	Andrew Eyres, Strategic Director: Integrated Health and Care
Management Lead	Pete Hesketh, Assistant Director Finance, LBL, Edward Odoi Associate Director Finance NHS South East London CCG
Data source / period	Lambeth Council Finance and Performance Report, South East London CCG Finance Performance Report.

2020-21 Lambeth Borough (SEL CCG) Financial Outturn

- At Month 12 the borough is reporting an underspend of £563k against its 2020-21 delegated budgets. Within the reported position are underlying pressures on Continuing Healthcare and prescribing services which were mitigated by non-recurrent flexibilities and underspend in other budget areas.

2021-22 H1 (Q1&Q2) Lambeth Borough (SEL CCG) Financial Plan The 2021-22 H1 (Q1&Q2)

- Lambeth delegated budget (**£84,219K**) is based upon a roll forward from 2020/21 H2 with further adjustments required to apply agreed 2021/22 uplifts. Whilst the CCG's H1 2021/22 financial plans deliver a balanced financial position, there are significant uncertainties, risks, and opportunities for the CCG in H1 including the delivery of the £6.1m savings. The borough is expected to contribute its share of the savings through a combination of non-recurrent and recurrent savings. Details of the financial arrangements for the second half (H2) of 2021/22 not yet confirmed.

2020-21 Lambeth Council

- Adult Social Care and Public Health reported a near breakeven position of a £104k overspend against its budgets for 2020-21. However, within this net position there were significant amounts of unbudgeted income and expenditure relating to the COVID-19 pandemic. Increases in expenditure were mainly related to: higher costs on packages of care for high numbers of people discharged from hospital; payments to care providers for one-off fee increases the council made to support the market; payments to care providers for government schemes such as the Infection Control Fund; COVID-19 specific expenditure on items such as PPE; costs associated with supporting people that are Clinically Extremely Vulnerable; and costs associated with the new Test and Trace service and other testing initiatives. These extra costs were funded from a variety of income streams including the NHS discharge scheme, grant funding for specific schemes and grant funding to meet the pandemic costs more generally.

2021-22 Lambeth Council

- Funding is based on a roll forward from 2020/21 with adjustments made for agreed savings and increases in resources that have come in the form of government grants for social care and other growth that the Council has funded. There is financial uncertainty due to the impact of the pandemic. There is expected to be an underlying overspend of £0.7m-£1m based on pre-pandemic trends in client numbers and costs that do not relate to the pandemic. There are higher expected costs in 2021/22 for people discharged from hospital under COVID measures in 2020/21 but it is not known at this stage whether this will have a long-term impact on the client base and lead to a higher underlying overspend going forward.

Annex

A1 Glossary

This glossary will be developed as the framework is populated with assurance material

Acronyms and abbreviations	Term	Acronyms and abbreviations	Term
AHC	Annual Health Check		
BAF	Board Assurance Framework		
CCG	Clinical Commissioning Group		
CHC	Continuing Healthcare		
H1	Half 1, referring to the first 6 months of the financial year, April - September		
H2	Half 2, referring to the first 6 months of the financial year, April - September		
ICS	Integrated Care System		
KPI	Key Performance Indicator		
LBL	London Borough of Lambeth		
LWNA	Lambeth Living Well Network Alliance		
SEL	South east London		
SMI	Severe Mental Illness		

South East London Clinical Commissioning Group

ENCLOSURE:

AGENDA ITEM:

Lambeth Together Strategic Board

DATE: 26th May 2021

Title	S75 Agreement 2020-21	
This paper is for **noting**		
Executive Summary	Section 75 (S75) of the National Health Service Act 2006 contains powers enabling NHS organisations to exercise certain local authority functions and for local authorities to exercise various NHS functions. Lambeth Borough Council (LBL) and NHS Lambeth Clinical Commissioning Group entered into a S75 agreement to utilise those powers with a commencement date of 1st July 2018 and an initial term ending 31st March 2021. On 31st March 2020 NHS Lambeth Clinical Commissioning Group dissolved and its rights and obligations under the agreement transferred to the NHS South East London Clinical Commissioning Group with effect from 1st April 2020. Both parties wished to vary the agreement to reflect minor changes to governance, certain contractual arrangements, and to record the 2019/20 and 2020/21 budget allocations. The documents revised to reflect those amendments were presented to the Lambeth Together Strategic Board on 24 March 2021 and Board members endorsed signature.	
Recommended action for the Committee	To note signed S75 variation as attached.	
Potential Conflicts of Interest		
Impacts of this proposal	Key risks & mitigations	
	Equality impact	*Please consider both the Health Inequalities act & PSED (see guidance)*
	Financial impact	*Is there a financial cost/ gain? Has this been agreed with finance?*

Which corporate objective does this item link with? (please mark the relevant line with an x in the right hand box)	1: To ensure we commission services which meet the health and wellbeing needs of the population and reduce health inequalities	X
	2: To work in partnership to maintain and improve the quality of our commissioned services, and ensure all safeguarding protections are in place	X
	3: To enhance collaborative working with other health and care organisations to develop and deliver an effective ICS – able to deliver national, ICS and local objectives - with our population at the centre	X
	4: Strengthen our partnership working and develop a culture which embraces lessons learned and surfaces and embeds best practice	
	5: To secure the active participation and visibility of patients and local people, including from diverse and seldom heard groups, in the planning and design of local services	
	6: To ensure that clinical leadership is embedded in our ways of working and our change programmes including the involvement of member practices and system partners	
	7: Develop an organisation and workforce capable of delivering the CCG's objectives and ensure members of the organisation feel valued and enjoy coming to work.	
	8: Ensure that the CCG meets its commitments with regards financial and performance improvement, maintains effective governance within the organisation and across partnerships, and optimises progress against the delivery of NHS constitutional standards	X

Wider support for this proposal	Public Engagement	*N/A*
	Other Committee Discussion/ Internal Engagement	
Author:	Jane Bowie, Director Integrated Commissioning (adults)	
Clinical lead:		
Executive sponsor:		

DATED 1st April **2020**

THE MAYOR AND BURGESSES OF THE LONDON BOROUGH OF LAMBETH

and

SOUTH EAST LONDON CLINICAL COMMISSIONING GROUP

DEED OF VARIATION OF s75 AGREEMENT

THIS DEED is made on 1st the day of April 2020

BETWEEN:

(1) **NHS SOUTH EAST LONDON CLINICAL COMMISSIONING GROUP** of 160 Tooley Street, London, SE1 2TZ (the '**CCG'**)

and

(2) **THE MAYOR AND BURGESSES OF THE LONDON BOROUGH OF LAMBETH,** Lambeth Town Hall, Brixton SW2 1RW ('the **Authority**')

(each a 'Party' and jointly 'the Parties')

RECITALS:

(A) Section 75 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) (the "Act") contains powers enabling NHS Bodies (as defined in section 28(6) of the Act) to exercise certain local authority functions and for local authorities to exercise various NHS functions.

(B) The Authority and NHS Lambeth Clinical Commissioning Group entered into an agreement ('the Agreement') in exercise of those powers under section 75 of the Act and pursuant to the Partnership Regulations 2000 with a commencement date of 1st July 2018 and an initial term ending 31st March 2021.

(C) On 31st March 2020 NHS Lambeth Clinical Commissioning Group dissolved pursuant to a determination made under s14H of the National Health Service Act 2006 (the 'NHS Act').

(D) By a property transfer scheme made by the National Health Service Commissioning Board under s14I of the National Health Service Act 2006, NHS Lambeth Clinical Commissioning Group's rights and obligations under this Agreement have transferred to the NHS South East London Clinical Commissioning Group (the 'CCG') with effect from 1st April 2020.

(E) By operation of the said property transfer scheme NHS Lambeth Clinical Commissioning Group is substituted in this Agreement with effect from 1st April 2020 by NHS South East London Clinical Commissioning Group.

(F) The Parties now wish to vary the Agreement to reflect minor changes to governance, certain contractual arrangements, and to record the 2019/20 and 2020/21 budget allocations.

(G) The Authority and the CCG have agreed to vary the Agreement as set out in this Deed.

IT IS AGREED as follows:

1. DEFINITIONS AND INTERPRETATION

1.1 The words 'the Agreement' mean the agreement entered into between the Authority and NHS Lambeth Clinical Commissioning Group in exercise of powers conferred by section 75

of the Act and pursuant to the Partnership Regulations 2000 with a commencement date of 1st July 2018 (but including the April 2018 – March 2019 financial year), and which is with effect from 1st April 2020 an agreement between the Authority and NHS South East London Clinical Commissioning Group as successor body to NHS Lambeth Clinical Commissioning Group.

2. VARIATIONS

2.1 The Agreement is varied with effect from 1 April 2020 as particularised in the attached document marked 'Appendix A'.

2.2 The Parties acknowledge that no consideration is given for the variations particularised in Appendix A, hence they are agreed by way of Deed.

3. SEVERABILITY

The provisions of this Deed are intended by the Parties to be severable in the event that any part of it is held to be illegal or unenforceable (in whole or in part) and such part shall not affect the validity and enforceability of the remaining provisions or the remainder of the affected provision under this Deed.

4. AUTHORITY AND COSTS

Each Party undertakes that it has full power and authority to enter into and shall be responsible for its own costs arising in relation to this Deed.

5. THE CONTRACTS (RIGHTS OF THIRD PARTIES) ACT 1999

This Deed is not intended to create any benefit, claim or rights of any kind whatsoever enforceable by any person who is not a party to this Deed. Accordingly, the Parties confirm that no term of this Deed is enforceable under the Contracts (Rights of Third Parties) Act 1999 by a person who is not a party to this Deed.

6. GOVERNING LAW AND JURISDICTION

The Parties agree that this Deed and any dispute arising under or in any way connected with the subject matter of this Deed (whether of a contractual or tortious nature or otherwise) shall be governed by and construed in accordance with the laws of England, and the Parties submit to the jurisdiction of the English Courts.

EXECUTED AS A DEED on the next page by the Parties or their authorised representatives the day and year first above written

EXECUTED as a Deed by affixing the)
Common Seal of the **Mayor & Burgesses of the**)
London Borough of Lambeth in the presence of)

Michael O'Hora

DocuSigned by:
Michael O'Hora
D8E0141CE94649C...

Sealed By: The Mayor and Burgesses of The London Borough of Lambeth
Sealed Time: 4/13/2021 12:05:03 AM PDT

EXECUTED as a Deed by **South**
East London Commissioning Group acting by Andrew Bland)

Accountable Officer and Usman Niazi, Chief
Financial Officer as its authorised)
signatories)

Authorised Signatory

Authorised Signatory

APPENDIX A - SCHEDULE OF VARIATIONS

1 DEFINITION AND INTERPRETATION

Delete definition of **Authority's Authorised Officer**

Delete definition of **CCG's Authorised Officer**

Add new definition:

Joint Authorised Officer: the individual named in Clause 23.2.

23 GOVERNANCE

Clause 23 is substituted with new Clause 23:

23.1 The CCG and the Authority shall have a Joint Authorised Officer with effect from 1 April 2020 who shall be the main point of contact for the CCG and the Authority and shall be responsible for representing the CCG and the Authority's in connection with the Partnership Arrangements.

23.2 The Joint Authorised Officer shall be Andrew Eyres, but the CCG and the Authority may at any time agree in writing to appoint a different officer to act as Joint Authorised Officer.

23.3 The Joint Authorised Officer shall be responsible for referring matters to the Committee in Common for a decision, unless they indicate that the decision is one that may be taken by the Integrated Director for Adult Services or the Integrated Director for Children Services, as the case may be, or which must be referred to their respective Governing Body.

23.4 The Parties shall each appoint officers to the Integrated Programme Board in accordance with the terms of reference set out in Appendix 1.

23.5 The Governance arrangements set out in this clause 23 and Appendix 1 shall be subject to review 6 months from the Commencement Date.

23.6 Any changes which are necessary following that review, including the inclusion of additional services and the establishment of additional committees, shall be subject to the Change Process as set out in Schedule 11.

26 COMMISSIONING RIGHT TO CHALLENGE

Sub-clauses 26.2(d) – (e) are substituted with new sub-clauses 26.2(d – (e)):

26.2(d) the Authority shall consult with the Joint Authorised Officer in determining its response to the Relevant Body;

26.2(e) the Authority shall promptly notify the Joint Authorised Officer where a decision is made that may affect the Services;

38 CONFLICT OF INTEREST

Clause 38.1 has a new sub-clause 38.1.3:

38.1 The Parties acknowledge that circumstances in which a conflict of interest may arise include, but are not limited to, the following:

38.1.1 when the private interests of an Integrated Programme Board Member or Post Holder conflict with the interests of the Non-Employing Party in the context of the Arrangements (a "Private Interest Conflict");

38.1.2 when the duties of an Integrated Programme Board Member or Post Holder arising under or in connection with the furtherance of integrated working conflict with the duties owed by that Integrated Programme Board Member or Post Holder to the Appointing Party (an "Integrated Working Conflict").

38.1.3 when the duties of the Joint Authorised Officer conflict or may conflict with the duty owed by him to either the CCG or the Authority in his function as officer of the CCG or the Authority as the case may be.

Integrated Working Conflict

New Clause 38.8A is added:

38.8A In the event that a conflict of interest arises within the meaning of Clause 38.1.3 the Joint Authorised Officer shall arrange for the CCG and the Authority respectively to nominate an alternative officer to represent them as temporary Authorised Officer in connection with the matter in which the conflict of interest arises.

41 DISPUTE RESOLUTION

Clause 41.4 is deleted.

Clause 41.5 is substituted with new Clause 41.5:

41.5 If the meeting(s) referred to in Clause 41.3 do not resolve the matter in question then the matter shall be referred to the CCG's Chief Officer and the Authority's Chief Executive, who shall meet in order to resolve the dispute within 3 days of such referral. Such meeting(s) shall

be conducted in such manner and at such venue (including a meeting conducted over the telephone) as to promote a consensual resolution of the dispute in question.

SCHEDULE 9 Exit Strategy

Schedule 9 is substituted with:

1. Before considering withdrawal from the service, the Committee in Common will discuss the merits of continuing or discontinuing the Agreement with the Joint Authorised Officer. The Committee in Common may invite the Joint Authorised Officer to the Committee in Common meeting to discuss options if required.

2. Should either Party give notice to terminate this Agreement, the Committee in Common will consider the withdrawing Party's reasons for the withdrawal and determine any necessary arrangements.

3. The Committee in Common will agree an exit strategy for the Agreement which ensures appropriate service continuity and safe service delivery to the Service Users of contracted services both before and after the notice is effective.

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South East London Clinical Commissioning Group

Lambeth Together Strategic Board

DATE: 26 May 2021

Title	**Month 12 Finance Report**	
This paper is for **discussion**		
Executive Summary	This paper sets out the CCG's financial position as at month 12. At the time this report was produced, the overall surplus for 2020/21 was £488,000. This is as detailed in the attached report. This position is consistent with the draft Annual Accounts presented to the Audit Committee at its meeting on 22 April. Subsequent to the report being written, the CCG has received notification of an additional "top up" allocation of £599,000. This will be reflected in the final version of the draft Accounts and will increase the CCG's year-end surplus from £488,000 as highlighted in this report to £1,087,000. This allocation relates to central CCG/Covid-19 expenditure and therefore there will be no impact upon the borough positions included in this report. The final version of the draft Annual Accounts was submitted by 27 April in line with the national timetable. The deadline for submission of the final, audited Annual Accounts is 15 June.	
Recommended action for the Board	The Board is asked to **NOTE** the financial position at month 12.	
Potential Conflicts of Interest	N/A	
Impacts of this proposal	Key risks & mitigations	Financial risks and mitigations are set out in the Finance Report
	Equality impact	N/A
	Financial impact	The Finance Report sets out the CCG's financial position
Wider support for this proposal	Public Engagement	N/A

	Other Committee Discussion/ Internal Engagement	The monthly Finance Report is presented at all relevant CCG meetings and Committees.
Author:	Usman Niazi, Chief Finance Officer	
Clinical lead:	N/A	
Executive sponsor:	Usman Niazi, Chief Finance Officer	

NHS
South East London
Clinical Commissioning Group

SEL CCG Finance Report

Month 12 2020/21

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1. Executive Summary

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At a glance position at Month 12

Month 12 represents the final month of the revised financial arrangements that came into operation in October 2020, covering the final 6 months of 2020/21. This follows the operation of temporary financial management processes during the first 6 months of the year as the NHS focused on its response to the first wave of the Covid-19 pandemic. **As previously reported the CCG received all requested retrospective funding in full for Months 1-6, generating an overall break-even position for this period.**

At Month 12 the CCG is reporting an underspend against its (BAU) budgets of £1.17m (0.03% of allocation), and is reporting a £0.68m overspend against its Covid-19 budgets. The Covid-19 position relates to expenditure on Covid Vaccinations (£524k), Flu Vaccinations (£88k) and Asylum Seekers (£68k). These are all Covid-19 vaccination related and are allowable overspends. **Therefore, overall the CCG is reporting an underspend of £0.49m against its 2020/21 resource limit.** Any additional Covid-19 funding received before the draft annual accounts are submitted would generate an increase in the year-end surplus position.

The Covid-19 Hospital Discharge Programme (HDP) has incurred a further £4.46m of expenditure in Month 12 (compared to the £3.07m spent in Month 11). This relates to the continuation of HDP expenditure, with spend of £3.15m on Scheme 1 (discharges from March to August) and £1.31m on Scheme 2 (which covers the cost of patients for the first 6 weeks of discharge from September whilst assessments are undertaken). The position includes a final correction to HDP1 relating to prior month costs following the receipt of further information from Local Authority colleagues. The financial risk relating to pausing CHC assessments during the final quarter of the year (to enable staff to be redeployed), has been reported against the CCG's overall financial position. From the 1st April, HDP1 has ceased to operate, although funding relating to HDP2 will be phased out over the first 6 weeks of 2021/22. The final value for HDP expenditure was in line with the forecast made at month 11.

At Month 12 (based on Month 10 PPA data), the prescribing price variance has risen in month to a cumulative 5.1% increase for the year. However the activity impact has reduced again in month, with the number of items prescribed showing a cumulative reduction of 2.1%. In addition, in-month the CCG received flu funding from NHSEI (£0.5m above plan) which contributed to an overall improved position on the prescribing budget.

2. Financial Position

South East London Clinical Commissioning Group

- The table below sets out the CCG's financial position for the period to Month 12.

Headline Financial Performance

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCGs (Non Covid)	Covid-19	Total SEL CCGs
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Expenditure Position										
YTD Total Budget	119,980	209,006	162,622	172,259	137,230	132,934	2,451,114	**3,385,144**	89,192	**3,474,336**
YTD Total Expenditure	119,530	208,092	162,233	171,696	136,480	132,002	2,453,943	**3,383,975**	89,872	**3,473,848**
YTD In Year Total Surplus/ (Deficit)	451	913	388	563	750	932	(2,829)	**1,169**	(680)	**488**
YTD Expected Retrospective Allocation										-
YTD In Year Revised Surplus/ (Deficit)										-
YTD Planned In Year Surplus										-
YTD Variance against planned in year Surplus/ Control Total										-
YTD Variance against planned in year Surplus/ Control Total %								**0.03%**		**0.01%**
Previous Month YTD Variance before adjustment	**550**	**613**	**168**	**205**	**516**	**631**	**(2,683)**	**0**	-	-

- In-month the CCG is reporting a £1.17m underspend against its normal BAU programme budgets, with a £680k overspend against Covid-19 related expenditure. This generates a net overall year-end underspend of £0.49m or 0.01% of overall allocation. Any additional Covid-19 funding received before the draft annual accounts are submitted would generate an increase in the year-end surplus position.

- For the 2020/21 financial year, the CCG has received retrospective allocations totalling £71.50m relating to Covid expenditure and a further £20.19m for non-Covid spend. The non-Covid allocation enabled the CCG to break-even for the Months 1-6 period, and this funding was used at a top level except for CHC, Mental Health and Prescribing where specific adjustments were made to bring budgets into line.

3. Budget Overview

South East London Clinical Commissioning Group

Month 12

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCGs (Non Covid)	Covid-19	Total SEL CCGs
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Variance										
Mental Health Services	(299)	(189)	60	(23)	(144)	(293)	(219)	**(1,109)**	(162)	**(1,270)**
Continuing Care Services	102	734	(0)	0	286	260	(890)	**492**	-	**492**
Prescribing	429	158	126	(418)	454	188	244	**1,182**	-	**1,182**
Contracts Team	-	-	-	-	-	-	(429)	**(429)**	-	**(429)**
Other Acute Services	(73)	(156)	3	162	(113)	175	1,964	**1,963**	-	**1,963**
Other Community Health Services	(75)	318	(334)	240	8	2	750	**908**	(9,936)	**(9,028)**
Other Primary Care Services	250	(96)	(15)	74	342	197	(1,887)	**(1,136)**	(2,849)	**(3,985)**
Other Programme Services	69	(43)	45	118	(70)	46	(3,948)	**(3,783)**	(481)	**(4,264)**
Delegated Primary Care Services	(95)	(273)	(339)	(288)	(331)	91	33	**(1,202)**	90	**(1,112)**
Corporate Budgets	144	459	843	698	319	267	1,552	**4,281**	12,658	**16,939**
Total Year to Date Variance	**451**	**913**	**388**	**563**	**750**	**932**	**(2,829)**	**1,169**	**(680)**	**488**

Month 11

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCGs (Non Covid)	Covid-19	Total SEL CCGs
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Variance										
Mental Health Services	(252)	(176)	4	102	(54)	(275)	0	**(652)**	(155)	**(806)**
Continuing Care Services	177	581	(497)	(389)	69	(4)	(0)	**(63)**	(87)	**(150)**
Prescribing	(228)	7	194	(455)	13	266	0	**(203)**	-	**(203)**
Contracts Team	-	-	-	-	-	-	1,192	**1,192**	-	**1,192**
Other Acute Services	37	(19)	313	-	-	0	(0)	**331**	-	**331**
Other Community Health Services	312	291	(55)	46	(168)	(79)	(51)	**295**	(4,934)	**(4,639)**
Other Primary Care Services	256	(294)	(58)	61	342	333	(1,008)	**(368)**	(1,737)	**(2,105)**
Other Programme Services	(53)	(57)	89	54	(47)	181	(4,115)	**(3,947)**	(766)	**(4,713)**
Delegated Primary Care Services	66	(194)	31	(99)	26	(12)	436	**253**	158	**410**
Corporate Budgets	234	474	147	885	336	223	864	**3,163**	7,520	**10,683**
Total Year to Date Variance	**550**	**613**	**168**	**205**	**516**	**631**	**(2,683)**	**0**	**0**	**0**

Overview:

The table alongside shows the budgetary positions against the individual boroughs and directorates. As funding has been received to cover the months 1-6 position, these variances are focused on months 7-12 only.

- The CCG has received funding to cover the costs of Covid HDP in full. The overspend on Covid-19 relates to expenditure on Covid Vaccinations (£524k), Flu Vaccinations (£88k) and Asylum Seekers (£68k). These are all allowable areas of spend. Any additional Covid-19 funding received before the draft annual accounts are submitted would generate an increase in the year-end surplus position.
- The prescribing position contains a price pressure relating to the present Covid-19 environment which is partially offset by a reduction in activity. This position is built off month 10 data. Following a review of prescribing budgets and spend, together with confirmation of flu funding, the overall position has moved to a £1.2m underspend at year-end.
- The Continuing Healthcare position has been adjusted in month to reflect the impact of the HDP provision relating to the pause in CHC assessments. The CCG has funded this position through non recurrent flexibilities and therefore all boroughs are reporting breakeven or better.
- The Mental Health overspends in Bexley, Bromley, Lewisham and Southwark are due primarily to high cost patients. This is a known pressure and has been mitigated by underspends elsewhere in borough budgets.
- The end of year position on Corporate Budgets reflects the vacancy rate seen in local boroughs and central teams since the start of 20/21. This position has helped to mitigate pressures elsewhere within borough budgets. Overall, corporate budgets were underspent by £4.3m.

4. Covid-19

South East London Clinical Commissioning Group

As at Month 12:

- The CCG is reporting in-month expenditure of £11.35m in response to the Covid-19 pandemic. For the year, the CCG has now incurred total expenditure of £89.87m.

- The main driver to these costs has been the hospital discharge programme (HDP) where £56.39m has been spent, including a further £4.46m in-month - £3.15m on Scheme 1 (discharges from March to August) and £1.31m on Scheme 2 (which covers the cost of patients for the first 6 weeks of discharge from September whilst assessments are undertaken). The in-month position for HDP 1 includes a one-off adjustment following a review of their cost base by Local Authorities. The CCG has received funding in full from NHSEI for HDP spend.

- In addition, the CCG has incurred additional Covid-19 vaccination costs during March of £0.68m, relating to expenditure on Covid Vaccinations (£524k), Flu Vaccinations (£88k) and Asylum Seekers (£68k). These are all Covid-19 related and are allowable overspends.

- The remaining areas of spend have increased in-month, with non HDP expenditure of £6.16m incurred. This includes £1.0m reported against primary care in relation to the GP Capacity Expansion Fund. The CCG's overall budget for month 7 to 12 Covid expenditure is £12.7m. Against this the CCG has committed the funding in full.

Month 12

	Other CCG Revenue	CCG Revenue	Primary Care	Hospital Discharge		Grand Total
				LA	CCG	
Bexley	0	2,451,048	346,154	9,131,000	136,304	12,064,506
Bromley	0	4,400,069	467,660	2,838,000	2,530,000	10,235,729
Greenwich	175,000	2,183,975	404,677	8,226,000	4,036,830	15,026,482
Lambeth	640,000	3,911,629	673,677	10,836,000	593,000	16,654,306
Lewisham	50,000	2,593,124	601,646	7,955,000	681,000	11,880,769
Southwark	0	1,849,562	507,733	7,432,000	2,001,000	11,790,295
SEL Wide	7,753,031	-508,000	4,975,000	0	0	12,220,031
Total	**8,618,031**	**16,881,408**	**7,976,547**	**46,418,000**	**9,978,134**	**89,872,120**
Grand Total						**89,872,120**

Month 11

	Other CCG Revenue	CCG Revenue	Primary Care	Hospital Discharge		Grand Total
				LA	CCG	
Bexley	0	2,019,896	346,154	8,282,000	111,304	10,759,354
Bromley	0	3,982,984	467,660	2,493,000	2,428,000	9,371,644
Greenwich	175,000	1,835,196	404,677	7,632,000	3,960,830	14,007,703
Lambeth	640,000	3,059,173	673,677	9,760,000	387,000	14,519,850
Lewisham	50,000	2,344,020	601,646	7,088,000	598,000	10,681,665
Southwark	0	1,694,718	507,733	7,229,000	1,761,000	11,192,451
SEL Wide	3,860,340	0	3,919,821	0	210,000	7,990,161
Total	**4,725,340**	**14,935,987**	**6,921,368**	**42,484,000**	**9,456,134**	**78,522,828**
Grand Total						**78,522,828**

5. Financial Accounts

Further detail of the overall financial accounting position is available within the CCG's draft Annual Accounts. The draft Accounts were reviewed at the Audit Committee on 22 April and subject to the usual presentational amendments were approved for submission on 27 April. With respect to debtors, cash and creditors the key end of financial year positions are:

Key Headlines at Month 12:

- The CCG has an **overall debt position of £26.0m** at Month 12; this compares to £28.3m at Month 11. Of, this £1.4m relates to legacy debt from the 6 CCGs which is a significant improvement on the £4.4m reported last month. The main debtor balances remain with NHS England (predominantly GPIT), SE London local authorities and other local providers. These are being actively chased by borough finance colleagues.

- The CCG delivered its year-end **cash book position**, well within the target cash balance.

- Under the **Better Payments Practice Code** (**BPPC)**, CCGs are expected to pay 95% of all creditors within 30 days of the receipt of invoices. This is measured in terms of the total value of invoices and the number of invoices by count. At the year end the **CCG has met the target cumulatively on both value and count** for NHS and non NHS creditors.

- There is ongoing work to reduce the levels of **aged creditors** which were brought forward from the legacy ledgers. At the end of March 2021 there were **113 (£0.7m in value) items outstanding** compared with 233 (£1.9m) as at the previous month. Work will continue in the new financial year to close down all of these items.

The draft Annual Accounts are now subject to external audit.

6. Revenue Resource Limit

South East London Clinical Commissioning Group

- The table below sets out the movements in the Revenue Resource Limit together with the overall financial allocation at as Month 12. The main change in month has been a reduction in provider allocations (pass through allocations to the CCG) relating to system top-up funding. The total financial allocation for the year as at Month 12 is £3,474.3m.

Revenue Resource Limit	Total SEL CCGs (Non Covid)	Covid-19	Total SEL CCGs
	£'000s	£'000s	£'000s
Revenue Resource Limit (RRL)			
Total Start Allocation	3,243,858	107,515	3,351,373
Total Movement in Month	(6,184)	(19,042)	(25,226)
Total Month 12 Allocation	**3,232,322**	**88,473**	**3,320,795**
Running Cost Allowance (RCA)			
Total Start Allocation	34,265	719	34,984
Total Movement in Month	6	-	6
Total Month 12 Allocation	**34,271**	**719**	**34,990**
Total RRL and RCA			
Total Start Allocation	**3,391,322**	89,192	**3,480,514**
Total Movement in Month	(6,178)		**(6,178)**
Total Month 12 Allocation	**3,385,144**	**89,192**	**3,474,336**

NHS
South East London
Clinical Commissioning Group

2021/22 H1 SEL CCG FINANCIAL PLANS

LAMBETH BOROUGH BASED BOARD,26 May 2021

1. SUMMARY – SEL CCG AND SYSTEM H1 FINANCIAL PLANS

NHS
South East London
Clinical Commissioning Group

- The CCG and system are currently finalising draft operational plans for the first half (H1) of 2021/22, which will be submitted on 6th May. Full year and final Mental Health plans will be submitted on the same day in line with Mental Health Investment Standard (MHIS) requirement.
- The SEL CCG allocation has been confirmed for H1 2021/22 at £1,899.893m, including system top-ups and Covid allocations but excluding national Service Development Funds (SDF) and potential for further Elective Recovery Funds.
- In setting its financial plans for H1, the CCG has followed national planning guidance, which predominantly means a rollover of M7-12 2020/21 budgets, both for nationally calculated block contracts and other commissioned budgets, plus the application of 2021/22 uplifts and adjustments, including the MHIS uplift of 4.41%.
- Discussions have been on-going across our ICS partners to finalise financial positions and to agree the allocation of system top-ups and Covid funds, but we are aiming to submit a balanced H1 position across the ICS.
- The CCG will secure an H1 Covid budget of £9.7m.
- Details of high level financial plans by borough/ SEL wide and by service/ budget area are set out in next slide in line with the CCG's H1 allocation of £1.9bn.
- While the CCG plans deliver a balanced financial position, our current assessment is that savings of £6.1m will be required to deliver a break-even position, noting also that providers will similarly need to deliver efficiencies in H1.
- The CCG savings will need to be delivered in H1 through a combination of non-recurrent savings, recurrent savings and an exercise looking at all Covid commitments for H1 and identification of slippage against the CCG's budget of £9.7m.
- Whilst the CCG's H1 2021/22 financial plans deliver a balanced financial position, there are significant uncertainties, risks and opportunities for the CCG in H1 including the delivery of the £6.1m savings. Furthermore the CCG and wider system will need to ensure it maintains close control of all of its spend.
- Following the agreement of H1 plans, we will also increase our focus on maximising key deliverables and also on managing the return to business as usual in H2 or in 2022/23. Details of the financial arrangements for the second half (H2) of 2021/22 are to be confirmed.

2. APPLICATION OF FUNDS - H1 2021/22 BOROUGH & SEL WIDE BUDGETS

South East London Clinical Commissioning Group

- High level budget plans by service/ budget area and by borough/ SEL are set out below, reflecting the SEL wide planning approach.
- Overall, borough budget values have been based upon a roll forward from 2020/21 H2. However, where virements between budgets for individual services were required, these have been reflected in the table below.
- Further adjustments will be required to apply agreed 2021/22 uplifts to budgets.
- System top-up and Covid allocations are currently shown as 'system commitments' and have not yet been applied to organisations/ budget areas.

	ROLLOVER M7-12 BUDGETS										21/22 GROWTH	TOTAL BEFORE SYSTEM TOP-UPS AND COVID	TOP-UPS		TOTAL AFTER SYSTEM TOP-UPS AND COVID
	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	Borough Total	SEL wide budgets	SEL CCG Total	2020/21 Growth (incl. MHIS)	2021/22 Growth & Adjustmemts		2021/22 System top-up allocation	2021/22 Covid allocation	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Continuing Care Services	10,028	10,958	10,211	11,778	10,803	9,170	62,947	0	62,947	0	1,145	64,092	0	0	64,092
Planned & Commissioning (Acute, Community & Mental Health)	0	0	0	0	0	0	0	1,033,018	1,033,018	15,568	6,081	1,054,666	0	0	1,054,666
Corporate Budgets	411	878	936	783	589	785	4,382	13,241	17,623	0	0	17,623	0	0	17,623
Corporate Budgets Non Running Cost	991	1,603	1,275	1,432	2,081	1,139	8,520	3,545	12,064	0	132	12,196	0	0	12,196
Delegated Primary Care Services	15,898	23,643	20,281	31,669	23,321	24,886	139,698	(41)	139,657	0	9,951	149,024	0	0	149,024
Mental Health Services	2,289	4,672	4,025	8,175	1,983	2,325	23,469	()	23,469	0	1,034	24,503	0	0	24,503
Other Acute Services	688	338	8,963	336	461	357	11,144	49	11,193	0	22	11,215	0	0	11,215
Other Community Health Services	4,471	26,280	7,363	3,326	3,057	2,669	47,166	0	47,166	0	316	47,482	0	0	47,482
Other Primary Care Services	1,463	1,535	1,147	1,581	729	526	6,981	1,932	8,913	0	401	9,315	0	0	9,315
Other Programme Services	3,706	8,936	6,169	7,598	6,358	9,556	42,323	17,447	59,770	717	(6,575)	54,496	0	0	54,496
Prescribing	16,372	22,275	16,505	17,542	18,592	15,629	106,915	0	106,915	0	727	107,642	0	0	107,642
System Commitments										0	0	0	217,118	130,465	347,583
TOTAL	**56,317**	**101,119**	**76,875**	**84,219**	**67,972**	**67,043**	**453,545**	**1,069,191**	**1,522,736**	**16,285**	**13,233**	**1,552,253**	**217,118**	**130,465**	**1,899,839**

- As highlighted above, savings of circa £6.1m will be required to be achieved during H1 to deliver a CCG break-even position. These savings will need to be delivered through a combination of non-recurrent savings, recurrent savings and an exercise looking at all Covid commitments for H1 and identification of slippage against the CCG's budget of £9.7m.

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South East London Clinical Commissioning Group

Lambeth Together Strategic Board

DATE: 26 May 2021

Title	**Month 12 Finance Report**	
This paper is for **discussion**		
Executive Summary	This paper sets out the Adults and Public Health's financial position as at month 12. Adults and Public Health had a near break-even position of £103k overspend. There has been significant COIVD-19 related activity which has resulted in large amounts of unbudgeted expenditure and income. This is as detailed in the attached report.	
Recommended action for the Board	The Board is asked to **NOTE** the financial position at month 12.	
Potential Conflicts of Interest	N/A	
Impacts of this proposal	Key risks & mitigations	Financial risks and mitigations are set out in the Finance Report
	Equality impact	N/A
	Financial impact	The Finance Report sets out Adults and Public Health's financial position
Wider support for this proposal	Public Engagement	N/A
	Other Committee Discussion/ Internal Engagement	The outturn Finance Report is presented at various relevant Council meetings.
Author:	Pete Hesketh, Assistant Director of Finance (Adults & Public Health)	
Clinical lead:	N/A	
Executive sponsor:	Andrew Eyres, Strategic Director, Integrated Health & Care.	

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Lambeth Council Finance Report – Adults and Public Health

Month 12 2020/21

Financial Position

Adults & Public Health	Budget	Outturn	Variance
	£000	£000	£000
Adult Social Care			
Income	(23,450)	(53,977)	(30,527)
Expenditure	113,465	144,096	30,631
Net	90,015	90,119	104
Public Health			
Income	(34,554)	(36,540)	(1,986)
Expenditure	33,152	35,139	1,987
Net	(1,402)	(1,401)	1
Strategy & Commissioning - Adults			
Income	(9,649)	(10,490)	(841)
Expenditure	9,986	10,825	839
Net	337	335	(2)
Adults and Public Health			
Income	(67,653)	(101,007)	(33,354)
Expenditure	156,603	190,060	33,457
Net	88,950	89,053	103

Outturn Overview (1)

- There have been significant amounts of unbudgeted income and expenditure in 2020/21 relating to the COVID-19 pandemic.
- At the outset of the First Wave health and care systems including in Lambeth acted quickly to free up hospital beds to address the need for additional capacity to care for people requiring urgent inpatient care for Coronavirus This was supported by new streamlined processes to support far higher numbers of people being discharged from hospital than usual but often resulting in additional costs to Councils. These hospital discharges were facilitated through the NHS discharge scheme where the Council was able to claim back the additional costs of people's care and this additional income has off-set the increased expenditure.
- In addition there have been payments made to social care providers related to the pandemic, either in the form of one-off fee increases the Council decided to make or through government schemes such as the Infection Control Fund and the Rapid Test Fund. These have been funded either by additional earmarked grants, which has increased the amount of income received in the department, or from funding the Council has received more generally to cover costs related to the pandemic. There have also been other COVID-19 specific expenditure such as PPE and costs associated with supporting people that are Clinically Extremely Vulnerable.

Outturn Overview (2)

- Public Health expenditure was fully funded by the Public Health Grant and financial risks that were expected to occur during the year relating to sexual health services were averted as clinics were closed during the COVID-19 lockdown and, along with more stringent triage processes, activity was directed to online services.
- Significant work has also been undertaken across the borough in support of Outbreak Control, coordinated through the public health team. The Test and Trace service has also been established with the expenditure being funded by a new ring-fenced grant and more recently surge testing costs have been occurred for which government funding has been claimed.

Report to: Lambeth Together Strategic Board

Date 26 May 2021

Report Title	Integrated Health and Care Business Plan 2021/22 and NHS Planning Guidance 2021/22
Authors	Andrew Parker, Director Primary Care and Transformation, Brian Reynolds, Associate Director Health and Care Planning and Intelligence
Summary	We are pleased to present Lambeth's integrated health and care business plan for 2021/22. The plan has been developed over recent months, and in setting out the aims for the year ahead was produced on reflection of the previous year, the ongoing response to the Covid-19 pandemic and other associated plans such as the Lambeth Together Recovery Plan. This business plan serves to describe the continued focus, outcomes and objectives of our Lambeth integrated health and care directorate and its programmes of work within for the period ahead, as we look to the future of health and care within the borough, with partners, and across south east London. As 2021/22 progresses, performance updates will be included within the regular integrated assurance report. The Board are also asked to note the headlines from the recently published, 25 March 2021, NHS priorities and operational planning guidance for 2021/22. As these plans develop for south east London, these will be reflected as relevant in local plans and priorities for the year ahead.
Recommendation(s)	The Strategic Board is asked to receive for information: • The 2021/22 Lambeth Integrated Health and Care Business Plan (enclosure 10a) • The recently published NHS planning guidance 2021/22 (enclosure 10b)

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10a. Integrated Health and Care Directorate Business Plan 2021/22

March 2021

Lambeth

Sections

1. Our Strategic Vision and Introduction
2. Our Directorate Objectives
3. Our Planned Deliverables
4. Appendices;
   - Strategic Programmes
   - Workforce
   - KPIs
   - Finance data

Lambeth

1. Our Strategic Vision and Introduction

The Integrated Health and Care Directorate works to support people to manage their health and wellbeing and to address health inequalities and inequity in Lambeth. The Council and CCG work with local providers of health and social care and other partners to ensure that people in Lambeth are able to live healthy independent lives, to promote personal and community resilience and to ensure they are able to access high quality support and care when they need it.

COVID-19 has presented us with extraordinary and far-reaching challenges over the past 12 months. More than 550 Lambeth people have died from COVID-19, and many more have had existing underlying conditions worsened by COVID-19. Vulnerable people, those from a black and/or minority ethnic backgrounds, older people or those living with disability have been disproportionately hit hardest. Our health and care services have responded innovatively, at pace and with a clear focus on these challenges, and our Lambeth Together partnership arrangements have proved effective, and indeed have been strengthened, through our shared responses and collaborative approaches.

In its final year and for the third successive year, NHS Lambeth CCG was rated as 'Outstanding' (November 2020) by NHS England and Improvement in its annual assessment. Council and CCG teams have continued to address core service delivery and sustain performance standards throughout the past year despite the impact of the COVID-19 pandemic. Our teams have shown tremendous commitment and flexibility in responding to the pandemic and in supporting Lambeth residents.

This Business Plan document sets out the key deliverables for the year ahead for the Directorate recognising the threefold need to respond to COVID-19, to recover from its impact and to address strategic service transformation. The Directorate Management Team has reviewed progress against last year's plan and identified new actions, along with brough forward activities. In September 2020 we published our Lambeth Together Recovery Plan covering the 18 months to March 2022, and more recently we have also recently produced our Lambeth Together COVID-19 Borough Vaccination Delivery Plan to ensure a joined-up roll-out of the vaccination programme within Lambeth. The Lambeth Outbreak Control Plan has also been recently refreshed and will continue to be updated over time and also forms a critical part of the Directorates objectives. These documents are referenced within the Appendices to the Plan.

Through 2021 the Government White Paper proposals on integrating care will be progressed for implementation from April 2022. Lambeth Together remains at the forefront of this work and in collaboration with NHS and other partners we will wish to help shape and implement effective arrangements and ways of working, both at 'Place' within Lambeth and across the South East London 'System'.

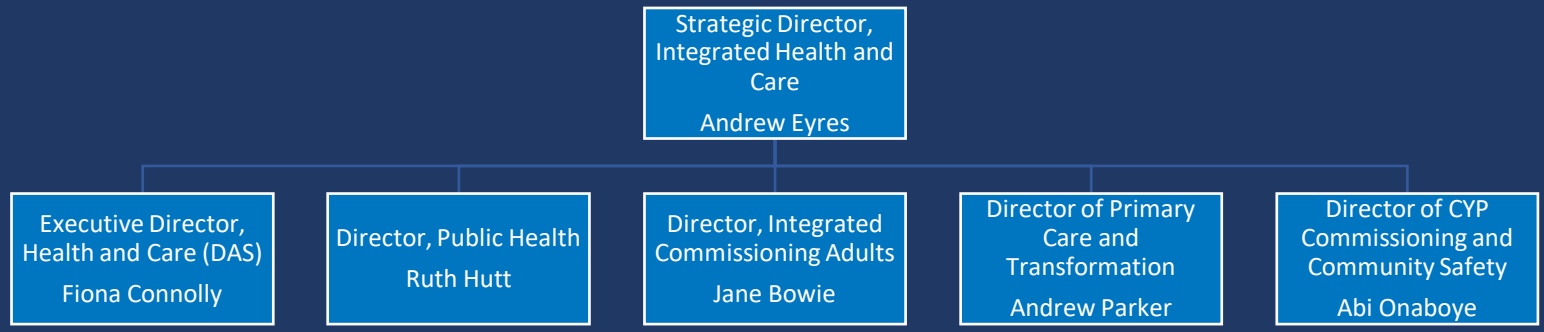
We look forward to delivering the Plan with you and with our Lambeth Together partners working in partnership through our Delivery Alliances and other shared programmes.

Andrew Eyres, Strategic Director Integrated Health and Care

Lambeth

2. Our Directorate Objectives

- The Integrated Health and Care Directorate, headed up by the Strategic Director Andrew Eyres, and consists of 5 divisions led by Directors
- The Strategic Director reports into both the Chief Executive of LB Lambeth and to the Accountable Officer of SEL CCG.
- Director of CYP Commissioning & Community Safety reports to the Strategic Director Integrated Health and Care and to the Strategic Director Childrens Services.



Adult Social Care

- Adult Social Care works to improve outcomes for adults in Lambeth and make the best use of health and care resources. The focus is on supporting people to manage and improve their health and wellbeing and to prevent avoidable health and care needs.
- Delivering high quality and safe adult social care, supporting individuals (and their families) with care and support needs to maintain choice and control of their lives, stay safe and maintain their independence are key outcomes for people accessing adult social care support.

Public Health

- Public Health Works to enable local partners to deliver coherent and strategic health improvement action and to take a strategic and evidence based approach to decision making and prioritisation in health improvement so as to improve population health and wellbeing and reduce health inequalities.
- Plans for and responds to threats to public health including Covid-19 pandemic planning and response, including the Outbreak Control Plan as well as wider threats.

Lambeth

2. Our Directorate Objectives – continued

Integrated Commissioning - Adults

- Elective Care programmes aimed at bringing together acute care clinicians with primary care to ensure seamless referral for testing, diagnosis and onward referral to appropriate specialist services, such as cancer. The Urgent Care workstream aims to ensure that patients are able to access the right care at the right time when medical care is required urgently.
- To support older people to remain independent and able to manage their health well with the right level of timely support and advice when they need it to remain at home. That fewer older people will be admitted to hospital or residential care reducing the number of beds required, shifting resources to community based care. To provide good quality care and achieve cost efficiencies by providing more integrated health and social care. To maintain stability within the social care market.
- To support neighbourhood and Wellbeing Delivery Alliance bringing together different providers to offer a better service to Lambeth residents facing a range of issues, including long-term illnesses.
- A comprehensive programme of Medicines Optimisation, to improve the quality and length of life of people, people with three or more long term conditions (LTCs), and to promote the clinical and population behaviours which allow the right care to be delivered in the right setting.
- To ensure that people with adult mental health problems obtain access to support as early (and so avoid crisis) and as close to home as possible. It is supported by the Lambeth Living Well Collaborative (LLWC), which is the partnership platform aiming to apply co production practice to the commissioning and delivery of mental health care and support in the borough. The LWNA is in year three of its seven year contract. The alliance is delivering a large transformation programme including new community services.

Lambeth

2. Our Directorate Objectives – continued

Integrated Commissioning - Children and Young People

- Responsible for making and implementing decisions in relation to commissioned services for children, young people and maternity in Lambeth including physical and emotional wellbeing, working with Lambeth Childrens and young People Alliance partners to transform childrens services and improve the life chances of our Lambeth children.
- Also reporting to the Strategic Director Children's Services and working alongside Childrens Social Care, Education and community safety teams .

Primary Care and Transformation

- The Primary Care and Transformation Team work to enable a transformation of community based /out of hospital care where high quality, locally responsive and sustainable primary care as a core building block for the future health and care system. Through this, Lambeth citizens can expect a primary care system that is proactive in its approach, accessible and responsive to local needs and coordinated around the individual.
- The Team support the Covid-19 Vaccination programme in the Borough.
- Lambeth Together partnership development and governance, programme management and enabling arrangements are supported through the Team.

Lambeth

3. Our Planned Deliverables

- This planned deliverables section sets out the transformation priorities for the year ahead. Some of these business plan actions are continued from 2020/21 either due to being an ongoing activity, an activity that has been carried forward into the new year through re-prioritisations associated with the response to the COVID-19 pandemic, or are new priority actions identified for 2021/22.

- The appendices contains references to relevant associated documents for 2021/22, such as the Lambeth Together Recovery Plan (which covers the 18 month period from September 2020 to March 2022), the Lambeth Together COVID Vaccination Delivery Plan (approved February 2021), and the Key Performance Indicators for each area for the year ahead.

- Sections
  - Adult Social Care
  - Staying Healthy and Health Improvement
  - Substance Misuse
  - Local Outbreak Control Plan
  - Older People
  - Adults Transformation
  - Medicines Optimisation
  - Long Term Conditions
  - Children and Young People
  - Primary Care and Transformation
  - Enablers

Lambeth

Adult Social Care (Lead Richard Outram, SRO Fiona Connolly)

Borough Plan Pillars

- Promote care and independence by reforming services.
- Be Passionate about equality, strengthening diversity, delivering inclusion.

Through:

- Deliver **high quality and safe** adult social care – continue to improve performance on key performance indicators.
- **Workforce –** to define and shape new ways of working as we emerge from wave 2 of the Covid-19 pandemic, promote inclusion and strengthen diversity. To lead and embed an Equalities Diversity and Inclusion plan within ASC. Focusing on inclusion, to ensure that there is a clear vision and outcomes that support the increase in workforce diversity within the directorate.
- **Integration** – continue our transformation work with key health partners, and the VCS to further integrate services and make them as seamless to the eyes of our population.
- **Statutory Returns**: including Short and Long Term Support (SALT), Safeguarding Adults Collection (SAR), Deprivation of Liberty Safeguards (DOLS).

Lambeth

Staying Healthy/Health Improvement (Lead Andrew Billington, SRO Ruth Hutt)

Staying Healthy

- Priority of remobilization of services such as Health Checks, Stop Smoking and Weight Management after impact of COVID on service delivery.
- Review of service models post Covid and in line with national review and consultation with GP Federation.
- Stability of contracts to enable recovery whilst undertaking review - especially of new technology and implementation and impact on those most vulnerable including BAME.

Sexual health (local authority contracts)

- Finalise the governance to extend the GSTT and KCH's integrated sexual health clinical services contracts by 1 year through March 2023. We will also be working through governance for permission to negotiate new contracts for both of these services after March 2023.
- Lambeth, Southwark and Lewisham's Programme of Change will carry forward a number of pieces of work: A year long engagement programme with citizens and service users who will feed into the priorities for our sexual health clinical services. A financial analysis, taking in the public health grant position and spend and activity at sexual health clinical services and the e-service, looking back at the five year contract and looking forward at what will be affordable for the council and sustainable for SRH services. A LARC demand and capacity audit to inform future service commissioning priorities.

Reproductive health (CCG contracts)

- Extend current abortion contracts with MSI Reproductive Choices and Bpas. This will be done on an LSL footprint with Bromley likely to join. Agree joint tariffs among at least LSL and Bromley, potentially all of SEL, in contracting with MSI and Bpas for 2021/22. Undertake a review of the central booking system for abortion services in Q1. Make a unified decision in SEL on retaining, updating or decommissioning the CBS. Over 2021/22, work towards a single contract and tariffs for all SEL boroughs for our abortion services.
- Sexual health commissioners to work with CCG commissioners towards co-funding the online SHL contraception offer which public health is currently commissioning on its own.

Lambeth

Substance Misuse (Lead Andrew Billington, SRO Ruth Hutt)

- **Implementation of new PHE Grant for Rough Sleepers with Drugs and Alcohol use**: working collaboratively with the Supported Housing team. Potential implementation of further Section 31 funding for LA for additional drug, alcohol crime and harm reduction.
- **Review, consideration and implementation of a number of important report and recommendation areas**:
  - Dame Carol Black Substance Misuse report and Government response to findings.
  - Treatment Consortium and potential shadowing as a Living Well Alliance structure.
  - Substance Misuse Review and Alcohol Action Plan post Covid.
  - Feedback from CQC/HMIP thematic review of Substance Misuse services covering access and service delivery for those in the Criminal Justice System.
  - CQC/HMIP Thematic review feedback expected mid-March 2021 and any action plan developed from March 2021.

Lambeth

Local Outbreak Control Plan (SRO Ruth Hutt)

Lambeth's Local Outbreak Management Plan (LOMP) establishes processes for and capacity to prevent and respond to residents infected with SARs-CoV-2 virus and outbreaks in local public settings known to be at high risk of transmission of the virus (e.g. schools or care homes). It is part of the national government strategic approach to ease the social restriction, including timely control of the spread of the virus at local level.

Key Objectives:

- Establish measures to prevent transmission and protect vulnerable residents (vaccination, risk assessment, testing, ensure timely and effective identification and notification of contacts; support to cases and contacts)
- Rapidly responding and controlling incidents, clusters and outbreaks
- Establish local surveillance and intelligence (timely and effective monitoring, build local intelligence)
- Use legislative powers & enforcement where necessary to ensure compliance with COVID-19 control measures
- Working with our diverse communities to ensure they have the knowledge & tools to help reduce transmission
- Reduce the impact of COVID-19 on existing inequalities.

Key deliverables:

- Ensure boroughwide access to testing, contact tracing and vaccination with an emphasis on tackling patterns of inequality
- Enable safe opening of the economy, schools and businesses by ensuring infection rates stay low and covid safe measures are in place
- Continue to enhance the contact tracing and self isolation support offer available to residents
- Develop early warning surveillance tools, and methods for tracking inequalities
- Apply an integrated population health management approach which can be transferred to wide health and inequalities work.

Lambeth

Older People (Lead Jade Holvey, SRO Jane Bowie)

- **Care homes strategic modelling**: Capacity and delivery models needed post Covid alongside monitoring performance and resilience of providers.
- **Discharge and community services**: As part of NWDA, progressing One Front Door and home care recommissioning programmes.
- **Quality and safety**: Improve standards and oversight through implementation of PAMMS and co-ordination of concerns processes.
- **Continuing Health Care (CHC) integration**: Enhanced joined-up processes, data oversight and co-ordination of roles.

Lambeth

Adults Transformation (Lead Jo Keats, SRO Jane Bowie)

- **Cancer Screening**: Gain a better understanding of current performance of cancer screening with a view to support Primary Care develop and deliver improvements in the uptake of NHS cancer screening programmes, taking into account changes as a result of COVID.
- **Demand/Referral Management**: Work with Primary and Secondary Care to scope out services/pathways for opportunities to standardize practices and pathways, reduce unnecessary referrals and to identify any learning/training opportunities.
- **Urgent Care**: Work with GPs and Providers to increase admission avoidance and support early discharge. Models that were implemented to support COVID, may be able to be adapted for other cohorts of patients.
- **Neighbourhood Wellbeing Delivery Alliance**: whole directorate will link in with this delivery alliance and Lambeth Together partners across all areas to work to meet the needs of our diverse communities.

Lambeth

Medicines Optimisation (Leads Finlay Royle/Jenny Sivaganam, SRO Vanessa Burgess/Jane Bowie)

- **Medicines value:** identify high-value quality & cost improvement initiatives for medicines optimisation that improve adherence, safety and disease control to reduce harm, avoid admissions and reduce costs.
- **Demand management**: work with community pharmacy, GPs and secondary care to build effective integrated systems to reduce harm and maximise value from medicines, whilst reducing low-value workload.
- **Digital solutions & Clinical Effectiveness**: work with Clinical Effectiveness Lambeth to identify and implement digital solutions and tools to identify and reduce inequalities in patient outcomes arising through variable use and uptake of medicines.

Lambeth

Long Term Conditions Optimisation (Leads Finlay Royle/Jenny Sivaganam, SRO Vanessa Burgess/Jane Bowie)

Working through key alliance structures:

- Long Term Condition optimisation: develop a post-Covid recovery plan to improve measurable outcomes in key Long Term Conditions, focusing on reducing inequalities and increasing personalised care planning
- Improve detection and optimisation of:
  - Diabetes: 8 care processes, 3 treatment targets, social prescribing, self-care & education
  - Cardiovascular disease: blood pressure, atrial fibrillation, lipid dysfunction.
  - Respiratory disease: quality-assured diagnostics, redesign of rehabilitation, appropriate inhaler choice and use, care planning
  - Mental illness: support primary care to increase physical health & drug monitoring, and implement shared care.

Lambeth

Adult Mental Health (Lead David Orekoya, SRO Jane Bowie)

- **Mental Health Prevention:** Work with our local communities and SEL partners to co-produce comprehensive suite of digital and place-based trauma informed mental health prevention and promotion interventions. Wil include refresh of Suicide Prevention Plan to promote both individual and neighbourhood resilience in the wake of impact of Covid-19 on population well-being.
- **Support to Housing Regeneration Liveability Workstream**: work with operations and regeneration colleagues across 5 stages in Estates Programmes to ensure early identification and engagement of residents with care needs.
- **Lambeth Hospital:** Take forward the reprovision of the Lambeth wards together with SLaM, and associated development of culturally appropriate clinical inpatient and community service and peer support offer with Black Thrive and Lambeth's black communities.
- **Community Mental Health Transformation:** Implementation of Year 1 funding programme to deliver: closer alignment and closer integration with Primary Care Networks; improve physical health outcomes; and improve access to community reablement and specialist support for dual diagnosis, young people 18-25, and emotional and eating disorders. Develop Lambeth Living Well Network Delivery Alliance Year 2 & financial plans.
- **Risk Share:** Agree LWNA risk share agreement to underpin service transformation programme and support achievement of outcomes and agreed financial matrices.

Lambeth

Adults with Learning Disabilities (Delivered by David Orekoya, SRO Jane Bowie)

- **Coburg Crescent:** Opening of Learning Disability Resource Centre with VCS partners during Q3 2020-21 to provide greater access to community based accommodation, day support and potential employment opportunities for people with learning disability.
- **SEL Learning Disability and Autism programme:** Maintain momentum in moving people from restrictive hospital settings to the community by developing provider market strategy to ensure access to a range of quality providers including specialist and complex care. Involves working with existing provider partnerships to ensure current development pipeline comes on-stream during 2021-22.
- **Annual Health Checks:** Work with General Practice and GSTT to refresh current delivery programme, to achieve target number of AHCs (75% of those on register with LD).

Lambeth

Children and Young People (Lead Dan Stoten, SRO Abi Onaboye)*

- Progress strategic initiatives through development of the Lambeth Together CYP Delivery Alliance.
- Establish emotional health and wellbeing alliance group, developing clear workstreams informed by the needs assessment.
- Establish community health workstream, and work with partners to develop a sustainable approach to population health management.
- Pilot Lambeth DataNet in one of the children's alliance workstreams, and ensure data integration remains a key theme across all 3 workstreams.

*Links with Childrens Services 2021/22 directorate business plan delivery priorities, ensuring they are safeguarded and benefit from improved opportunities, and a Child Friendly Lambeth.

Lambeth

Primary Care and Transformation (Lead Garry Money, SRO Andrew Parker)

- Ensure that all have good access to high quality and responsive primary care services commissioned for Lambeth, including:
  - Fully discharging our responsibilities as a delegated commissioner of primary care
  - Implementing any new models of Extended Access set out nationally for April 2022
  - Recovery from Covid-19 and Proactive Care.
- Ensure that all Primary Care Providers in Lambeth are supported to be sustainable, and develop into a thriving system of Practices, PCNs and Federations working in a neighbourhood model with partners and patients – including:
  - PCN Development
  - Quality Improvement & Clinical Effectiveness
  - Enabler Development – Digital First Primary Care, Workforce and Estates.
- Delivery of the Lambeth Covid-19 Vaccination Programme, maximising uptake across all population groups.

Lambeth

Delivery Enablers

- **Lambeth Together (Delivered by Tom Barrett, SRO Andrew Parker)**
  - Develop and deliver programme of support to deliver the enabling factors that support integrated health and care.
  - Develop and deliver programme of support to Lambeth Together priority areas: assurance; equalities, diversity and inclusion; population health approach.
  - Review Lambeth Together governance and deliver agreed change in preparation for ICS.
  - Develop and deliver Lambeth Together Organisational Development programme to ensure system is ICS ready.
  - Continue to develop suitable approach to programme management across Lambeth Together.

- **Equalities (Delivered by Juliet Amoa, SRO Fiona Connolly)**
  - With support from across directorates develop an EDI plan and programme to support and address workforce inequalities.
  - Developing meaningful engagement with all communities, VCS and partners to address health inequalities.

- **Population Health Management (Amanda Coyle, Hiten Dodhia and Brian Reynolds, SRO Ruth Hutt and Andrew Parker)**
  - Development of outline and scope of Population Health Management to support Lambeth Together Delivery Alliances and strategic priorities.
  - Review of Lambeth Together alignment within Population Health Management activities in Lambeth and south east London.

- **Assurance (Delivered by Brian Reynolds, SRO Andrew Parker)**
  - Development of further thinking and establishment of a sub committee, or equivalent arrangement that provides more detailed oversight assurance of the Lambeth Together integrated assurance agenda.

Lambeth

Delivery Enablers – continued

- **Estates (Delivered by Malcolm Brydon, SRO Andrew Parker)**
  - Clapham Park Medical Practice Project (Phase I and II) will be complete at the end on 31/03/2021.
  - Crown Dale Medical Practice Project to commence on 23/04/2021
  - Gracefield Gardens (Exchange Medical Practice / Streatham High Medical Practice) Programme to be complete by 31st May 2021. Includes the development of the first of the Living Well Alliance Hubs for the Borough.
  - Akerman Health Centre / Baldry Gardens are in the Design and Development Phase. Akerman is to develop the second of the Living Well Alliance Hubs and maximise the use of existing void space. The Business Case for approval to be submitted at the end of June 2021. The Baldry Gardens Project to re-locate the Streatham Common Medical Practice to modern purpose-built Primary Health Care Centre.
  - The Nine Elms Vauxhall Project comprises of three Practices – Binfield Road / Mawbey Brough / South Lambeth Road - additional capacity to meet increase in the local population with significant new residential developments. The Project is the process of final Design and Development and it is expected that the Business Case will be submitted for approval by the 31st April 2021.
  - North Lambeth Project - potential to co-locate the Lambeth Walk and Vauxhall Practices and as part of the wider Black Prince Trust Development. Funding secured to develop options appraisal / feasibility study, Business Case is expected by the end of the calendar year.

Lambeth

Delivery Enablers – continued

- **Communications and Engagement (Delivered by Catherine Flynn, NHS South East London CCG)**
  - Strategic communications and engagement advice and support to transformation programmes eg Covid-19 vaccination plan, major developments eg Nine Elms and Vauxhall, and new service models eg digital access
  - Further develop partnership approaches to communications and engagement, including continuing support to Communications & Engagement Steering Group. 2 new joint funded posts within the LBL S&C structure to lead on the shared CCG/LBL comms and engagement work programme and ensure closer integration between LBL and the CCG.
  - Support and grow Lambeth Together communications and engagement system partnership to increase resident participation in its work and increase awareness and understanding of Lambeth Together, and its constituent parts, supporting the Lambeth Borough Plan goals.
  - Support ICS development through communications and engagement activity, eg increase visibility and followership of Lambeth Together through use of website and social media.

- Governance and Quality (Delivered by Cheryl Smith, NHS South East London CCG)
  - Step up governance arrangements from April following a pause related to COVID-19 response
  - Developing new risk management system in collaboration with central SEL CCG team and embedding within each borough.

- ICT (Delivered by Niymeti Ramadan, SRO NHS South East London CCG)
  - Interoperability of digital systems including corporate systems as well as matrix working with partners.

Lambeth

Appendices

- Strategic Programmes
  - Active COVID and Lambeth Together governance and collaborative working arrangements
  - Active Lambeth Together Recovery Plan and our Lambeth Together Delivery Alliances: https://lambethtogether.net/wp-content/uploads/2020/09/LambethBoroughCovidRecoveryPlan20200914.pdf with associated delivery alliance and programmes highlight reports through Lambeth Together Strategic Board
  - Active Lambeth Together COVID Vaccination Borough Delivery Plan and Steering Group
  - Active Lambeth Outbreak Control Plan: https://www.lambeth.gov.uk/coronavirus-covid-19/outbreak-prevention-and-control
  - Links with council strategic programmes: see next page
  - Links with Childrens Directorate Business Plan
  - Links with NHS South East London CCG plans.
- Workforce:
  - CCG: Headcount of 46, FTE 44.04 (7 people working part time).
  - Council: Headcount of 352, FTE 331
  - Full breakdown on workforce slide
- KPIs
  - For the time being the KPIs that we will be using mostly the ones carried over from last year from the Council's tier 1 and 2 suite of indicators. At the time of writing the KPIs are being reviewed in the context of the council plans as we go into the new year. Link to sharepoint file here
- Finance
  - CCG: The usual Quarter 4 NHS annual planning round has been delayed in the context of the pandemic second wave impact over this same period. The planning round is now expected to take place over Quarter 1 of 2021/22. National planning guidance has only very recently been published but is unlikely to be applied before Quarter 1 2021/22.
  - Council: Budget as loaded for 2021-22 on Budget slide.
  - Council: Savings proposals for 2021-22 on Savings slide

Lambeth

Links with other Strategic Programmes within the council

- Director and leads from IHC are connected into the majority of strategic programmes across the council, summarised in the tables below

Strategic Programme	Senior Responsible Owner	Programme Sponsor	Board Member leads from IHC	Programme Manager	Planned End Date
SP1: Workforce Transformation To be the London Local Govt employer of choice with a highly motivated, diverse and inclusive workforce that can deliver the ambitions and goals of our Borough Plan and their individual career ambitions	Andrew Eyres	Dean Shoesmith	Andrew Eyres (Chair) Fiona Connolly	Eibhlín McInerney	July 2022
SP2: Lambeth Together A partnership of NHS, Council and voluntary sector organisations working together with local people and stakeholders to improve health and wellbeing and reduce inequalities in Lambeth	Andrew Eyres	Andrew Eyres	Andrew Eyres (Chair) Abi Onaboye Ruth Hutt Fiona Connolly Jane Bowie Pete Hesketh Juliet Amoa	Tom Barrett	TBC
SP3: Lambeth Made Education, Skills and Employment To be a child and young person-friendly community where our children and young people are encouraged and enabled to exceed their potential.	Merlin Joseph	Abi Onaboye Nabeel Khan	Abi Onaboye Richard Sparkes Juliet Amoa	Nicola McLean	July 2024
SP4: Lambeth Made Safer	Merlin Joseph	Abi Onaboye	Abi Onaboye Ruth Hutt	Thomas Murphy	June 2029
SP6: Total Resident Services Transformation To: - ensure compliance standards are met to keep our residents safe and well - generate revenue to support core and community services by being more commercial - build resilient communities to help people help themselves and others - promote a culture that values new ways of working, equality and diversity	Bayo Dosunmu	Paul Wickens	Jane Bowie	Paul Wickens	March 2022

Strategic Programme	Senior Responsible Owner	Programme Sponsor	Board Member leads from IHC	Programme Manager	Planned End Date
SP7: Children at Heart of Practice To put children and families in need at the heart of practice so they are safe and thrive	Andrew Travers	Merlin Joseph	Abi Onaboye Richard Outram	Danielle Lexton	March 2021
SP8: Estate Regeneration Homes for Lambeth has been created by Lambeth Council to work with us to provide high quality new housing and regeneration in Lambeth that addresses local housing need, contribute positively to communities and assist with the economic recovery from Covid 19	Sara Waller/Eleanor Purser	Thomas Branton	Jane Bowie	Lee Wilson	January 2040
SP10: Climate Change Response To transform the council's operations so that we reach carbon neutrality by 2030, and to develop a collaborative borough-wide approach to significantly reducing carbon emissions and improving the borough's resilience to the impacts of climate change.	Sara Waller/ Eleanor Purser	Rob Bristow Hannah Jameson	*Board undergoing review - Dec 2020*	Kate Hogarth	TBC
SP11: Growth & Development To attract and bring new growth into the borough and to ensure the delivery of the strategic projects and infrastructure activity that underpins the council's corporate strategies and financial resilience	Sara Waller/Eleanor Purser	Thomas Branton	Andrew Eyres	Charlotte Glazier	TBC
SP12: Enterprise and Economy To develop an inclusive, resilient economy with more equitable share of wealth and opportunity for all residents.	Fiona McDermott	Nabeel Khan		Joahanne Flaherty	TBC
SP13: Digital Lambeth	Fiona McDermott	Dami Awobajo		Adrian Thompson	TBC

Lambeth

Workforce – Lambeth and CCG staff

Grade and agency status	LBL	CCG	Total
Employees (Headcount)	351	46	397
Employees FTE	331	44	375.05
Agency Staff	50		50
Apprentices			0
Employees at Bands 4-5	61	<5	>61
Employees at Bands 6-7	60	11	71
Employees at Bands 8a and 8b	134	18	152
Employees at Bands 8c and 8d	80	11	91
Employees at Band 9	11	<5	>11
Employees at Other	5	<5	>5
Sickness			
Average days lost to sickness	7.49		7.49
Age bands			
=<20 Years		<5	N/A
21 - 30 Years	17	<5	>17
31-40 Years	67	11	78
41-50 Years	85	16	101
51-60 Years	119	15	134
>60 Years	63	<5	>63

Gender (self defined)	LBL	CCG	Total
Female	249	30	279
Male	102	16	118
Any other answers	N/A	N/A	N/A
Disability (self defined)			
Number of staff who have stated that they have a disability	33	<5	>33
Prefer not to say	<5	<5	N/A
Unknown	110		110
Ethnicity (self defined)			
Asian	23	5	28
Black	170	10	180
Mixed	10	<5	>10
Other	5	<5	>5
Not Specified	17	<5	>17
Prefer not to say	none		N/A
White	126	25	151
Staff who identify as LGBTQ			
Staff who identify as LGBTQ	20	<5	>25
Prefer not to say	21	5	25
Unknown	188		188

Lambeth

Budget – London Borough of Lambeth

	Employee Expenditure	Non Employee Expenditure	Total Expenditure		Grants and Contributions	Other Income	Total Income		Total
ADULTS & HEALTH	21,316	138,624	159,940		(54,905)	(11,026)	(65,931)		94,009
ADULT SOCIAL CARE	17,855	97,502	115,357		(12,128)	(11,026)	(23,154)		92,203
ADULTS WITH LEARNING DIFFICULTIES	2,577	34,040	36,617		0	(1,843)	(1,843)		34,774
ADULTS WITH MENTAL HEALTH NEEDS	2,786	12,584	15,370		(5,536)	(224)	(5,760)		9,610
ADULTS WITH PHYSICAL DISABILITIES	0	13,067	13,067		0	(1,283)	(1,283)		11,784
OLDER PEOPLE	7,775	24,286	32,061		(674)	(7,434)	(8,108)		23,953
OTHER - ADULTS	4,717	2,774	7,491		(283)	(170)	(453)		7,038
SUPPORTED HOUSING		6,103	6,103		(5,635)		(5,635)		468
SUPPORTING PEOPLE	0	4,648	4,648			(72)	(72)		4,576
INTEGRATED COMMISSIONING	0	9,832	9,832		(9,649)		(9,649)		183
POLICY, RESEARCH & CUSTOMER RELATIONS	0	183	183						183
STRATEGY & COMMISSIONING - ADULTS BCF		9,649	9,649		(9,649)		(9,649)		0
PUBLIC HEALTH	2,041	31,237	33,278		(32,930)		(32,930)		348
PUBLIC HEALTH - ADULTS	2,041	21,509	23,550		(23,202)		(23,202)		348
PUBLIC HEALTH - CHILDREN		9,728	9,728		(9,728)		(9,728)		0
SENIOR MANAGEMENT - ADULTS & PUBLIC HEALTH	1,420	53	1,473		(198)		(198)		1,275
SENIOR MANAGEMENT - ADULTS & PUBLIC HEALTH	1,420	53	1,473		(198)		(198)		1,275

Lambeth

Savings – London Borough

One related saving in the current agreed savings proposals:

Reductions to the overall cost to Lambeth of care packages as a result of successful legal transfer of care responsibilities to correct local authorities. To produce a 'pipeline' from Direct Payment fraud case work that is expected to reduce Direct Payment expenditure and ensure appropriate use of public funds.

Ref	Directorate	Proposal Name	Savings Type	Cabinet Member	2021/22	2022/23	2023/24	2024/25	Grand Total	Full Description	Risks	Risk Mitigation	Order	Type of Change
A&PH.21.22-001	ADULTS & HEALTH	Health & Care - Ordinary Residence & Counter Fraud	Service Transformation – Non Staffing	Cllr Jim Dickson	100	100	100	100	**400**	Reductions to the overall cost to Lambeth of care packages as a result of successful legal transfer of care responsibilities to correct local authorities. To produce a 'pipeline' from Direct Payment fraud case work that is expected to reduce Direct Payment expenditure and ensure appropriate use of public funds.	Relevant local authority does not acknowledge their requirement to accept the case.	Compilation of robust evidence to support cases and legal support.	1	Service Transformation – Non Staffing

Lambeth

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10b. 2021/22 NHS priorities and operational planning guidance

Purpose:

- The Lambeth Together Strategic Board are asked to note the headlines from the recently published (25 March 2021) NHS priorities and operational planning guidance for 2021/22: https://www.england.nhs.uk/publication/2021-22-priorities-and-operational-planning-guidance/
- We will continue to connect locally and through SEL on evolving work and planning, and think about these priorities and our local priorities.
- Plans are submitted at a SEL level with input from boroughs like Lambeth.

Recommendation:

- To note the recently published NHS planning headlines for 2021/22.

Summary:

- The focus of the recently published guidance is on recovering NHS services through enhanced system working.
- It sets the NHS priorities for the year ahead against a backdrop of the challenge to restore services, meet new care demands, reduce the care back logs that are a direct consequence of the pandemic whilst supporting staff recovery and taking further steps to address inequalities in access, experience, and outcomes. The guidance reiterates the importance of the NHS Long Term Plan.
- It sets an agreement around the financial settlement for months 1-6, whilst months 7-12 are to be determined. The plan asks systems to develop fully triangulated plans across activity, workforce and money for the first half of the year.
- Priority areas of particular focus for systems for the first half of 2021/22 are:
    A. Supporting the health and wellbeing of staff and taking action on recruitment and retention. Eg, support to staff, improve diversity, new ways of working, grow the workforce.
    B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19. It mentions for instance the important continuing role of Primary Care Networks in vaccinating.
    C. Building on what has been learned during the pandemic to transform the delivery of services, accelerate the restoration of elective, and cancer care (in full with a separate cancer plan), and manage the increasing demand on mental health services. Including: planning for highest possible level of elective activity (subject to criteria), taking advantage of opportunities to transform (ie, non-face to face outpatient) and learning from others. Expand and improve mental health services and services for people with a learning disability (registers and health checks) and/or autism, and existing Mental Health (Mental Health Improvement Plan, Mental Health Improvement Standards) standards, and Children and Young People access. Deliver improvements in maternity care, including responding to the

recommendations of the Ockenden review to improve outcomes and patient experience and to reduce unwarranted variation.

D. Expanding primary care capacity: restore and improve access, implement Population Health Management and personalised care approaches to improve health outcomes and address health inequalities.
E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay. Ie, timely and improved discharge, NHS111 as primary route for accessing urgent care.
F. Working collaboratively across systems to deliver on these priorities. To achieve these goals, while restoring services and recovering backlogs, will require doing things differently, accelerating delivery against and redoubling commitment to strategic goals agreed in the Long Term Plan. Expectations for how ICSs are expected to build on existing arrangements during 2021/22. These requirements include:
    - having system-wide governance arrangements to enable a collective model of responsibility and decision-making between system partners.
    - Develop local priorities that reflect local circumstances and health inequalities.
    - Develop the underpinning digital and data capability to support population-based approaches.
    - Develop ICSs as organisations to meet the expectations set out in Integrating Care.
    - Implement ICS-level financial arrangements.

- Alongside the 2021/22 priorities and operational planning guidance, implementation guidance has been published, https://www.england.nhs.uk/publication/implementation-guidance/ and provides further detailed policy and technical information to enable Integrated Care Systems (ICSs) and their constituent organisations to develop and agree operational plans.
- These plans are asked to summarise how as systems the priorities set out in the 2021/22 planning guidance will be delivered, with a focus on the six months to the end of September 2021 for most areas.
- ICSs are expected to work across their partner organisations to produce plans that consider alignment between CCGs and providers, and between activity, workforce and finances. The national planning timetable is below.
- The new NHS System Oversight Framework being consulted upon to 14 May 2021, some information on this is available at: https://www.england.nhs.uk/commissioning/regulation/ , and updates on this will be considered.

Key Tasks	Date
Publication. • 2021/22 priorities and operational planning guidance • Guidance on finance and contracting arrangements for H1 2021/22 • Implementation guidance • Technical definitions	Thursday 25 March 2021
Templates issued. • Non-functional activity, workforce • Narrative	Friday 26 March 2021
System financial planning template and SDF schedules issued	Monday 29 March 2021
Organisation (provider) capital and cash plan submission	Monday 12 April 2021
• System finance plan submission. • Mental Health finance submission **Draft plan submission deadline.** • Draft activity, workforce (primary and secondary care) and MH workforce numerical submission • Draft narrative plan submission	Thursday 6 May 2021
Non-mandated provider organisation finance plan submission	w/c 24 May 2021
Final plan submission deadline. • Final activity, workforce and MH workforce numerical submission • Final narrative plan submission	Thursday 3 June 2021

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South East London Clinical Commissioning Group

ENCLOSURE:

AGENDA ITEM:

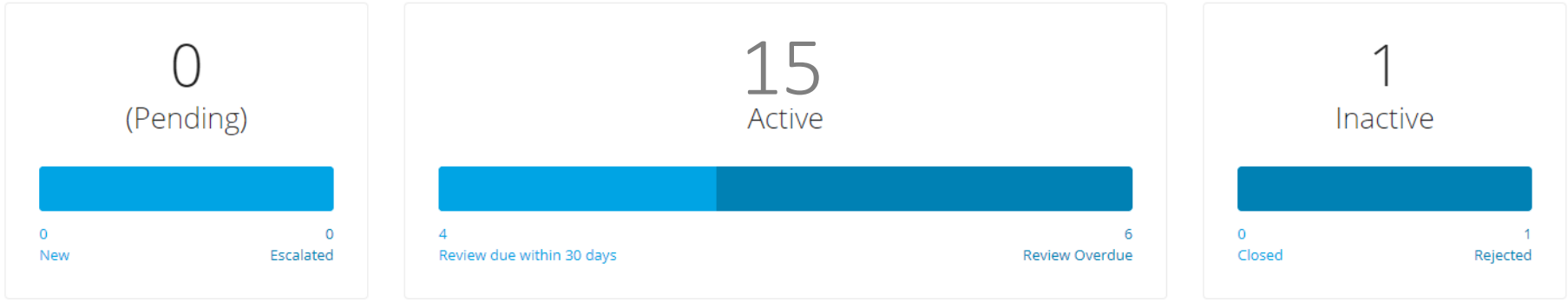
Lambeth Together Strategic Board

DATE: 26th May 2021

Title	**SEL CCG Lambeth Risk Register – May 2021**		
This paper is for **information**			
Executive Summary	This is the first formal report of the Lambeth Risk Register since moving to the new Datix System. The snapshot and report overleaf show the number of open risks currently held on the Lambeth risk register and the controls and assurances in place for each. Currently we are restricted with the content available for reporting. This will improve as the Corporate Governance team work with Datix over the coming months.		
Recommended action for the Committee	To note for information		
Potential Conflicts of Interest			
Impacts of this proposal	Key risks & mitigations		
	Equality impact	*Please consider both the Health Inequalities act & PSED (see guidance)*	
	Financial impact	*Is there a financial cost/ gain? Has this been agreed with finance?*	
Which corporate objective does this item link with? (please mark the relevant line with an x in the right hand box)	1: To ensure we commission services which meet the health and wellbeing needs of the population and reduce health inequalities		X
	2: To work in partnership to maintain and improve the quality of our commissioned services, and ensure all safeguarding protections are in place		X
	3: To enhance collaborative working with other health and care organisations to develop and deliver an effective ICS – able to deliver national, ICS and local objectives - with our population at the centre		
	4: Strengthen our partnership working and develop a culture which embraces lessons learned and surfaces and embeds best practice		
	5: To secure the active participation and visibility of patients and local people, including from diverse and seldom heard groups, in the planning and design of local services		
	6: To ensure that clinical leadership is embedded in our ways of working and our change programmes including the involvement of member practices and system partners		

	7: Develop an organisation and workforce capable of delivering the CCG's objectives and ensure members of the organisation feel valued and enjoy coming to work.	
	8: Ensure that the CCG meets its commitments with regards financial and performance improvement, maintains effective governance within the organisation and across partnerships, and optimises progress against the delivery of NHS constitutional standards	X
Wider support for this proposal	Public Engagement	
	Other Committee Discussion/ Internal Engagement	Lambeth Management Team
Author:	Cheryl Smith	
Clinical lead:	Various	
Executive sponsor:	Andrew Eyres, Strategic Director – Integrated Health and Care	

Lambeth – Risk Summary May 2021



	Consequence				
Likelihood	Negligible	Minor	Moderate	Major	Catastrophic
Almost Certain	0	1	0	0	0
Likely	0	6	1	1	0
Possible	0	1	5	0	0
Unlikely	0	0	0	1	0
Rare	0	0	0	0	0

There are 6 risks that are currently overdue a review, these were due for reviews on April 16th and 19th, training for the risk owners linked to 4 of these risks is in progress. 1 risk review has not been completed due to an issue with the Datix system and this is being looked into.

*The remaining overdue risk is rated Red and shown below - discussions are taking place to see whether this risk can be closed as a very similar risk sits on the South East London risk register.

ID	Title	Type	Subtype	Risk Review Date	Current Risk Grading	Escalated?
144	Risk of deteriorating IT service to Lambeth CCG and Lambeth GP's	IT and Information Governance	Equipment issues	2021-04-16 00:00:00	16	No

The inactive risk shown above is due to a risk being added to our register by another borough.

There has been an ongoing issue with IT giving risk owners access to their risks. This has now been rectified and all risk owners should now have access.

The May Risk Register does not show the gaps in controls, we are working with the team at Yellowfin to improve the reports available to us.

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Lambeth Risk Register - May 2021

Datix Risk ID	Risk Description	Initial Rating	Control Summary	Current Rating	Assurances	Gaps in Assurance	Target Rating
128	Increase to CAMHS waiting times	8	A number of other provisions are in place to support the emotional health and wellbeing needs of our young people – including Kooth, Centrepoint and more. Redesigned model of CAMHS implemented July 2019 has seen improvement in performance Successful bid for MHST funding - MHST programme commences Jan 2021	6	"MHST Implementation" "Monitoring of this indicator at council as well as CCG level" "Monthly contract monitoring meetings in place with SLaM enabling drill down into performance issues rapidly"		3
129	Failure to reduce diagnostic waiting times for children and young people awaiting an Autism or ADHD assessment.	8	ADHD working group ongoing aimed at better apportioning the resource between SLAM and Evelina to enhance pathway Transformation funding proposal from Evelina London is going through contract management meetings route in order to build paediatric capacity to manage this.	8	"Bi-monthly contract monitoring meetings with Evelina." "Monthly ADHD meetings with Evelina and SLAM."		4
130	There is a risk that the CCG will not meet budget or performance requirements for Prescribing and Continuing Health Care in 2021/22. This could contribute to an in-year and underlying financial pressure for the CCG.	16	Budget controls have been negotiated into CHC contracts with our major providers Continue to focus on areas of potential savings and value improvement as well as any emerging pressures Monthly monitoring of spend and also Cat M and NCSO spend Reduced Qipp Recovery Plan from Q3 due to capacity of team and providers to deliver but also for safety e.g. no drug switches to avoid destabilising the supply chain. Also non deployed CCG MM teams still linking in with practices but focus is on system and pathway work e.g. increasing electronic repeat dispensing which may support QIPP Robust CCG governance through Finance and service working groups in place to mitigate any potential impact of under-delivery. SEL rebate schemes continue to be processed	12	"CCG assurance processes in place through service specific focus groups and overseen by detailed review through the SEL Planning and Delivery Group. Further, this control ensures the risk is monitored with exceptions discussed at SEL level Meds mgt and finance meetings. This control attempts to minimise the risk as well as prioritises urgent COVID-19 decisions"		8
131	There is a risk that the Board does not have oversight and assurance for all of the health and care outcome areas through a single assurance framework	9	Existing commissioning leads monitor performance and escalate issues through management and programme groups. Sharing and reference of published performance reports (i.e. Council Finance and Performance Quarterly Report, South East London reporting and borough based assurance report) at regular board meetings	9	"Regular bi-monthly integrated assurance report and integrated assurance arrangements"		4
132	Risk that transfer of high cost Learning Disability clients from Specialised Commissioning under the Transforming care Programme results in potential unbudgeted costs	12	CCG-funded Lambeth inpatients identified and plans in place for discharge to community placements in 12-18 months. Definitive list of all Lambeth inpatients across the CCG and NHSE. Specialised commissioning and funding responsibilities. Ongoing review of CCG Lambeth inpatients, discharge plans and associated finances. Additional programme management and case management resource in place. Focus on improving discharge processes and admissions management. Community Care and Treatment Reviews and professional meetings also continue to prevent hospital admissions. Dynamic at risk register captures data on people with learning disability and or autism who are at risk of admission. The South East London Transforming Care Partnership Commissioning Memorandum of Understanding has been signed off.	8	"Continuing to be an active member of the SEL processes as well as engaged with Lambeth teams to oversee progress of both new cases coming out of hospital as well as preventing admissions where possible." "Reviewing any new changes in policy E.G. SoS intervention S117 aftercare responsibilities"		6
133	There is a risk to the sustainability of the Lambeth GP Federation which has the potential consequence to change Primary Care commissioning arrangements.	9	Continuing to work with PCNS's and feds through the Lambeth Clinical Cabinet to ensure sustainable arrangements for Primary Care funding and services.	8	"Regular meetings with PCN's and federation demonstrating contracts are being delivered Practice visits to establish support to practices from the Federations Board to Board meeting Risk reviewed at the Primary Care Working Group"		6
134	Possible risk of failure to safeguard children and identify and respond appropriately to abuse.	15	All designated and named professionals in post in CCG and Provider organisations. Named GP for Primary Care and Independent Contractors. Strong safeguarding governance arrangements in place across the borough and internally. Governing Body Clinical Lead for Children and Lead Integrated Director LCCG and Lambeth Local Authority. Compliant with the accountability and assurance framework for safeguarding vulnerable people 2015 Safeguarding and Looked After Children Working Group (SLAC). Quarterly Assurance Meetings with Provider Health Organisations Local Safeguarding – Transitional Arrangements statutory guidance. June 2019 new Lambeth Safeguarding Children Partnership arrangements were published. The new LSCP arrangements are in place. The annual work plan has been agreed. SEL STP Alliance Safeguarding Gap Analysis Project. Work is ongoing to ensure that the workforce is up to date on VAWG related training and that they offer for VAWG services is understood to ensure the appropriate safeguarding of adults and children.	10	"Action plans developed following SCRs, and SCR audits are monitored. SCRs published on LCSB website" "Annual Report updated annually detailing work of Safeguarding Team. Looked After Children Annual Report detailing work of Safeguarding and LAC Team. Public Health Annual CDOP report detailing annual review of work undertaken and recommendations" "Assurance Safeguarding and Looked After Children Working Group (SLAC) which reports to IGC" "Deep dive undertaken by NHSE - assured Safeguarding Quick Guide for GPs developed" "LSCB dataset KPIs reported to the board quarterly. OFSTED inspection completed – reported published 9 May 2018 Risk reviewed at Children's and Maternity Programme Board" "LSCB manager now in post and is a member of the SLAC, providing link between CCG and LCSB" "LSCP Business Plan and KPI's reviewed" "Quarterly Assurance meetings Chaired by CCG Lead Director for Safeguarding Children reviews S11 arrangements continually and reviews compliance with Accountability and assurance framework for safeguarding vulnerable people and CQC Safeguarding Inspection requirements" "Regular Safeguarding GP Bulletins, training and GP visits Multi-Agency Improvement Board now established responsible for improvements following OFSTED inspection" "The Director is a member of the CCG Governing Body and LSCB Business Management Group and has the responsibility and authority for ensuring full collaboration with the new statutory arrangements" "The Director of Children's Commissioning and Improvement; (LCCG and LBL) is the delegated senior CCG safeguarding children lead" "The LSCB has effective quality assurance information and analysis of the performance of the board or its partners" "The new LSCP arrangements in place"	Ofsted inspection May 2018 concluded that children services in Lambeth require	5
135	Risk of failure to safeguard adults and identify and respond appropriately to abuse	16	Controls Accountability and Assurance Framework for Safeguarding Vulnerable People in the NHS London Lambeth Adult Safeguarding Guidance cards for General Practice Safeguarding Training for CCG staff Basic Prevent Awareness and WRAP Training for CCG staff CCG Prevent Policy Adult Safeguarding Roles and Competencies GP Practice Template Policy GP Competency Guide LSAB Decision making tool	8	"Analysis of current SG adult policies in Primary Care undertaken SEL safeguarding assurance gap analysis and mapping project" "Annual CCG Safeguarding report for SAB and IGC" "Assurance NHSE deep dive of safeguarding process undertaken; assured as good in most areas" "CCG attendance at Safer Lambeth" "CCG contribution to multi-agency work at the Lambeth SAB CCG has completed London SAB self-audit tool" "CCG Safeguarding Lead attendance at provider Safeguarding Committees" "CCG Safeguarding Level 1 and Prevent training database maintained" "Close working with integrated commissioners and CHC commissioning team" "Close working with Lambeth Council Safeguarding team" "Designated Lead and Named GP practical support for GP practices" "Executive CCG attendance at Lambeth Channel Panel" "Major providers have completed LSAB self-audit tool" "Self-assessment for Care Act compliance completed" "Working effectively with SEL Quality and Safeguarding teams and new LSAB chair to agree local priorities"	"Enhanced SG assurance frameworks for major providers" "Primary Care Level 3 safeguarding training Lack of Care Act compliance with SG policies in Primary Care Domestic Abuse training/ referral pathway in Primary Care"	8
140	Risk that uptake of Covid-19 vaccination is suppressed due to issues of Hesitancy leading to poorer Health outcomes and inequalities	16	Comms and Engagement plan in place overseen through the Lambeth Vaccine Steering Group in turn reporting to the Lambeth Together Executive Group Hesitancy Plan in place for Lambeth	8	"Regular reporting to LTEG through vaccine steering group"		6
141	Possible risk that the provisions of the Mental Capacity Act and Deprivation of Liberty authorisations are not fully adhered to, resulting in a breach of the law and an individual's human rights.	12	Access to legal advice/ service via Capsticks CCG experience of legal processes in Court of Protection CCG MCA guidance CCG MCA Lead Continuing Care Team Commissioning Teams DoLS team available for advice Informal Resources such as the internet site ' Mental Capacity Law' Legal Updates from 39 Essex Street SCIE mental capacity resources National MCA Forum NHS MCA Commissioner Toolkit NHSE MCA Commissioner Guidelines LSAB MCA QA Tool Lambeth Safeguarding Adults Board Lambeth SAB MCA Subgroup remains in place with DR as chair - waiting release of national guidance for new LPS. MCA MCA Amendment Act 2019 Human Rights Act MCA Code of Practice/ DOLS Code of Practice	8	"DoLS audit demonstrated improved Form 1 quality from main providers" "Every CCG funded DOLs objection is overseen by legal services CCG knowledge of legal processes in Court of Protection Risk reviewed at the Management Team meeting Lambeth Advance Planning Consortium CCG register of DoLS cases." "LSAB MCA QA report demonstrates good baseline assurance in CCG and main providers MCA Lead" "MCA awareness events arranged via LSAB MCA training provided for Integrated Commissioning team" "MCA Masterclass session" "Policy in place for most commissioned nursing homes"		8
142	Failure to maintain high immunisations performance will pose a risk to young peoples health and subsequent need to access services.	12	Imms working group established and meets regularly. Immunisations action plan in place and overseen by commissioners and the imms working group. Immunisations is on the agenda of the CYP Alliance board.	12	"Appropriate working groups and documentations in place."		3
143	There is a risk that staff may be targeted by internet fraudsters looking to exploit their personal information to gain access to the secure computer servers. This could lead to a major data breach and a potential loss of secure patient data.	12	Continued campaign of staff awareness to business continuity and resilience issues. Commitment to participating in appropriate multi-agency exercising. Next business continuity exercise due early 2021. Staff made aware of process to be followed upon receipt of suspicious email.	8	"Awareness may not reduce the chance that the CCG will be targeted but the awareness will enable the CCG to be fully prepared." "Communications to staff highlight avenues available to report incidents or possible incidents – this allows the CCG to put into place actions that will support and protect all." "Exercise will ensure that staff understand procedures and processes for reporting."		8
144 *	Likely risk of deteriorating IT service to Lambeth CCG and Lambeth GP's resulting in services being unable to operate effectively and safely	16		16			8
145	Risk of failure to plan for future premises needs across Lambeth. Sites include Clapham Park, Crown Dale, Waterloo Health Centre and Nine Elms Vauxhall.	9	CCG is funding project post with Wandsworth CCG and NHSE CCG Senior Estates Project Manager in place since December 2018. CIL Funding approved for Phase 2 of the project and secured for Clapham Park Project Funding of feasibility study by CCG for Waterloo Health Centre Lambeth and Wandsworth CCGs have set up new constituted NEV Board and Governance; Phase 2 pre-planning complete, tender process complete and main contractor appointed for Clapham Park. Regular monitoring of CCG populations is being undertaken to assess growth and service change resulting from NEV population inflows by NEV Health Programme Board	9	"Monthly NEV Health Programme Board – with Wandsworth CCG, LBW and LBL" "Regular discussion with Practice/NHSE PAU NHSPS (as landlord of Crown Dale)" "Regular discussion with Practices/NHSE" "Regular updates to LCCG BBB"	Quality of healthcare deteriorates as pressure on existing capabilities & facilities increases Increased incidence of preventable diseases (public health e.g. stop smoking, vaccination, health visiting) Knock-on effect on social care in LB Lambeth & LB Wandsworth Cost pressure and capacity failure at A&E and urgent care facilities elsewhere in LB Lambeth & LB Wandsworth Reputational damage to Lambeth Council, Lambeth CCG, Wandsworth Council, Wandsworth CCG, NHS England, NHS Property Services, Mayor of London, MPs	4
158	Risk that Covid continues to have significant impacts on the CCG and partners that constrains the transformation programme for Lambeth Together including to improve health and reduce inequalities in the borough	16	Produced recovery plan to link Covid experiences to set future objectives; has continued to encompass national directives but sought delivery through LT partnerships to strengthen joint working The Lambeth Together programme has continued through the pandemic but revised meetings and work to account for current activity; LT programme has accounted for feedback from providers to ensure programme remains relevant and holds balance between managing immediate demands and longer-term objectives	12	"participation in SEL Executive, LBL Management Board, SEL Planning and Delivery Group, Directors Network and other service oversight groups to ensure and overseen by detailed review through the . Further, this control ensures the risk is monitored in partnership with stakeholders at LT programme meeetings." "weekly Lambeth MT and LT Executive meetings"		8

* Please see attached report for more information

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South East London Clinical Commissioning Group

ENCLOSURE:

AGENDA ITEM:

Committee Title Lambeth Together Strategic Board

DATE: 26 May 2021

Title	**Reforming the Mental Health Act**	
This paper is for **information**		
Executive Summary	The Department of Health and Social Care launched a consultation at the beginning of the year on potential changes of the existing Mental Health Act 1983 (MHA). Building on a previous exercise run in 2017, the consultation ran from 13 January 2021 until 21 April 2021. The Lambeth Living Well Network Alliance (LWNA) led a number of different sessions to discuss and collate views on the Act and proposed reforms, involving service users, carers, professionals and clinicians and key partners such as Healthwatch. The final draft response was reviewed by the LWNA leadership team and submitted within timescales.	
Recommended action for the Committee	The consultation response was submitted on 21 April 2021 at the end of the review period – the Board is asked to note for information.	
Potential Conflicts of Interest	None	
Impacts of this proposal	Key risks & mitigations	None in relation to submitting consultation response
	Equality impact	Potential positive impacts of changing legislation have been included in the consultation response
	Financial impact	None in relation to submitting consultation response
Which corporate objective does this item link with? (please mark the relevant line with an x in the right hand box)	1: To ensure we commission services which meet the health and wellbeing needs of the population and reduce health inequalities	x
	2: To work in partnership to maintain and improve the quality of our commissioned services, and ensure all safeguarding protections are in place	x
	3: To enhance collaborative working with other health and care organisations to develop and deliver an effective ICS – able to deliver national, ICS and local objectives - with our population at the centre	x
	4: Strengthen our partnership working and develop a culture which embraces lessons learned and surfaces and embeds best practice	x
	5: To secure the active participation and visibility of patients and local people, including from diverse and seldom heard groups, in the planning and design of local services	x

	6: To ensure that clinical leadership is embedded in our ways of working and our change programmes including the involvement of member practices and system partners		x
	7: Develop an organisation and workforce capable of delivering the CCG's objectives and ensure members of the organisation feel valued and enjoy coming to work.		
	8: Ensure that the CCG meets its commitments with regards financial and performance improvement, maintains effective governance within the organisation and across partnerships, and optimises progress against the delivery of NHS constitutional standards		
Wider support for this proposal	Public Engagement	Lambeth Healthwatch provided support to collect views including from service users to this response	
	Other Committee Discussion/ Internal Engagement	Lambeth LWNA members were involved in collating and contributing comments to the consultation response	
Author:	Sabrina Phillips Alliance Director, LWNA John Lavalle, Service Director, SLaM		
Clinical lead:	Adrian McLachlan, Lambeth Mental Health Lead, SEL CCG		
Executive sponsor:			

Theme	Consultation question	AMT response
1. Guiding principles	We propose embedding the principles in the MHA and the MHA code of practice. Where else would you like to see the principles applied to ensure that they have an impact and are embedded in everyday practice?	500 words We welcome this proposal to embed principles in the Mental Health Act and Code of Practice. Embedding the proposed general principles in the MHA and Code of Practice would be sufficient to ensure they have an impact and form part of everyday practice, as is the case for the principles in the Mental Capacity Act. To ensure these principles are embedded into everyday practice it is vital that there is sufficient resources in place as without resources the care demanded by these principles will be impossible to achieve. It would also be helpful for these principles to be incorporated into Alliance partners strategies, undergraduate and postgraduate education, and training in all disciplines involving or allied to mental healthcare.
2. Detention criteria	We want to change the detention criteria so that detention must provide a therapeutic benefit to the individual. Do you agree or disagree with this proposal.	• strongly agree • agree • disagree • strongly disagree • not sure Please give reasons for your answer (up to 500 words). Discussions with carers and patients found the term therapeutic benefit was welcome criteria and that there was also need to ensure that the environment where service users are detained should ensure there are resources to offer activities, Occupational Therapy and that wards are able to keep them safe.They also wanted clarity on who defines what is a therapeutic benefit if they have the capacity to define this. A carer expressed that where there is a need to detain

		their loved one due to risk to self or others that detention in these circumstances was supported. Therapeutic benefit is potentially a very subjective concept, and clinicians' and patients' views may differ significantly as to treatment goals and what kind of treatment would provide a benefit. Clarity and guidance is needed on how 'therapeutic benefit' should be defined and who is the ultimate decision maker is required. Therapeutic benefit should also be explicitly linked to the risks justifying detention, so that care and treatment has a clear purpose of helping a person progress towards discharge from detention. Applying this criterion should not preclude patients being detained where there are valid reasons to do so. Therapeutic benefit should be interpreted broadly enough to include for example, the avoidance or harm to self or others It is important to invest in community provisions (including social care) with the aim of reducing the need for detention in these circumstances. The Difference in opinion between patient/carers and professionals in deciding what is therapeutically beneficial for the patient and how will this be resolved. Concept of therapeutic benefit not vastly different from existing criteria of appropriate medical treatment for admission under s.3. It is important to note that threshold for admission and complexity of need varies immensely within UK. Acute inpatient thresholds and complexity of needs between Lambeth with Yorkshire dales or North Norfolk would vary significantly, and the complexity and severity of needs will also impact on inpatient services (acute more specifically) in being able to provide therapeutic setting.

3. Detention criteria	We also want to change the detention criteria so that an individual is only detained if there is a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person. Do you agree or disagree with this change?	• strongly agree • agree • disagree • strongly disagree • not sure Please give reasons for your answer (up to 500 words). This amended detention criteria concerns us as it perpetuates risk as the key determinant for detention, despite other proposed changes seeking to prioritise therapeutic benefit to the patient. We are concerned that due to existing disparities in the perception of risk posed to others by individuals from different ethnic groups, this higher risk threshold is likely to similarly disproportionately affect certain ethnic minorities. The uncertainty created by the new terms 'substantial likelihood' and 'significant harm' in the absence of clear guidance on interpreting them, and the effect this uncertainty will have on practical decision-making is concerning. The following types of admission should remain possible to meet the needs of individual patients: • Cases of patients who do not have mental capacity to decide on treatment and who may not be judged 'high risk' under the new criterion, but where timely admission is considered vital to prevent escalation of risk, facilitate briefer admission and promote better outcomes and functioning. • Cases where further deterioration in mental state is anticipated e.g. a patient with chronic relapsing-remitting

		mental illness stopping medication that keeps them well, but the risk does not yet meet the stricter threshold. This means admission for such patients would be delayed until the person has become more unwell and poses more risk, and correspondingly they will be more difficult to treat. . We are not aware of patients being detained under the Mental Health Act in respect of minor or remote risks to self or others. We therefore feel that amending this criterion is unlikely to change practice significantly, but is likely to create more uncertainty and potentially adversely affect some patient groups. The Definition of substantial likelihood and significant harm needs to be clarified as these will otherwise be very subjective and will therefore open the possibility of further discrimination. Clarity is required for standardised decisions.
4. Giving patients more rights to challenge detention	Do you agree or disagree with the proposed timetable for automatic referrals to the Mental Health Tribunal? (See table 1 for details.)	Patients on a section 3 • strongly agree • agree • disagree • strongly disagree • not sure 2) Patients on a community treatment order (CTO) • strongly agree • agree • disagree

		• strongly disagree • not sure 3) Patients subject to Part III • strongly agree • agree • disagree • strongly disagree • not sure 4) Patients on a conditional discharge • strongly agree • agree • disagree • strongly disagree • not sure Please give reasons for your answer (up to 500 words). We agree with the proposed timetable for automatic referrals to the Mental Health Tribunal and the additional scrutiny this provides. We welcome the right to an automatic referral for Conditionally Discharged patients who are significantly restricted and without this right could potentially remain under Conditional Discharge indefinitely. Without enough resources in place to underpin the proposed new timetable the process will be significantly weakened. The resource implications of more frequent Tribunal hearings include an increased

		Tribunal workload, plus increased time spent by administrative and clinical staff and social care staff in the Alliance. We anticipate that the costs of implementing the proposed new timetable would be substantial. We feel these new proposals will lead to an increased time commitment from staff in preparing for and attending Tribunal hearings, which potentially takes staff away from working with patients. We therefore suggest that Tribunal reports be simplified.
5. CTO	We want to remove the automatic referral to a tribunal received by service users when their community treatment order is revoked. Do you agree or disagree with this proposal?	• strongly agree • agree • disagree • strongly disagree • not sure Please give reasons for your answer (up to 500 words). We agree with the proposal to remove the automatic referral to a tribunal which is triggered when a community treatment order is revoked. We understand the right to appeal alsoremain in place.

6. Giving patients more rights to challenge detention	We want to give the Mental Health Tribunal more power to grant leave, transfers and community services. We propose that health and local authorities should be given 5 weeks to deliver on directions made by the Mental Health Tribunal. Do you agree or disagree that this is an appropriate amount of time?	• strongly agree • agree • disagree • strongly disagree • not sure Please give reasons for your answer (up to 500 words). The Alliance supports the principle of patients having more rights to challenge detention. We are aware barriers to discharge are not only due to the patients mental health status. We are concerned the Tribunal may not be well-placed to hold sufficient working knowledge of the range of inpatient and community services available for patients, and the details of how these different services operate in practice. It is our view that current practice recognises this knowledge imbalance appropriately, with Tribunals making recommendations to ensure least restrictive practice, which the Responsible Clinician and team then respond to using their knowledge of what is available for that service user. We are also concerned about risk and responsibility for patients in these circumstances. Where would responsibility lie if the Tribunal mandates leave from hospital which then results in harm to the patient or another person? We ask that the current system is maintained so it is clear that ultimate responsibility rests with the Responsible Clinician, and that the exercise of this responsibility is not unduly constrained or diluted by the Tribunal or any other external party. We question how we would liaise with the tribunal as the situation changes and this requires further details. With respect to the time limit suggested to give effect to Tribunal orders, we note that often it is helpful for the treating team to have a

		time-limited direction around e.g. transfers or community services in order to expedite these arrangements. We question if it is appropriate to set a universal blanket limit as proposed, due to the variability in individual cases, patients needs and the availability for suitable options for the patient to be moved to. These proposals also necessitate clear guidance on who is responsible for the management of directions and require appropriate records of directions, which creates an additional workload to be managed.
7. Giving patients more rights to challenge detention	Do you agree or disagree with the proposal to remove the role of the managers' panel in reviewing a patient's case for discharge from detention or a community treatment order?	• strongly agree • agree • disagree • strongly disagree • not sure Please give reasons for your answer (up to 500 words) We would like to see the system simplified so that it's easier for our patients, carers and staff to navigate. However we are concerned that the removal of the Associate hospital managers to discharge patients from detention or Community Treatment Orders would reduce patients' current rights under S.23 to appeal against their detention to Hospital Managers.

8. Strengthening the patient's right to choose and refuse treatment	Do you have any other suggestions for what should be included in a person's advance choice document?	Your answer can be up to 500 words • Personal details • The service user's own view of their mental health problems • Significant physical health problems that staff in mental health settings should be aware of • Personalised risk assessment i.e. space to allow the service user to indicate the scenarios they feel are most important to avoid • Preferences for emergency community care (e.g. Home Treatment Team care) • Service user views on thresholds for inpatient admission • Service user preferences on the process of MHA assessments • Service user views on the use of restraint and seclusion e.g. raising awareness of previous physical or psychological trauma that staff should be aware of • Service user views on who should have access to the contents of their ACD e.g. GP/family members/mental health services/voluntary care sector staff/culturally appropriate peer workers • Service user views on medication. • Capacity assessment of the service user's capacity to make their ACD and make treatment refusals • Space for carers/family to record their views if the service user wishes • We suggest that a person who recovers decision-making capacity during an inpatient admission should be offered the chance to create an ACD after discharge (i.e. when in the

		community). This would allow the person to access support in doing so, at a suitable time, from healthcare professionals who know about their care. We suggest that resources for community services will be required to enable this.
9. Strengthening the patient's right to choose and refuse treatment	Do you agree or disagree that the validity of an advance choice document should depend on whether the statements made in the document were made with capacity and apply to the treatment in question, as is the case under the Mental Capacity Act?	strongly agree •agree •disagree •strongly disagree •not sure Please give reasons for your answer (up to 500 words) We agree introducing advance decision-making into the Mental Health Act via advance choice documents (ACDs) is a positive and welcome step. Patients should be offered the opportunity to have their ACD authenticated by a health professional. The process of authentication would mean a health professional assesses and documents the patient has the capacity to make an ACD and gives the patient information on any foreseeable consequences of an ACD, including the potential risks of refusing treatment, the fact that in some circumstances treatment refusals can be overridden, and where treatment choices are considered inappropriate they will not be facilitated.

		Without a clear process in place it will be difficult for clinicians to retrospectively ascertain decision-making capacity at the time an ACD was made, particularly as decision-making capacity can fluctuate significantly in the context of cyclical mental illness. Patients at risk of detention who lack capacity should also be encouraged through supported decision-making to express their wishes in advance. This would avoid excluding patient who are deemed not to have capacity from benefiting from this provision, which would appear to be discriminatory. This could be in the same form as an ACD and clinicians would have regard to this as an expression of past wishes and preferences as part of treatment decision-making. However, as they would not be authenticated, they would not have the additional weight that authentication provides. In the event of disagreement requiring clarification by the court, the clinician could treat for mental disorder whilst waiting for clarification. It would be helpful for authenticated ACDs to be registered centrally and for a specialised body to provide guidance on ACDs for patients and clinicians. There should be appropriate training for staff in developing and implementing ACDs, with ACDs being part of everyday routine clinical care.

10. Strengthening the patient's right to choose and refuse treatment	Do you have any other suggestions for what should be included in a person's care and treatment plans?	Your answer can be up to 500 words.
		• Details of family/carers/Nominated Person and how they have been consulted and liaised with concerning:
		  ○ service user's care and treatment;
		  ○ discharge planning (including discussing plans with anyone the service user lives with);
		  ○ the service user's rights; and
		  ○ whether they have been offered support and a carer's assessment.
		• The rationale for the service user's treatment and care including details of any confirmed or suspected diagnosis;
		• Social care plan (including aftercare plan) also to be included
		• Short and long term anticipated effects of medication so that the service user has this information in writing;
		• Details of any physical health issues affecting the service user which should be taken into account during admission
		• Details of how an individual's ethnicity and culture should be considered as part of care planning
		• Details of any ongoing therapeutic or occupational activities in the community and plans for re-engaging the service user with these activities post-discharge;
		Discharge planning, details of (planned) liaison with social care services, voluntary sector agencies, culturally appropriate peer support and other agencies which may have a role in supporting the service user post-discharge with housing, benefits, social care packages etc. ;
		• Acknowledgment that the care and treatment plan should be kept under regular review so that it responds flexibly to changes in the service user's wishes and needs and changes in their insight and decision-making capacity.

		• The care and treatment plan should explain how any communication issues have been addressed (e.g. language barriers, other individual communication difficulties); • Plan for future ill health, including potentially how to manage future admissions to hospital if required. • We are concerned about the feasibility of timescales for creating Care and Treatment Plans (CTP), in particular the requirement for scrutiny and approval by the Medical or Clinical Director within 14 days of detention, representing a significant new administrative burden that requires appropriate resources to fulfil. This also further embeds the medical model of care which services are attempting to move away from in the Alliance. • We note that mandatory CTPs will lead to greater discrepancy between how compulsorily detained and informal patients are managed in hospital, meaning voluntary patients would be at a relative disadvantage.
11. Strengthening the patient's right to choose and refuse treatment	Do you agree or disagree that patients with capacity who are refusing treatment should have the right to have their wishes respected even if the treatment is considered immediately necessary to alleviate serious suffering?	• strongly agree • agree • disagree • strongly disagree • not sure Please give reasons for your answer (up to 500 words). We are in favour of giving effect to service users' autonomy by allowing those with capacity to refuse treatment which may be considered by others 'immediately necessary to alleviate serious suffering'. This will increase parity between mental healthcare and

		physical healthcare for those who have appropriate decision-making capacity. However, we would like to see safeguards around the objectivity of assessments of capacity to refuse treatment.
12. Strengthening the patient's right to choose and refuse treatment	Do you agree or disagree that in addition to the power to require the responsible clinician to reconsider treatment decisions, the Mental Health Tribunal judge (sitting alone) should also be able to order that a specific treatment is not given?	• strongly agree • agree • disagree • strongly disagree • not sure Please give reasons for your answer (up to 500 words). We support the proposal that the Mental Health Tribunal judge sitting alone will be able to review whether appropriate processes have been taken by the Responsible Clinician in overruling a patient's treatment refusal, and order that the Responsible Clinician reconsider their decision if this is not the case. This will provide a more accessible route for patients to challenge treatment decisions going against their wishes compared to the current option of judicial review. Information requested by the judge to aid decision making should not replace the clinical knowledge and judgment of the Responsible Clinician in making a final treatment decision, with the benefit of expertise and the full clinical picture over time. In such cases we would expect the role of the SOAD (second opinion doctor) to be

		strengthened as an additional safeguard and level of clinical scrutiny regarding treatment decisions in order to prevent inappropriate treatments being given.
13. Improving the support for people who are detained	Do you agree or disagree with the proposed additional powers of the nominated person?	•strongly agree •agree •disagree •strongly disagree •not sure Please give reasons for your answer (up to 500 words). We broadly agree with the proposed powers of the Nominated Person We agree the right to choose a Nominated Person must be accompanied by a corresponding agreement from the chosen person that they are willing and able to fulfil this role, and they should have a right to decline the role. There should be a procedure for what happens if a person is unable or unwilling to accept the role of Nominated Person. It would be helpful to have more guidance around assessing capacity to appoint a Nominated Person, and more detail is needed on how an

		'interim' Nominated Person would be appointed and operate in practice. It would be important to ensure that family and carers are given due consideration when an interim Nominated Person is chosen by the AMHP. We are concerned to ensure that guidance on the selection mechanism for an interim Nominated Person should be clear, workable and acceptable, particularly as it will likely be used frequently unless and until ACDs are routinely adopted. It would also be helpful to understand more detail e.g. on how challenges to an interim Nominated Person will be resolved where a patient lacks capacity. If a person decides that they do not wish to choose a Nominated Person, and would prefer to relinquish the right to have someone in this role, what is the fallback position? Will this be accepted, or will someone be appointed in any event? It will, however, be important to ensure that the safeguards of the Nominated Person (such as the right to appeal against detention) can be achieved in other ways, for example through access to IMHA services. We recognise that there is a risk that a service user who is unwell and requiring detention under the Mental Health Act may choose someone as their Nominated Person who others view as inappropriate, perhaps due to safeguarding issues e.g. financial, emotional or other abuse. We note that it is envisaged that the Tribunal would obtain the power to displace Nominated Persons, however the details of this proposal are unclear including how and on what grounds this will be possible, and who can make such a challenge.

		In addition to the proposed powers of the Nominated Person, it would be helpful to explicitly suggest a potential role for the Nominated Person in supporting a service user to create an advance choice document. A significant amount of clarity is required on the role, how it differs to the NR and what parts of the NR role is included within the NP rile and which are not. Where not what other safeguards are to be put into place.
14. Improving the support for people who are detained	Do you agree or disagree that someone under the age of 16 should be able to choose a nominated person (including someone who does not have parental responsibility for them), where they have the ability to understand the decision (known as 'Gillick competence')?	• strongly agree • agree • disagree • strongly disagree • not sure Please give reasons for your answer (up to 500 words). We are concerned about the vulnerability of this group (associated with life events and compounded by mental health difficulties and developmental difficulties) and the likely impact on their relationships, possible impact of coercion and undue influence on decision making. Huge safeguarding concerns especially in circumstances when child is being assessed at A&E or at other locations where professionals are unlikely to have all necessary information about child and their friends and relatives. Does this link to the Children's Act and what is the role of parents who have 'parental responsibility' for the child in terms of decision-making about child's care and treatment. Likely to result in disagreements between parents and NP and whose views would be considered

		more important? Where LA's are sharing parental responsibility of has full responsibility granted by the courts, can LA representative be NP? Will LA in these cases have any say in deciding NP? Likely to again lead to applications to court to arbitrate disagreements. Who decides whether child is Gillick competent? This is likely to also increase burden on AMHP and local authorities.
15. Improving the support for people who are detained	Do you agree with the proposed additional powers of Independent mental health advocates?	• strongly agree • agree • disagree • strongly disagree • not sure Please give reasons for your answer (up to 500 words). We agree that IMHAs should be available to informal patients, see also below. We agree that IMHAs should be available to assist patients to prepare advance choice documents. We agree that IMHAs should be able to support patients to take part in care planning We agree that IMHAs should be available on an opt out basis, i.e. the default position should be that an IMHA is offered, but the patient can decline this.

		We would like to see IMHAs available to patients on request when being assessed for MHA. If patients have another person, such as their nominated person, who they would rather be present at their MHA assessment, we would like to offer to provide information to the nominated person or other person present should that be required. This is not currently being proposed by the MHA white paper but we would like to see this added. It would have resource implications which may well not be covered, as it would require 24/7 IMHA availability on-call as for AMHPs. We agree with plans to ensure that there is a review of accreditation, training, regulation and registration processes for advocates and advocacy providers to ensure advocacy standards are at least adequate and consistent across the country. The proposal is that these should not just be for IMHAs but for other types of advocacy. There is already a Quality Performance Mark (QPM) and Qualification in Independent Advocacy with specialist units such as IMHA and IMCA as well as core units, but these qualifications are not mandatory. Making qualifications and accreditation mandatory would be a good place to start, so no one can set themselves up as an advocate or advocacy provider without having appropriate training and accreditation. We would also be keen to ensure that any such 'professionalisation' of advocacy does not work against the involvement of those with lived experience becoming advocates nor against advocates continuing to operate independently of service providers.

		Accreditation (QPM) costs depend on the size of the organisation. For the smallest organisations it is around £2500 and needs to be renewed every 3 years. The process of accreditation is very vigorous and time consuming to ensure all quality standards are met by policy, written submission, and meeting with relevant stakeholders. We are fully committed to ensuring that advocacy provided should and must be culturally appropriate, and that local advocacy services should seek to recruit as advocates persons who are representative of local communities of mental health service users in terms of ethnicity as far as possible. We agree that IMHAs should be able to appeal to MHT when patients are too unwell to do so themselves. There will need to be clear parameters written into the MHA Code of Practice and further thought given to how this would work in practice. For example, patients may not want to engage in an upcoming MHT that they have not initiated, but a paper hearing could occur to review whether or not the person should continue to be detained. Thought would need to be given as to whether and how an IMHA might be involved in a MHT if the patient does not want to participate when it is scheduled. If (an) IMHA(s) appealed on behalf of (a) patient(s), this would ensure that the patient(s)' are able to exercise the right to have their detention reviewed.

		We agree that IMHAs should be able to challenge treatment decisions to a Care and Treatment Tribunal where they have reason to believe that the decision is not in the patient's best interests. This again needs further thought and a clear code of practice drawn up governing the advocate's involvement. Advocates report that they often feel they have no real power to effect change in those circumstances, so the opportunity to go to a Tribunal, based on a patient's expressed wishes regarding their care and treatment at the time, and/or what the patient has previously written in an advance choice document would be a good check and balance to ensure that care and treatment was appropriate for the patient, the least restrictive option, and properly considered. When patients want a second opinion they are often distrustful that the second opinion will be independent and patients currently have no legal right to a second opinion. We are less clear about non-instructed advocacy as implied by 'reason to believe (that the treatment) is not in the patient's best interests'. As IMHAs we are not clinicians so it is not our role to make these type of judgements, whatever our previous professional and academic background might be. All of the aforementioned additional duties for IMHAs will require additional resources to be made available, so what IMHAs can take on will depend on what resources are made available as well as other factors including what ends up in the revised MHA

16. Improving the support for people who are detained	Do you agree or disagree that advocacy services could be improved by-	1) enhanced standards • strongly agree • agree • disagree • strongly disagree • not sure 2) regulation • strongly agree • agree • disagree • strongly disagree • not sure 3) enhanced accreditation • strongly agree • agree • disagree • strongly disagree • not sure 4) none of the above, but by other means • strongly agree • agree • disagree • strongly disagree • not sure Please give reasons for your answer (up to 500 words) See above answer

17. Improving the support for people who are detained	How should the legal framework define the dividing line between the Mental Health Act and the Mental Capacity Act so that patients may be made subject to the powers which most appropriately meet their circumstances?	Your answer can be up to 500 words MCA and MHA interface has been clarified over the years through landmark case laws. There is no need for any change.
18. Improving the support for people who are detained	Do you agree or disagree that the right to give advance consent to informal admission to a mental health hospital should be set out in the Mental Health Act (MHA) and the MHA code of practice to make clear the availability of this right to individuals?	• strongly agree • agree • disagree • strongly disagree • not sure If you agree, please provide reasons for your answer (up to 500 words). If a person wants to include the agreement to be treated informally in any advance choice document, we would expect that their consent would also be sought at the time when consideration is given to their admission to hospital. We are unclear how an advance choice document, to agree to be treated/admitted informally, would over-ride a person's unwillingness or lack of capacity to consent to be admitted informally on the day.

		We would be concerned that a person who is admitted informally based on an advance choice document may be denied access to the rights they would have as a detained patient and may be 'de facto' detained. Such 'de facto' detention would appear to be commonplace at the present time. Although the white paper talks about extending IMHAs duties to informal patients, it also says in a number of areas that implementation is dependent on resources. It would be critical that an IMHA at the very least would be available as a safeguard for informal patients who were admitted informally based on an advance choice document, to ensure that the patient's rights are upheld. The patient should also be given clear written information about what it meant that they had been admitted informally and what their rights are, and what to do if at any point they no longer consent to remain an informal patient.

19. Improving the support for people who are detained	Are there any safeguards that should be put in place to ensure that an individual's advance consent to admission is appropriately followed?	Your answer can be up to 500 words The person consenting in advance to informal admission should also specify clearly in advance what conditions of admission they are agreeing to; this could include type of ward (generic, specialist etc.), level of care and geographic location, and potentially the treatments available during that admission. If possible, a person with a history of admission to inpatient services could name specific wards they would agree to be admitted to informally. It would also be helpful if this consent was part of an authenticated Advance Choice Document to give the admitting team more information to help support the person towards recovery during admission, as well as providing the patient's view of 'substantial likelihood of significant harm' and a description of relapse indicators relevant to them as an individual. The person should specify a time limit within which the advance consent to informal admission would remain valid, after which a person could revisit their advance consent and amend it as appropriate. If any of the above stipulations by the person making the advance decision about informal admission could not be met, then the advance decision would not apply and a statutory framework would be required (Mental Health Act or Mental Capacity Act/DoLS/LPS). A person admitted and who has consented to informal admission should have access to an IMHA who could support them, to provide some reassurance that a person would not feel coerced into continuing with their informal admission once admitted.

20.	We want to ensure that health professionals are able to temporarily hold individuals in A&E when they are in crisis and need a mental health assessment, but are trying to leave A&E. Do you think that the amendments to section 4B of the Mental Capacity Act achieve this objective, or should we also extend section 5 of the Mental Health Act (MHA)? • rely on section 4B of the Mental Capacity Act only • extend section 5 of the MHA so that it also applies A&E, accepting that section 4B is still available and can be used where appropriate	Please give reasons for your answer (up to 500 words) We would recommend S5(2) to be extended to A&E. The availability of the resources and appropriate environment needed to do this in A&E will need to be taken into consideration. Staff would need to be trained to carry out this part of the Act.
21.	To speed up the transfer from prison or immigration removal centres (IRCs) to mental health inpatient settings, we want to introduce a 28-day time limit. Do any further safeguards need to be in place before we can implement a statutory time limit for secure transfers?	• Yes • No • Not sure Please give reasons for your answer (up to 500 words) We agree the transfer from prison or immigration removal centers to mental health inpatient settings should be time limited to ensure that patients receive the right care at the right time. There should be mental health support available to patients in immigration centres who will be able to assess the patients needs and provide early help whilst they wait for transfer to an inpatient setting.

22.	We want to establish a new designated role for a person to manage the process of transferring people from prison or an immigration removal centre (IRC) to hospital when they require inpatient treatment for their mental health. Which of the following options do you think is the most effective approach to achieving this? • expanding the existing approved mental health professional (AMHP) role in the community so that they are also responsible for managing prison/IRC transfers • creating a new role within NHS England and Improvement (NHSEI) or across NHSEI and Her Majesty's Prison and Probation Service to manage the prison/ IRC transfer process • an alternative approach (please specify)	Please give reasons for your answer (up to 500 words) We agree that a specific role is needed for managing this process. However we are of the view this new role is not best placed with AMHP's as it would take away from already stretched AMPH resources. We would recommend this new designated role for prison to hospital transfers should sit with NHSE &I. This would ensure standardisation and consistency of service for this patient group.

23.	Conditionally discharged patients are generally supervised in the community by a psychiatrist and a social supervisor. How do you think that the role of social supervisor could be strengthened?	Your answer can be up to 500 words. There are nurses fulfilling the social supervision role, those taking on this role should have the right training, competencies and experience. The provision of social supervisors in the community is a statutory duty that should be provided by the Local Authority. In the Alliance our teams are integrated and we realise that this is not the case nationally. Social workers may be best placed to provide social supervision and an important aspect is that staff undertake approved training and have the experience to undertake the role. Those in this role should also be subject to continuous evaluation and assessment to ensure that standards are maintained
24.	For restricted patients who are no longer therapeutically benefiting from detention in hospital, but whose risk could only be managed safely in the community with continuous supervision, we think it should be possible to discharge these patients into the community with conditions that amount to a deprivation of liberty. Do you agree or disagree that this is the best way of enabling these patients to move from hospital into the community? • strongly agree • agree • disagree	*Please give reasons for your answer (up to 500 words)* The distinction needs to be made between patients with capacity who may not agree to be subject to ongoing monitoring and/or supervision, and patients assessed to have no capacity with an intractable illness. There is also the potential for the patient to change their mind about accepting their deprivation of liberty. The general consensus is for this not to apply to those patients with capacity. We agree that there are patients who are complicated to discharge in our services, and there are identifiable risks pertaining to whether they will remain in hospital or be discharged. This proposal will enable the least restrictive option to be put in place for patients who require a high level of resourcing for community support, but

	• strongly disagree • not sure	organisations will need robust structures and an increase in resources to manage this group of patients. We are concerned about any proposed changes which further differentiate between forensic and non-forensic patients, and are keen to ensure that "forensic" patients are not unduly restricted on account of their status. Any proposals to restrict or deprive liberty must be matched with provision for dynamic assessment of risk, and restrictions are not in place for longer than is strictly necessary. There is community resourcing implications that needs to be taken into consideration and be available to support alternative to hospital admissions.
25.	We propose that a 'supervised discharge' order for this group of patients would be subject to annual tribunal review. Do you agree or disagree with the proposed safeguard?	• strongly agree • agree • disagree • strongly disagree • not sure Annual review is a reasonable time frame bringing this in line with the rights of other patients in the community such as those subject to CTOs.

26.	Beyond the above, what further safeguards do you think are required?	Your answer can be up to 500 words. No further comment
27.	Do you agree or disagree with the proposed reforms to the way the Mental Health Act applies to people with a learning disability and autistic people?	• strongly agree • agree • disagree • strongly disagree • not sure Please give reasons for your answer (up to 500 words) Whilst the principles proposed are supported there need to be more consideration given to/ articulation of the support these who may have a treatable mental illness and those who have LD and Autism which are lifelong conditions which can be impacted by behaviors that the antecedents to which can be multifactorial. S2 for people with LD/Autism may not allow for the time required to build relationships and compete subsequent assessments and define care pathways, which are required to ensure there is no co-occurring mental illness which would require continued detention under s3

		MHA. Patients could potentially miss out on interventions that would help them and improve their quality of life. Limited appropriate community provision may mean that a 28-day service provision deadline is not met and there is lack of clarity on what will happen in this situation. The criteria of “distressed behaviour” is discriminatory for people with LD/Autism - patients with other diagnosis will not be required to meet this criteria for detention to continue under s3. Access to hospital should not be impeded due to the person being required to be ‘distressed’. There is no provision for people who pose a significant risk to self or others in the context of autism but who are not in a state of acute distress. Concerns about how other aspects of the proposed reform will affect the role of the Consultant Psychiatrist when in the role of Responsible Clinician where decisions making for diagnosis and continued detention are more open to challenge by the IMHA or Nominated Person. The Consultant Psychiatrist may find themselves compelled to act on the basis of decisions with which they disagree, which contradicts the notion of being a RC, and potentially places the RC in an impossible clinical and ethical situation.

28.	Do you agree or disagree that the proposed reforms provide adequate safeguards for people with a learning disability and autistic people when they do not have a co-occurring mental health condition?	• strongly agree • agree • disagree • strongly disagree • not sure Please give reasons for your answer (up to 500 words). We believe that having a learning disability or autism should never be a reason for detention. Reforms are essential to prevent inappropriate detention which unfortunately in our experience is the case in the transforming Care agenda. Admissions are increasing for young people with autism, which is wholly inappropriate. We must invest in community solutions at the earliest opportunity to avoid any inappropriate admissions. Increased community support is required to ensure that this vulnerable group are better supported. Careful consideration should be given to monitoring this part of the act to ensure that those in these particular groups continue to receive the help they need whether that be under the MHA or otherwise. Assessment of mental health needs in people with LD/ASD can be very complex, and may not be achievable within the 28 days of S2, especially if initial admission is to non-specialist services. If they cannot be detained for longer than 28 days without a clear additional diagnosis additional resource is required to ensure that these individuals can be appropriately assessed within the timeframes of the act to safeguard against being given an potentially inappropriate diagnosis to ensure they can be detained under S3.

29.	Do you expect that there would be unintended consequences (negative or positive) of the proposals to reform the way the Mental Health Act applies to people with a learning disability and autistic people?	• Yes • No • Not sure Please give reasons for your answer (up to 500 words) Increased community support is required to ensure this vulnerable group are supported and looked after in local services. Our concern is the current pathway of acute inpatient provision for those with secondary diagnosis of LD or ASD will continue to have significant funding and supply issues. We see the current pathway of detention and placement within specialist inpatient unit in the first instance have significant funding implications. There is a need to improve value for money provision and local expertise to ensure that we reduce out of area placements as without this there will be decreased control in being able to impact on length of stay, outcome and experience for this vulnerable group.
30.	We think that the proposal to change the way that the Mental Health Act applies to people with a learning disability and autistic people should only affect civil patients and not those in the criminal justice system. Do you agree or disagree?	• strongly agree • agree • disagree • strongly disagree • not sure Please give reasons for your answer (up to 500 words) No discrimination should be made between patients who have civil or criminal sections detention based on their diagnosis of Learning Disability and or Autism. Doing so would create a two tier system meaning that individuals in the CJS are not offered the same safeguards with regards to their Mental health. Clarity and guidance eon this is needed.

31.	Do you agree or disagree that the proposal that recommendations of a care and treatment review (CTR) for a detained adult or of a care, education and treatment review (CETR) for a detained child should be formally incorporated into a care and treatment plan and responsible clinicians required to explain if recommendations aren't taken forward, will achieve the intended increase compliance with recommendations of a CETR?	•strongly agree •agree •disagree •strongly disagree •not sure Please give reasons for your answer (up to 200 words). Increasing link between CPA and CTR process is welcome to ensure increased likelihood that recommendations from CTR are implemented and owned by the clinical team responsible for the patient.
32.	We propose to create a new duty on local commissioners (NHS and local government) to ensure adequacy of supply of community services for people with a learning disability and autistic people. Do you agree or disagree with this?	• strongly agree • agree • disagree • strongly disagree • not sure Please give reasons for your answer (up to 500 words). There continue to be inappropriate admissions for people with LD and ASD to inpatient services when behaviours have escalated to the point of threshold for admission (presumably could be referred to as distressed' under new measures) as a result of inappropriate community support (i.e. inappropriate environment, lack of specialist knowledge or training, placement not able to meet the needs of an individual).

		We Support the proposal for a new commissioning duty on local authorities and CCGs to ensure an adequate supply of community services for these groups. Suggest that commissioning groups require clear minimum standards of support available in the community including standards of local support. Much rests on the availability of robust community services, the lack of which results in hospital detentions and delayed discharges, proposals and resourcing of services will need to be optimised, the plan is not clear as to how this will be achieved.
33.	We propose to supplement this with a further duty on commissioners that every local area should understand and monitor the risk of crisis at an individual-level for people with a learning disability and autistic people in the local population through the creation of a local 'at risk' or 'support' register. Do you agree or disagree with this?	• strongly agree • agree • disagree • strongly disagree • not sure Please give reasons for your answer (up to 500 words) This is included in the Transforming Care programme risk register which our commissioners have to report on. Is this reporting expected to be more formal? We would argue that this duty shouldn't just be for commissioners. We would ask if this should apply to all inpatients irrespective of whether they have ASD or LD? There needs to be a consideration to ensure parity for people with learning disability and autism of where and who would hold the register in line with the Serious Mental Illness Registers held by GP.

34.	What can be done to overcome any challenges around the use of pooled budgets and reporting on spend on services for people with a learning disability and autistic people?	Your answer can be up to 500 words. A systematic joining up of health and social care services is required especially to ensure parity with thresholds for receiving services. Consideration as to how needs beyond the Care Act will be met, including consideration to a higher level of specialist psychological therapy availability for people with Autism in generic community services. Most challenging behaviour is due to a mental disorder, and hospital admissions should not compensate for unmet social care needs for behavioural modification to reduce the risk of behaviours becoming medicalised. This approach could be an opportunity to change that. Action to implement with the right community models provided alongside robust respite care and specialist LD and Autism crisis teams.
35.	How could the Care Quality Commission support the quality (including safety) of care by extending its monitoring powers?	Your answer can be up to 500 words Our view is CQC should monitor services commissioned by CCGs and local authorities (including AMHP services) in order to increase the continuity of experience across the whole patient journey. It is important for the CQC to inspect supported accommodations, in particular those commissioned by CCGs, local authorities and health services. Such inspections could potentially be more streamlined than those required for hospitals. This would also ensure appropriate scrutiny of these care providers which are vital to patients' treatment and successful recovery, address e.g. AMHP shortages in certain areas which have a direct impact on the ability to provide timely

		Mental Health Act assessments. CQC powers should also extend to monitoring and assessing the steps Trusts and other providers are taking to reduce any mental health inequalities in their services. It would also be helpful for the CQC to identify trends in or examples of good practice and feed these back to other mental health Trusts in order to better support or embed best practice.
36.	We are interested in receiving numerical data, national and local analysis, case studies or qualitative accounts, etc that might inform what effect the proposals would have on the following: • different professional groups, in particular: ○ how the proposals may affect the current workloads for clinical and non-clinical staff, independent mental health advocates, approved mental health professionals, Mental Health Tribunals, SOADs etc	Please provide information (up to 500 words).

	○ whether the proposals are likely to have any other effects on specific interested groups that have not currently been considered • service users, their families and friends, in particular: ○ how the proposal may affect health outcomes ○ ability to return to work or effects on any other daily activity ○ whether the proposals are likely to have any other effects on specific interested groups that have not currently been considered ○ any other impacts on the health and social care system and the justice system more broadly	