LAMBETH TOGETHER STRATEGIC BOARD

Date: **Wednesday 7 September 2022**

Time: **1.00 am**

Venue: **Microsoft Teams**

Members of the Committee

Dr Di Aitken, Lambeth Together Care Partnership Co-Chair and Delivery Alliance Clinical and Care Professional Lead
Ruth Hutt, Director of Public Health
Fiona Connolly Strategic Director of Children's Services
George Vegrhese, Chair of GP & Primary Care Clinical Cabinet
Adrian McLachlan, Delivery Alliance Clinical and Care Professional Lead
Raj Mitra, Delivery Alliance Clinical and Care Professional Lead
Cllr Jim Dickson, Cabinet Member for Healthier Communities and Lambeth Together Care Partnership Co-chair (job-share)
Cllr Ben Kind, Cabinet member for Children and Young People
Natalie Creary, Programme Director, Black Thrive
Sue Gallagher, LT Lay Member
Andrew Eyres, Place Executive Lead, Strategic Director, Integrated Health & Care NHS SE London ICS (Lambeth) and Lambeth Council
Sarah Austin, GSTT NHS Foundation Trust
Julie Lowe, Kings College Hospital NHS Foundation Trust
James Lowell, South London and the Maudsley NHS Foundation Trust
Therese Fletcher, Managing Director, Lambeth GP Federation
Paul Coles, CEO Age UK Lambeth
Natalia Sali, Healthwatch Lambeth Chief Executive (until 1 August)
Mairead Healy, Healthwatch Lambeth, Chief Executive (from 1 August)
Penelope Jarrett, Chair Lambeth LNC

Further Information

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

AGENDA

Agenda Item 1

Lambeth Together Care Partnership
Public Forum and Board Meeting in Public

Wednesday, 7 September 2022
1 pm to 4.45pm
Microsoft Teams meeting

AGENDA

Members of the public are welcome and encouraged to attend the public forum and Board meeting via Teams link.

Agenda Item No. and Time	Agenda Item Title	Attachment / Supporting Information	Agenda Item Lead
1 p.m.	**Public Forum**		
60 mins	**Welcome and introductions** **The Public Forum and how to take part** **Questions from the public** *Please use link to join the Public Forum – Click here to join the meeting.*		Cllr Jim Dickson
2 p.m.	**Board Meeting in Public**		
1.	**Introductions** Welcome, introductions and apologies		Dr Di Aitken
2.	**Declarations of Interest** Members are asked to declare any interests on items included in this agenda.		Dr Di Aitken
3.	**Review of Minutes** Approve minutes and review matters arising from the Board meeting on 20th July 2022.	Paper enc.	Dr Di Aitken
4. 2.10pm	**Lambeth Together Care Partnership Update** An update to the board of key developments since the last board meeting.	Paper enc.	Andrew Eyres
5. 2.20pm	**Lambeth Together Strategy Development** An update to the board on the development of the Health and Wellbeing Strategy. Board	Presentation enc.	Bimpe Oki / Ruth Hutt

Agenda Item No. and Time	Agenda Item Title	Attachment / Supporting Information	Agenda Item Lead
	members are asked to provide feedback on the emerging priorities and outcomes.		
6. 2.35pm	**Equality, Diversity & Inclusion Update, and Inequalities Funding** An update to the board on Equality, Diversity & Inclusion activities, and the application of SE London Health Inequalities funding in Lambeth. The Board is asked to discuss options for learning and development on Equality, Diversity & Inclusion for 2022/23.	Presentation enc.	Juliet Amoa Clinical lead: Di Aitken
7. 2.50pm	**Better Care Fund 2022/23** Board members are asked to comment on the draft 2022/23 Better Care Fund plan.	Papers enc.	Jane Bowie / Jen Burgess
8. 3.00pm	**Primary Care Governance** Board members are asked to approve the establishment of a sub-group of the board and note the Lambeth membership of the SEL Primary Care Leadership Group.	Paper enc.	Garry Money Clinical lead: Divanka Wijendra
3.15pm	**BREAK**		
9. 3.30pm	**Children and Young People Alliance – Deep Dive** Board members to receive an overview of current priorities and developments regarding Children & Young People in Lambeth as part of our Alliance, including emotional health and wellbeing, maternity services, the Safer Taskforce and Poverty Strategy.	Presentations & papers enc.	Jeanette Young / Dan Stoten / Monique Bertrand / Kathleen Richards / Bimpe Oki Clinical lead: Raj Mitra Children and Young People Alliance
10. 4.45pm	**AOB** **Close** Date of next meeting: 2nd November 2022 – Public forum 1-2pm and Board meeting in Public 2-5pm		Dr Di Aitken

LAMBETH TOGETHER STRATEGIC BOARD MINUTES

Wednesday 20 July 2022 at 1.00 pm

Clerks Note: "The Lambeth Together Strategic Board" currently acting as the Shadow Lambeth Together Care Partnership.

Links to the recording:

- Part 1 - Public Forum
- Part 2 - Meeting in Public

Members Present:

Adrian McLachlan	GP & Delivery Alliance Clinical and Care professional Lead
Andrew Eyres	Strategic Director, Integrated Health & Care NHS SE London ICS (Lambeth) and Lambeth Council
Cllr Ben Kind	Cabinet member for Children and Young People
Cllr Jim Dickson	Cabinet Member for Healthier Communities, (job-share) LTCP Co-chair
Di Aitken	GP & LTCP Co-chair and Delivery Alliance Clinical and Care Professional Lead
George Verghese	GP & Chair of Lambeth Primary Care Clinical Cabinet
Cllr Marcia Cameron	Cabinet Member for Healthier Communities (Job Share)
Paul Coles	CEO, Age UK Lambeth
Sue Gallagher	Lambeth Together Lay Member
Kate Procter	Deputy for Penelope Jarrett, Lambeth Local Medical Committee
Sarah Corlett	Healthwatch Lambeth
Dan Stoten	Deputy for Fiona Connolly, Strategic Director Children's Services
Richard Outram	Deputy for Fiona Connolly, Strategic Director Adult Social Services

In attendance:

Bimpe Oki	Consultant in Public Health, LB Lambeth
Cath Millington	Child Friendly Lambeth
Catherine Flynn	NHS SEL CCG (Lambeth)
Cheryl Smith	Corporate Governance Lead (SEL ICS - Lambeth)
Edward Odoi	Associate director. Finance NHS SE London ICS (Lambeth)

Finnian Anyanwu	Child Friendly Lambeth
Francesca Wickens	Child Friendly Lambeth
Garry Money	Director of Primary Care & Transformation, NHS SE London ICS (Lambeth)
Gerry Evans	Lambeth Together Engagement Lead
Hiten Dodhia	Lambeth Council, Public Health Team
Jane Bowie	Director of Integrated Commissioning (Adults), NHS SE London ICS (Lambeth) and Lambeth Council
Jennifer Curley	Lambeth Council, Public Health team
Juliet Amoa	Associate Director Community Health and Engagement
Pamela Handy	LBSAT Business Support Manager
Paul Fawcett	Corporate Programme Manager
Rebecca Manzi	LBSAT Business Support / PA
Richard Sparkes	Lambeth Council
Sabrina Phillips	Alliance Director, Lambeth Living Well network Alliance
Shyrina Rantisi	Lambeth Democratic Services Officer
Sophia Looney	Joint Health and Wellbeing Strategy Manager
Sophie Taylor	Lambeth Together Programme Lead
Warren Beresford	Associate Director Health and Care Planning and Intelligence

Apologies:

Sarah Austin	Chief Executive Integrated and Specialist Medicine at Guy's and St Thomas'
Ruth Hutt	Director of Public Health (Bimpe Oki deputising)
Cllr Marcia Cameron (Attended online)	Cabinet Member for Healthier Communities (job-share)
Raj Mitra	Delivery Alliance Clinical and Care professional Lead
Fiona Connolly	(Dan Stoten deputising for her DCS role and Richard Outram for her DASS role)
James Lowell	South London and the Maudsley NHS Foundation Trust
Julie Lowe	Kings College Hospital NHS Foundation Trust
Natalie Creary	Programme Director, Black Thrive
Penelope Jarrett	Chair Lambeth LMC (Kate Proctor deputising)

1 Agenda

1a Introductions

Dr Di Aitken welcomed members to the meeting and noted apologies from Sarah Austin, Ruth Hutt, and Raj Mitra. It was also noted that Councillor Marica Cameron, Cabinet Member for Healthier Communities (job share), would be joining online.

George Verghese and Dr Di Aitken shared kind words to honour the memory of Pamela Elliot and Les Elliot (not related), who had added valuable contributions to the work of Lambeth Together.

2 Declarations of Interest

Members were asked to declare any conflicts of interests linked to the items on the agenda.

No Conflicts of interest were declared.

3 Minutes from 25 May 2022 Meeting

The minutes of the meeting of Wednesday 25 May 2022 were agreed as an accurate record of the meeting pending an amendment in the attendance record.

4 Lambeth Together Update

Andrew Eyres, Strategic Director Integrated Health and Care, provided an overview of the new standing report which highlighted the progress of the previous two months, and it was noted that:

- The Integrated Care system had been established on 1 July 2022 as a new statutory organisation via the Integrated Care Board, and with that the existing South East London CCG was disestablished.
- The South East London CCG's achievements over the years were recognised.
- The Integrated Care Board had its first meeting where governance structures were established, and it was noted that the meeting was well attended.
- George Verghese was appointed as the Primary Care Representative. Further details regarding appointments are available under item 6.
- As a result of the governance review, development needs were identified. This included increasing the voice of the public and appointing clinical leadership.
- Other developments included the Health and Wellbeing Strategy and Plans and the application to the National institute of Health and Research.
- The paper provided an update on each Alliance and further details could be found in the assurance report.
- The work around inequalities and successful bid to South East London for £958,000. An update on these projects was to be provided at the September meeting.

RESOLVED

1. To note the update.

To listen back to this item, refer to 00:12:15 of the second recording.

To view the presentation/report accompanying this item, refer to pages 9 to 12 of the agenda pack.

5 Lambeth Together Assurance

Sue Gallagher and Warren Beresford provided an update. During the discussion it was noted that:

- Nationally, Lambeth achieved second place for health checks for people with learning disabilities and the eight recommended good practice care programme for people with type two diabetes.
- Improvements to the report would include a review of the new governance structure to sense check the metrics and measure objectives
- A health inequalities data task and finish group has been set up to develop the metrics and DEI indicators, identify gaps, and to avoid duplication.

RESOLVED

1. To note the report.

To listen back to this item, refer to 00:19:15 of the recording.

To view the presentation/report accompanying this item, refer to pages 13 to 60 of the agenda pack.

6 Governance and Leadership

Update covered under item 4.

RESOLVED

1. To note the report.

To listen back to this item, refer to 00:13:00 of the recording.

To view the presentation/report accompanying this item, refer to pages 61 to 66 of the agenda pack.

7 Lambeth Together Strategy Development

Sophia Looney provided an update, and it was noted that:

- The Lambeth Together (LT) Strategy sits across different strategic bodies of work and the Health and Wellbeing Strategy provided the strategic direction for the LT Strategy and Delivery Plan.
- The current strategy was to expire at the end of the year and the new five year strategy would be agreed at the Health and Wellbeing Board meeting in October 2022.
- Consultation work was being reviewed and the results from other consultations were used to fill any gaps.
- Other work included finalising the ambition statement, sharpening areas of focus, ensuring the approach was anti-racist and asset based, and building integrated systems.

RESOLVED

1. To note the report.

To listen back to this item, refer to 01:23:46 of recording

To view the presentation/report accompanying this item, refer to pages 67 to 74 of the agenda pack.

8 Next steps for integrating Primary Care

George Verghese and Garry Money noted the purpose of the Integrating Primary Care review was to form recommendations to maintain viability, sustainability and ensure general practice could thrive. Officers provided an overview which included the four elements of focus that will be integrated into the work and finally provided the next steps of action. It was noted that the action plan would be brought back to a public board meeting later this year.

RESOLVED

1. To note the report

To listen back to this item, refer to 01:45:40 of recording

To view the presentation/report accompanying this item, refer to pages 75 to 82 of the agenda pack.

9 Child Friendly Lambeth

Francesca Wickens, Finnian Anyanwu, and Cath Millington presented an overview and update. In discussion it was noted that:

- The partnership with UNICEF UK, which had launched a three-to-five-year programme, began in November 2021 and partnering organisations were across various sectors.
- The programme aimed to place impacted children and young people at the heart of decision making and was designed to raise the profile of children and young people in Lambeth.

- The programme operated across strategic programmes and fed into the Borough Plan.
- The four stages of the programme were discovery, development, delivery and recognition.
- The current six-month discovery stage involved talking to children and young people, including those with educational needs, disabilities and care leavers to develop a Child Friendly Plan that was right for Lambeth.
- An overview of the methodology and the variety of engagement activities were provided.
- Development of the plan would involve checking with young people to see whether their input had been incorporated suitably.
- The delivery phase was estimated to take three years, and recognition phase would involve a panel of UNICEF representatives and children and young people to evaluate the work.
- Finally, an overview of what the delivery phase could look like was presented, including four focus areas: children's rights and voices, safe spaces and places, child friendly services and sustainability.

RESOLVED

1. To note the report.

To listen back to this item, refer to 00:29:02 of recording

To view the presentation accompanying this item, refer to pages 83 to 100 of the agenda pack.

10 Lambeth HEART

Jennifer Curley and Hiten Dodhia provided a proposal update for a Health Determinants Research and Evaluation Network, which included an overview of stage two and the next steps, including that:

- The past few years had seen funding shift local governments to become more active in research.
- The value of the contract was £5 million over five years.
- The consultation focused on how research was used by staff and service delivery improvement was cited as the most important reason for this.
- Officers were thinking strategically about securing funding through network building with local researchers.

RESOLVED

1. To note the report.

To listen back to this item, refer to 02:09:18 of recording

To view the presentation accompanying this item, refer to pages 101 to 118 of the agenda pack.

11 AOB

The date of the next meeting was confirmed as 07 September 2022.

The meeting ended at 16:32

CHAIR
LAMBETH TOGETHER STRATEGIC BOARD
Wednesday 28 September 2022

Date of Despatch: Thursday 04 August 2022
Contact for Enquiries: Shyrina Rantisi
E-mail: srantisi1@lambeth.gov.uk
Web: www.lambeth.gov.uk

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Report to: Lambeth Together Care Partnership

September 2022

Report Title	**Lambeth Together Update**
Lead Author	Andrew Eyres – Strategic Director, Integrated Health, and Care
Summary	The purpose of this paper is to update the board of key activities across the Lambeth Together partnership, including: • Governance and Leadership • Strategic Development • Inequalities and Equity • Our Alliances • Public Health • Lambeth Country Show
Recommendations	To note the report.

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Lambeth Together Care Partnership Board

Lambeth Together Place-lead Executive Update
7 September 2022

Andrew Eyres; Strategic Director, *Integrated Health, and Care*

Our governance and leadership

I am pleased to announce that Andrew Carter has been appointed to the role of Strategic Director of Children's Services for Lambeth Council, Andrew will also join the Lambeth Together Care Partnership Board from November.

In addition, I am also pleased to announce that Mairead Healy has been appointed to the role of CEO for Healthwatch Lambeth and joined the board in August.

The 3rd phase of our recruitment of Clinical and Care Professional Leads is now complete, and I'm pleased to confirm that Dr Di Aitken has been appointed to the CCPL roles for Quality & Safety and Population Health Management & Inequalities, Dr Mark Adams to the lead role for Cancer, and Nicola Sands to the lead role for Engaging with Communities.

Finally, our process to recruit Patient and Public Voice members to the Board is well under way, with interviews finalised last week, and offers expected to go to successful candidates this week. The new Board members will be in post and introduced to you all at the September Board meeting, and we look forward to having their 'grassroots' voices supporting our ever-increasing need to keep our focus on the needs of our local communities.

Our strategic development

The development of the Health and Wellbeing Strategy and Lambeth Health and Care Plan continues to progress well, and we are also contributing to the development of the new Lambeth Borough Plan. The early engagement phase of the Health and Wellbeing Strategy is now complete, and a new set of priorities and outcomes have been developed from that work. The emerging priorities and outcomes have formed the basis of the public consultation which launches on the 22nd August alongside the publication of the Lambeth health profiles as part of the Joint Strategic Needs Assessment. A series of engagement sessions with Voluntary Community and Faith Sector organisations has started with a well-attended workshop with over 40 organisations represented. Further workshops are now scheduled for Lambeth Together members in September.

Tackling inequalities and improving equity

In our last update, we were delighted to inform board members that Lambeth was awarded £958,000 of funding for projects specifically focussed on reducing health inequalities in the borough. As we are already in the middle of quarter two, we have only received a proportionate amount of £638,000 of this funding for 2022/23. Our Inequalities Working Group have progressed this work to ensure all approved projects have solid plans in place to get started as soon as possible.

The final projects will see Lambeth really working together, with projects from the Children's and Young People's Alliance investing in Emotional Health and Wellbeing support for unaccompanied asylum-seeking children with SEL ICB, SLAM and Evelina, as well as an emotional support project for vulnerable children who are not in education, training or employment or educated other than at school.

The Living Well network will target inequalities by providing well-being pop up clinics in partnership with Mosaic Clubhouse, Emotional Emancipation Circles for the Black community led by Black Thrive and a project focused specifically on the wellbeing of Black carers by Carers4Carers.

Further work is being done to develop plans for community health events and provide innovation funding for smaller projects from our Neighbourhood and Wellbeing alliance, and the Lambeth Clinical Cabinet and our nine Primary Care Networks (PCNs) are also rolling out an inequalities programme focussing on creating a network of new Inequalities Champions. We will keep members updated on these important projects.

Our Alliances

Work in the children and young people's space continues, with our Emotional Health and Wellbeing and Early Years workstreams stood up and meeting regularly, despite pausing over the summer. Both are forming programmes of work, with the former focusing on our response to the needs assessment and developing an outcomes framework; while the latter will also consider our approach to Start for Life and Family Hubs alongside continuing integration of our early years pathways and maternity. We will be using the development of our Health and Care Plan to drive the strategic direction of the Alliance at some away time in September. Our Summer Holiday Activity and Food programme went live in late July; and our CAMHs waiting times continue to see positive improvement.

The Living Well Network Alliance (LWNA) continues work to improve the access, experience, and outcomes of those needing mental health services. We have aimed to widen our focus to include the determinants of health such as work, the physical health of the people we care for, with a focus on communities in the most deprived areas of Lambeth. We are pleased Alliance colleagues were part of the Lambeth Together public health stall at the Lambeth Country fair, staff, including the alliance director, supported with taking blood pressures, engaged with the community and shared information on how to access mental health services within Lambeth. We are also pleased that at the end of July, our 2-year pilot of Individual Placement Support (IPS) Pilot service, that supports service users to find meaningful work, is being delivered by alliance partner Thamesreach. The service is initially supporting service users in the Lambeth Early Intervention Community team and are working with the Living Well centres to build referrals. The IPS team work closely with the SLAM lead to ensure consistency of recording and good practice is shared. The team are also engaged with a pan-London IPS network which include other voluntary sector providers. We continue to engage with key stakeholders as we develop our next 3-year LWNA business plan.

Work on the Neighborhood & Wellbeing Delivery Alliance priorities continues with multiple projects relating to Thriving Communities (neighborhood health & care networks), chronic pain & care homes. Thriving Communities networks continue to expand with the project launch of the digital platform in Thriving Stockwell. The SEL Health Inequalities community funding is in development working with these neighborhood organizations and the social prescribing link workers.

Other projects, such as the Diabetes & Health Inequalities Test & learn, works with those with protected characteristics & black and multi-ethic at risk patients to provide targeted supported self-management (via a health coach model) is underway. With Chronic Pain, we are developing a patient reference group to integrate the patient voice within our work stream. We are also undertaking a significant review of the NWDA priorities to inform our input to the development of the Lambeth Health and Care Plan and drive the strategic direction of the Alliance at our next board meeting in September.

Our public health

Cases of monkeypox have continued to rise across London. A borough-based breakdown is now being published weekly which shows Lambeth (followed by Southwark) has the highest number of cases in London. Over 22,000 people in London at highest risk of being exposed to monkeypox have now had the smallpox vaccine which offers protection against monkeypox. GSTT delivered over 8,000 doses primarily to gay, bisexual men who have sex with men. Further doses of vaccine are expected to arrive in September. In the meantime, messaging is going to LGBTQ communities to be vigilant for the symptoms of monkeypox, avoid intimate contact with anyone who is infected and advice around reducing the risk of getting monkeypox. Locally, Lambeth and Southwark met with the chairs of the LGBT forums in both

boroughs to improve communication to the gay and bisexual community and discuss ways to ensure vaccination is targeted appropriately to those at highest risk.

Lambeth has had over 300 cases of monkeypox and is known to have one of the largest GBMSM populations in the country. As more vaccines become available, there will be a particular focus on reaching those not known to sexual health services or who do not identify publicly as gay or bisexual and may be more reluctant to come forward for vaccination. For most people, monkeypox is mild with very few people requiring hospitalisation.

We have now submitted all elements of our application for Lambeth HEART to the National Institute for Health and Care Research (NIHR). Lambeth HEART will enable us to build research infrastructure to develop a culture of using research, evidence, and evaluation to reduce health inequalities by addressing some of the factors which impact on residents' health outcomes. Following submission of our detailed business case with costings, four of our application team presented a summary of our vision before answering a series of detailed questions from an NIHR panel. We encapsulated our vision in this 2-minute video. We expect announcement of the outcome in September.

Lambeth County Show

I was delighted to join many staff from across Lambeth Together at the Lambeth Country Show in July. Despite the high temperatures leading to reduced numbers at the Show, we performed over 300 blood pressure checks, 46 people were advised to contact their GP and were given the appropriate advice and literature. Other services available were smoking cessation, pharmacy advice, mental health support and eye health. The Health and Wellbeing bus was staffed with the Wellbeing ambassadors who provided information to residents. Lambeth HealthWatch was also represented. 273 residents filled in postcards to tell us what mattered to them about their health and care and how this could be addressed. Apart from access to services, particularly GPs and A&E, there was a notable focus on mental health services and accessible information. The overwhelming response to what mattered to them most was general good health: people want to be and feel fit and well. Suggestions received included building stronger links between health and environment, more information at community events, and having healthcare sessions in libraries. The data will inform our Health and Care Plan and the Join Health and Wellbeing Strategy; specific data will be shared with the relevant LT alliance.

I would like to thank the staff who helped to make this event a success.

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Report to: Lambeth Together Care Partnership

July 2022

Report Title	**Lambeth Together Strategy Development**
Lead Author	Bimpe Oki – Consultant in Public Health Sophia Looney – Health and Wellbeing Strategy lead
Summary	The purpose of this paper is to update the Lambeth Together Care Partnership on the development of our Health and Wellbeing Strategy. Since reporting to this board in July, the strategy development has continued at pace. Engagement with more than seventy groups and individuals has taken place and the emerging priorities have been refined. Work has taken place to establish a series of potential outcomes related to each priority and these are now out for public consultation. The consultation survey launched to the general public on the 22nd August and continues until 18th September. A series of workshops with the VCSE sector are being facilitated and hosted by Integrate to give a voice to the whole sector, with the first one having over 40 participants. The draft strategy will be presented to the Health and Wellbeing Board in the autumn with the final being ready for early 2023.
Recommendation(s)	The Lambeth Together Care Partnership is asked to: 1. Note the progress that has been made on the development of the Health and Wellbeing Strategy and provide any feedback on the emerging priorities and outcomes.

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Lambeth Together Health and Wellbeing Strategy 2023 – 2028 Progress update

Lambeth Together Care Partnership

7th September 2022

Working in partnership for a healthier borough

The development of the new strategy continues

- Early engagement with 70+ individuals, boards, teams and organisations, allowing for the development of our areas of focus and providing feedback – notably the need to focus on those areas where we are only succeed through working together

- Confirmed the broad principle of tackling health inequalities in line with the Marmot principles

- Consolidation of the output and refinement from the ‘long list’ of potential areas of focus to priority themes and associated outcomes, which are now being tested through the consultative phase

- Public consultation launched August 22nd, seeking the views of the general public on the emerging themes and priorities and particularly asking them to rank outcomes in order of importance

- Workshops for the Voluntary and Community Sector hosted by Integrate started August 22nd and run through into September, with further workshops for stakeholders scheduled concurrently and aligning with the Borough Plan engagement process.

- Related health profiles completed and published

What's emerged from this work?

3 areas of focus designed to tackle health inequalities:

- Ensuring the best start in life
- Supporting people to lead healthy lives and have good physical and mental wellbeing
- Supporting communities to flourish and build their resilience

Consultation will now help identify specific outcomes that partners (statutory & non-statutory organisations and residents) can work together on to make a significant impact within these 3 areas. It is based on the potential outcomes, and asks for participants to prioritise which they feel are most important.

Potential Outcomes: Ensuring the best start in life

- Fewer children live in poverty
- More children achieving a good level of development by age 5
- Less childhood obesity
- Less serious violent crime involving young people
- The emotional wellbeing of parents and caregivers, babies and children is supported

Potential Outcomes: Supporting people to lead healthy lives and have good physical and mental wellbeing

- People are able to (and are supported to) increase levels of physical activity
- Preventing long term conditions (such as diabetes, high blood pressure, heart disease and lung disease) and avoiding further health complications for those with existing long term conditions
- People are supported to live well independently for as long as possible
- Fewer people are using tobacco
- Substance misuse is low (drugs/alcohol)
- Fewer sexually transmitted infections
- People at risk of and with depression, anxiety and other mental health issues access the right early help and resources
- The number of deaths from avoidable causes is reduced

Potential Outcomes: Supporting communities to flourish and build their resilience

- Fewer people are living in poverty
- People are able to eat well and have food security
- People access good, sustainable employment opportunities
- People have access to good quality sustainable housing and homelessness is reduced
- People are safe and feel safe
- Social isolation is prevented and loneliness is reduced
- People feel connected to other people and resources in their community
- People feel in control of their lives
- Air quality improves
- People are able to withstand the impact of serious climate events such as extreme heat or flooding

Our approach to delivery

Working Principles – in delivering the strategy we will take

- a positive and action orientated approach to equity throughout all we do, adopting an anti racist approach;
- an integrated, systems approach, which understands that no one organisation has the answers to these complex issues we are attempting to tackle;
- an asset based approach, building and amplifying what is already in the community.

- These principles emerged through the early engagement and remain as important value statements that underpin our work.
- They will be refined as further more detailed feedback is obtained through the consultation and will link into the detailed delivery planning taking part for the strategy and as part of the Health and Care Plan development process.

Feedback from consultation to date

Some themes from the first VCSE workshop:

- Recognition of the power of individuals and the role of agency, citizen involvement and engagement in tackling health inequalities
- The importance of understanding and recognising the resourcefulness of the community and featuring how we can best champion that in tackling health inequalities
- The need to build on ‘health in all policies’ particularly around the built environment, housing and creating environments that ‘spark joy’
- Connecting existing projects and activities better, moving away from silos and creating easier access for people and building a ‘buzz’ around activities happening in the same place, we need to create the energy and excitement to draw people in and make it easier for them to access what’s needed
- We need to improve the continuity of contact with individuals and build and grow trust

Next Steps

- Completion of the engagement workshops and consultation – through to mid-September
- Refinement and finalisation of the outcomes, aligning with Borough Plan and Health and Care Plan – through to October
- Presentation of Draft Strategy (Health and Wellbeing Board, October 2022)
- Development of appropriate delivery plans (October – December 2022)
- Strategy Sign Off (Health and Wellbeing Board, January 2023)

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Report to: Lambeth Together Care Partnership

August 2022

Report Title	**Equality, Diversity & Inclusion Update, and Inequalities Funding**
Lead Author	Juliet Amoa – Associate Director Equality, Diversity & Inclusion Community Health, and Engagement Di Aitken – co-Chair Lambeth Together Strategic Board and Care and Clinical Professional Lead PHM & Inequalities Asha Winifred – Development Manager, Equalities, Diversity & Inclusion
Summary	The purpose of this presentation is to update the Lambeth Together Care Partnership on our Health Inequalities Funding projects, Data and metrics progress, and feedback on EDI Organisational Development discussions. **Health Inequalities Funding:** In July, the group requested approval for 8 projects at the Lambeth Together Executive Group and now: • Three Living Well Network Alliance projects have approved project plans and have submitted grant forms to Integrated Care Board finance • Projects from the Neighbourhood & Wellbeing Delivery Alliance & Primary Care Networks have approved project plans and need to submit their finance forms to draw down funds • Of the three children's projects, Project Initiation Documents have been approved, and funding forms need to be submitted to finance. Once the reporting structure and monitoring framework has been agreed by the funding working group, the funding sub-group will need to transform into a project group to track and monitor each project and report to relevant boards. **Metrics & Data:** A Health Inequalities Data Task & Finish group has been meeting fortnightly and is currently looking through reporting options. This work has been led by Warren Beresford. **Review of EDI Organisational Development:** The EDI Group reviewed and discussed progress since the two workshops held for the Lambeth Together Care Partnership Board & EDI group in April and June 2021.

Recommendation(s)	The Lambeth Together Care Partnership is asked to: 1. Receive the update on the mobilisation of the Health Inequalities proposals 2. Note the update on the development of a reporting process on EDI workplans from each Alliance. 3. Discuss options for 2022-2023 learning and development on EDI and make a recommendation for the next LTCP seminar.

Lambeth Together
EDIm Group Update
7th September 2022

Presented by
Juliet Amoa, Associate Director, Community Health and Engagement
and
Dr Di Aitken, GP & co-Chair LT Strategic Board & EDI Group

Key areas to update

- SEL Health Inequalities Funding update
- Metrics & Data
- Further Organisational Development in EDI

SEL HI Funding update

Agreed PIDs

Alliance	Title	Start	Full Cost per year	2022/23	2023/24 (Full year)	Status 24.04.2002
Mental Health (ICB Grant agreement)				8 Months		
Living Well Network Alliance (LWNA) & Carers4Carers	Black Carers Well Being Project	Sep 2022	£52,600.00	£52,600.00	£0.00	Grant form being reviewed by finance
Living Well Network Alliance (LWNA) & Black Thrive	Emotional Emancipation Circles	Sep 2022	£64,100.00	£64,100.00	£0.00	Grant form being reviewed by finance
Living Well Network Alliance (LWNA) & Mosaic Clubhouse	Wellbeing Pop Up Clinics	Sep 2022	£50,000.00	£50,000.00	£0.00	Grant form being reviewed by finance
Neighbourhoods (Section 256 with council)				8 Months		
Neighbourhood and Wellbeing Delivery Alliance (NWDA)	Building Trust with our Communities - Health events and innovation fund and grassroots	Oct 2022	£250,000.00	£166,667.00	£250,000.00	Awaiting section 256 agreement form
Primary Care Network (PCN) Health Inequalities Programme	Lambeth Together PCN Health Inequalities Programme	Oct 2022	£270,000.00	£180,000.00	£270,000.00	Awaiting NHS contract/variation
Children and Young People (NHS contract variation)				3-4 Months		
Children's - Emotional Health and wellbeing support for Unaccompanied Asylum-Seeking Children (UASC)	Emotional Health and wellbeing support for Unaccompanied Asylum-Seeking Children (UASC)	Dec 2022	£53,092.00	£13,273.00	£53,093.00	Awaiting NHS contract/variation
Children's -School Nursing EOTAS	Emotional and Mental Health Support within school nursing team to support vulnerable children who are not in education / educated other than at school	Dec 2022	£77,851.00	£19,463.00	£77,851.00	Awaiting NHS contract/variation
Public Health & Children's and Young People's Alliance – Child Obesity	Improving childhood obesity	Nov 2022	£120,000.00	£57,500.00	£120,000.00	Awaiting section 256 agreement form
	TOTAL	**£937,643**		**£603,603**	**£770,943**	

2022/23 £638,666.67 - £603,603 = £35,064 slippage 2023/24 £958,000 - £770,943 = £187, 057 remaining

EDI fund Process and next steps

- All PIDs are now completed
- Appropriate documents need to be completed to draw down the money (grant forms, section 256, contracts etc)
- Establish a group of all the project managers, this can evolve for the current working)
- This group will need to meet every 4 weeks.
- The group will track and support all 8 projects through the project managers

Metrics and Data

- In our last update we discussed the recommendations of the EDI Group that the LT Assurance Group is where the monitoring of inequalities data takes place
- A Data Task & Finish group has commenced and is chaired by Warren Beresford
- The aim is for a robust framework of equalities measures, in line with the Lambeth Together Health and Care plan, that delivers an enhanced shared measurement approach to share knowledge, and provide assurance.
- Coding and classification will be important to ensure robust and consistent analysis as the data will be used to influence other parts of the system to help reduce inequalities
- The group will be looking at whether a dashboard, or suite of reports or a hybrid option is required
- The EDI Group will facilitate and assist with coordination
- The EDI Group are collaborating with Alliances, Public Health and Business Intelligence teams to curate a 'Data wishlist'

Organisational Development EDI

Last group learning was April & June 2021.

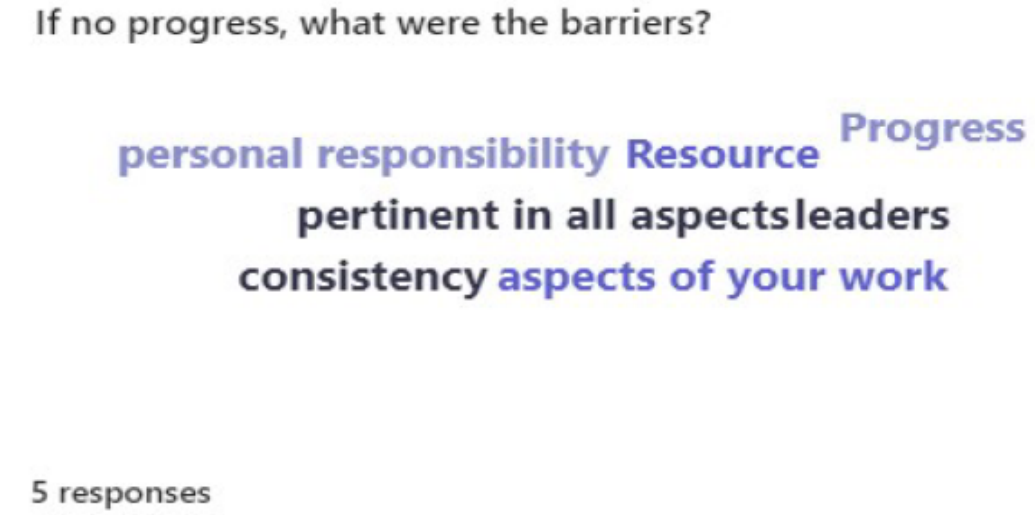
New ideas to support Health & Care Plan from EDI Group on 24.8.22 are:

- Not just to “do” an EDI session, build in moving to action-planning for your role
- Being actively anti-racist – “why are we doing EDI”
- Objective setting – corporate vs personal/team based
- What “white managers” think – understanding the impact of racism from colleagues
- What should commissioners be doing? Commissioners (and now Partnerships) should be able to explain why their services have differential outcomes
- Building in more accountability from senior leaders

POLL: feedback on OD in 2021

ID	Start time	Completion time	Have you included objec
1	8/24/22 11:51:38	8/24/22 11:51:44	Yes
2	8/24/22 11:51:39	8/24/22 11:51:47	Yes
3	8/24/22 11:51:39	8/24/22 11:51:49	Yes
4	8/24/22 11:51:37	8/24/22 11:51:51	Yes
5	8/24/22 11:51:56	8/24/22 11:51:56	Yes
6	8/24/22 11:51:43	8/24/22 11:52:07	Yes
7	8/24/22 11:51:37	8/24/22 11:52:17	Yes
8	8/24/22 11:51:40	8/24/22 11:52:20	Yes
9	8/24/22 11:53:00	8/24/22 11:53:07	No
10	8/24/22 11:51:38	8/24/22 11:53:13	Yes
11	8/24/22 11:53:31	8/24/22 11:53:31	Yes
12	8/24/22 11:51:38	8/24/22 11:56:19	Yes

ID	Start time	Completion time	If no progress, what wer
1	8/24/22 11:56:53	8/24/22 11:57:40	Progress has been made therefore NA
2	8/24/22 11:56:49	8/24/22 11:58:57	consistency
3	8/24/22 11:56:51	8/24/22 11:59:26	other leaders
4	8/24/22 11:57:00	8/24/22 12:03:22	Resource
5	8/24/22 12:03:12	8/24/22 12:05:31	remembering it is pertinent in all aspects of your work and personal responsibility



Comms & Engagement

- Lambeth Together Website EDI page now live

https://lambethtogether.net/about-us/equality-diversity-and-inclusion/

Questions and ideas?

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Report to: Lambeth Together Care Partnership

September 2022

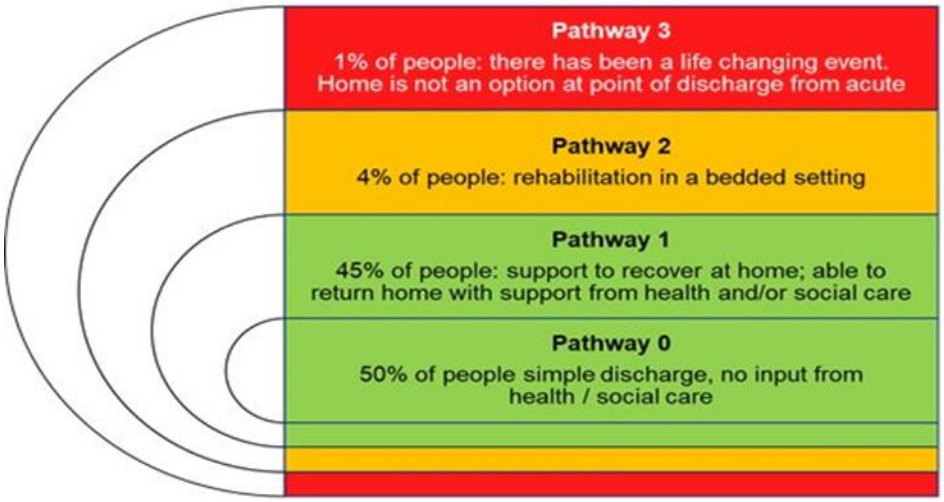
Report Title	**Better Care Fund 2022/23**
Lead Author	Jane Bowie – Director Integrated Commissioning Jennifer Burgess - Integrated Commissioning Manager, Adults and Health
Summary	The purpose of this paper is to provide a **draft** of the Better Care Fund plan 2022/23 to the Lambeth Together Care Partnership for comment. The Better Care Fund (BCF) programme was established to support local systems to deliver integration of health and social care through ring-fenced budgets from Integrated Care Board (ICB) allocation, and funding directly paid to local government, i.e. Disabled Facilities Grant (DFG), and the improved Better Care Fund (iBCF) grant. Local areas submit an annual BCF plan to NHS England for moderation and approval, and subsequently report quarterly on progress to the national team for oversight. The BCF plan for 2022/23 consists of: - a template providing information on income and expenditure, four measures (metrics) to inform the national team of progress, and whether the plan fulfils the four national conditions of the plan. - A narrative plan describing Lambeth's approach to integration, focus for the year, governance arrangements. - Additionally, this year the national team have introduced a capacity and demand template for intermediate care. The value of Lambeth's BCF 2022/23 is £46,122,134.00. The four national conditions are: - A jointly agreed plan between local health and social care commissioners and signed off by the Health and Wellbeing Board. - NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution. - Invest in NHS commissioned out-of-hospital services. - Implementing the BCF policy objectives. The four metrics are: - proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation (effectiveness of reablement)

	- older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population (manage admissions to residential care homes) - unplanned hospitalisation for chronic ambulatory care sensitive conditions (avoidable admissions to hospital) - improving the proportion of people discharged home, based on data on discharge, to their usual place of residence.
Recommendation(s)	The Lambeth Together Care Partnership is asked to: 1. Note the **draft** Better Care Fund plan 2022/23 and provide comments on content.

1. Introduction

BCF policy framework and planning guidance were published on 19 July 2022. Governance requires that the ICB/ICP review and agree the plan, that is subsequently signed off by Lambeth Council CEO, and the Health and Wellbeing Board. Sign off should happen prior to submission of the planning template, narrative plan, and intermediate care demand and capacity template on 26 September 2022.

The intermediate care demand and capacity template is an additional request from the national BCF team. It will not be part of moderation at national level but is required as part of submission. The demand and capacity template is an estimate of intermediate care provision set against the four discharge pathways developed in the Hospital Discharge and Community Support: Policy and Operating Model published 21 August 2020 – see below. Completion of the template is being progressed however identifying data sources is taking longer than anticipated, therefore not available for this meeting.



To note, the planning template has an error in the metrics section, and is therefore showing incomplete on the cover sheet, and the avoidable admissions metric is not included in the summary page. This has been recognised by regional BCF team as a flaw in the template.

2. BCF Narrative Plan - priorities

Lambeth's BCF priorities for 2022/23 are:

- Continued collaborative implementation and streamlining of hospital discharge processes – partners are Lambeth Adult Social Care, Lambeth Integrated Commissioning, Southwark Commissioning, Guy's and St Thomas' Hospital (GSTT) and King's College Hospital (KCH)
- Continued development of Alliance models as part of Lambeth Together, specifically Neighbourhood and Wellbeing Delivery Alliance (NWDA) and Living Well Network Alliance (LWNA)
- Refresh of Lambeth Carers Strategy, and development/implementation of subsequent action plan

The plan provides updates on the priorities above together with updates on work from the EDI Group and use of the Disabled Facilities Grant.

3. BCF plan template - Income and Expenditure

The income and expenditure for 2022/23 has been agreed by Finance Leads for Lambeth Council and NHS ICS.

Income:

Funding Sources	Income	Expenditure	Difference
DFG	£1,678,410	£1,678,410	£0
Minimum NHS Contribution	£28,654,962	£28,654,962	£0
iBCF	£14,946,411	£14,946,411	£0
Additional LA Contribution	£0	£0	£0
Additional ICB Contribution	£842,351	£842,351	£0
Total	**£46,122,134**	**£46,122,134**	**£0**

Expenditure:

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£8,142,927
Planned spend	£15,171,372

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£13,028,690
Planned spend	£13,483,590

Scheme Types

Assistive Technologies and Equipment	£0	(0.0%)
Care Act Implementation Related Duties	£1,445,665	(3.1%)
Carers Services	£290,000	(0.6%)
Community Based Schemes	£525,589	(1.1%)
DFG Related Schemes	£1,678,410	(3.6%)

Enablers for Integration	£0	(0.0%)
High Impact Change Model for Managing Transfer of Care	£3,722,850	(8.1%)
Home Care or Domiciliary Care	£14,116,507	(30.6%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£0	(0.0%)
Bed based intermediate Care Services	£10,838,576	(23.5%)
Reablement in a persons own home	£3,250,919	(7.0%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£1,998,116	(4.3%)
Prevention / Early Intervention	£1,624,598	(3.5%)
Residential Placements	£6,630,904	(14.4%)
Other	£0	(0.0%)
Total	**£46,122,134**	

Better Care Fund 2022-23 Template

6. Metrics

Selected Health and Wellbeing Board: Lambeth

8.1 Avoidable admissions

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition	Checklist Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population	Indicator value	232.5	231.6	243.5	186.9	A reduction of 5% is anticipated with continued development of community prevention and early intervention.	Continued development of community services in response to ongoing system work for D2A.	
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan			
(See Guidance)	Indicator value	220	209	231	177			Yes

>> link to NHS Digital webpage (for more detailed guidance)

8.3 Discharge to usual place of residence

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Quarter (%)	95.9%	96.4%	95.7%	95.9%	Ambition is to achieve a steady state for 2022/23 - there are increased levels of acuity due to C19 and residents coming to health services later and sicker as a consequence, C19 also complicating those with long term conditions, both cohorts requiring additional support, hence further interventions required in advance of going home e.g. bed based	Monitoring per quarter - steady state working on the assumption that continuing work on system discharge processes will enable people to go home.	Yes
	Numerator	5,213	5,369	4,981	4,770			
	Denominator	5,434	5,571	5,203	4,974			
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan			
(SUS data - available on the Better Care Exchange)	Quarter (%)	95.8%	96.4%	96.0%	96.0%			
	Numerator	1,632	1,763	1,605	1,605			Yes
	Denominator	1,703	1,829	1,672	1,672			Yes

8.4 Residential Admissions

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	413.5	470.4	511.6	473.8	We are assuming a small reduction of permanent admission to care home beds. This is cautious as there was an unexpected increase in 2021/22.	Monitoring per quarter - steady state working on the assumption that continuing work on system discharge processes will enable people to go home vs a permanent admission to a care home.	Yes
	Numerator	116	137	149	142			Yes
	Denominator	28,050	29,126	29,126	29,973			

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	90.7%	91.9%	91.9%	92.2%	Steady state - using the system discharge processes, expectation is that individuals will remain in their home or usual place of residence following reablement. However higher levels of acuity could affect this position.	Monitoring per quarter - steady state working on the assumption that continuing work on system discharge processes will enable people to remain well and able following reablement package.	Yes
	Numerator	78	171	125	190			Yes
	Denominator	86	186	136	206			Yes

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Better Care Fund (BCF) narrative plan 2022-2023

Lambeth Health and Wellbeing Board

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

How have you gone about involving these stakeholders?

Lambeth's Better Care Fund (BCF) plan has been prepared and developed by Integrated Commissioning, Adult Social Care, and Finance Leads for Council and South East London Integrated Care System (ICS). Development of the plan has included discussion with the Primary Care Network lead, Housing and Health Board lead, Equality, Diversity and Inclusion Group lead, and within the context of work undertaken by Neighbourhood and Wellbeing Delivery Alliance, Living Well Network Alliance and Age UK Lambeth.

The BCF plan has been presented and discussed at Senior Management Team, Councillor Members Briefing, at Local Care Partnership Board, and the Health and Wellbeing Board of which Healthwatch Lambeth is a member, and within the context of work undertaken by Delivery Alliances as part of Lambeth Together.

Lambeth has a well-established partnership, Lambeth Together, with an Executive Group chaired by the Strategic Director, Integrated Health and Care, and comprising key partnership executive leads and local stakeholders. That includes nominees from Guy's and St Thomas' NHS Foundation Trust, Kings College Hospital NHS Foundation Trust, South London and Maudsley NHS Foundation Trust together with the Lambeth Living Well Network Alliance, London Borough of Lambeth (Adults/ Children and Public Health, Housing), Primary Care (PCN, GP Federation and LMC Leads) along with VCS, Healthwatch, and the Delivery Alliance programme leads.

Lambeth Together is the main driver for integrated and person-centre care, using an Alliance model of programmes to support decision making. Through the Delivery Alliances and our Lambeth Staying Health Board, Lambeth Together continues iterative conversations and coproduction with Council services including adult social care and housing, as well as with community and acute health providers, GPs, VCS, local community groups and individuals, informing commissioning and service transformation, including those identified in the Lambeth BCF plan.

Executive summary

This should include:

- Priorities for 2022-23
- Key changes since previous BCF plan

Priorities for 2022-23

As in last year's plan, our priorities for 2022-23 are focused on continuing essential transformation work associated with **hospital discharge and discharge to assess**, and specifically a response to the Hospital Discharge and Community Support Policy published in August 2020.

We also continue focus on the Alliance models within **Lambeth Together**, our integrated and collaborative umbrella, to determine priorities and focus. Lambeth Together brings together health and care services, voluntary and community groups, and individual residents living in Lambeth.

Lambeth has identified **supporting unpaid carers** as a key priority for 22/23. The landscape affecting carers has significantly changed since the Lambeth Carers Strategy was first developed in 2017, including a rise in the number of people caring, the fallout of the COVID-19 pandemic and the cost of living crisis.

1. Continued system development of Discharge to Assess (D2A) processes

In response to the *Hospital Discharge and Community Support: Policy and Operating Model* published 21 August 2020, Lambeth Adult Social Care, Integrated Commissioning, Southwark commissioners, and local hospitals (Guy's and St Thomas Hospital, King's College Hospital – Denmark Hill) are implementing the best system approach to introducing D2A as a standard discharging process from hospital to community.

Lambeth's discharge plan was developed and approved via a cross-organisational delivery group comprised of Kings College Hospital (KCH), Guys and St Thomas' Hospital (GSTT) and Lambeth Adult Social Care. Partners meet regularly alongside colleagues from SEL ICS to monitor activity and demand, and share learning at three key meetings:

- **South East London (SEL) Discharge group** – the group meet fortnightly for 1 hour. This group is co-chaired by Lambeth's Executive Director of Health and Social Care. This meeting allows partners to have sight of any pressures hitting different parts of SEL, share good practice and collaborate on any asks flowing from DHSC/NSHE.

- **Local Southwark & Lambeth System Discharge Group** – the group meet fortnightly, chaired by Lambeth's Acting Director of Health and Social Care, with membership at AD level and above across KCH, GSTT, Lambeth and Southwark representatives from SE London ICB. This meeting allows partners to coordinate any responses and work needed into SEL and wider as our collective voice is stronger if we a can agree approach. The group also allows for early sight on any local pressures, collective problem solving and sharing of transformation strategies.

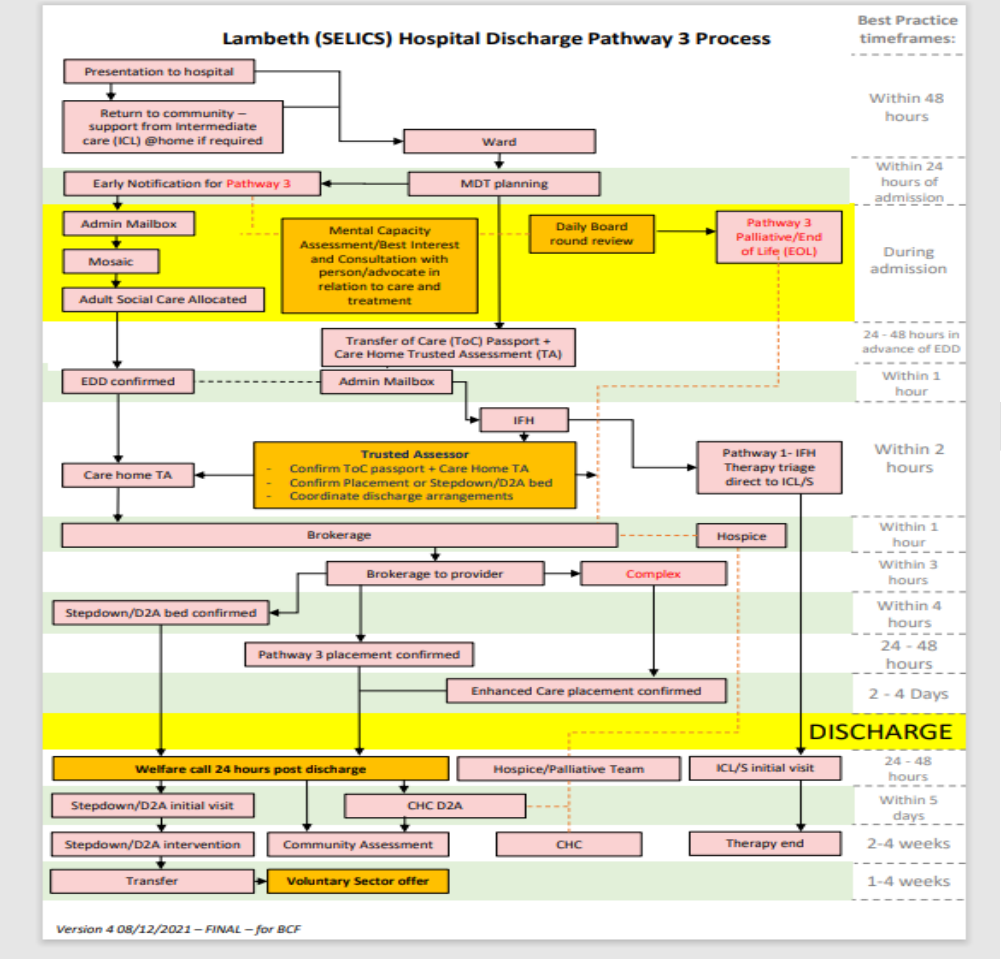
- **Two working groups - pathway 1 and 3; reporting into pathway 2 -** This meeting is chaired by Lambeth's Associate Director of Health and Social Care, supported by Southwark's Head of Service and Service Managers. Also in attendance is the Associate Director of Integrated Commissioning and representatives across KCH and GSTT.

Mapping of current systems for discharge under pathways 1 and 3 of the Hospital Discharge and Community Support Policy have been completed, and inform system pathways to enable safe, swift discharge.

Work is ongoing to streamline transfer processes across the system and working towards best practice timeframes, and the introduction of the Transfer of Care (TOC) passport ensures effective information sharing about individuals as they move through the system.

Below is the agree Pathway 3 developed collaboratively by the system; the example includes best practice timeframes.

Lambeth Hospital Discharge Pathway 3 – process map



The system approach to discharge responds to the High Impact Change Model (HICM) in ensuring timely, person-centred support for the person during transfers of care between hospital and their home or usual place of residence. A self-assessment of Lambeth's response to the HICM can be found in National Condition Four Section of this narrative plan – page 14.

2. **Continued development of Lambeth Together**

As previously mentioned, Lambeth uses an Alliance approach to service delivery, with each Alliance developing a collaborative and coproduced approach to supporting residents. Learning from the response to COVID-19 pandemic identified that the Lambeth Together partnership approach of working across Lambeth Council, NHS primary, community and secondary care, and voluntary and community sector providers created a community focused response to the pandemic. Learning identified increased information sharing, connection between community and statutory services, and inclusive and collaborative work with the voluntary and community sector.

Learning from recovery from the pandemic has informed the Lambeth Together approach to integration, collaboration and joint working to improve health and wellbeing outcomes for Lambeth residents.

2.1 Neighbourhood and Wellbeing Delivery Alliance

Applying this partnership approach is core to the Neighbourhood and Wellbeing Delivery Alliance (NWDA), a collaboration between local residents, Lambeth's health, social care, voluntary, and community sector organizations. NWDA works together to share intelligence, cocreate solutions, and improve Lambeth residents' health and well-being. Ongoing projects include below.

- **Thriving Communities**

Thriving Communities is a network of local people, projects, resources, and organizations in Lambeth designed to connect residents to local opportunities and improve local health and wellbeing. Thriving Communities is based on the Wards in the borough and associated Primary Care Networks of GPs (PCNs). Currently there are five Thriving Communities.

The loneliness test and learn project involved five GP practices and a social prescribing link worker, with the aim to reduce loneliness and social isolation for residents over 65 years with long-term health issues. The project successfully delivered interventions and developed into the creation of Thriving HBD (Tulse Hill, Herne Hill and Thurlow Park).

There will be regular themed community events with established communication channels and digital infrastructure e.g., website, social media, WhatsApp. Additionally, work is underway to explore widening the network.

- **Chronic Pain**

The chronic pain project aimed to improve referrals and self-management for chronic pain patients. Highlighted health inequalities in chronic pain (most prevalent in Lambeth's black, female, and deprived communities) led to lived experience focus groups to understand how chronic pain impacts the wider determinants of health. Chronic pain community programmes were promoted and digital champions helped local residents access online self-management programmes.

Chronic pain is part of the Lambeth Together's Health Inequalities Core 20+7 objectives. A proposed NWDA programme aims are to gather data and evidence and patient experiences to refresh the chronic pain referral pathway and promote community programmes.

- **Care Homes**

Care homes are critical to supporting our most vulnerable residents. NWDA members supported care home staff get their vaccinations and this work included drop-in sessions, workshops, webinars, and FAQs. A group of GPs, geriatricians, and other NHS and Council professionals has been established to co-ordinate support to nursing home residents.

NWDA continues support to Enhanced Health in Care Homes across Lambeth by fostering robust leadership provisions, expanding and developing the multi-disciplinary support team, provide care homes with access to technology, tools, and patient information through digital development.

- **End of Life**

Advance care planning can prevent unnecessary hospitalization in the last year of life. NWDA supported GP surgeries and established action plans to increase advance care plans among their registered population and improved end-of-life care through workforce training. Support includes migration from the 'Co-ordinate My Care' system to the emergency care platform.

This programme will move to a monitor stage with annual reporting on end-of-life care planning across Lambeth.

- **Multiple Long-Term Conditions**

In 2021 the Multiple Long-Term Conditions (MLTC) team convened partner organizations using a coaching process to explore the provision of personalized care for people with multiple and complex long-term conditions, in one PCN. The ambition was to change care through collaboration between healthcare professionals working across boundaries, with people and their family at the centre, and addressing health needs in the context of social, mental and physical wellbeing.

The first cycle of multi-disciplinary team (MDT) clinics reviewed and coordinated care for patients seen in two or more specialties. Learning from the first cycle highlighted the challenges of working across and within health and care organizations together with workforce and cultural barriers, to provide joined-up care for people with a complex set of conditions.

Diabetes and Health Inequalities project – The aim of the Diabetes and Health Inequalities project is to explore reducing barriers to health through identifying at risk patients, and to provide targeted supported self-management focusing on patients with protected characteristics.

Using a health coach, the project aims to explore what support is needed to enable socially appropriated self-management, and links to community groups, for a focused group of people with diabetes. At present, the team are in dialogue with ICS to identify a tool to monitor self-management (Patient Activation or other).

NWDA partners are reviewing current and new priorities in the summer to input into the Lambeth Health and Care plan, to determine their priorities for 2023 and beyond.

2.2 Living Well Network Alliance

The Living Well Network Alliance (LWNA) supports people in Lambeth who are experiencing mental illness or distress. The LWNA partners are Certitude, Lambeth Council, South East London ICB (Lambeth), South London and Maudsley NHS Foundation Trust and Thames Reach.

The Alliance engaged with people who use mental health services. People felt they wanted more options for support when they were in crisis. They also wished teams could work more closely together to reduce the number of times they had to give personal information and tell their story.

Based on engagement outcomes, the Alliance is improving mental health services to be more joined up, quicker and easier to access, and more focused on prevention, avoiding crises and unnecessary admissions to hospital. By joining up services, there should be less need for repeat assessments or unnecessary referrals from one part of the system to another.

The Alliance supports people to say how they would like their own care and treatment to be provided, and includes those that care for the person, as equal partners in support and recovery.

- **Lambeth Single Point of Access**

This service launched in September 2019. People are able to get in touch if they are worried about their mental health. Depending on the person's needs, the most likely form of support will be from one of the Living Well Centres.

- **Living Well Centres**

Three Living Well Centres are based in community mental health services in the borough. The centres contain teams made up of psychiatrists, therapists, nurses, social workers, voluntary and community workers, and peers – people with lived experience of mental health issues.

Living Well Centres offer short-term support for those with low to moderate needs from the combined team of clinicians, social workers and support workers, and medium to long-term support for those with greater need from a focused support team.

- **Other services**

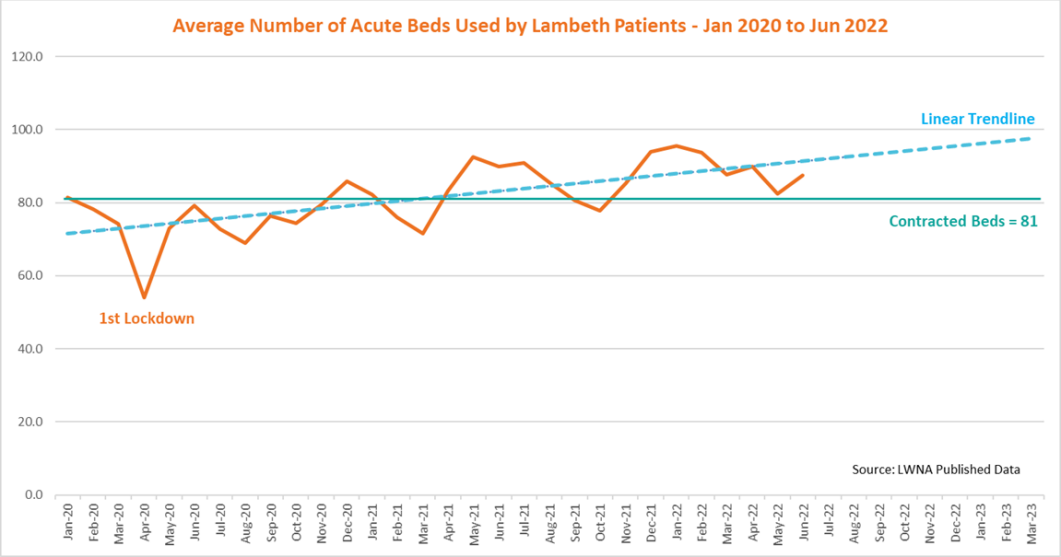
The LWNA have also established other new services to improve mental health in Lambeth:

- Crisis Outreach Service – support for people in crisis aged 18 to 65 who are not in contact with a mental health team.
- Community Liaison and Support Service (CLaSS) – specifically created to improve the flow of people through inpatient beds, minimising delays for patients who are medically fit for discharge
- Culturally Appropriate Peer Support and Advocacy (CAPSA) Service – a ground-breaking new service, developed with partners from Black Thrive and people from the local Black community with lived experience – ensuring our support is more culturally sensitive and appropriate whilst improving trust and relationships.
- Staying Well – a VCS led team, including clinicians and social care, who work with primary care to keep people well in their communities and support those who have been recently discharged from secondary mental health services.

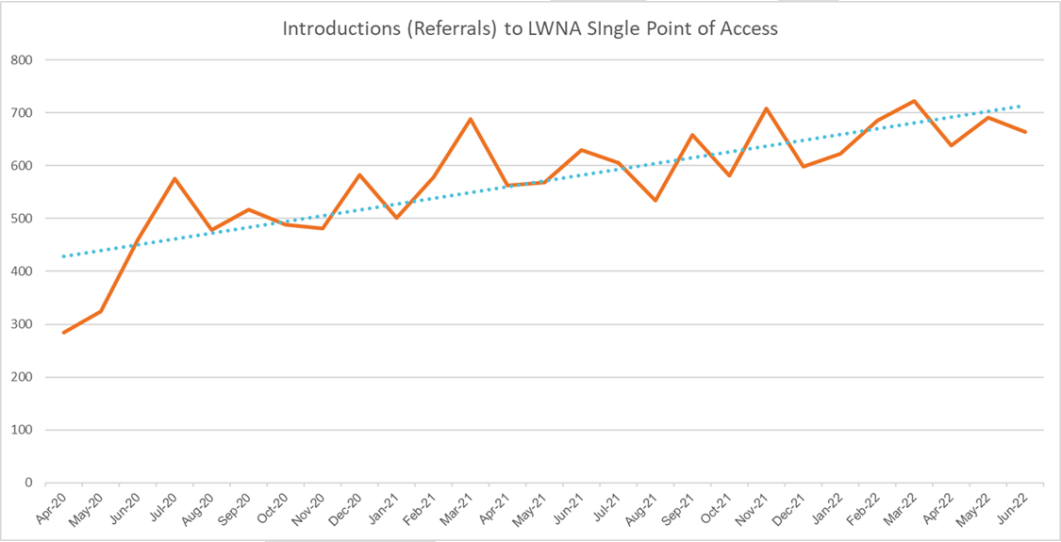
Response to growing need

Following the COVID-19 pandemic, there has been a significant increase in mental health need in the borough. The above new services are designed to prevent need worsening, ensure people get the right support at the right time and deal with crises earlier and more effectively.

Acute mental health bed utilisation by Lambeth residents: January 2020 – June 2022



Introductions (referrals) to LWNA Single Point of Access: April 2020 – June 2022



In addition, mental health services have put significant additional resource into the local A&E to divert those who attend due to mental health issues.

The Alliance has increased the size of the Single Point of Access and streamlined processes to reduce waiting times. LWNA continues to expand and improve talking therapies to increase access and effectiveness, and personality disorder pathway has been redesigned, moving expertise into the community alongside GPs to provide stepped care.

3. Support to unpaid carers

In collaboration with partners and unpaid carers across the community, Lambeth has begun work to review and progress a refreshed Lambeth Carers Strategy alongside a series of engagement opportunities. Work has commenced to develop an outline plan for the delivery of the refresh, which will take place over 2022, which was agreed by the Carers Collaborative Group. As a starting point for the strategy refresh, Lambeth are working with partners to gather feedback and ideas from

members of the Carers Collaborative Strategy Group to help shape planning, give an initial sense of progress made, and identify areas to consider.

A key forum for this work will be the Carers Collaborative Strategy Group (CCSG), which brings together carers and representatives from Age UK Lambeth, Carers4Carers, Carers' Hub Lambeth, Lambeth Learning Disability Assembly, Lambeth Parent Forum, London Borough of Lambeth, NHS SEL ICB and South London and Maudsley NHS Foundation Trust.

During 22/23, Lambeth will be collaborating with partners and unpaid carers to:

- Identify and facilitate opportunities for collaboration and consultation, both in person and online
- Seek input and views through surveys, events and the CCSG
- Gather data and review best practice guidance to inform our strategy
- Develop our strategy in collaboration with partners across the community
- Promote and raise awareness of our strategy
- Set clearly defined measures to track and report progress

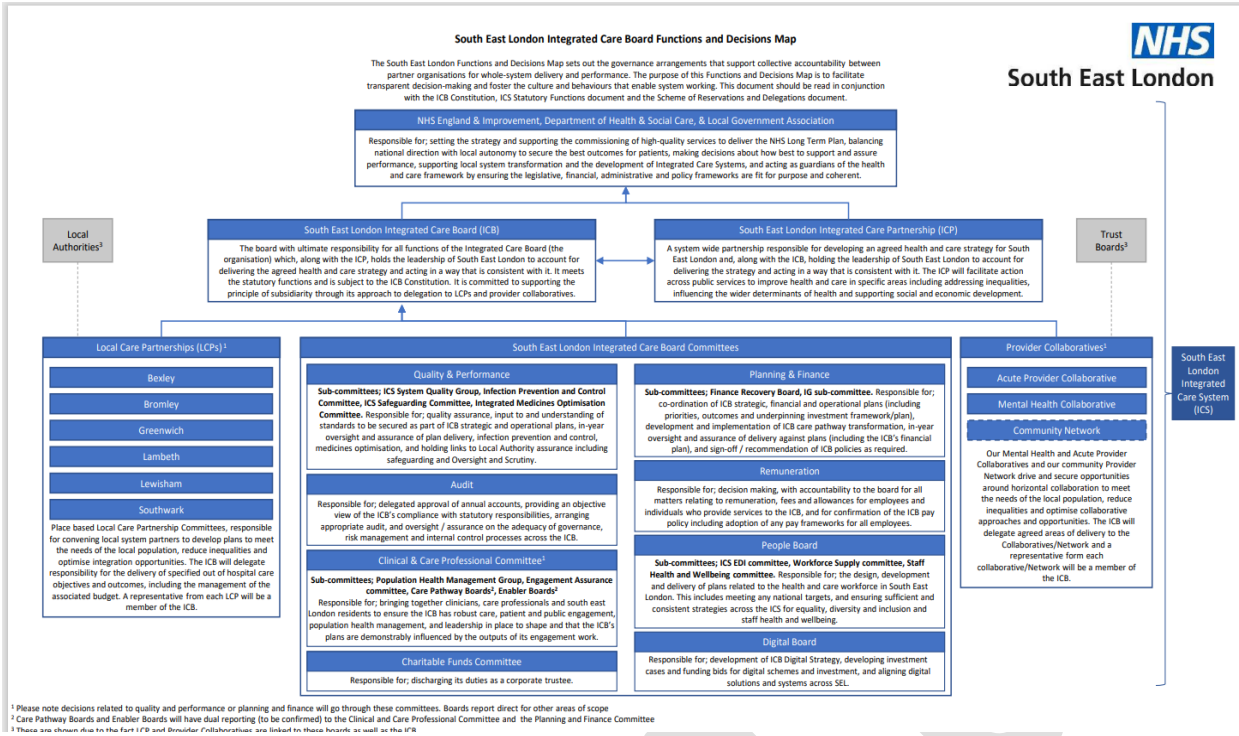
Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

Lambeth's BCF plan template and narrative plan were reviewed and agreed through the Local Care Partnership Board, South East London Integrated Care Board, the Chief Executive Officer of Lambeth Council, the Strategic Director of Integrated Health and Social Care (Lambeth), and Lambeth Health and Wellbeing Board.

The Local Care Partnership for Lambeth and all other boroughs in South East London, attend the Integrated Care Board – please see below governance structure for Integrated Care System.

South East London Integrated Care Board – Functions and Decisions Map



Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person-centred health, social care and housing services including:

- Joint priorities for 2022-23
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2021-22.

Lambeth's BCF plan prioritises integrated health and care community services and transformation programmes, and prevention and early intervention in the community. Services and transformation programmes support people to remain independent in their home or usual place of residence, maintaining their health and wellbeing.

Lambeth's BCF continues to jointly invest in integration and community health services, and fund above national requirements for NHS commissioned out of hospital services. The collaborative work between health and care services brings a system response to supporting improved health and wellbeing, ensuring people are seen by the right service in a timely way so they remain safe, well and independent, with home first as the best discharge option.

A good example is Lambeth's response to the Hospital Discharge and Community Support: Policy and Operating Model published 21 August 2020. Lambeth Adult Social Care, Integrated Commissioning, Southwark commissioners, and Guy's and St Thomas and King's College Hospitals continue to improve discharge practice, and determining the best system approach to Discharge to Assess (D2A)

as the standard discharging process from hospital to community. The D2A approach ensures the person is supported in the right place by appropriate staff, and at the right time.

Integrated intermediate care and reablement community services that support transfer from hospital are integral to Lambeth's BCF, ensuring people return home and are supported to remain safe and cared for, as well as supporting those who are struggling with health issues to remain in their home or usual place of residence without the need for an admission to hospital.

Lambeth Together Alliances

- The Neighbourhood and Wellbeing Delivery Alliance (NWDA) is prioritising improving support in the community as part of early intervention and prevention to support healthy, safe and independent communities and reducing health inequalities; helping people to manage long-term health conditions including provision of culturally appropriate community-based pain services in local neighbourhoods and creating 'easier to access' care pathways between hospitals, GP practices and community services; improving the quality of support to care homes to enhance care to residents (and the families and carers); and coordinating excellent end-of-life care, encouraging and supporting residents to consider and plan for end of life.

  NWDA is focused on enabling people to remain independent in their own home or usual place of residence. Independence and wrap around services avoids the need to be admitted to hospital, and NWDA fosters a local response to ensure independence and resilience for residents.

- The Living Well Network Alliance (LWNA) focuses on delivering collaborative services in the local community, ensure people get the right support at the right time and deal with crises earlier and more effectively.

Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Please use this section to outline, for each objective:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care
- How BCF funded services will support delivery of the objective

Plans for supporting people to remain independent at home for longer should reference

- steps to personalise care and deliver asset-based approaches

- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level.

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.
- Carry out collaborative commissioning of discharge services to support this.

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

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1. Enable people to stay well, safe and independent at home for longer

Using the tested Alliance approach, Lambeth enables localised, collaborative support to residents that puts the individual at the centre of their care. The Alliances' work programmes are focused on local responses to need and developing communities of health and care stakeholders that work at neighbourhood level. The alliances also introduce the concept of those people living locally with lived experience of a health condition, being part of a service or local support system.

Lambeth takes a population health approach to improving outcomes, not just for people being discharged from hospital but also to improve step-up services in the community to avoid a person having to be admitted to hospital.

Work led by Lambeth's operational locality teams and community partners are structured around the needs of the different neighbourhoods within the borough to provide support delivered in a targeted way that meets the needs of Lambeth's diverse communities.

GPs in the borough are part of established primary care networks that provide medical care and enable social prescribing services locally. Through these networks, needs are assessed by neighbourhood and localised decisions are made about health and wellbeing.

Lambeth has a strong preventative offer, focused on admission avoidance and improving recovery outcomes. Through collaboration with partners and residents, Lambeth has developed services that respond specifically to both avoiding admission and recovering following admission. Below are examples of local collaborative health and care support services enabling people to remain safe and well in their home or usual place of residen

The Neighbourhood and Wellbeing Delivery Alliance

Focuses on enabling people to remain independent in their own home or usual place of residence. Independence and wrap around services avoid the need to be admitted to hospital, and NWDA fosters a local response to ensure independence and resilience for residents.

NWDA supported GP surgeries and established action plans to increase advance care plans among their registered population and improved end-of-life care through workforce training.

The Living Well Network Alliance

The LWNA has moved services for people struggling with poor mental health, into the community. Services are collaborative and a good example of this is the Culturally Appropriate Peer Support and Advocacy (CAPSA) service – a ground-breaking service, developed with partners from Black Thrive and people from the local Black community with lived experience – ensuring support is more culturally sensitive and appropriate whilst improving trust and relationships.

Prevention / Early Intervention

Under the work led by Lambeth Together, Lambeth has continued to maintain a strong focus on supporting communities and individuals to manage their own health and wellbeing or condition with access to the right information and assistance, to help people (especially those living independently) avoid a crisis, or minimise it, and to build stronger community ties.

An innovative part of this is Project Smith, which uses a coproduced approach with local residents, working to improve identified issues that they felt were important:

- improve health and wellbeing
- connect isolated people
- help create healthier communities

Project Smith enables local residents to participate in development of local services, have a voice in what is important in their community, work within their community to support those who are marginalised, struggling with poor health and wellbeing, linking them with statutory services to prevent deterioration, and participating in the mixed model of social prescribing in Lambeth.

Rehabilitation and falls service

Provides a 30-week programme to support those at high risk of falls, and in 2019 a falls prevention programme was created to help people maintain fitness and avoid falls. Strength and balance exercises are an effective, evidence-based way to prevent falls.

The services maintain contacts with local vetted exercise groups to enable residents to continue exercising in their local area once they have completed either programme.

The service is now including care homes as part of a developing approach to falls. The service will provide information and training for care home staff where falls has been identified as a concern via quality and safety reviews carried out by commissioners.

Reablement

Intermediate Care Lambeth (ICL) provides an integrated reablement team to support people remaining at home and continuing their journey of recovery, enabling them to reduce dependency on statutory services and remain as independent as possible.

Stroke Support

GSTT community provide the integrated stroke advice and support team provide therapy, psychological support and advice on benefits and support groups for people who are stroke survivors and their families. The service works from hospital bed to home, supporting independence, a potential return to work, and providing much need advice and support following a life changing event for the stroke survivor and their family, reducing the need for further hospital admissions.

The BCF has a strong focus on community services with approximately 90% of BCF funds supporting early intervention/prevention, packages of care at home, reablement, intermediate care, responding to building works, internal adjustments and equipment in a person's home for safe and easy use, and support to unpaid carers.

2. Provide the right care in the right place at the right time

The need to reduce the length of a person's admission to hospital is critical in improving their chance of recovery and life returning to 'normal'. Availability of acute hospital beds is key to the whole health and care system functioning well, therefore timely discharge from hospital requires a safe, streamlined system response.

Discharge and Discharge to Assess

BCF funded activity directly supports safe, timely and effective discharge via distinct pathways identified in the Hospital Discharge and Community Support: Policy and Operating Model published 21 August 2020.

Lambeth Adult Social Care, GSTT Community Health and acute services and KCH acute services work in partnership overseeing and delivering safe, timely and effectively discharge via Integrated Internal Flow Hubs established in KCH Denmark Hill site, and St. Thomas' Hospital, to jointly manage all hospital discharge work. There is a Single Point of Access hosted by GSTT, which jointly manages all discharge related referrals and ensure continuity and efficiency.

The care home market is well supported via commissioning and public health with a number of care homes able to response to winter pressure as needed through targeted block contracts, including to take referrals on a 7-day basis being awarded for a defined period.

Age UK Lambeth deliver a Home from Hospital service, supporting people with practical help in the days following discharge from hospital.

Following discharge, Intermediate Care Lambeth (ICL) which went live 10th November 2020, jointly manage therapy and reablement alongside Urgent Response teams.

Intermediate Care Lambeth (ICL) - Admission Avoidance and Rapid Response

The @Home service is part of Intermediate Care Lambeth (ICL), an integrated health and care delivery system provided by a multidisciplinary team. @home provides support to a person at home who is showing signs of deterioration and requires a clinical and potential social intervention so that they can remain at home and avoid going into hospital. @Home offers intensive medical support for a targeted period of time within a patient's home. This service enables patients either to avoid coming into hospital at all, or to help them return home sooner with extra support. This type of service is sometimes called a 'virtual hospital'.

ICL also includes the Enhanced Rapid Response Service that facilitates discharge from hospital and provides home based rehabilitation and support targeted at adults and older people with a physical or sensory disability, or mental health condition. The aim of the service is to support patients regaining or maintaining independent living within the community and preventing unnecessary hospital admission.

Lambeth's approach to hospital discharge is 'strengths' based, reablement approach with an ethos of home first in order to maintain independence and reduce reliance on long-term care for as long as possible.

BCF funded activity has a strong focus on supporting safe, timely and effective discharge.

Operational teams use a localised approach to ensure efficient discharge back to the community in a safe and effective way, utilising services funded through the BCF fund such as the @Home service, Enhance Rapid Response service, reablement and intermediate care, and integrated stroke service.

High Impact Change Model (HICM) – self assessment

The HICM supports local system partners to improve health and wellbeing, and minimise unnecessary hospital stays. The model offers a practical approach to supporting local health and care systems to manage a person's inpatient journey and discharge.

A review of current practice across the nine changes identified in the HICM, has been carried out based on the updated 2020/21 version HICM – 'Managing transfers of care between hospital and home'.

Lambeth's work on implementing the Hospital Discharge Policy 2020, has enabled the local systems to develop solutions and processes to facilitate safe and timely transfer following a hospital admission and prevention and early intervention in local communities, helping people to remain in their home or usual place of residence, providing support and care when needed.

Change 1: Early discharge planning	**Established - Mature (emergency/unplanned care)** In responding to a health crisis in a person's home or usual place of residence, Intermediate Care Lambeth (ICL) is an integrated health and social care service supporting people to avoid a hospital admission (Urgent Response) and providing health and social care support following an admission (Rehabilitation and Reablement). The service optimises independence and wellbeing, offering the right support at the right time in the right place. If an admission to hospital is required, discharge planning starts with alerting the Single Point of Access, established at one local acute hospital

	site, that jointly manages all discharge related referrals and ensure continuity and efficiency across the discharge system. Internal flow hubs at the two local acute hospital sites enable early discharge planning, the estimated date of discharge (EDD) is established, and an MDT plan with regular discussion, including ongoing conversations with family/friends, and preparation during hospital stay to effectively provide a safe discharge e.g. pathway 3 example on page 3. The ongoing implementation and embedding of the system response to the discharge model continues via three designated meetings: • South East London (SEL) Discharge group • Local Southwark & Lambeth System Discharge Group • D2A Pathways Group
Change 2: Monitoring and responding to system demand and capacity	**Established** A responsive market for home care and care homes is essential to safe and timely discharge from hospital. Lambeth has: The care home market is well supported and monitored via commissioning and public health with a number of care homes able to response to winter pressure as needed through targeted block contracts, including to take referrals on a 7-day basis being awarded for a defined period. Demand assumptions based on 2021/22. Home care commissioning market is through an approved provider list (APL) framework to ensure sufficient capacity to respond to home packages of care. The APL will re-open to consider additional interested providers, ensuring they provide a quality and safe service, to be completed by September 2022. Demand assumptions based on 2021/22.
Change 3: Multi-disciplinary (MDT) working	**Mature** Daily ward rounds feed into MDTs within internal flow hubs to ensure transfer is timely and safe.
Change 4: Home first	**Mature** Lambeth's approach to hospital discharge is 'strengths' based, a reablement approach with an ethos of home first in order to maintain independence and reduce reliance on statutory services for as long as possible. All discharges are considered as part of a home first approach, and Lambeth's 5 step down D2A beds enable ongoing care whilst decisions are made jointly with family/friends to ensure, where possible, a person can return to their home or usual place of residence.
Change 5: Flexible working patterns	**Mature** The internal flow hubs at both acute hospital sites are working seven days a week, with access to clinical and social care colleagues to support decision making regarding discharge arrangements.
Change 6: Trusted assessment	**Mature** Use of Trusted Assessment (TA) documentation is standard practice in both SE London discharge hubs using a format agreed with local care homes.
Change 7: Engagement and choice	**Mature** A Choice Policy was developed in 2015 and refreshed in 2018. The policy was developed with Healthwatch, relevant local authorities and commissioners, and Guy's and St Thomas' Hospital, King's College Hospital,

	and Princess Royal Hospital, Bromley. The policy is currently being refreshed for re-issue in September 2022.
Change 8: Improved discharge to care homes	**Mature** Use of Trusted Assessment (TA) in place, and development of Transfer of Care (TOC) passport provides essential information about a patient for care homes, so they are confident in receiving the admission with all necessary information on arrival.
Change 9: Housing and related services	**Established** Lambeth's Home Improvements Agency (HIA) and adaptations pathway supports key duties around prevention, promoting independence and support to stay well. The work carried out enables independence of individuals at home and supports quicker hospital discharge across a range of physical, sensory or mental health needs.

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Lambeth takes an integrated and collaborative approach to supporting unpaid carers. As part of BCF funded activity, both young and adult carers are empowered to access services and support to enable them to carry out their caring role. As part of this offer, Lambeth collaborates closely with local voluntary and community sector organisations to deliver a varied offer of support.

Care Act duties

At the point of identification, Lambeth carers are offered a statutory Carers Assessment which assesses carer need and explores what support they may want to access to enable them to continue what they want to achieve outside of their caring role, such as work or study. Assessments also serve an important function for social work teams to safeguard against carer breakdown, inappropriate caring roles in younger children, and establish whether the carer is able to continue in their caring role.

This assessment is carried out by social work teams across the borough, who work with carers towards agreeing a support plan, and to provide support to access services in the borough. Assessments consider how someone's caring role affects their health and wellbeing which includes:

- physical, mental and emotional health
- relationships
- social activities
- goals
- work
- studies and training
- leisure

Local commissioned organisations also play a key role in empowering carers to understand their rights in relation to their caring role, and how to access legal advice and information.

BCF Funded Services

Lambeth dedicates funding via our Independent Living and Carers Partnership contract, respite and short breaks offers to support carers.

As part of these contracts, the services offer:

<u>Information, Support and Advice</u>

- One-to-one support
- Peer support groups, where carers can share their experience, make friends, and develop new skills.
- Information sessions and learning opportunities

- Signposting and referrals onto other services, such as benefits advice, mental health support and advocacy

Training and activities

- Monthly social activities to provide opportunities for carers to meet others, build new friendships, have fun and stay connected
- First aid training and free legal clinics
- Dedicated projects working with schools to support young carers with their education
- Awareness raising through outreach in the community, with GP practices and local hospitals, presentations to schools and social work teams, partnership working and work around the Lambeth Carers' Strategy.

Respite / Carers Breaks

Respite and short breaks are a key part of Lambeth's offer to unpaid carers. Respite can be accessed for a short period on a regular basis, for one-off periods such as a holiday, or regular routine help. Lambeth dedicates funding for residential and nursing placements to enable carers to take a break from their caring role, in addition to funding opportunities for short breaks and daily support through packages of care.

Lambeth Carers Card

The Lambeth Carers Card has been informed and inspired by the concept of community Carers Passports developed by the national charities Carers UK and the Carers Trust, with backing from the Department of Health and Social Care. The scheme has been established to help recognise carers and their vital contribution to our community. It seeks to identify a greater number of carers in the borough, and most crucially connect them to the information and support that can improve their quality of life.

The carers card offers:

- Free access to the Lambeth version of Carers UK's Digital Resource for Carers and the Jointly App, offering access to essential and high-quality information for their caring role.
- A welcome pack with a suite of emergency planning resources including the Lambeth Carers Card which has space for ICE contacts, emergency planning templates and tips. This is to encourage carers to put contingency plans in place.
- In collaboration with VCS partners, the implementation team are working towards offering discounts at local businesses. The local discount scheme will seek to help to reduce the financial strain of caring, increase carer access to local health and wellbeing and leisure activities.
- Once carers have joined the scheme they receive regular newsletters promoting signposting information to local organisations, events and training. This is to ensure a greater number of carers are connected to the support and assets Lambeth has to offer. Carers are also able to access quarterly workshops to support emergency planning.

Outcomes

Lambeth takes an outcomes-focused approach to carers support, and partners regularly report against key outcomes to measure impact on carers' wellbeing. In 22/23 Lambeth will look to build upon the success of the last year, which saw:

- 70% of young carers report improved increased confidence in their caring role
- 78% of adult carers report increased connections with services and other carers
- 86% of adult carers report reduced feelings of loneliness and isolation

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Lambeth's Home Improvements Agency (HIA) and adaptations pathway supports key duties around prevention, promoting independence and support to stay well. The work carried out enables independence of individuals at home and supports quicker hospital discharge across a range of physical, sensory or mental health needs. Home adaptations are an excellent example of provision which enables wellbeing and independence; adaptations prevent need by targeted interventions aimed at individuals who have an increased risk of developing needs. Adaptations also provide services, resources or facilities that may help slow down or reduce further deterioration or prevent other needs from developing.

Lambeth takes a collaborative and integrated approach to ensure people are supported to remain in their own home for as long as possible, with multi-disciplinary teams and departments working together so that individuals' needs are considered and met holistically.

In 2022, Lambeth redefined the Health, Adult Social Care and Housing Board to consider, amongst other priorities, pathways and processes in place for the DFG, and how they might be integrated, improved and streamlined. The Board membership consists of the Director of Adult Social Care, and Assistant Directors for Housing, Finance, Practitioner Managers and the Head of Direct Labour Organisation (DLO).

Despite the impact of the COVID-19 pandemic, significant progress has been made to deliver on the intentions set in 2019. In 2019, Lambeth announced that it was going to radically redesign its repair and maintenance services in pursuit of its commitment to deliver better quality, socially responsible and digitally driven services. Further to this commitment, in November 2020 an exciting proposal was approved which saw Lambeth create an in-house Direct Labour Organisation (DLO). The idea of starting an in-house DLO communal repairs team was developed in collaboration with residents, who formed a Task and Finish group, making 21 recommendations for the Council to improve the way communal repairs are reported, recorded, done and inspected after completion. This change has seen Council employees undertaking communal repairs in the community and providing tailored property adaptations for some of the borough's most vulnerable residents in need of additional support and care.

Significant work has been undertaken to review processes due to the historic challenges of operating across a number of data bases and systems cutting across housing, adult social care and finance systems. To help streamline the processes, a number of changes have been made to the system. This will improve efficiency and tracking of work orders with expected improvement in response times. The key changes are outlined below:

1. To raise jobs for minor adaptations via the Northgate contractor module so that the newly formed DLO can carry out minor and major adaptations work.
2. To introduce a service level agreement to maintain the client (Internal) contractor relationship and ensure that jobs raised are being processed and delivered within an acceptable timeframe.

3. To ensure all outstanding current works are loaded and captured into the new DLO Northgate system according to DLO requirements.

Building upon the work done in the period so far, the Health, Adult Social Care and Housing Board have identified and agreed the next stages to be delivered over the next period:

- The DLO being established to deliver work on behalf of the HIA
- Adult social care agreeing to this change as part of the partnership working agreements for the HIA
- The formal establishment of the Health and Housing Board to provide oversight on the DFG budget and report into the formal BCF reporting framework.
- Action plan to be developed to address waiting list for surveyors – 2 additional surveyors have been appointed and the team are working with contractors to reduce the waiting list.
- Work to consolidate and increase staffing within HIA for Occupational Therapy in recognition of demand.
- Work is also underway to look at reducing backlog and mapping of resources required to do this; procurement processes are also being looked at for major adaptations work

Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

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Lambeth has high levels of social deprivation. Nearly one third of the population of Lambeth live in areas which are among the most deprived 20% of areas in the country and approximately 23% of children (12,400) live in low-income families.

Lambeth's population is highly diverse with 60% describing their ethnicity as other than white British. 24% describe themselves as Black, although this varies by age group, with nearly 80% of 10-19 year olds describing their ethnicity as other than white British. There is a predicted 9% increase in residents by 2025, and a significant increase in the over 85 population.

Lambeth's vision is to improve the health and well-being of local people by services and communities working together with shared resources. Lambeth has four overriding objectives based on Lambeth Council and ICB strategic objectives, Lambeth Together and Primary Care Network development. These are:

- Health and wellbeing are improving for all, and improving fastest for those with the poorest health and wellbeing;
- People are able to reach their full potential and feel good about themselves;
- Everyone feels valued and has choices about their health and wellbeing; and
- People are safe from harm.

Lambeth Together Equalities Working Group

The COVID-19 pandemic highlighted the disproportionate affect the virus had on Black Afro-Caribbean, Black African, Asian and other ethnic communities in Lambeth, and for those people who are discriminated against because they are part of a protected characteristic group e.g. LGBTQ+.

The Lambeth Together Equalities Group continues to develop comprehensive and quality ethnicity and Core 20+5[1] data to support focused and person-centred support and reduce health inequalities. A dashboard is being devised in conjunction with GPs with the intention that collection and recording are part of routine NHS and social care data collection systems, ensuring data are readily available to local health and care partners to inform future thinking and transformation programmes.

[1] NHS England » Core20PLUS5 – An approach to reducing health inequalities

The Group, in collaboration with Public Health and our Alliances are accelerating efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing, and effective management of chronic conditions including diabetes, hypertension and asthma.

Primary Care Networks (PCN) and Lambeth Together Equalities Group

A two-year Tackling Neighbourhood Health Inequalities programme has been developed to establish a network of nine Health Inequalities Champions, one for each of the primary care network of GPs (PCNs). The programme has approached health colleagues in the London Borough of Lewisham where this type of programme is advanced, for shared learning.

Working with the PCN Clinical Directors, Health Equalities Champions will be working closely with the NWDA, other Delivery Alliances, sharing resources and delivering community engagement events. The Champions will be employed by each PCN to work on building and delivering the champions' programme.

Clinical Directors and Champions will use neighbourhood level data, build upon pre-existing Health Inequalities (HI) Plans, in order to map PCNs future activity so the programme can meet the needs of the local (PCN) population. For example, many PCNs are looking at how blood pressure problems are detected and managed appropriately.

Public Health and NWDA

A two-year Community Event and Innovation programme has been developed with the aim of engaging in conversations with residents (targeting those protected characteristics to reduce health inequalities), about their general health and wellbeing while building trust with the health and social care sector.

Impacts measures

The main impact measures/outcomes of the programme are:

- Activate Lambeth citizens to engage in health promoting behaviours (physical and mental) and reduce health inequalities for those with protected characteristics
- Understand what residents feel is important for them for their own health and wellbeing,
- Reduce medical scepticism in those communities who are most mistrustful of traditional methods of engagement, explore how residents would like health services to engage with them (e.g. screening offers, health checks)
- Promote the vaccination uptake and signpost residents to nearest GP/vaccination site,
- Provide health and wellbeing advice and signpost to local services,
- Collect learning from the project to influence PCN development to address health inequalities and the Building Healthier Communities board (& associated investments)

Outcomes:

- Improve trust in the health and social care system particularly with marginalised and Black, Asian and Multi-Ethnic groups (No of events, residents attendance numbers and surveys
- Capture the positive health benefits of community led events – Resident engagement Weight/Blood pressure measurement, screening etc.

- Learn from the creative ways of engaging communities in health and wellbeing including intergenerational approaches – Grassroots community feedback
- Increased understanding of influencers in families and communities through increased Increase engagement with ethnic groups about general health and wellbeing (Learning workshop report)
- Develop evaluation expertise and knowledge to assess the learning of each VCS programme and share learning to influence local systems

BCF Planning Template 2022-23

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2022-23. It will be pre-populated with the minimum NHS contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.

2. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

3. Please use the comment boxes alongside to add any specific detail around this additional contribution.

4. If you are pooling any funding carried over from 2021-22 (**i.e. underspends from BCF mandatory contributions**) you should show these on a separate line to the other additional contributions and use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

5. Allocations of the NHS minimum contribution (formerly CCG minimum) are shown as allocations from ICB to the HWB area in question. Mapping of the allocations from former CCGs to HWBs can be found in the BCF allocation spreadsheet on the BCF section of the NHS England Website.

6. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

5. Expenditure (click to go to sheet)

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Conditions 2 and 3 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend under National Condition 3. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2022-23:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2022-23 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2022-23. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2022-23.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2022-23. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2020)
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Exact script used to pull pre-populated data can be found on the BCX along with the methodology used to produce the indicator value:
https://future.nhs.uk/bettercareexchange/viewdocument?docid=142269317&done=DOCCreated1&fid=21058704
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2021-22, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2022-23 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

3. Residential Admissions (RES) planning:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

4. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2022-23 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

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Better Care Fund 2022-23 Template

2. Cover

Version 1.0.0

HM Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2022-23.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.
- Where BCF plans are signed off under a delegated authority it must be reflected in the HWB's governance arrangements.

Health and Wellbeing Board:	Lambeth
Completed by:	Jennifer Burgess
E-mail:	jennifer.burgess@selondonics.nhs.uk
Contact number:	07771 344372
Has this plan been signed off by the HWB (or delegated authority) at the time of submission?	Yes
If no please indicate when the HWB is expected to sign off the plan:	
If using a delegated authority, please state who is signing off the BCF plan:	Cllr Jim Dickson

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Cabinet Member for Healthier Communities - HWB Chair
Name:	Cllr Jim Dickson

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Jim	Dickson	jdickson@lambeth.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Sarah	Cottingham	sarah.cottingham@selondonics.nhs.uk
	Additional ICB(s) contacts if relevant		Michael	Fox	michael.fox@selondonics.nhs.uk
	Local Authority Chief Executive		Bayo	Dosunmu	bdosunmu@lambeth.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Richard	Outrum	routram@lambeth.gov.uk
	Better Care Fund Lead Official		Jane	Bowie	jbowie@lambeth.gov.uk
	LA Section 151 Officer		Christina	Thompson	CThompson3@lambeth.gov.uk
Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->	Strategic Director, Integrated Health and Care, Lambeth Together		Andrew	Eyres	andrew.eyres@selondonics.nhs.uk
	Finance Lead, Lambeth Council		Pete	Hesketh	phesketh@lambeth.gov.uk
	Finance Lead, SE London ICB		Edward	Odoi	edward.odoi@selondonics.nhs.uk

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	No
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board: Lambeth

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£1,678,410	£1,678,410	£0
Minimum NHS Contribution	£28,654,962	£28,654,962	£0
iBCF	£14,946,411	£14,946,411	£0
Additional LA Contribution	£0	£0	£0
Additional ICB Contribution	£842,351	£842,351	£0
Total	**£46,122,134**	**£46,122,134**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£8,142,927
Planned spend	£15,171,372

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£13,028,690
Planned spend	£13,483,590

Scheme Types

Assistive Technologies and Equipment	£0	(0.0%)
Care Act Implementation Related Duties	£1,445,665	(3.1%)
Carers Services	£290,000	(0.6%)
Community Based Schemes	£525,589	(1.1%)

DFG Related Schemes	£1,678,410	(3.6%)
Enablers for Integration	£0	(0.0%)
High Impact Change Model for Managing Transfer of C	£3,722,850	(8.1%)
Home Care or Domiciliary Care	£14,116,507	(30.6%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£0	(0.0%)
Bed based intermediate Care Services	£10,838,576	(23.5%)
Reablement in a persons own home	£3,250,919	(7.0%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£1,998,116	(4.3%)
Prevention / Early Intervention	£1,624,598	(3.5%)
Residential Placements	£6,630,904	(14.4%)
Other	£0	(0.0%)
Total	**£46,122,134**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)				

Discharge to normal place of residence

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan

Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	95.8%	96.4%	96.0%	96.0%

Residential Admissions

		2020-21 Actual	2022-23 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	414	474

Reablement

		2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	92.2%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes

NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2022-23 Template

4. Income

Selected Health and Wellbeing Board: Lambeth

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Lambeth	£1,678,410
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£1,678,410**

iBCF Contribution	Contribution
Lambeth	£14,946,411
Total iBCF Contribution	**£14,946,411**

Are any additional LA Contributions being made in 2022-23? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

Checklist
Complete:

Yes

Yes

NHS Minimum Contribution	Contribution
NHS South East London ICB	£28,654,962
Total NHS Minimum Contribution	**£28,654,962**

Are any additional ICB Contributions being made in 2022-23? If yes, please detail below	Yes

Additional ICB Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
NHS South East London ICB	£842,351	This reflects the fact that the CCG contributes
Total Additional NHS Contribution	**£842,351**	
Total NHS Contribution	**£29,497,313**	

	2021-22
Total BCF Pooled Budget	**£46,122,134**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Yes

Yes

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2022-23 Template

5. Expenditure

Selected Health and Wellbeing Board: Lambeth

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£1,678,410	£1,678,410	£0
Minimum NHS Contribution	£28,654,962	£28,654,962	£0
iBCF	£14,946,411	£14,946,411	£0
Additional LA Contribution	£0	£0	£0
Additional NHS Contribution	£842,351	£842,351	£0
Total	**£46,122,134**	**£46,122,134**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£8,142,927	£15,171,372	£0
Adult Social Care services spend from the minimum ICB allocations	£13,028,690	£13,483,590	£0

>> Link to further guidance

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Reablement - GSTT	Reablement and rehabilitation services	Reablement in a persons own home	Reablement service accepting community and		Social Care		LA			NHS Community Provider	Minimum NHS Contribution	£1,709,096	Existing
1	Reablement - LA	Reablement and rehabilitation services	Reablement in a persons own home	Reablement service accepting community and		Social Care		LA			NHS Community Provider	Minimum NHS Contribution	£1,118,379	Existing
2	At Home Schemes 1 and 2	Support enabling people to remain at home avoiding hospital	Bed based intermediate Care Services	Rapid/Crisis Response		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£3,543,910	Existing
3	Care Act	Implementation of Care Act duties	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,445,665	Existing
4	Project Smith	Coproduced community development as part of prevention/early	Prevention / Early Intervention	Social Prescribing	local citizen participation and grants scheme to	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£157,950	Existing
5	Carers	Advice and support to carers	Carers Services	Other	social care support and advice to carers	Social Care		LA			Local Authority	Minimum NHS Contribution	£290,000	Existing
5	Carers	Advice and support to carers	Prevention / Early Intervention	Social Prescribing	Dedicated voluntary support to carers	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£727,000	Existing

6	Residential placements	placing into residential and nursing care homes	Residential Placements	Care home		Social Care		LA			Private Sector	Minimum NHS Contribution	£5,801,000	Existing
7	Social care input into At Home and ERR (schemes 1	social care support as part of admission avoidance and rapid	Bed based intermediate Care Services	Rapid/Crisis Response		Social Care		LA			Local Authority	Minimum NHS Contribution	£638,000	Existing
8	Disabled Facilities Grant (DFG)	social care equipment to maintain independence at home	DFG Related Schemes	Discretionary use of DFG - including small adaptations		Social Care		LA			Local Authority	DFG	£1,050,000	Existing
9	iBCF Local Government settlement	care home placements	Residential Placements	Care home		Social Care		LA			Local Authority	iBCF	£829,904	Existing
10	Enhanced Rapid Response ERR (schemes 1 and 2)	Rapid response to support early discharge and admission avoidance	Bed based intermediate Care Services	Rapid/Crisis Response		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£2,703,393	Existing
11	Intermediate Care	Bed based rehabilitation in dedicated community unit	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)	bed based rehabillitation unit to support	Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£3,743,273	Existing
12	Supported discharge	Support enabling early transfer home from hospital	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£2,602,850	Existing
13	Care Home Support	specialist nursing and therapies services for care home residents	Personalised Care at Home	Physical health/wellbeing	specialist support to care home residents e.g.	Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£868,415	Existing
14	Falls service	Targeted classes and support to those at risk of falls	Prevention / Early Intervention	Risk Stratification	community based identification of	Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£384,250	Existing
14	Falls service	Targeted classes and support to those at risk of falls	Prevention / Early Intervention	Risk Stratification	community based identification of	Community Health		CCG			NHS Community Provider	Additional NHS Contribution	£4,829	Existing
15	Pharmacy support to care homes	Specialist pharmacy support, audit and advice to care homes	Community Based Schemes	Integrated neighbourhood services	specialist pharmacy support in	Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£111,511	Existing
15	Stroke advice and support	Advice and support following a stroke for people and their families	Community Based Schemes	Integrated neighbourhood services	Social care advice and support to those living with	Community Health		CCG			NHS Community Provider	Additional NHS Contribution	£56,593	Existing
16	Advice and Support	Support to enable individuals and carers remain independent	Prevention / Early Intervention	Social Prescribing	Advice and Support	Social Care		LA			Local Authority	Minimum NHS Contribution	£266,500	Existing
17	Enhanced clincial services to care homes with	GP/MDT support to care home for admission avoidance	Community Based Schemes	Multidisciplinary teams that are supporting		Primary Care		CCG			Private Sector	Additional NHS Contribution	£357,485	Existing
18	Home equipment	NHS specialist equipment to support independance	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£1,129,701	Existing
19	Advice and support following dementia	Voluntary sector support to people and carers following a diagnosis of	Prevention / Early Intervention	Social Prescribing	Service providing advice, support and signposting	Community Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£84,069	Existing
20	Social care input into supported discharge and ERR	Social care participation in care planning to support discharge	Bed based intermediate Care Services	Rapid/Crisis Response		Social Care		LA			NHS Community Provider	Minimum NHS Contribution	£210,000	Existing
21	Supported discharge - Pathway 1 from	Support enabling early transfer home from hospital	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,000,000	Existing
22	Housing Related Support	Step down extra care flat	High Impact Change Model for Managing Transfer	Early Discharge Planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£120,000	Existing

8	Disabled Facilities Grant (DFG)	Aids and adaptions and DFG grants	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	DFG	£628,410	Existing
9	iBCF Local Government settlement	home care packages	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Social Care		LA			Local Authority	iBCF	£13,677,047	Existing
9	iBCF Local Government settlement	home care packages	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Social Care		LA			Local Authority	iBCF	£439,460	New
2	Hospital at Home services	Support enabling people to remain at home avoiding hospital	Reablement in a persons own home	Reablement service accepting community and		Community Health		CCG			NHS Community Provider	Additional NHS Contribution	£423,444	New

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Further guidance for completing Expenditure sheet

National Conditions 2 & 3

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:

- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:

- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2022-23 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Safeguarding 4. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.

11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

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Better Care Fund 2022-23 Template

6. Metrics

Selected Health and Wellbeing Board: Lambeth

8.1 Avoidable admissions

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population	Indicator value	232.5	231.6	243.5	186.9	A reduction of 5% is anticipated with continued development of community prevention and early intervention.	Continued development of community services in response to ongoing system work for D2A.
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
(See Guidance)	Indicator value	220	209	231	177		

>> link to NHS Digital webpage (for more detailed guidance)

8.3 Discharge to usual place of residence

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Quarter (%)	95.9%	96.4%	95.7%	95.9%	Ambition is to achieve a steady state for 2022/23 - there are increased levels of acuity due to C19 and residents coming to health services later and sicker as a consequence, C19 also complicating those with long term conditions, both cohorts requiring additional support, hence further interventions required in advance of going home e.g. bed based intermediate care.	Monitoring per quarter - steady state working on the assumption that continuing work on system discharge processes will enable people to go home.
	Numerator	5,213	5,369	4,981	4,770		
	Denominator	5,434	5,571	5,203	4,974		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
(SUS data - available on the Better Care Exchange)	Quarter (%)	95.8%	96.4%	96.0%	96.0%		
	Numerator	1,632	1,763	1,605	1,605		
	Denominator	1,703	1,829	1,672	1,672		

8.4 Residential Admissions

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	413.5	470.4	511.6	473.8	We are assuming a small reduction of permanent admission to care home beds. This is cautious as there was an unexpected increase in 2021/22.	Monitoring per quarter - steady state working on the assumption that continuing work on system discharge processes will enable people to go home vs a permanent admission to a care home.
	Numerator	116	137	149	142		
	Denominator	28,050	29,126	29,126	29,973		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	90.7%	91.9%	91.9%	92.2%	Steady state - using the system discharge processes, expectation is that individuals will remain in their home or usual place of residence following reablement. However higher levels of acuity could affect this position.	Monitoring per quarter - steady state working on the assumption that continuing work on system discharge processes will enable people to remain well and able following reablement package.
	Numerator	78	171	125	190		
	Denominator	86	186	136	206		

Please note that due to the demerging of Northamptonshire, information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- 2020-21 actuals (for **Residential Admissions** and **Reablement**) for North Northamptonshire and West Northamptonshire are using the Northamptonshire combined figure;
- 2021-22 and 2022-23 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2020-21 estimates.

Better Care Fund 2022-23 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Lambeth

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between ICB(s) and LA; been submitted? Has the HWB approved the plan/delegated approval? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes			
	PR2	**A clear narrative for the integration of health and social care**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally • The approach to collaborative commissioning • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the document will address these. The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.	Narrative plan	Yes			
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes			
NC2: Social Care Maintenance	PR4	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	PR5	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the NHS minimum BCF contribution?**	Does the total spend from the NHS minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Implementing the BCF policy objectives	PR6	**Is there an agreed approach to implementing the BCF policy objectives, including a capacity and demand plan for intermediate care services?**	Does the plan include an agreed approach for meeting the two BCF policy objectives: - Enable people to stay well, safe and independent at home for longer and - Provide the right care in the right place at the right time? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? •Has the area submitted a Capacity and Demand Plan alongside their BCF plan, using the template provided? • Does the narrative plan confirm that the area has conducted a self-assessment of the area's implementation of the High Impact Change Model for managing transfers of care? • Does the plan include actions going forward to improve performance against the HICM?	Narrative plan Expenditure tab C&D template and narrative Narrative plan Narrative template	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 31 – 43 of Planning Requirements) (tick-box) • Has the area included a description of how BCF funding is being used to support unpaid carers? • Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plan Narrative plans, expenditure tab and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching ambitions been agreed locally for all BCF metrics? • Is there a clear narrative for each metric setting out: - the rationale for the ambition set, and - the local plan to meet this ambition?	Metrics tab	Yes			

Report to: Lambeth Together Care Partnership Board

September 2022

Report Title	**Primary Care Governance**
Lead Author	Garry Money – Director of Primary Care & Transformation
Summary	As part of the development of the Southeast London (SEL) Integrated Care System (ICS), the Integrated Care Board (ICB) has agreed a mandate and a scheme of delegation with each Local Care Partnership (LCP) for the planning, delivery and associated decision-making for out of hospital services, including general practice. To oversee that there are effective arrangements for the discharge of the delegated functions related to primary care in Lambeth, it is proposed that a new "Lambeth Together Primary Care Committee" (LTPCC) is created as a formal sub-committee of the Lambeth Together Care Partnership Board (LTCPB), to which it will be accountable. This will bring together the right people to consider, challenge, guide and oversee the planning and delivery of primary care services in Lambeth. Initially the remit will cover GP Practices or forms of organisation providing core general and primary medical services (GMS/PMS/APMS), Primary Care Networks (PCNs), GP Federations and Out of Hours GP services. The Committee will also provide leadership around the elements of Community Pharmacy and Pharmacy Federations currently commissioned at Place-level. As the SEL ICB takes on further delegated responsibilities, over time this will expand to include further Community Pharmacy, General Optometry and Dentistry services when the LTPCC's remit will be reviewed. The attached Terms of Reference (ToR) have been produced and amended following engagement with the Lambeth Clinical Cabinet, LTCPB members, SEL and Lambeth leads, and the Lambeth Local Pharmaceutical Committee. These ToR are presented for approval by the LTCPB to allow the new committee to be set up and mobilised rapidly, with the first meeting ideally held by early October 2023 at the latest.
Recommendation(s)	The Lambeth Together Care Partnership is asked to: 1. Approve the creation of the new Lambeth Together Primary Care Committee (LTPCC); 2. Approve the Terms of Reference of the new LTPCC. 3. Note the accompanying verbal update around Lambeth nominations to the SE London Primary Care Leadership Group.

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Lambeth Together Primary Care Committee

Terms of Reference

V1.3

August 2022

Approved by	Lambeth Together Care Partnership Board
Date approved	
Name and title of originator/author	Garry Money, Director of Primary Care & Transformation Michele Elston, Associate Director of Primary & Community Care
Effective date	September 2022
Review date	March 2023

Version Control and Document Review Information

Version	Summary of changes	Date	Author/Reviewer
1.0	Initial Draft	08/08/2022	Garry Money
1.1	Amendments	09/08/2022	Michelle Elston
1.2	Amendments based on feedback from Lambeth Clinical Cabinet Executive	16/08/2022	Garry Money
1.3	Amendments based on feedback from LTCPB members, and LPC/Chief Pharmacist	22/08/2022	Garry Money
	Final Signoff Sought	07/09/2022	Lambeth Together Care Partnership Board

Terms of Reference

1. Context

1.1. As part of the development of the South East London (SEL) Integrated Care System (ICS), the Integrated Care Board (ICB) has agreed a mandate and a scheme of delegation with each Local Care Partnership (LCP) for the planning, delivery and associated decision-making for out of hospital services, including general practice, and community pharmacy services commissioned at place.

1.2. The Lambeth Together Primary Care Committee (LTPCC, **the Committee**) has two main functions:

- To support the Lambeth Together Care Partnership Board (LTCPB), the Local Care Partnership for Lambeth, by considering primary medical services contractual issues and providing recommendations for decision to that Board, or to ICB officers, as per the relevant Standing Financial Instructions and adhering to agreements/policies around Delegation and Managing Conflicts of Interest. This will also include those elements of Community Pharmacy commissioned at place, with iteration over time re wider primary care and out of hospital services as the ICS and LCP develop further.

- To support the LTCPB in its overall leadership and oversight role around the delivery of high quality, accessible, responsive and sustainable primary care services in Lambeth, including the delivery of the vision for integrated primary care as defined by the Next steps for integrating primary care report. This will include working in partnership with other relevant forums within the Local Care Partnership where most out of hospital transformation work takes place, in particular the:
  - Lambeth Clinical Cabinet
  - Lambeth Together Executive Group
  - Lambeth Together Delivery Alliances – Neighbourhood & Wellbeing, Living Well, and Children & Young People.
  - Medicines & Clinical Pathways Group (MCliP)

- The Committee will be the main place within the Local Care Partnership where the performance and commissioning of the areas within its remit are overseen, however regular content for the Lambeth Together Assurance Group (LTAG) Assurance Pack will remain, with the ability to decide where best to discuss actions around areas of concern (e.g. on system areas that affect more than just Primary Care).

- Appendix A sets out the formal reporting accountability for the LTPCC, as well as the extensive range of Lambeth- and SEL- based groups and programmes which will inform the delivery and development of general practice and wider primary care services in Lambeth.

1.3. The Committee will oversee that there are effective arrangements for the discharge of the delegated functions related to primary care, bringing together the right people to consider, challenge, guide and oversee the planning and delivery of primary care services in Lambeth.

1.4. This initially includes GP Practices or forms of organisation providing core general and primary medical services (GMS/PMS/APMS), Primary Care Networks (PCNs), GP Federations and Out of Hours GP services. The Committee will also provide leadership around the elements of Community Pharmacy and Pharmacy Federations currently commissioned at Place-level. As the SEL ICB takes on further delegated responsibilities, over time this will expand to include further Community Pharmacy, General Optometry and Dentistry services when these Terms of Reference will be reviewed.

2. Remit and Responsibilities

2.1. The Committee will consider all aspects of General Practice – including GP Core Contract, and other services and projects commissioned from Practices, Primary Care Networks and the GP Federation by SEL ICB and Lambeth Council teams. This will include Quality, Performance, Finance and Public Health Improvement services. It will also cover all elements of Community Pharmacy commissioned at place-level. This includes, but is not limited to:

2.1.1. Overseeing the planning, quality, performance, development and delivery of general practice and wider Primary Care services in Lambeth via Commissioning and contracting processes; financial management and budget controls; and quality and performance monitoring and improvement (including medicines and prescribing schemes and spend, informed by the work of the Medicines & Clinical Pathways Group).

2.1.2. Providing advice, recommendations and assurance to the LTCPB and SEL ICB regarding the delivery of high quality Primary Care services within Lambeth.

2.1.3. Supporting officers to make transactional contractual and funding decisions within the scope of their remit, for reporting at the LTCPB within the scope of the Standard Operating Model and Procedures agreed across London with NHSE, and relevant ICB Standing Financial Instructions.

2.1.4. Discussing business and/or making recommendations where decisions concern all 6 boroughs in SEL, and where regular SEL ICB meetings will take place so these decisions can be considered.

2.1.5. Identifying risks and issues relating to primary care, monitoring mitigations and escalating risks to the LTCPB as appropriate

2.1.6. Planning Primary Care Services in the borough of Lambeth, including carrying out needs assessments, and undertaking reviews of Primary Care Services in respect to the borough

2.1.7. Overseeing the management of primary care funds delegated to Lambeth.

2.1.8. Supporting the LTCPB to coordinate a common approach to the commissioning and delivery of Primary Care Services with other health and social care bodies

2.1.9. The Committee will cover key Transformation programmes and projects within Primary Care. However these will also take place within the Lambeth Clinical Cabinet and a pragmatic approach will be taken about the best use of Committee members' time. This includes working in partnership with other relevant fora within the Local Care Partnership where out of hospital transformation discussion and work takes place, most notably:

- Lambeth Clinical Cabinet
- Lambeth Together Executive Group
- Lambeth Together Delivery Alliances: Neighbourhood & Wellbeing, Living Well, and Children & Young People.
- Lambeth Estates Forum
- Lambeth Together Training & Development Hub
- Relevant local groups covering Digital and IT

2.1.10. Other ancillary activities that are necessary in order to exercise the Delegated Functions.

3 Key success criteria of the Committee are to achieve measurable progress in:

3.1 The enablement of a primary care system that is sustainable, accessible, proactive, transformative, coordinated and provides value for money.

3.2 Investment in primary care with clear and tangible benefits for patient outcomes and a reduction in health inequalities.

3.3 Achieving a motivated and fit for purpose primary care workforce.

4 **Membership**

4.1 The core membership of the Committee is outlined below, however other Lambeth and SEL leads and stakeholders will be invited to attend meetings as appropriate dependant on agenda items. Members of the Lambeth Borough Primary Care Team will routinely attend the meeting also as appropriate.

4.2 Members who are unable to attend should ensure they sent a deputy on their behalf.

4.3 Core Membership:

Role	Organisation
Lay Member (Chair)	SEL ICB
Director of Primary Care & Transformation (Vice-Chair)	SEL ICB
Associate Director of Primary & Community Care	SEL ICB
Healthwatch Lambeth Representative	Healthwatch Lambeth
Associate Director for Health & Care Planning and Intelligence	SEL ICB
Chief Pharmacist	SEL ICB
Director of Public Health	LB of Lambeth
Associate Director of Finance (Lambeth)	SEL ICB
SEL Quality Team Lead	SEL ICB
SEL Primary Care Team Lead	SEL ICB
GP Chair of Lambeth Clinical Cabinet	Lambeth Clinical Cabinet
Chair of Lambeth LMC	Lambeth LMC
Lambeth GP Federation Representative	Lambeth GP Federation
Clinical and Care Professional Lead for Primary Care	SEL ICB
Community Pharmacy / Pharmacy Federation Representative	Community Pharmacy / Community Pharmacy Federation

Clinical and Care Professional Leads for Lambeth Delivery Alliances x3	Lambeth Delivery Alliances

5 Role of the Chair

5.1 The Chair of the Committee will be a Lay Member on the LTCPB.

5.2 At any meeting of the Committee the Chair or a nominated deputy shall preside.

6 Accountability and Reporting Arrangements

6.1 The Committee is accountable to the Lambeth Together Care Partnership Board (LTCPB).

6.2 The Committee will advise and assure the LTCPB on Lambeth-specific decisions.

6.3 The Committee will report on its activities to the LTCPB. In addition, any accompanying report will summarise key points of discussion; items recommended for decisions; the key assurance and improvement activities coordinated by the Committee; and any actions agreed to be implemented.

7 Conflicts of Interest

7.1 Any Conflicts of Interest (real or perceived) will be managed in accordance with the ICB's Standards of Business Conduct and Conflict of Interest Policy.

7.2 Compliance will be overseen by the Chair of the Committee.

8 Meeting Frequency and Attendance

8.1 The Committee will meet every 2 months for 2 hours, and no less than 6 meetings should take place each year.

8.2 Meetings should take place at least 2 weeks before the LTCPB to enable any recommendations to be made at the earliest opportunity.

8.3 Members are responsible for identifying a suitable deputy to attend in their place should they be unable to attend.

8.4 Guests and/or subject matter experts can be invited to all or part of the meetings by any member, when appropriate, to assist and inform specific agenda item discussions. The Chair and Director of Primary Care should be notified in advance of any guest or subject matter experts attending the meeting.

9 Quorum

9.1 The quorum for a meeting of the Committee shall be at least 50% of the members to ensure sufficient numbers of the members are engaged. The Committee will reach conclusions by consensus.

10 Decision-making

10.1 The aim of the Committee will be to achieve consensus decision-making wherever possible.

11 Administration

11.1 The meeting will be administered and led by the ICB Borough Primary Care Team, with close collaboration with other key leads – e.g. Medicines Management/LTCs, Public Health, SEL Primary Care. Administrative support will be responsible for completing minutes of meetings and action log trackers.

11.2 Draft minutes with the Chair's approval will be circulated to members together with a summary of actions within five working days of the meeting.

11.3 Notes of meeting should be made available to the LTCPB for onward reporting as required.

11.4 To ensure robust programme management there will be a clear forward planner agreed, together with appropriate dashboards/data inputs.

12 Monitoring adherence to the Terms of Reference

12.1 The Chair will be responsible for ensuring the Committee abides by these terms of reference.

13 Policy and Best Practice

13.1 The Committee will operate within the framework of the ICB's local policies including Standards of Business Conduct, Conflict of Interest Policy and Procurement Strategy where these relate to the discharge of its functions.

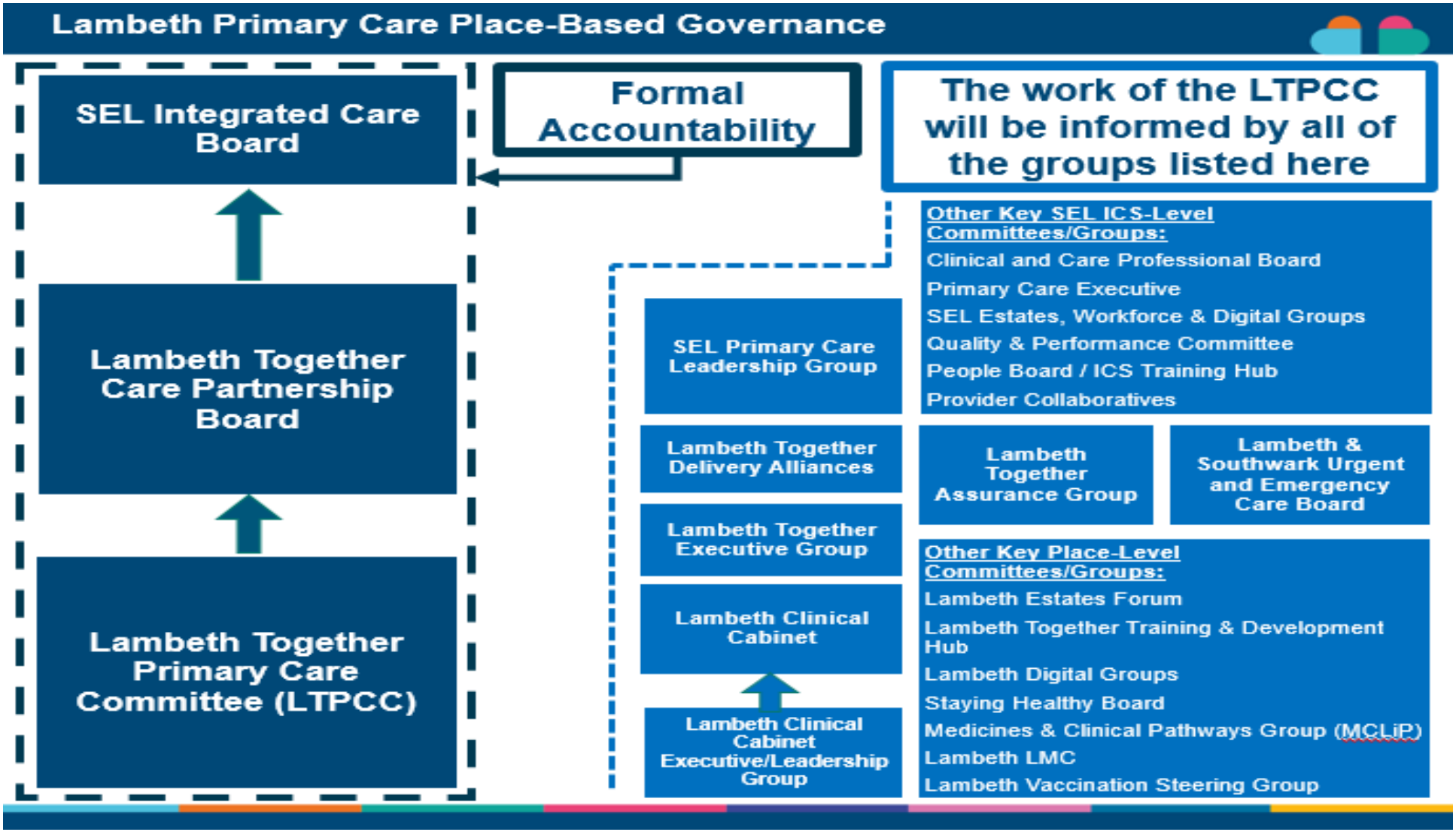
13.2 The Committee will enact its responsibilities as set out in these Terms of Reference in accordance with the Nolan Principles for Standards in Public Life.

14 Review arrangements

14.1 The Committee shall undertake a self-assessment and evaluation of its effectiveness on an annual basis.

14.2 The Terms of Reference will be reviewed initially after six months and then on an annual basis thereafter.

Appendix A: Lambeth Primary Care Place-Based Governance Diagram



Report to: Lambeth Together Care Partnership

September 2022

Report Title	**Children and Young People Alliance deep dive**
Lead Author	Jeanette Young, Director of Integrated Children's Commissioning and Community Safety, LB Lambeth and SEL ICS Fiona Connolly, Strategic Director of Children's Services, LB Lambeth Dan Stoten, Integrated Associate Director of Children, Young People, Maternity and CAMHs Commissioning, SEL ICS (Lambeth) and LB Lambeth Bimpe Oki, Consultant in Public Health, LB Lambeth Claire Spencer, Clinical Lead, Maternity, GSTT and SEL ICS (Lambeth) Jo Fernandes, Planning Intelligence, and Improvement Manager, SEL ICS (Lambeth) Jacqui Kempen, Head of Maternity, SEL ICS
Summary	The purpose of this paper is to update the Lambeth Together Care Partnership on a number of programme areas within Children and Young People's services. These updates cover work within the direct remit of the Children and Young People's Alliance as well as within the wider partnership structures.
Recommendation(s)	The Lambeth Together Care Partnership is asked to: 1. Note the report from officers working on children's programmes across the partnership.

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NHS South East London

Lambeth

Children and Young People Alliance

Children's Deep Dive

Fiona Connolly, Acting Strategic Director for Children
Jeanette Young – Director, CYP Commissioning & Community Safety
September 2022

Being presented today …..

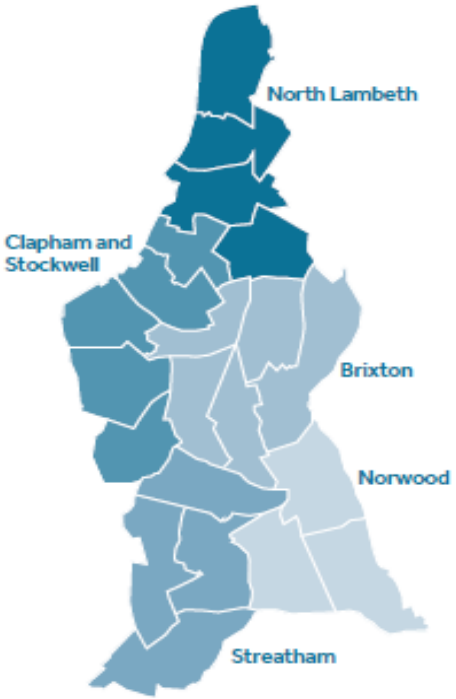
- Overview of Children & Young People in Lambeth & our Alliance with partners
- Update on our work supporting the Emotional Health & Well being of young people in Lambeth
- Maternity services for Lambeth
- Safer Taskforce supporting children in education with specific intervention at the point of transition
- Poverty Strategy – update from public health colleagues

Children and Young People in Lambeth

Children at the Heart of Practice

Population & deprivation

- Approx. **63,210** children and young people under the age of 18 live in Lambeth (19% of the population)
- **5th** most densely populated borough nationally
- **43%** of children in Lambeth are living in poverty (after housing costs)
- Very high cost of housing, benefit cap making private rental market out of reach for many families



High need

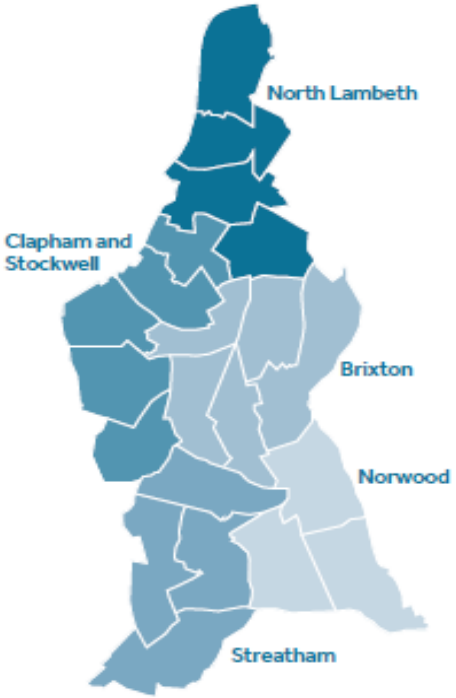
- **17.8%** of pupils in Lambeth schools are identified as having Special Educational Needs
- **3,848** of 5-16-year-olds have a mental health disorder
- Lambeth has one of the **highest numbers** of victims of **serious youth violence** in London

Children and Young People in Lambeth

Children at the Heart of Practice

Diverse communities

- **63%** of children and young people are Black, Asian and Multi-Ethnic (compared to 21% nationally)
- Over 150 different languages spoken, Black Caribbean, African and Portuguese communities
- Over representation of Black boys aged 11+ in social care referrals and interventions and entering care system



Changing

- Lambeth has a transient population- roughly **12%**
- **Inequality** in the borough is **rising**
- Increasing contrasts within the borough: lots of growth/development in the north of the Borough
- Pupil numbers dropping in some areas due to Brexit and Covid
- 11.8% drop in birth rate in past 11years

Supporting Children and Young People in Lambeth by LBL

Children at the Heart of Practice

Lambeth

Children we are working with				
	2018/19 outturn	2019/20 outturn	2020/21 outturn	Current figure Feb 22
Early Help	438	384	456	437
Children in Need	2023	1777	1597	1651
Child Protection	254	229	262	330
Children Looked After	348	358	371	400
Care Leavers	408	386	416	562
UASC	97	68	74	44(U18) 136(18+)
NRPF	122	80	112	103

Children's Alliance

- Working in partnership to enable positive solutions for the health of children in Lambeth
- Includes – London Borough of Lambeth, SEL Integrated Care System, Evelina, GSTT, Kings, SLAM & others
- Hosted by Children's Commissioning Team
- Led by Children's Alliance Director currently in recruitment
- Development day Sept 8th to decide our key areas of focus for next 12 months
  - Ideas include – Early Years, Emotional Health & Wellbeing & immunisations

Maternity - Update

Claire Spencer – Clinical Lead, Maternity
Dan Stoten – AD, Integrated CYP Commissioning
Lambeth Together Care Partnership Board
September 2022

Ockenden Report - Progress

- The Ockenden Report was published in early 2022 and highlights a number of key failings in Maternity care at Shrewsbury and Telford NHS Trust.
- There has been a significant volume of work undertaken in South East London since the publication of the interim report some months ago.
- A wide-ranging set of documents was submitted in Spring 2022, including:
  - An update on the Ockenden interim report actions.
  - A re-benchmarking / re-assessment report of actions from the Morecambe Bay report
  - An in-depth maternity self-assessment document, completed by each Trust
  - Workforce plan.
- 22/23 ‘assurance visits’ are in the process of being undertaken by the NHS England regional team; responsibility for this will switch to local LMNS colleagues from 23/24. SEL has been included in the second tranche of these visits, meaning visits have been taking place in SEL Trusts since July, and are due to end in September. These visits will be validating the findings from each Trust in their self-assessments.
- A report from East Kent is also due to be published in Autumn 2022. Once this has been published, we will be drawing out the common themes from this and the Ockenden Report, and update recommendations to ensure we are compliant across the board. The national team will then publish an updated transformation programme plan and information on the new taskforce.

Maternity Governance – SEL & Place

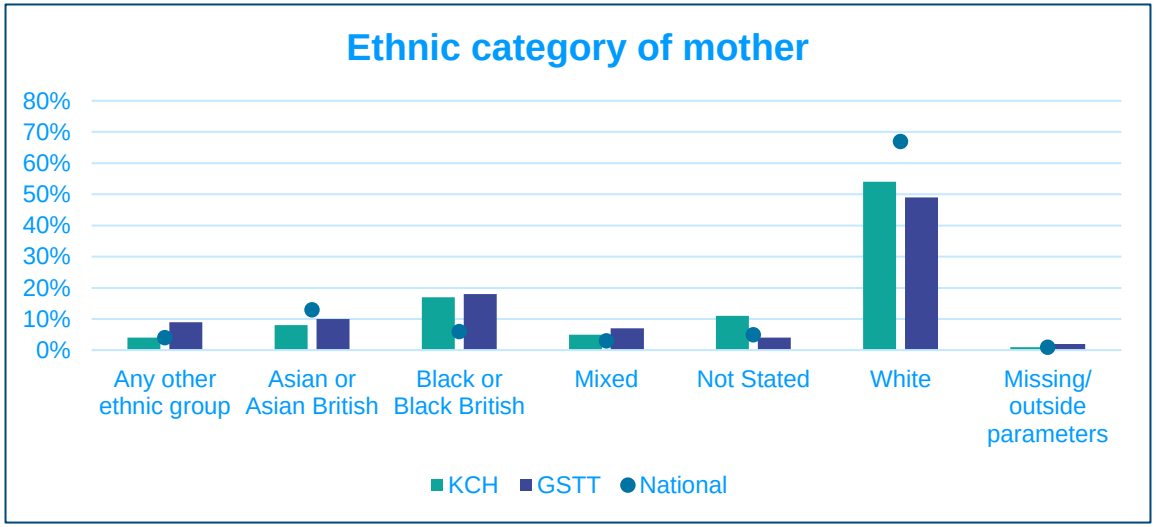
- Maternity Surveillance Group established
- Outcomes for different ethnicities monitored as part of the LMNS equity and equality action plan
- LMNS has numerous cross-cutting workstreams including: Pelvic and mental health; continuity and personalised care linking into inequalities; perinatal optimisation including transitional care; inequalities working group; and MVP local working
- Maternity is also under the remit of the Early Years workstream within the CYP Alliance.

Maternity metrics

- This next section shows a number of key maternity indicators sourced from NHS Digital, SEL ICS Business Intelligence and local partners, including:
    1. National Maternity Dashboard
    2. SEL Maternity dashboard
    3. SEL Local Maternity and Neonatal System Health Needs Assessment report
    4. Lambeth Early Action Partnership (LEAP)

- It should be noted that the datasets are varied: some are at Trust level, some at SEL level, and some at Borough level. The LMNS continues to work closely with the ICS business intelligence team, provider trusts as well as regional and national maternity teams to improve data collection and quality with the end goal for MSDS to be the “one stop” for data for providers.

Ethnicity of women / birthing people – KCH & GSTT



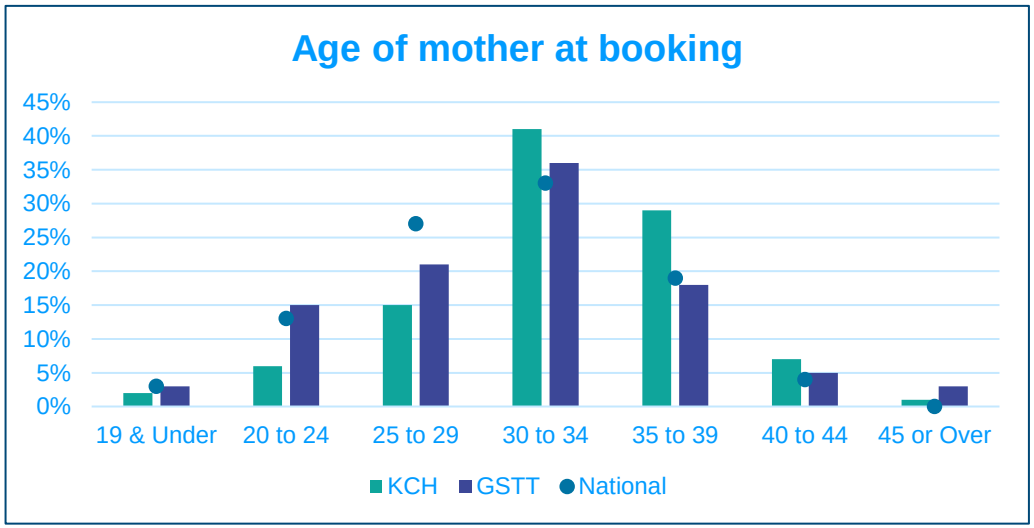
This graph indicates:

- In line with MBRRACE findings, SEL has a maternity population at higher chance of adverse maternity and neonatal outcomes which may include increased rates of preterm birth, stillbirth, neonatal mortality, and maternal mortality.

What are we doing?

- Developing a more robust data collection process
- Creating an Equity and Equality action
- Working with FiveXMore providing cultural humility training for SEL maternity staff and provision of colourful wallets for Black and Brown women with empowering and advocacy messaging.
- In practice, caseloading and continuity of carer teams are being focused on those most at need in particular postcodes, as well as being triaged accordingly.

Age of Mother / birthing person – KCH & GSTT



This graph indicates:

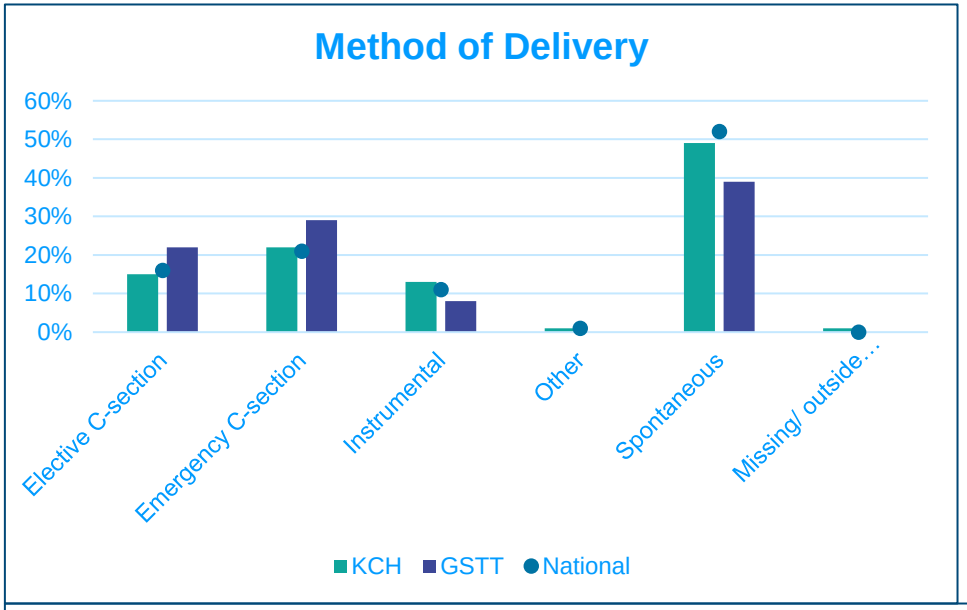
- Across SEL there are higher numbers of women and birthing people booking for maternity care aged 30 and above, with a significant number aged 35 years and older

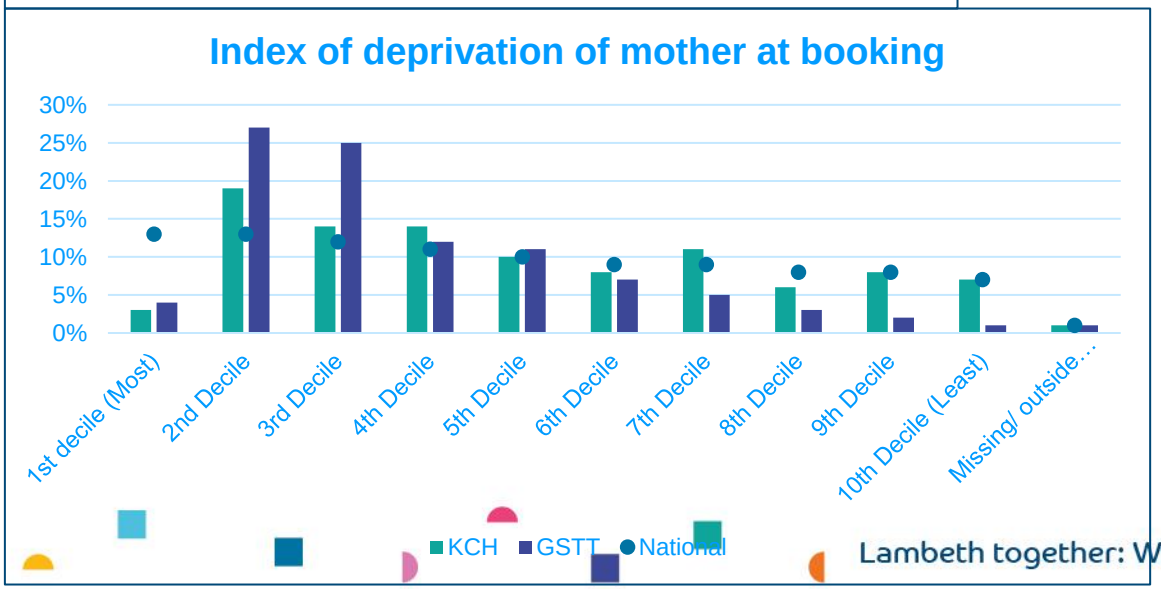
What are we doing?

- Ensuring that women and birthing people aged 18 and below and 35 years and above are provided with appropriate information and communication regarding their pregnancy and their higher chance of complications, however small and ensure they are cared for on the correct pathway of care. We will do this through the review of current pathways of care that are in place and whether these are appropriate to the needs of older and adolescent pregnant women and birthing people.

Data sourced from NHSD National Maternity Dashboard for April 2022

Method of Delivery & Deprivation – KCH & GSTT





These graphs indicate:

- SEL Trusts see a higher percentage of C-section delivery (elective and non-elective) than national – indicating the increased complexity of women in SEL.
- SEL Trusts have a significantly higher percentage of women from the 2nd and 3rd most deprived indices booking for maternity care.

What are we doing?

- Develop a more robust data collection and postcode analysis that will provide insight as to where women and birthing people living in deprivation are within our communities with further analysis on women and birthing people with complex social factors.

Data sourced from NHSD National Maternity Dashboard for April 2022

User experience – KCH, GSTT & SEL

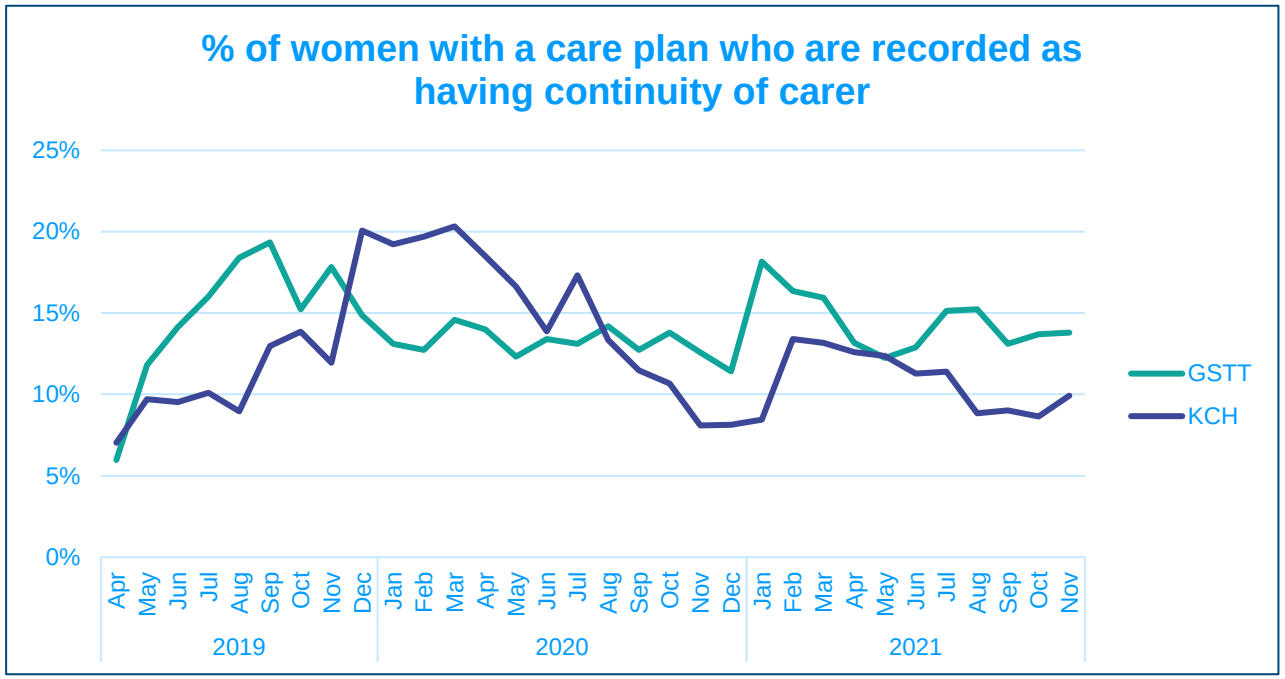
Domain - User Experience	KCH	GSTT	SEL ICS	National
Adequacy of time spent on antenatal discussions	66%	62%	72%	73%
Consistent HCP presence during labour	67%	67%	69%	75%
Feeding support and encouragement	43%	58%	54%	63%
Involvement in antenatal care decisions	74%	78%	77%	77%
Kindness during postnatal hospital care	59%	52%	58%	71%
Response to concerns during labour and birth	69%	77%	78%	79%
Responsive postnatal hospital care	41%	37%	58%	62%
Domain - Choice of Continuity of Carer	**KCH**	**GSTT**	**SEL ICS**	**National**
Adequacy of time spent with midwives postnatally	40%	52%	50%	61%
Enabling an informed choice of birthplace	38%	45%	48%	47%
No choice of birthplace offered	27%	14%	17%	20%
Respect for choice of feeding method	78%	79%	79%	83%
Woman reported continuity of carer	11%	7%	13%	11%

This user experience data shows that SEL ICS as whole is tracking in line or just below national figures. It should be noted that 2021 was heavily impacted by Covid.

What are we doing about this?

- Annual maternity surveys will be picked up by the continuity workstream. Trusts are required to provide an action plan in response to lower scoring results.

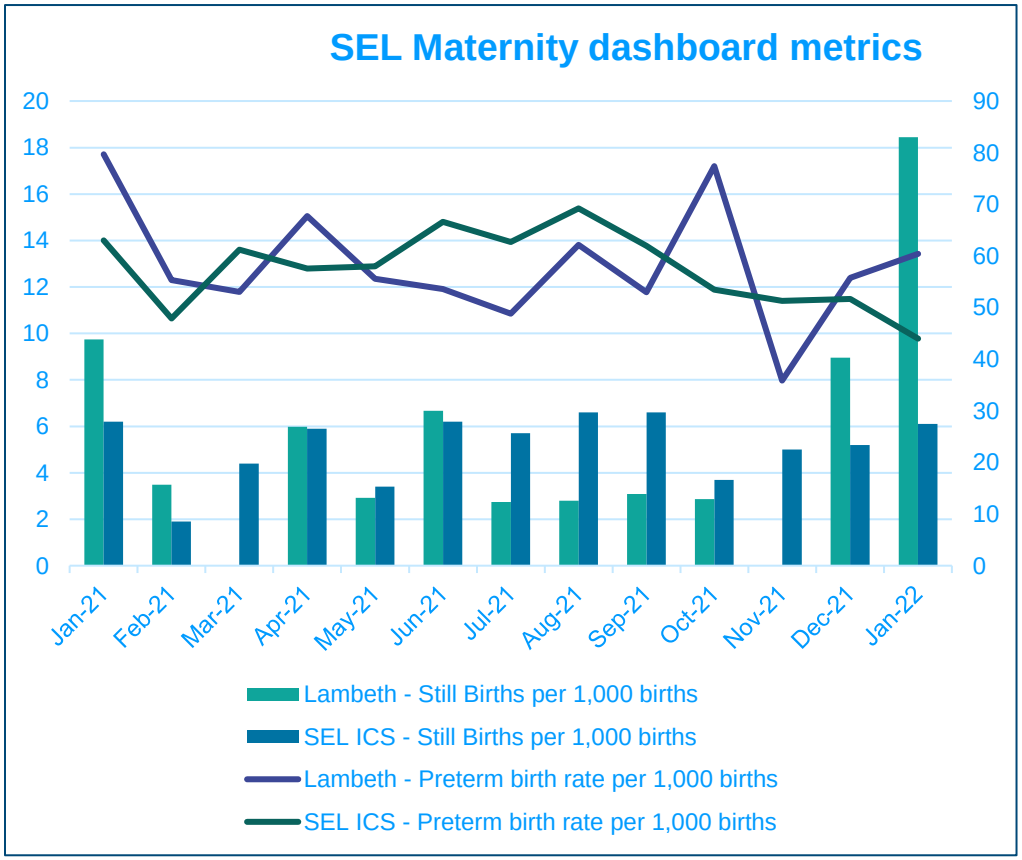
Continuity of Carer - SEL

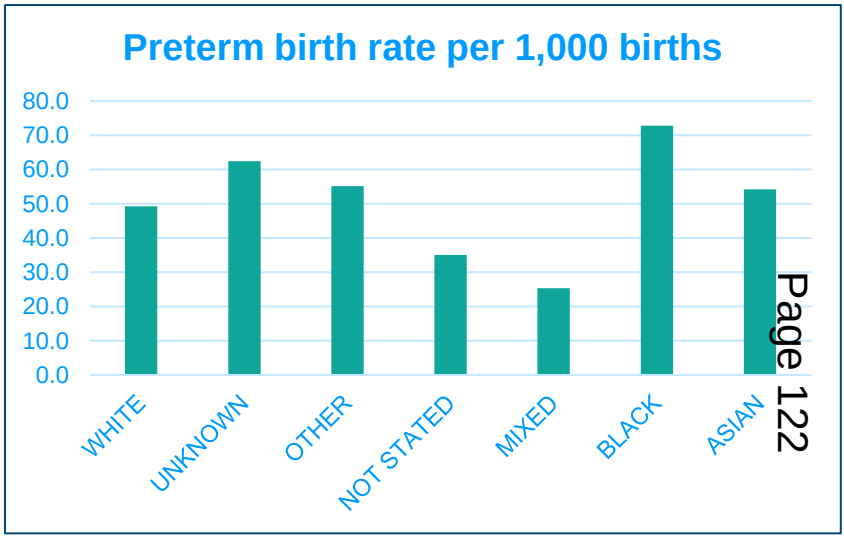


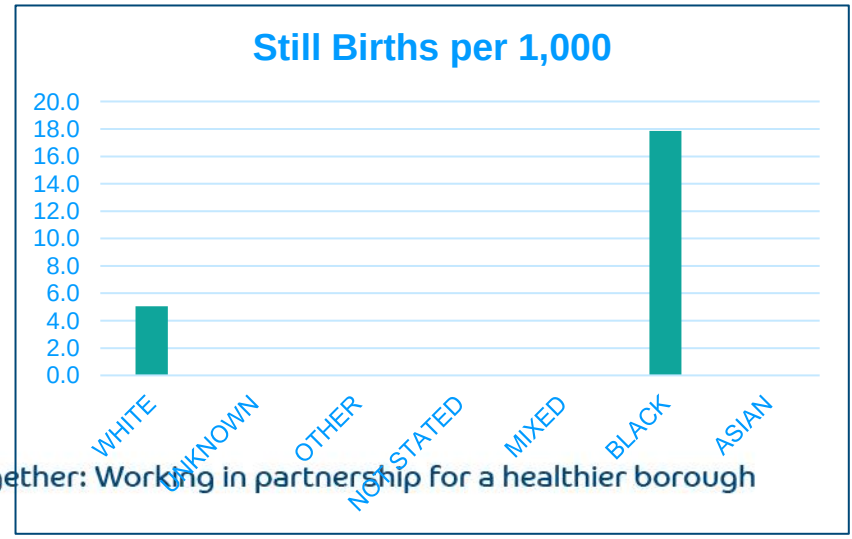
- SEL Maternity dashboard shows key metrics sourced from Secondary Uses Service and Maternity Services Data Set.
- Here we see that despite having not reached pre-pandemic levels, Trusts have consistently kept the focus on continuity of carer
- Safety requirements put in place following Ockenden have also impacted, with Trust targets put on hold.

Stillbirth & preterm – Lambeth & SEL

- SEL Trusts Ethnicity breakdown at Q4 21/22







Stillbirth & Preterm

Stillbirth

- Lambeth women have a higher stillbirth per 1,000 rate than the SEL figure. Black women have a higher stillbirth per 1,000 rate than all other ethnicities.
- Significant work has been carried out across the provider maternity units to reduce rates of avoidable stillbirths as per national recommendations and guidance.

What are we doing?

- Monitoring stillbirth data as part of perinatal quality and safety surveillance; improving the oversight of sharing and learning of Perinatal Mortality Reviews (PMRT) and wider learning from incidents; and improving ethnicity data collection as part of the review process

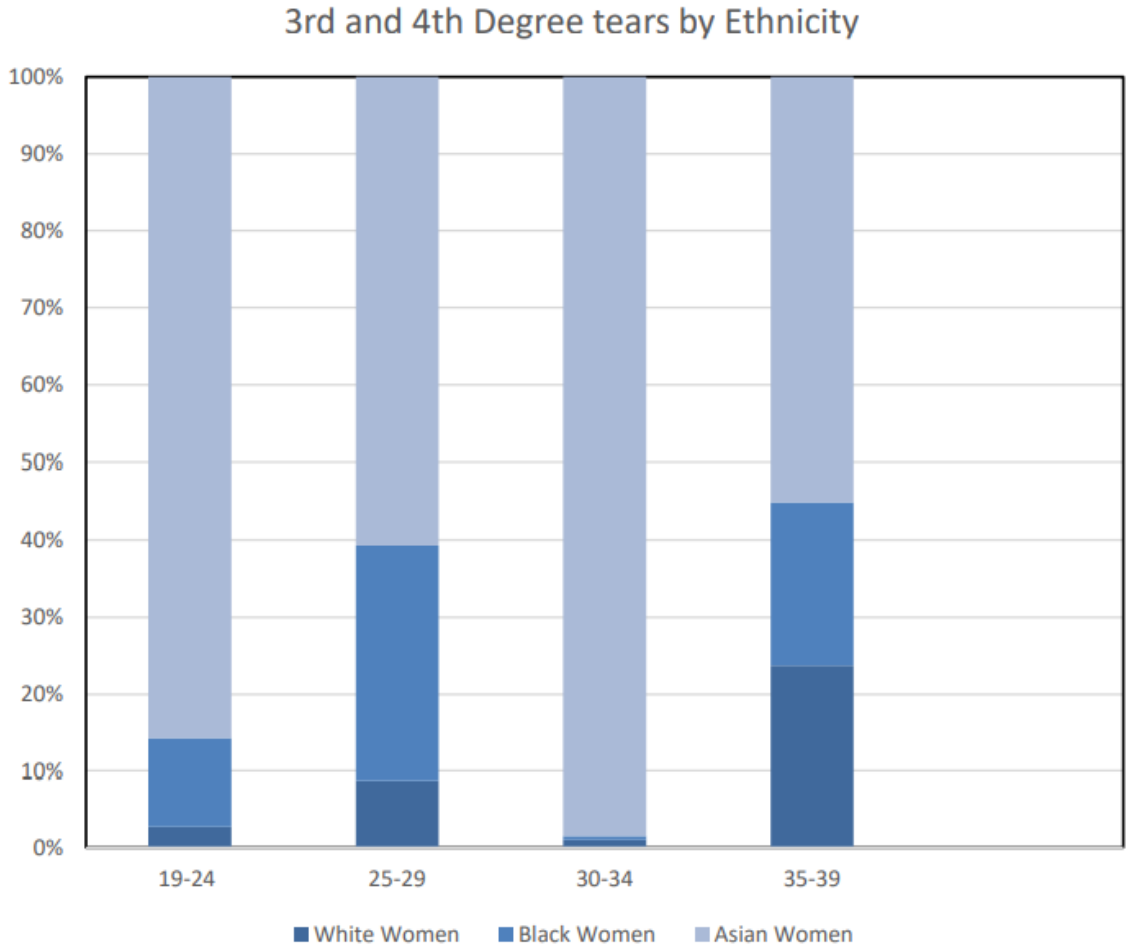
Pre-term

- Women and birthing people from Black, Asian and multi-ethnic backgrounds have a higher chance of preterm birth. Data is available at SEL-level which highlights the same disproportionate findings
- A significant amount of work has been carried out across the maternity and neonatal units across SEL to prevent and improve pre-term birth. The PReCePT model has been implemented by PReCePT champions at each maternity unit who were able to raise awareness and successfully role out the model.
- Following on from this work preterm safety champion midwives have been in place at each of the sites

What are we doing?

- Continuing to monitor pre-term birth rates and areas for learning and development to support pre-term birth pathways; working as a system to improve data monitoring of pre-term birth in relation to ethnicity and deprivation, thus supporting planning for improvement.
- The ‘Halve It’ workstream (which will soon be becoming a perinatal group) reviews and monitors all failed in-utero transfers. SEL is currently the highest scoring for babies born in right place in the last quarter. This perinatal group will pick up on perinatal optimisation as a follow on.

Pelvic health – SEL

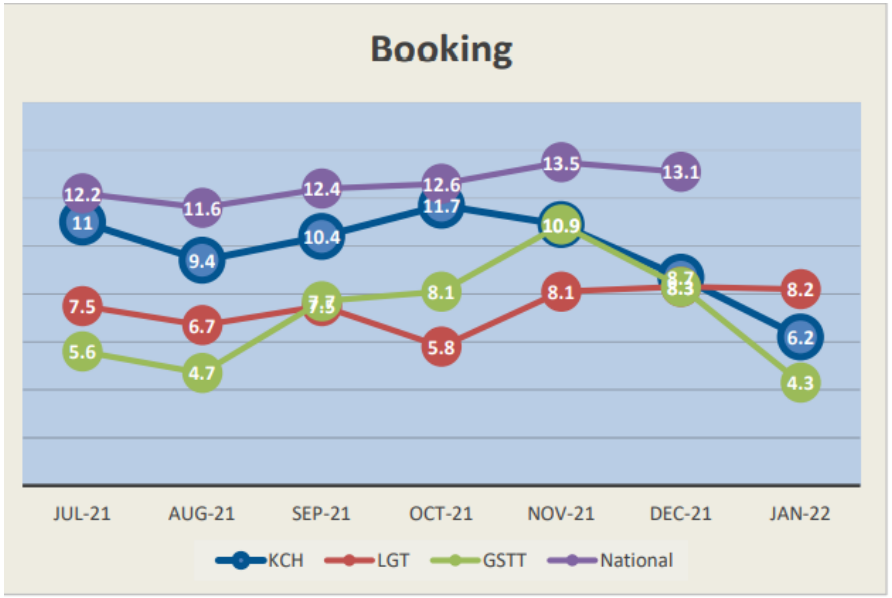


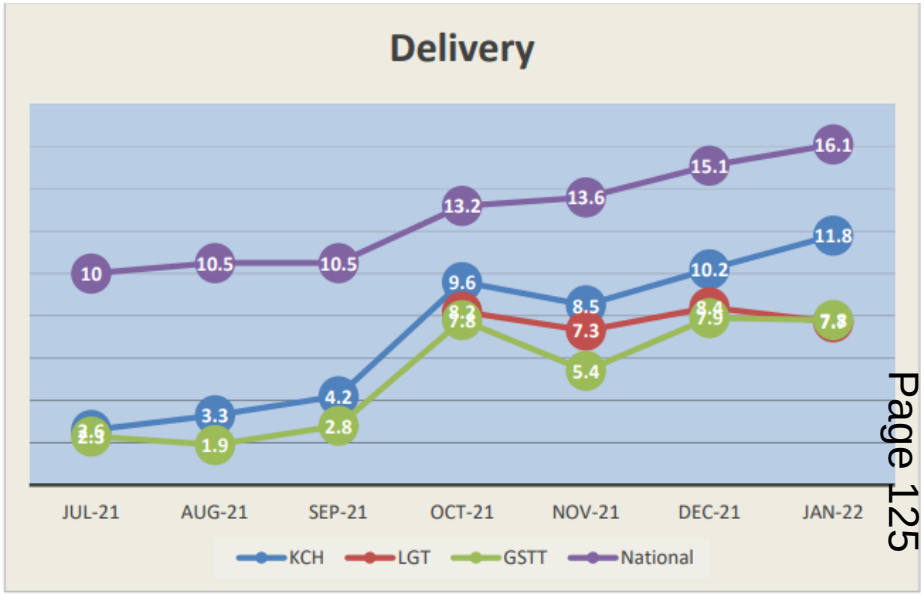
- SEL dashboard data shows poor pelvic health outcomes for Black and Asian women/birthing people compared with white women/birthing people. This data is from Q1 2019-2020 and is similar across all quarters.

What are we doing?

- Working as a system to collect further in depth pelvic health data in relation to ethnicity and BMI; pelvic health team in LMNS to educate and support staff and women.

Smoking at booking and delivery – GSTT, KCH & LGT





- Smoking at booking and at time of delivery across SEL are consistently below the national rates

What are we doing?

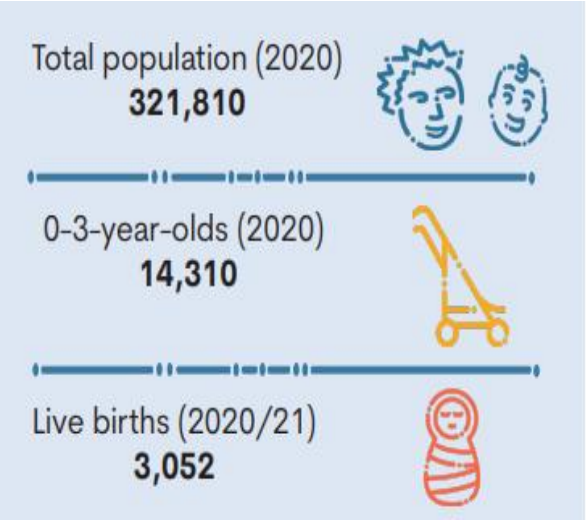
- Implementing an in-house maternity smokefree pregnancy programme within each of the maternity units as part of the Long Term Plan deliverables

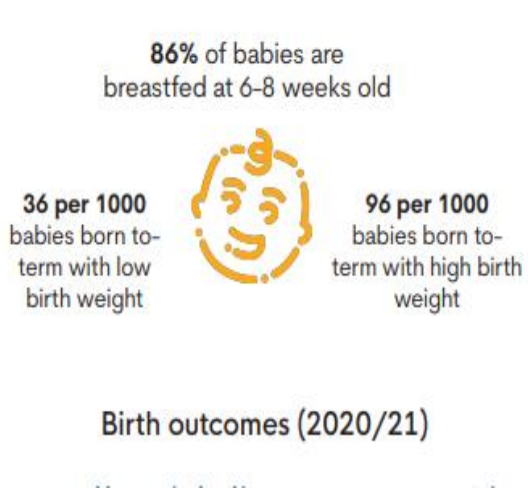
Other updates…

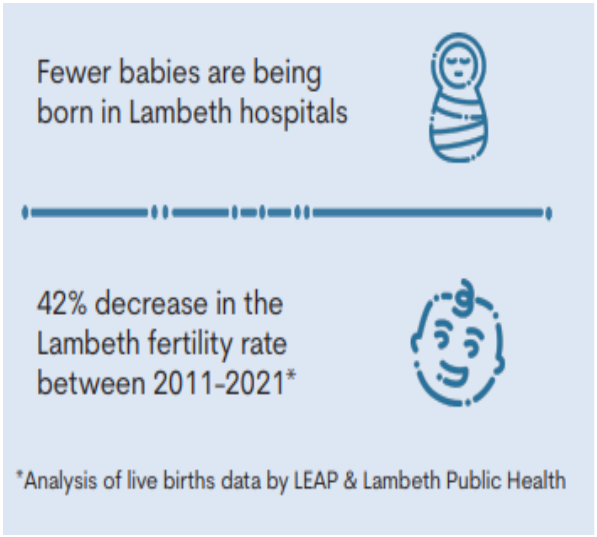
	GSTT/Evelina	KCH
Maternity Voices Partnership	Meetings have restarted under Chief Midwife. Chair is in place: Clotilde Abe. Need more women to attend. LMNS have commissioned national maternity voices to support the MVP in recruiting a vice-chair and improve engagement.	Work plan for this financial year in place Chair and Vice-Chair in place.
FiveXmore	• Campaign are training to staff at both units, pregnancy notes wallets frombooking with 6 steps (https://www.fivexmore.com/6steps) given to black and brown women • Black mother's survey results in May 2022 with 1,340 responses. Around the UK but mainly London. Predominantly educated, in work and relationship women completed the survey – not matching assumptions that disparities are due to deprivation and poverty. Women felt the discrimination is due to their race. Women recounted many negative experiences from health care professionals in relation to attitudes, knowledge and assumptions. • 6 recommendations: 1. Annual survey aimed at Black women 2. Increasing knowledge on conditions specific and disproportionately affect Black women 3. Improve quality of ethnic coding 4. More community approaches to improve maternal outcomes 5. Improved system for feedback 6. Education institutions to ensure awareness of disparities to students.	

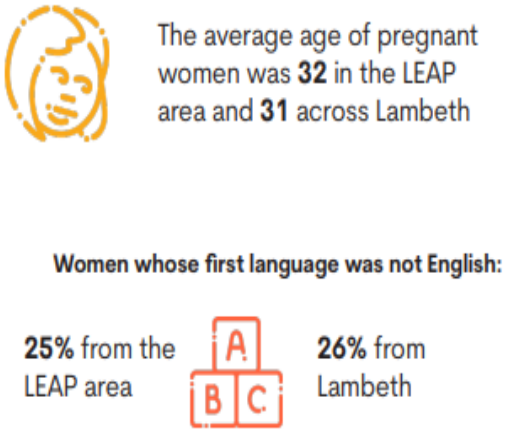
Lambeth Early Action Partnership (LEAP)

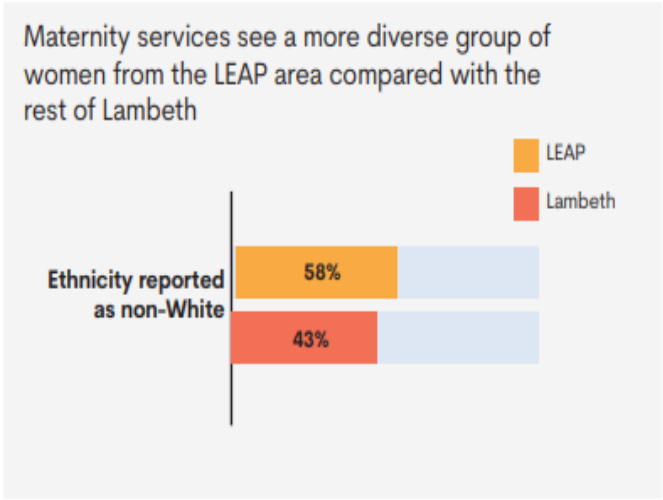
LEAP data set spotlights on Lambeth women. Trends match with national and SEL picture. LEAP focus on data which impacts early years development of children. Maternity important element of Children and Young people's alliance.





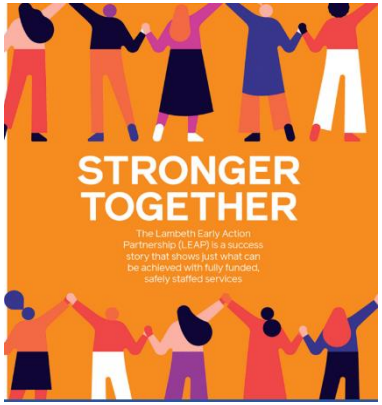






LEAP Legacy

LEAP continues to inform wider projects across the system in Lambeth and nationally:



LEAP caseload - Continuity of Carer

- RCM magazine in May ’22
- Research continues with KCL Professor Jane Sandall

MatVAT Maternity Vulnerability Assessment Tool

- National steering group with RCM
- Next steps discussion for national implementation and ongoing evaluation with KCL Professor Jane Sandall
- Pilot study at KCH with results forthcoming with discussions for SEL LMNS rollout Autumn 2022

CAN (BMI over 25) and PINE materials

- CAN health improvement facilitators will be delivering Starting Solids support sessions for new parents Autumn 2022 – joining the system from pregnancy to early years
- PINE materials being used at both GSTT and KCH for nutrition and exercise information

Appendix

- LMNS: Local Maternity and Neonatal System
- MMN: Maternal Medicine Networks
- MSDS: Maternity Services Data Set
- HSIB: Healthcare Safety Investigation Branch
- MBRRACE: Mothers & Babies: Reducing Risk Through Audits & Confidential Enquiries
- HCP: Healthcare Professional
- PReCePT: Prevention of Cerebral Palsy in Pre-term Labour

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Emotional Health and Wellbeing – Workstream Update

Jeanette Young – Director, CYP Commissioning & Community Safety
Dan Stoten – AD, Integrated CYP Commissioning
Lambeth Together Care Partnership
September 2022

Workstream Progress

- Workstream established and met a number of times
- Excellent attendance from across the partnership
- Emotional Health and Wellbeing Joint Strategic Needs Assessment due to go through final governance 26th September
- CAMHS Local Transformation Plan to go via workstream ahead of sign-off in October
- Planning future meetings to include:
  - Logic model development and outcomes framework
  - Oversight of mapping work in schools
  - Monitoring of pilot projects
  - Responding to needs assessment

CAMHs Update

- Lambeth CAMHs had in place a 3 month 'pause' in acceptance of non-urgent referrals between 11th April and 4th July.
- This was aimed at creating more capacity to see the most unwell and at-risk children and young people as well as reducing some of the long-waiting cases; whilst also allowing new staff to come into post.
- The pause impacted on just 20 children and young people who were signposted to a wide range of other resources available.
- The pause had a positive impact, enabling:
- A reduction in the waiting times for complex children
- Significant reduction in waiting times for urgent children, with the longest down from 11 weeks to 3.
- Successful recruitment of 4 new staff
- The average waiting time for a first appointment at Lambeth CAMHs is now 7.3 weeks, which is the best in South-East London.

- In further good news, our next wave of Mental Health Support Teams in Schools (MHSTs) funding arrives in January, meaning further schools from April will have on-site MHSTs on top of the existing 14.

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SAFE Taskforce

Lambeth Together Care Partnership – 7 September 2022

SUPPORT	young people with challenging behaviour, enabling them to
ATTEND	school regularly so that they can
FULFILL	their potential and prevent costly poor life outcomes by inspiring them to
EXCEED	their expectations

The why

The cross-government Beating Crime Plan introduced an investment of £30 million for specialist teams in mainstream schools in 10 serious violence hotspots, to support young people at risk of involvement in violence to re-engage in education.

Lambeth **SAFE** Taskforce brings together schools, the Local Authority, and partners to commission evidence-informed interventions to **Support** young people with challenging behaviour, enabling them to **Attend** school regularly so they can **Fulfil** their potential and prevent costly poor life outcomes by inspiring them to **Exceed** their expectations.

10 SAFE Taskforce areas:

- Birmingham
- Bradford
- Haringey
- Lambeth
- Leeds
- Liverpool
- Manchester
- Newham
- Sheffield
- Southwark

The how

The Lambeth SAFE Taskforce will follow the “child first principle” – prioritising the best interests of children and young people recognising their needs, capacities, rights, voice, and potential.

To get upstream of serious violence, the Taskforce will see the cohort of children and young people in the Local Authority area as their responsibility, regardless of the school they attend.

To ensure cultural appropriation both the commissioning of services and the building of capacity will be co-produced with children, families and Third Sector Organisations.

Lambeth SAFE Taskforce members:

- Head Teachers & Principals from 17 Lambeth schools (Secondary, primary & all through schools)
- Alternative Provision senior leader
- Police representative
- Representatives from Education, Violence Reduction Unit, Contextual Safeguarding, Youth Justice Service, Children's Social Care

In Summary

The Lambeth SAFE Taskforce is a strategic group bringing together the expertise of schools and other local partners to collectively ensure young people at risk of involvement of serious violence can access support to engage them in education.

This programme is designed to be schools led because school leaders, teachers, and staff have a distinct expertise and access to make a difference in young people's lives.

The Taskforce will decide on the evidence-led interventions which will support the right children (aged 10-14 years old) at the right time to prevent or reduce serious violence.

The Taskforce will be funded for 3 years (financial years 2022-23, 2023-24, 2024-25). Lambeth is estimated to support 200 pupils per year with funding via a grant agreement with the Department for Education (DfE) of £475,480 per year.

The Youth Endowment Fund (YEF) are funding the evaluation of the SAFE Taskforce programme.

RAND Europe, FFT Education Datalab and the University of Westminster have been appointed to carry out the evaluation. The evaluation aims to support the delivery of high-quality interventions and shape the thinking on tackling serious youth violence.

Outcomes and data collection

NHS Digital

- Hospital admissions for assault with a sharp object
- A&E admissions

National Pupil Database

- Education outcomes
- Attendance; exclusions; and NEET (Not in Education, Employment or Training) data.

Police National Computer

- Serious violence offences

What's happened so far

* The Taskforce have elected a Chair & Vice Chair. The Commissioning Lead has been in post from June following the initiation of the programme by the Assistant Director of Education and Learning: Standards, Safeguarding and Partnerships.

* The recruitment of the SAFE Taskforce Project Coordinator post is underway.

* We have taken up the DfE offer for commissioning support. This involves working with the Public Service Transformation Academy, to add value to the commissioning of services and to build a Community of Commissioners with the other Taskforce areas.

What's happened so far

* Analysts, most notably the Contextual Safeguarding Programme Delivery Manager, have put data from cross-departments together with surveys and interviews (students, parents and teachers) providing a rich picture on the priority needs and the existing provisions to identify the intervention types required to meet these needs.

* The Taskforce have met several times to consult and collaborate on the Strategic Needs Assessment (SNA) and Delivery Plan.

* The priority needs have been identified using the evidence captured in the SNA.

Identified priority needs

Knife enabled youth violence

- Over the last year, 88 children and young people were victims of a knife injury in Lambeth
- In the last year there were 260 offences for possession of a knife in Lambeth

Disrupted education

- 54% of these children had a disrupted education under the age of 16
- Including significant periods of not attending school / accessing education

Complex needs

- 40% of Serious Youth Violence (SYV) offenders and 44% of victims had been diagnosed with Special Educational Needs and Disability (SEND)
- In particular Attention Deficit Hyperactivity Disorder (ADHD) and Speech, Language and Communication needs (SLCN)

Trauma and instability in family and close relationships

- 85% of the children found to have committed offences related to SYV had trauma and instability in their lives
- 43% had previously been injured in violence outside of the home and 32% had experienced domestic abuse

Aims of the SAFE Taskforce

Reduce	involvement in serious violence
Improve	social emotional regulation and wellbeing
Improve	attendance
Improve	behaviour in school and the local area

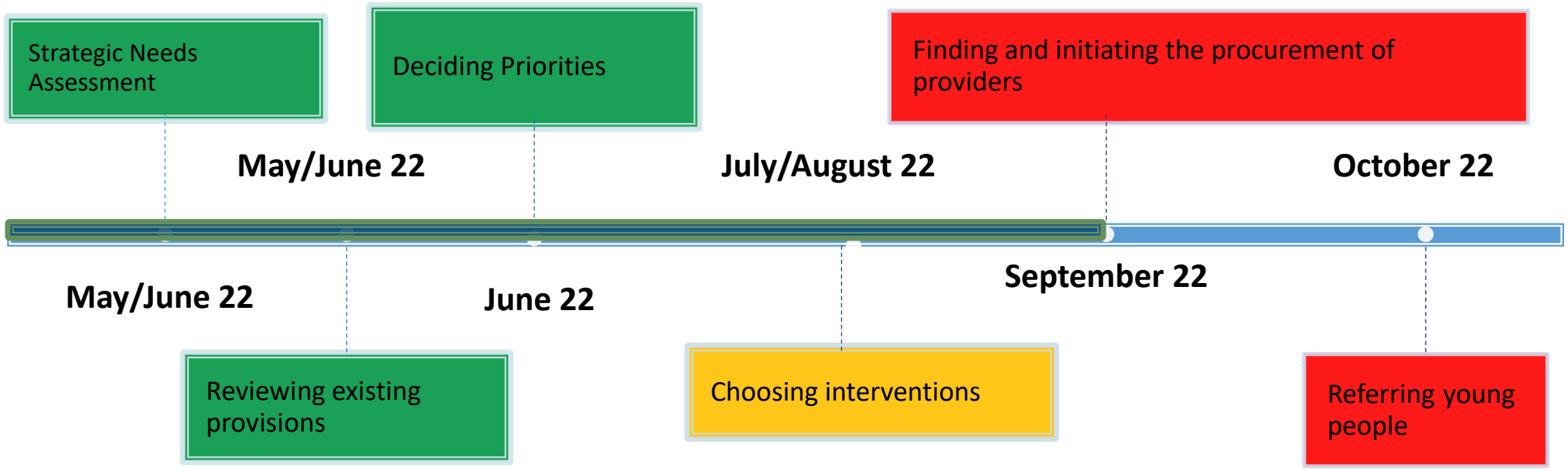
The next steps

* Developing the Delivery Plan including theories of change for the chosen interventions.

(As per the DfE guidance there should be no less than 3 and no more than 7 interventions.)

* Choosing interventions by collaboratively working with key stakeholders to determine and co-produce: the interventions; grant arrangements; referral routes; and the monitoring of the commissioned services.

The programme timeline (RAG rating)



Co-production on choosing interventions requires engagement with:

1.	Children and young people
2.	Families and carers
3.	Voluntary Sector Organisations and the community
4.	Members of the Lambeth SAFE Taskforce
5.	Lambeth Made Safer Board for overview and governance
6.	SAFE Taskforce Community of Commissioners from all Taskforce areas
7.	Anyone else?

Contact details for the SAFE Taskforce

Kathleen Richards, Commissioning Lead

- KRichards@lambeth.gov.uk

Monique Bertrand, Assistant Director of Education and Learning: Standards, Safeguarding and Partnerships

- MBertrand@lambeth.gov.uk

Preventing Serious Youth Violence in Lambeth

Strategic Needs Assessment 2022

ImpactEd on behalf of Lambeth Safe Taskforce

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Introduction

Lambeth has experienced an increase in Serious Youth Violence of 21% in the year ending February 2022, with 54 more victims compared to the previous year. In comparison, there was an increase of 10.5% in the capital in the same period. Numbers of serious youth violence incidents peaked in 2017 and have not returned to this volume, however there is a marked and worrying increase in severity, particularly in offences using knives and firearms.

In the context of rising serious youth violence, the DfE has approached Lambeth with a proposal to fund the 'SAFE' (Support, Attend, Fulfil, Exceed') taskforces which will be *'led by local schools, bringing head teachers together to support vulnerable young people, and avoiding them becoming involved in county lines and criminal activity.'* This SAFE Strategic Needs Assessment will use the following definition of serious youth violence, suggested by the DfE:

"Direct interpersonal harm through knife crime, gun crime or homicides, or other serious offences such as robbery and weapons possession between young people of school age."

1.1 Aims

This report aims to capture the characteristics and motivations of those involved in and at risk of involvement in youth violence. The document has a dual purpose:

- To inform the targeting, commissioning, and implementation of a range of interventions to prevent involvement in serious youth violence in Lambeth
- To provide Lambeth school leaders with analysis which they would not normally access which can be used to inform school and multi-agency practice

The analysis draws upon statutory data, survey data and qualitative research and addresses two central questions:

- *Which young people's lives are most at risk of being affected by the harmful impact of serious violence?*
- *Where is disengagement from education acting as an indicator of additional need?*

1.2 Executive Summary

This Strategic Needs Assessment presents comprehensive analysis of serious youth violence as it relates to young people in Lambeth. Key themes illustrated through the statutory data are:

A complex picture of disrupted education; the prevalence of weapons enabled offences and possession of knives and firearms; modern slavery and exploitation; prevalence of complex needs and the effects of multi-generational trauma including poverty and racism.

Throughout this needs assessment, the accounts of teachers, families and young people's lived experiences, perceptions and goals, are used to deepen understanding of the factors that lead to and arise from serious youth violence. These first-hand accounts are also used to inform suggestions for action that can be implemented by the community of Lambeth as a whole, with schools at the heart of change.

1.2.1 What does the data tell us about who commits serious youth violence?

Through analysis, we have gained a detailed picture of the characteristics of young people most at risk of involvement in youth violence.

- Young people involved in serious youth violence are majority male and Black British Caribbean; White British and African British are the second and third most at risk cohorts
- The average age of children was **16.3** years (3 aged 14)
- The average age for first offence was **14.8** years (2 aged 12; and 7 aged 13)
- There is a high prevalence of SEND **40%** Speech, Language and Communication needs (SLCN) and Attention Deficit Hyperactivity Disorder (ADHD) which is often combined with poor mental health and in particular anxiety disorders[1]
- **85%** of young people who commit serious youth violence have previously witnessed or been the victim of violence, abuse and bullying by peers, adults in the community and in the home

1.2.2 At-risk cohort: The risk posed by unmet need

The available data shows trends of unmet need, in particular in relation to Black British boys; entrenched inequities are linked to risk factors for serious youth violence. This starts early; in Lambeth (2017), Black children were **50%** less likely to achieve a good level of development at the end of the Early Years Foundation Stage compared to White British children.

- Disrupted education is a factor for victims and offenders; **53%** had been to more than one secondary school and **51%** had been permanently excluded from school
- **28%** of offenders and **41%** of victims were not supported by Children's Social Care and this is a key cohort in need of targeted school support
- **37%** of victims are not supported by or open to working with the Youth Justice Service and this is a key risk group for offending
- **44.3%** of secondary school children with an Education Health and Care Plan (EHCP) are significantly more likely to be persistently absent than other groups
- Significantly more Black British Caribbean children are noted as having unauthorised absences **2.6%**, compared to Black British African **1%** and White British **0.6%** children

1.2.3 What might this mean for how we target our interventions?

Through in depth qualitative work, we have learned that disrupted education is multi-factorial and cannot be identified through single indicators such as permanent exclusions and attendance. There are also significant obstacles to data sharing across agencies; a good example of this is managed moves, a factor on which very little statutory data exists.
As a result of the research, we recommend individual schools undertake the following in order to identify the target cohort:

[1] https://www.rcslt.org/wp-content/uploads/media/Project/improving-mental-health-outcomes.pdf

- Develop an indicator for ‘days of education lost’; we recommend this includes days of education lost should include days in internal exclusion, days of fixed term exclusion and days of unauthorised absence or missing in education
- A review of internal exclusion, suspensions and sanctions (such as detentions) to assess the profile of pupils frequently referred with close attention to; SLCN and ADHD, Anxiety Disorders and Persistent Absence.
- Undertake a review of pupils who are known or suspected to have been a victim of violence at school, in the community, or at home; this includes bullying.
- Undertake a review of pupils who have been the subjects of permanent exclusion, managed moves, or referral to alternative provision to identify those who are not supported by Social Care, Youth Justice Service or other forms of statutory support.

1.2.4 Methods for Reaching Young People

It is clear that there are a range of groups and networks operating in Lambeth with the purpose of understanding and preventing serious youth violence. What has become clear is that targeting for these interventions is often broad, when targeted; it often uses a characteristic, such as race, gender or age rather than consideration of the needs that underpin that community. An example of this is Adverse Childhood Experiences (ACEs). Number of ACEs is often used as an indicator of severity, more recent evidence[2] points to the importance of looking at the risk and protective factors for a particular traumatic experience. In order to be effective any interventions must be delivered within a framework of anti-oppressive practice[3] with careful consideration of peers, families and teachers lived experiences.

The methods recommended below are based on the evidence contained in this report and in particular qualitative research with young people, their parents and teachers and the background evidence on effective methods[4][5] which target serious youth violence.

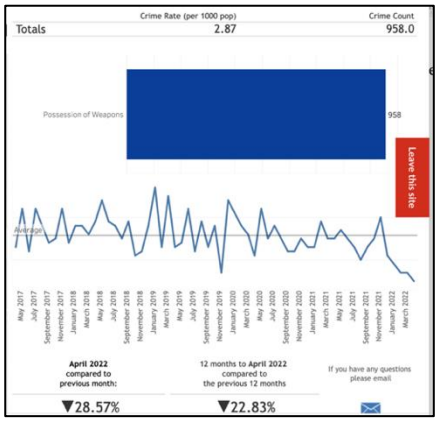
- **Multi systemic family therapy:** support to address child and parent mental health concerns and to address relationship breakdowns between families and with practitioners
- **Primary school transition:** an intensive support and assessment process: based on best practice for identifying and supporting complex needs
- **Cognitive behaviour therapy linked to sports:** targeted particularly to those young people who are known to be victims of violence but taking in other risk factors
- **School based peer mentoring:** a communication/oracy based approach with a key aim to increase availability of positive pro-social connection

A. Understanding the serious violence landscape

[2] [2] Early Intervention Foundation. Adverse childhood experiences: What we know, what we don’t know, and what should happen next: https://www.eif.org.uk/files/pdf/adverse-childhood-experiences-summary.pdf
[3] https://www.open.edu/openlearn/pluginfile.php/618861/mod_resource/content/1/k205_1readerchap14.pdf
[4] https://youthendowmentfund.org.uk/toolkit/
[5] Early Intervention Foundation. (2018, August 10). Preventing gang and youth violence: Spotting signals of risk and supporting children and young people. https://www.eif.org.uk/report/preventing-gang-and-youth-violence-spotting-signals-of-risk-and-supporting-children-and-young-people

In the last year, Lambeth ranked first of all London boroughs for the number of incidents where a young person was injured by a knife and first of all London boroughs for gun crimes involving lethal barrelled discharge (3 times more incidents than in any geographical neighbours). Lambeth also has the fourth highest volume in London for serious violence affecting young people (SYV), recording 311 victims. Serious youth violence plays a large and growing part in the overall crime landscape in Lambeth.

The overall crime rate in Lambeth at 515.68 crimes is higher than the London rate of 473.32 (per 1,000 population). For possession of a bladed article (pictured in the graph), Lambeth has a crime rate of 2.87 compared to 1.75 for London. For possession of a fire arm Lambeth has a crime rate of 0.48 compared to 0.36 for London.[6]



Possession of a bladed weapon- Lambeth monthly average 15.7 (high 27) Apr 2017-Apr 2022

A.1 What is the volume of serious youth violence offences?

Serious Youth Violence in Lambeth experienced an increase of 21% (n=54 more victims) in the year ending February 2022, compared to the previous year. In comparison, there was an increase of 10.5% (n=585 more victims) in the capital in the same period.

Over the last year, 88 children and young people (0-24yrs) were victims of a knife injury in Lambeth. In the five month period analysed (November 2021-March 2022), there were a total of 107 SYV victims recorded. With almost a quarter of those being a victim of Robbery (24% = 26 victims) and the remainder three quarters, for Violence Against the Person (76% = 81 victims).

A.2 What types of offences are being committed?

The overall figure for Violence Against the Person between March 2021 and 2022 was 10,825. Violence without injury – 7,087 and violence with injury – 3,730. Sanction and detection rates for the same period totalled 1,034, Violence without injury – 575 and Violence with injury 451. Sadly, there were also 8 Homicides recorded. In the last year, there were 260 offences for possession of a knife in Lambeth. Other weapons possession offences included 19 possession of firearms, 17 possession of firearms with intent, other firearms offences 14.

A.3 How have they changed over time?

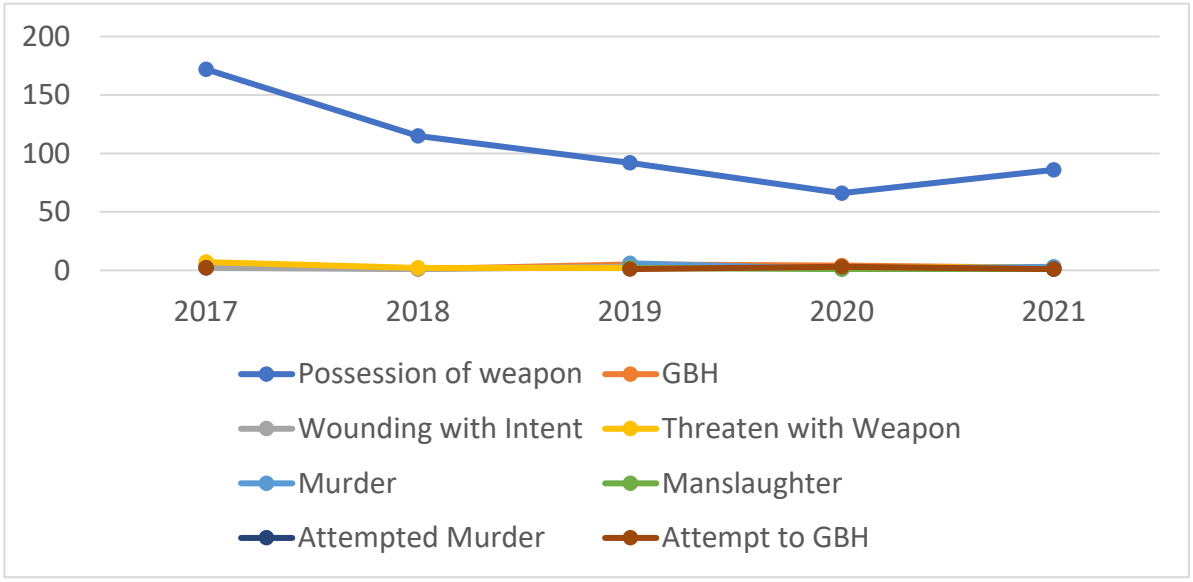
Lambeth has had significantly higher rates of violent offences than England since 2010/11 however rates have levelled in recent years peaking in 2017/18 and then falling. This trend mirrors that of London as a whole, though Lambeth maintains slightly higher rates. Data from the 2019 Index of Multiple Deprivation (IMD)[7] data shows that Lambeth ranks 29th worst out of 317 local authorities in England for crime deprivation, compared to 2015 where Lambeth ranked 1st worst.

The level of crime in an area is associated with increased risk of SYV. In 2017/18 Lambeth had 26.4 violent offences per 1,000 population and ranked 11th out of 16 comparator boroughs.

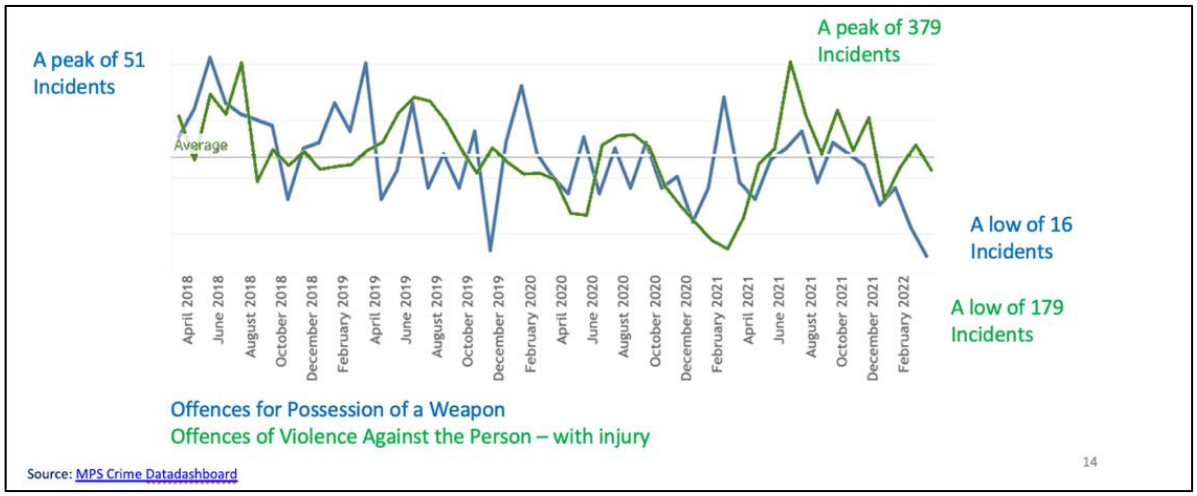
Whilst there has been a reduction since 2017 in the total number of SYV events occurring in Lambeth, the nature of SYV incidents has changed; with more incidents involving sharp objects and fewer

[6] The nature of violent crime: appendix tables - Office for National Statistics (ons.gov.uk)
[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/835115/IoD2019_Statistical_Release.pdf

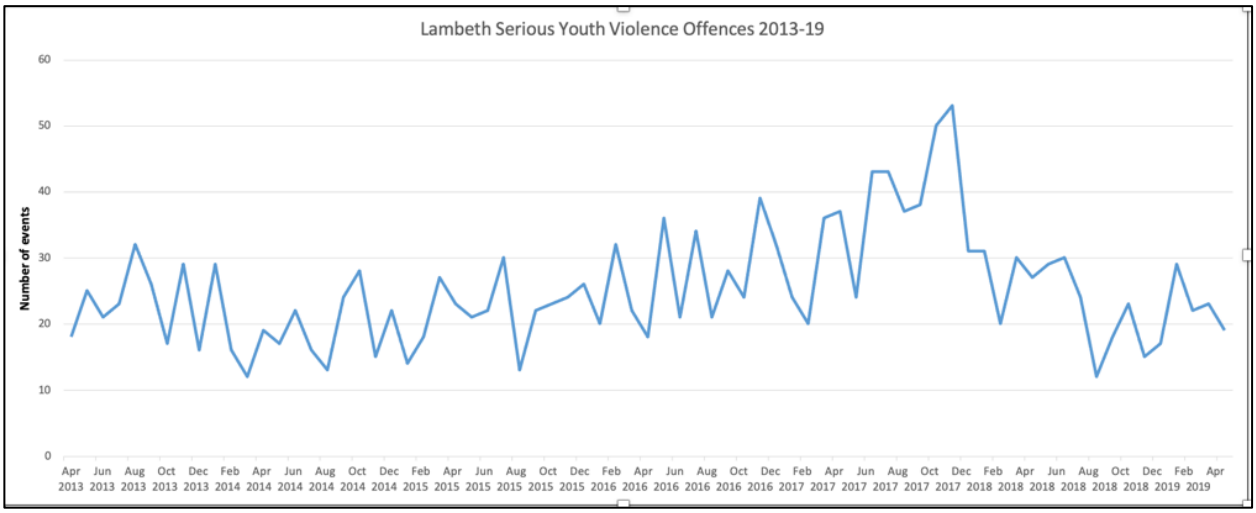
involving bodily force. This suggests, that whilst the number of events may have reduced, the severity of injury may be greater. The graph shows the types of violent offences committed over a five year period and the sustained high prevalence of weapon enabled and weapon possession offences.



Offences for possession of a weapon have fluctuated around an average of 34 offences per month. This has dipped for the most recent months, with 16 offences in March 2022. Offences for violence against the person have had wider fluctuations, often in quick succession. There is a monthly average of 285 offences of violence against the person.

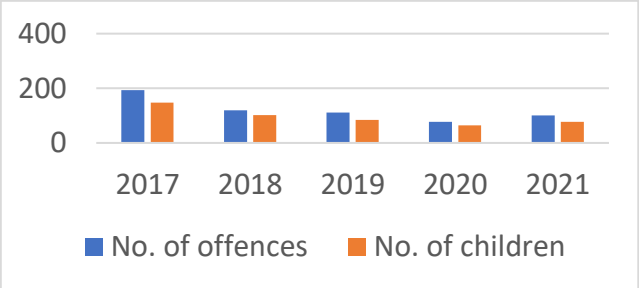


The total number of SYV Offences in Lambeth increased between February 2014 and October 2017 after which there has been a decrease.



A.3.1 How many children have committed violence or possession of weapons offences in last 5 years?

The total number of SYV Offences in Lambeth increased between February 2014 and October 2017 after which there has been a decrease. The number of offences and number of children involved in serious youth violence increased in 2021, following a dip in 2020, but has not increased to the levels seen in 2017 and 2018.



A.4 When do SYV incidents take place?

- The peak times young people were more likely to become a victim of SYV was between 2-6pm aligned to the after school period.
- The most frequent week day was a Wednesday, peaking between 14:00 and 15:49.
- During the weekend the time of day was similar to in the week, although there were a few more incidents recorded in the late evening and into the early hours.

Day of the Week	00:00 - 00:59	01:00 - 01:59	02:00 - 02:59	03:00 - 03:59	04:00 - 04:59	05:00 - 05:59	06:00 - 06:59	07:00 - 07:59	08:00 - 08:59	09:00 - 09:59	10:00 - 10:59	11:00 - 11:59	12:00 - 12:59	13:00 - 13:59	14:00 - 14:59	15:00 - 15:59	16:00 - 16:59	17:00 - 17:59	18:00 - 18:59	19:00 - 19:59	20:00 - 20:59	21:00 - 21:59	22:00 - 22:59	23:00 - 23:59	Total
Monday									1	1			1		2	1	1	1	1				2		11
Tuesday	1								1		1		1		3		1	3		1			1		13
Wednesday	2				1				1		1		2	2	2	4	1	1		1	2			1	21
Thursday	1				1				2	1	1				1	2	1	1		1	2	1	1		16
Friday		1							1	1		1	1	1		1	2		2	2		1		2	16
Saturday					2							1				1	1	4	1	1	1		3		15
Sunday			1	1			1				1		1		2	2		2	1	1	1			1	15
Total	4	1	1	1	4	0	1	0	6	3	4	2	6	3	10	11	7	12	5	7	6	2	7	4	107

A.5 Where do SYV incidents take place?

When we consider all offences of *Violence Against the Person* that have occurred in Lambeth wards in the 12 months from February 2021, Bishops and Coldharbour Wards recorded the most victims of violence against the person, and Streatham South and Thornton recorded the fewest.

Ward	Number of VAP offences
Bishop's	3572
Coldharbour	2881
Ferndale	2016
Clapham Town	1606
Oval	1803
Larkhall	1577
Herne Hill	1571
St Leonard's	1530
Brixton Hill	1517
Prince's	1411

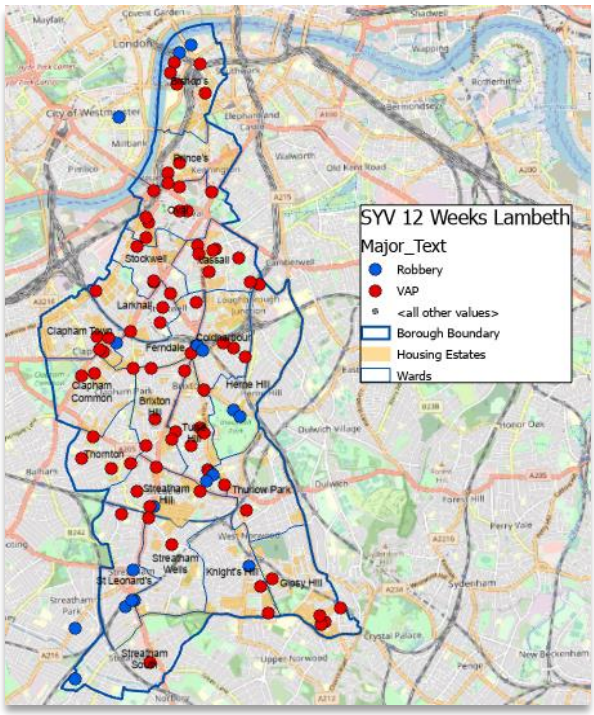
Ward	Number of VAP offences
Vassall	1180
Stockwell	1178
Gipsy Hill	1168
Knight's Hill	1143
Clapham Common	1131
Streatham Hill	1075
Thurlow Park	1065
Streatham Wells	1055
Streatham South	988
Thornton	621

[8]This map plots the location of serious youth violence incidents over the period November 2021-March 2022.

During this period, Bishop's ward recorded the most victims, with Belvedere Road accounting 5 offence locations and Westminster Bridge accounting for 2. Both locations receive high numbers of visitors from outside of the borough.

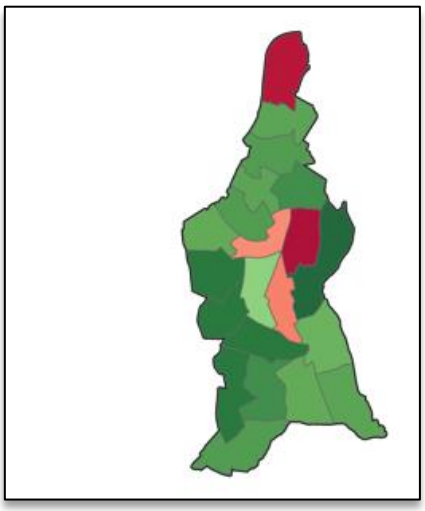
- Bishops Ward is the least populated area in Lambeth. While there are clusters of incidents around commercial centres with thriving night-time economies, violent incidents happen throughout the borough, with only the south west of the borough showing notably fewer incidents.

- There are clusters of violence against the person in proximity to housing estates and residential areas, with additional clusters of robberies around Brockwell Park and St Leonards.



[8] Source: Met Police Data SYV Committed between 01/11/2021 and 18/03/2022.30 Domestic Related records were removed. Total records 107

Prevalence of possession of knife offences continues to be higher in Coldhabour Ward and Bishops Ward. Other weapons possession offences included 19 possession of firearms, 17 possession of firearms with intent, other firearms offences 14.28% of these incidents happened in Bishop's Ward and 25% of these incidents happened in Coldharbour Ward. Prevalence of possession of knife offences continues to be higher in Coldhabour Ward and Bishops Ward. Other weapons possession offences included 19 possession of firearms, 17 possession of firearms with intent, other firearms offences 14.



13.7% of possession of knife offences took place in Coldharbour Ward and 13.6% Bishop's Ward

As previously reported, clusters of incidents take place around Bishops Ward a commercial centre with a high number of tourists and visitors suggesting a potential relationship with organised crime which cannot be confirmed using the available data. There are smaller clusters around residential areas with both robbery and violence against the person seen in close proximity to Brockwell Park and Clapham Common.

A.6 What priority cohorts, settings, places, or outcomes have been identified?

Changes in the serious youth violence landscape in the last five years suggest the need to target young people at risk of involvement in weapons enabled violence including knifes/sharp objects and firearms. The data shows similar numbers of 'robbery' and 'violence against the person' offences. However, the current data set is suggestive of two types of area based clustering; one grouped around residential areas used largely by Lambeth residents and another concentrated on commercial centres including but not limited to Coldharbour Ward, Brockwell Park and Clapham High Street/Common which are also used by visitors to the area.

There is a pattern of offending in the early afternoon/evening closely aligned to the end of school period with Coldharbour Ward some distance from residential areas and most Lambeth schools. This may present a challenge if schools wish to commission focussed deterrence: this may require engaging with young people through street based (detached youth work) and targeting individuals from across schools.

A.7 Limitations

Data sharing agreements have limited access to certain data sets needed to fully analyse victim/offender profiles and detailed incident level data. The following data sets would be especially useful in building an understanding of serious youth violence in Lambeth:

- The incidences of serious youth violence and other crime perpetrated by adults in the vicinity of schools as well as incidents occurring on school property
- Granular data and VOLT analysis related to drug related exploitation of young people and modern slavery.

The definition of serious youth violence used for this report does not include domestic and sexual violence. However, the Serious Youth Violence in Lambeth Evidence Review (2019) and previous

research carried out in London[9] '*showed that the predictors of domestic violence and street violence were similar and that individuals who perpetrated both types had the most risk factors overall'*. Therefore, we have included up to date information relating to these crimes below to ensure consideration of these factors as a relevant part of the overall landscape of serious youth violence. Between March 2021 and 2022 there were 1461 sexual offences, 853 other sexual offences, 608 Rape. Sanction and detection rates 91 other sexual offences and 24 Rape in Lambeth. There were 688 Domestic Abuse MARAC Cases. There were 361 Domestic Abuse MARAC cases where children are mentioned within the case, this equates to 52% of all cases.

B. Understanding the background of young people who commit serious violence

Lambeth's most recent annual data from the Youth Justice Service exemplifies the academic findings in previous strategic need assessments (2015, 2019) about the association between complex needs, risk factors and children who commit, or become victim to, serious violence. Research by the Office for National statistics[10] points the strong relationship between youth justice outcomes and a range of complex needs:

- A large share of young adults who received custodial sentences were identified as vulnerable during childhood; 41.7% were children in need (CIN) and 17.6% had been children looked after (CLA).
- Despite high levels of vulnerability among those who received custodial sentences, receiving a custodial sentence remains unusual; 92.2% of CIN and 84.9% of CLA did not subsequently receive a custodial sentence.

This may be particularly relevant in Lambeth given the high rates of possession of weapons offences in relation to other offence types.

In the year to April 2022:

- 47 children were found guilty of offences associated with serious violence, including possession of a weapon
- Within this cohort there is a significant overrepresentation of boys (94% n= 44)
- The majority of offenders in this group identify as Black Caribbean (47% n= 22)
- The second largest groups were White (British, English, European and Other n= 9) and Black (African and Other n= 7)
- The average age of children was 16.3 years (the youngest 3 were aged 14)
- The average age for first offence was 14.8 years (the youngest 2 aged 12; and 7 aged 13)
- 51% had been permanently excluded from school (24 children)
- The vast majority (72%) were being supported by Children's Social Care (23% CLA and 26% CPP)
- A sizeable proportion had been diagnosed with SEND (40%), particularly ADHD and Speech and Language

[9] Hughes, Karen, et al. - The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis 2017

[10] The education and social care background of young people who interact with the criminal justice system, Office for National Statistics: May 2022

B.1 Understanding the role of previous trauma in offending

An overwhelming majority of young people in the offender cohort had experienced traumatic events in their lives. For the purposes of this report, we have not included analysis of multiple traumatic childhood experiences often referred to as Adverse Childhood Experiences (ACEs). These include experiences such as maltreatment or witnessing domestic violence which have been shown to lead to higher levels violence, in adolescence and adulthood.[11] While ACEs are useful to build a contextual picture of an individual child, ACEs are not a reliable predictive data set. it is important to note that[12]:

- ACEs do not predict involvement in violence.
- ACEs are more prevalent among those who are living in poverty, in particular food insecurity.
- The impact of ACEs varies widely: one ACE may have a profound impact on a particular individual, and another may experience multiple ACEs and be less impacted.

The prevalence of ACEs in the general UK population is high; almost half (47%) of individuals in the UK experienced at least one of the nine ACEs. Prevalence of childhood sexual, physical, and verbal abuse was 6.3%, 14.8%, and 18.2% respectively (population-adjusted) (Bellis et al, 2014)[13]. As such we have determined that ACEs are not a robust enough indicator to use to target the cohort of children at risk of direct involvement in serious youth violence in Lambeth. We have focussed instead on reports of specific trauma related to violence. It is known that 85% of the young people found to have committed offences related to serious violence had experienced previous trauma, including:

- 43% had previously been injured in violence outside of the home (n= 20)
- 32% had experienced domestic abuse (n= 15)
- 23% had a friend of family member seriously injured (n= 11)
- 15% had a family member with a history of offending

B.2 Understanding the background of victims of serious youth violence

Between January 2021 and May 2022, 32 children were injured/attacked with a knife or firearm. This group largely mirrors the group of children found to have committed violent offences:

- A significant overrepresentation of boys 94% (n= 29)
- The majority identified as Black British 69% (n= 21) however, this was split across Black British African (n=9) Black British Caribbean (n= 8) Black British (n= 4)
- The average age of young people was 16.2 years (youngest 3 aged 14 and 50% aged 17)
- The majority (59%) were being supported by Children's Social Care (53% CPP and 3% CLA).
- A greater number were also open to and working with the Youth Justice Service 63%
- A sizeable proportion had been diagnosed with SEND (44%), including 25% with an EHCP. Concerns were particularly ADHD and Speech and Language
- Six children (19%) were registered at same GP – Herne Hill Group Practice
- The children were found to reside all over the borough, 9% Clapham East (n= 3), 9% Myatt's Fields (n= 3)
- 19% appear to have been entirely random attacks/mistaken identity (n=6)

[11] LGA. Public Health Approaches to Reducing Violence: https://www.local.gov.uk/sites/default/files/documents/15.32%20-%20Reducing%20family%20violence_04_WEB.pdf

[12] Early Intervention Foundation. Adverse childhood experiences: What we know, what we don't know, and what should happen next: https://www.eif.org.uk/files/pdf/adverse-childhood-experiences-summary.pdf

[13] Bellis, M.A., Hughes, K., Leckenby, N. *et al.* National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England. *BMC Med* **12,** 72 (2014). https://doi.org/10.1186/1741-7015-12-72

B.3 The relationship between exploitation and serious youth violence

There was evidence of exploitation for a disproportionate number of children in this group, with reasonable grounds to consider 13 of the children (41%) victims of modern-day slavery. 10 children (31%) were worryingly repeat victims of serious violence, having been injured in the year prior. When you remove the children who appear to have been attacked at random or through a case of mistaken identity, this jumps to 38%.

There had been previous concerns for the vulnerability of most of the children in this group (66%), with concerns around missing episodes, possession of drugs with intent to supply, possession of weapons, and theft. When you remove the children who appear to have been attacked at random or through a case of mistaken identity, this jumps to 81%. According to case records, 6 children (19%) had experienced domestic abuse.

B.4 Gang Involvement

Evidence suggests that there is considerable overlap between young people who are perpetrators and young people who are victims of youth violence, and so the risk factors described here relate to factors that are associated with involvement in youth violence broadly, as either a victim or perpetrator. Gang offending has links with serious youth violence and has a significant impact upon the quality of life of local residents.

The Metropolitan Police service define a gang as: *'relatively durable, predominantly street-based group of young people who:*

(1) See themselves (and are seen by others) as a discernible group, and
(2) Engage in a range of criminal activity and violence.

They may also have any or all of the following features:

- *identify with or lay claim over territory*
- *have some form of identifying structure feature*
- *are in conflict with other, similar gangs'*

This definition is distinct from – and should not be confused with – other criminal structures, such as organised crime networks, which merit a different policing approach'.[14]

The Metropolitan Police tightened the definition of gangs to recognise the centrality of drug related organised crime, for example 'County Lines'[15] as distinct from a broader definition of gangs. There is no legal definition of organised crime in England and Wales.[16]

As of January 2019, across London there were approximately 3,000 individuals on the gang violence database and 180 gangs believed to be active in London. This database enables the Police to identify the most violent or at risk gang members and to work with partners to respond. It also identifies gang members who have been repeat victims of violence and need support to safeguard them from being further victims and to divert them away from gangs.

The Metropolitan Police Service (MPS) Central South Basic Command Unit (BCU) comprises Lambeth and Southwark boroughs. Central South BCU has a large number of gangs. Some oppose

[14] https://www.met.police.uk/police-forces/metropolitan-police/areas/about-us/about-the-met/gangs-violence-matrix/#:~:text=A%20'gang'%20is%20defined%20as,of%20criminal%20activity%20and%20violence.
[15] https://www.met.police.uk/advice/advice-and-information/cl/county-lines/
[16]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/248645/Serious_and_Organised_Crime_Strategy.pdf

each other and some illustrate a reliance on other gangs. These relationships are fluid and often change following a single incident of violence. There are over 350 individuals (as of June 2019) identified as gang members within Central South, although this is a constantly fluctuating picture. They are typically males aged between 13 and 24 years old.

Whilst violence within Southwark and Lambeth is not exclusively a gang problem, being associated with a gang means the propensity to become a victim or perpetrator of violence is greater than not being in a gang. Central South BCU has seen a significant level of violence in the year to June 2019, with 65 lethal-barrelled firearm discharges, 1,319 knife offences including 198 knife injury offences where the victim was under 25 and 254 firearm offences. Whilst the majority of these are not specifically youth violence events, they help describe the general picture of gang-related violence in Lambeth and Southwark. Serious Youth Violence remains one of the most pressing issues facing the MPS at present. A significant proportion of violent offending on Central South BCU can be attributed to gangs and much of that involves victims and perpetrators who are under 18.

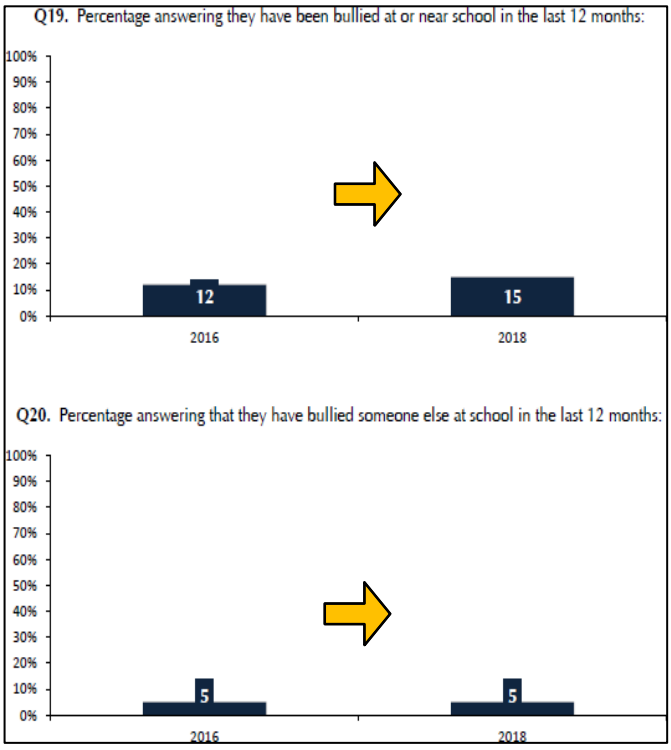
The MPS 'gang' definition explicitly recognises the definitional difference between organised crimes and gangs as well as the different strategies required to respond to these different offence/offender typologies. These typologies were not clearly defined in data analysed for the purpose of this report; including in social care/youth justice service data. This may be a key barrier for schools providing focussed deterrence work to these two respective groups, as motivations, behaviours and offence types are very different for those involved in organised crime. There is evidence that both make up the crime landscape in Lambeth.[17]

B.5 Bullying

Nearly half (48.5%) of all 15 year olds in Lambeth responding to the 'What About YOUth' survey in 2014/15, reported being bullied in the last 2 months. This was similar to the national and London averages.

13.2% of 15 year olds reported having bullied others in the last 2 months*. This is not significantly different to national and regional averages, however Lambeth ranked 14th out of 16 comparator boroughs (16th represents highest i.e., worst rate).

2016 and 2018 SHEU survey data (previous slide) indicates a much lower proportion of children being involved in bullying (both as victims and perpetrators) than suggested by the 'What About YOUth' data. The two surveys use very different definitions of bullying, with the What about YOUth definition being much broader.



[17] Safer Lambeth Partnership Strategic Assessment of Crime and Disorder, 2020-21

B.5.1 Lambeth Primary pupils' experiences of bullying[18]

- 26% of pupils overall reported that they felt afraid to go to school because of bullying in the last month,
- 3% of pupils overall said they felt afraid to go to school because of bullying in the last month, at least sometimes
- Behaviour widely reported as causing distress included being called nasty names, being pushed, or hit for no reason and being teased or made fun of. 30% said nasty things were said about someone in their family
- 53% of pupils said that their school deals with bullying 'quite or very well', 12% said bullying wasn't a problem in their school. 17% said their school dealt with bullying 'badly' or 'not very well'
- 5% of pupils reported that they thought others might have been frightened of going to school because of them in the last month

B.5.2 Lambeth Secondary pupils' experiences of bullying

- 13% of pupils reported a fear of going to school at least sometimes because of bullying in the last month and 15% said they had been bullied in the last 12 months
- 5% said they had bullied someone else in the last 12 months
- 11% of pupils said they worry 'quite a lot' or 'a lot' about bullying

B.6 Motivations for involvement in Serious Youth Violence

A group of 40 pupils from Lambeth schools took part in 45 minute semi structured interviews with one independent researcher to understand their experiences of school, youth violence and living in Lambeth. 27 Year 9 pupils took part from 3 secondary schools and 1 all through school and 13 Year 6 pupils took part from 1 primary school and 1 all through school. There was no specification regarding race however the final sample was 100% young people from minoritised backgrounds, the majority Black British, with three children from white minorities. The group included 17 girls. Direct quotes from children included in this report were all from this group. Pupils were selected for interviews based on the following measurable criteria:

1. Persistent absentees and those who fall below the 10% threshold but are frequently absent from school
2. Pupils who have experienced a managed move or school based inclusion provision
3. Pupils with known speech language and communication issues
4. Pupils with a high number of behaviour points or suspensions

These were based on existing evidence of evidenced risk factors for youth crime (including MOJ/DfE 2022[19], Bercow [20] and Bercow ten years on[21] and EIF Rapid review[22].

There is a strong evidence base for the role of peer influence as a risk factor in youth crime and equally there is robust body of evidence for peer influence as a protective factor in other public health issues such as smoking (ASSIST, Smoking in Schools RCT[23]). In addition to the measurable

[18] Source: SHEU survey, 2018
[19] DFE/MOJ Education, children's social care and offending, descriptive statistics, (2022)
[20] **Bercow**, J. (2008) The **Bercow Report**: A **review** of services for children and young people (0-19) with speech, language and communication needs.
[21] *Bercow: Ten Years On* is a report on the state of provision for children's speech, language and communication needs (SLCN) in England. The report has been published by I CAN , the children's communication charity, and the Royal College of Speech and Language Therapists (RCSLT).
[22] https://www.eif.org.uk/report/preventing-gang-and-youth-violence-a-review-of-risk-and-protective-factors
[23] https://www.cardiff.ac.uk/research/impact-and-innovation/research-impact/past-case-studies/decipher-assist

criteria, schools were also instructed to select pupils based on the following observable behaviours which are based on this model of 'peer influence' and the interest of the taskforce and research team to qualitatively assess the presence and absence of protective as well as risk factors;

1. Charismatic leaders - able to lead a group either negatively, positively or in both directions.

2. Students who you feel may follow or develop dependencies of on children who show either of the above behaviours.

3. Students who display dependencies and are more easily influenced by peers are more likely to be pulled in to exploitation. One clear observable behaviour would be poor refusal skills[24].

4. Skilled 'disappearers' - attends school but rarely engages with academic or extra/super curricular work, may engage with other pupils but may not engage willingly with adults.

School behaviour and exclusion policies largely focus on children with externalising behaviour such as disruption, aggression, defiance and violence. However, there is also a strong evidence base which suggests a relationship between internalising behaviours[25], such as anxiety, lack of positive pro-social relationships, rejection and rumination and crime in the child and adult population. This group is also more likely to show tendencies towards 'displaced aggression' which is *'when someone directs their anger towards an innocent bystander, rather than the provocateur'*.

Young people displaying rumination and anxiety disorders, including those experiencing emotion based school avoidance (distinct from truancy)[26] are less likely to be picked up by schools than those displaying defiant and aggressive behaviours. These children are a key risk group for exploitation and for gang related knife crime, which is highly associated with displaced aggression. Because of the long term relationships schools have in comparison to other support agencies around the child and family they may be uniquely placed to observe internalising behaviours and this may be a key area for consideration for schools wishing to target pupils who would benefit from more intensive therapeutic support as part of the SAFE Taskforce interventions in Lambeth.

B.6.1 Proximity to Serious Youth Violence

Of the broader group identified by schools as at risk of involvement in serious youth violence, a smaller number disclosed having current/direct experience of youth violence either through peer or family relationships and this was confirmed by teachers. There was evidence of young people's attitudes to serious youth violence varying according to their proximity to experiences of violence.

B.6.2 Motivations for involvement in violence – young people's experiences

Family attitudes to violence and 'Self Defence': All secondary and primary pupils apart from two felt that physical violence is acceptable when provoked and several explicitly used the term 'self defence' which they said they had learned from their parents. Both primary and secondary pupils

[24] Herrenkohl, Todd I., Jungeun Lee, and J. David Hawkins. 'Risk versus Direct Protective Factors and Youth Violence: Seattle Social Development Project'. American Journal of Preventive Medicine 43, no. 2 Suppl 1 (August 2012): S41–56. doi:10.1016/j.amepre.2012.04. 030.

[25] Vasquez, Eduardo A., Sarah Osman, and Jane L. Wood. 'Rumination and the Displacement of Aggression in United Kingdom Gang-Affiliated Youth'. Aggressive Behaviour 38, no. 1 (February 2012): 89–97. doi:10.1002/ab. 20419.

[26] https://schools.oxfordshire.gov.uk/cms/sites/schools/files/folders/folders/documents/learnerengagement/coronavirus/EBSAGuidanceandTimeline.pdf

feel that aggressive and/or violent confrontation is the best way to permanently stop a conflict with a peer.

Postcodes and Neighbourhoods: Young people who told us that they had direct experience/involvement of crime (and could point to specific incidents) were more likely to name residential areas/neighbourhoods as the main locations for risk of crime, in particular upper and lower Tulse Hill, Angell Town and Croydon were mentioned multiple times. These children were able to point to specific incidences of targeted 'gang related' violence, as well as mistaken identity. Young people with no direct involvement/experience in crime were more likely to name Brixton and Peckham as youth violence hotspots but were unable to point to any specific instances/experiences when prompted.

'I wouldn't recommend places like Peckham because I feel that you know it's a had a very tough, tough, tough history. But I'm personally, I'm fine with being in Peckham day or night because I've been there and I didn't grow up there but I've been round there from when I was young and I'm kind of used to that type of environment. But certain individuals, I feel coming from like America versus overseas. Big change, like you know, it's very ghetto around there.' (Year 9 pupil)

Money: Most young people saw money rather than status as the primary motivator for involvement in serious youth violence. Both primary and secondary school children made a distinction between inter-gang conflict 'postcode beef' which they see primarily linked to status and crimes which lead to violence, but which motivated by money such as drug related offences and fraud (for which both primary and secondary school pupils were able to name different types).

Bullying and conflict between peers: The majority of children feel safe with peers from their own schools which is a protective factor for involvement in SYV, however children in primary and secondary school gave multiple detailed examples of violence taking place after school including threats from the parents of their peers, violence by peers from other schools and violence by adults and older peers all taking place within the radius of the school and in one case within a neighbouring school. This was also mentioned by parents as a key factor in escalating violence between peers.

Social media and music: Young people with no reported direct involvement in youth violence were most likely to hear about youth violence from social media, with boys reporting Twitter (not Tik Tok) as a key source of viewing videos depicting stabbings, shootings and other violence from the UK and abroad. There was also evidence (particularly in Primary school) of conflict starting in WhatsApp groups which has led to threats and violence between parents and peers. Primary pupils (Year 6) had high familiarity with drill music and could expand on language such as 'ops' (gang members) and 'catching 'm's (intention to kill) as well as 'cheffing' (intention to stab). Two primary pupils recounted specific incidences of being targeted and subjected to assault due to gang affiliated family members.

'I'll tell you what motivates it, this postcode theory about why youth are going out there and doing criminal activities what motivates it is like, if you grew up in a certain area, you get people coming up to you. And then they'll motivate you to rep or represent your ends, the area that you grew up in. And then that sort of cycle where people keep coming up to you or it keeps going into your brain and that's why.' (Year 9 pupil)

"I've seen it, I've seen people get on the wrong path because they've been forced to or they have nothing else to do. Like, for example, like if their family or something or somebody is struggling or something's happening in life, and they have nothing else to do or to have a source of income, they'll go into the gang life them and feel like that's the only option." (Year 9 pupil)

There is inconsistent evidence pointing to a direct causal link between consumption of violent media and youth violence, however evidence from systematic reviews and meta-analyses in the US shows that consumption of violent media has a relationship with aggressive behaviour, especially for younger teenaged boys.[27]

Perhaps more importantly, young people in Lambeth's view of the community, and their own self-identity, is shaped by the violence they are consuming in the media. The findings of interviews echoes previous research conducted with young people in Lambeth[28]:*'The depiction of young people in the UK media, particularly young Black boys, perpetuating harmful stereotypes and sensationalising the crime epidemic, making other young people scared and causing them to turn to carrying knifes as a perceived form of protection.'*

B.7 What priority cohorts, settings, places, or outcomes have been identified?

The data which has been gathered suggests that boys in Year 9, with from Black Caribbean, Black African and White British backgrounds with previous experiences of violence and specific SEND needs are the priority cohort for this work. Schools and Lambeth local authority should also work together to identify offenders and victims who are not currently receiving support from Social Care (41%) and or the Youth Justice Service (37%).

B.8 Limitations

National Referral Mechanism data was not available for the purposes of this needs assessment and as such we have not been able to precisely identify the prevalence of modern slavery and exploitation in the Lambeth SYV cohort. Further research is needed to establish the proportion of incidents which are directly linked to organised crime and/or exploitation. This would necessitate consideration of children who are newly arrived in the UK. This priority group are less likely to be present in multi-agency data due to high mobility. The Local Government Association defines these children as *'Children who are not UK citizens or do not have immigration status – the precariousness of their immigration status is an additional vulnerability that enables gangs to target them'.*[29] For the purposes of intervention this group should be considered as distinct from those involved in or affiliated to gangs. Further work with the existing youth justice cohort to create case studies of pathways in to crime would be a recommended next step as well as producing clearer typologies, specific to Lambeth which specify young people's experiences of gang involvement.

There is an extensive body of research on the link between SEND and in particular SLCN and ADHD and youth and adult violence, however the data available to this study was limited. Further work may be needed comparing school CENSUS data to other agencies to identify the best indicators for SEND and ADHD within the at risk cohort.

C. Understanding educational indicators for young people at risk of serious violence

[27] Browne KD, Hamilton-Giachritsis C. The influence of violent media on children and adolescents:a public-health approach. Lancet. 2005 Feb 19-25;365(9460):702-10. doi: 10.1016/S0140-6736(05)17952-5. PMID: 15721477.
[28] https://moderngov.lambeth.gov.uk/documents/s122975/Appendix%20A%20-%20Lambeth%20Made%20Safer%20Strategy%20v19.pdf
[29] https://www.local.gov.uk/publications/tackling-child-exploitation-resources-pack

Research by the Office for National statistics suggests that around one in five (22%) of children that had ever been permanently excluded were also cautioned or sentenced for a serious violence offence[30].

- Young adults who received custodial sentences had lower levels of educational attainment, with 36.9% achieving the expected level of English and maths by the end of key stage 2 compared with 53.0% of their peers with non-custodial sentences or cautions, and 72.4% of those without criminal convictions.
- More than half (52.5%) of young adults who received custodial sentences had been persistently absent during schooling, compared with 35.9% of those with non-custodial sentences or cautions; persistent absence was lowest among those with no criminal convictions (10.9%).
- Nearly three-quarters (72.2%) of those who had a custodial sentence had received a fixed exclusion compared with half (50.3%) of those with non-custodial sentences or cautions, and 9.0% of those with no criminal convictions.

We know from previous needs assessments in Lambeth (2015, 2019), as well as Rapid and Child Safeguarding Practice Reviews that education is the biggest protective factor for children and young people in Lambeth. From our reviews, and in understanding of children who are at medium to high risk of violence, we have identified that:

- The transition from Primary to Secondary and Secondary to 16+ can be a period of heightened risk for children;

- While permanent exclusions have significantly reduced in recent years, those children who have been excluded do not always access the alternative provision offered to them. This has led to children not accessing an education for significant amounts of time. In the Safeguarding Reviews undertaken by the LSCP (2020-22), at least seven such children have been identified, with their gaps in education ranging from 9 months to 5 years.

C.1 Disrupted Education

54% of these children had a disrupted education under age 16, with significant periods of time not attending school/accessing an education. **53%** had been to more than one secondary school.

- **9** children were NEET
- **6** children had been on roll at Park Campus
- **5** children had been on roll at ARK Evelyn Grace
- **5** children had been on roll at Platanos College
- **4** children had been on roll at Jus'T'Learn
- **3** children had been on roll at City Heights
- **3** children had been on role at Lambeth Academy
- **3** children had been on roll at Lambeth College
- **2** children were electively home educated (EHE)
- **2** children had been on roll at Southbank UTC

[30] The education and social care background of young people who interact with the criminal justice system, ONS: May 2022 cited in THE COMMISSION ON YOUNG LIVES, April 2022

- **2** children had been on roll at Norwood School

C.2 School Connection and Disrupted Education

We have utilised statements from two validated scales to build our understanding of pupils, teachers and parents self-efficacy [31] and motivation (goal direction[32]) which are important predictors of range of academic, career and social outcomes. Intentionally, we have looked at motivations towards 'positive' and 'negative' goals and adaptive and maladaptive behaviours rather than choosing to focus only on motivations towards offending behaviour. There is now an influential body of research regarding teacher autonomy based on self-determination theory (Deci & Ryan and others) that demonstrates a causal relationship between teacher motivation [33] and pupil outcomes.

- *"An important reason I do my class work is because I enjoy it":* An average score of 2.8 is aligned to the benchmark of 2.8 which suggests an adaptive (positive) attitude to academic goals.
- *"One of my goals in class is to avoid looking like I can't do my work":* An average score of 2.8 is slightly but not significantly higher than the benchmark 2.5 which suggests a low-level (maladaptive) attitude to academic goals.
- *"Doing well in school doesn't improve my chances of having a good life when I grow up":* An average score of 2.3 is higher than the benchmark 1.7 suggesting a modest level of avoidance in relation to importance of education as means to obtain life goals.
- *"I feel that my home life and my school life are like two different worlds":* An average score of 3.6 is significantly higher than the benchmark 1.9 suggesting a high level of dissonance between school and home environments, which is predictive of difficulty with school achievement and motivation.
- *"On the weekends, I can find worthwhile things to do in my area":* An average score of 3.1 is closely matched to the benchmark 3.6 suggesting an adaptive attitude towards leisure and recreational goals.
- *"After school, I have trouble finding safe places to hang out with my friends":* There is no benchmark for this statement as it was reversed specifically for the purposes of this study, however this was the lowest average score across all statements, scoring an average of 1.8 out of a possible 5.9 points, suggesting a high level of disagreement with the statement. This is a very important finding for schools, as it suggests that young people have an adaptive and generally positive viewpoint in relation to their ability to stay safe when associating with friends in the borough.

There was striking alignment between teacher surveys and pupil interviews, with behaviour sanctions and internal exclusions reported by teachers as a key factor affecting pupil motivation. Pupils gave detailed accounts of experiences in isolation provision.

[31] Bandura, A. (2006). Guide for constructing self-efficacy scales. In F. Pajares & T. Urdan (Eds.), *Self-efficacy beliefs of adolescents* (Vol. 5, pp. 307-337). Greenwich, CT: Information Age Publishing.

[32] Midgley, C., Maehr, M. L., Hruda, L. Z., Anderman, E., Anderman, L., Freeman, K. E., & Urdan, T. (2000). Manual for the patterns of adaptive learning scales. *Ann Arbor: University of Michigan*.

[33] Deci, E. L., Vallerand, R. J., Pelletier, L. G., & Ryan, R. M. (1991). Motivation and education: The self-determination perspective. *Educational psychologist*, *26*(3-4), 325-346.

C.2.1 The Primary to Secondary Transition: In depth parent case study

This mother was selected by the school for an interview because she has lived experience of a number of risk factors included in the body of this research; she has a large family, all boys, who range in age between early years and sixth form.

She has one son who has now been assessed and diagnosed with ADHD and another who is on the Autistic Spectrum and has dyslexia. These excerpts, in her own words, highlight her different experiences of transitions, assessments, her perceptions of teachers view of her as a parent and of her children and her experiences of what has worked well. Parent surveys highlighted above average scores for rumination, anxiety, loss of sleep and inability to cope across all race and gender categories.

Assessment of Complex Needs

'I believe when he got to year 10, the same teacher that had a confrontation with my younger son. She was like, even though I love your son, there's something about him. Do you mind if I push to get him tested? So he had to have someone in with him in the next exam? Because even though he can do it, he can't digest information. And he fidgets. I find with young black men, they don't test them as much, or ethnic; anyone of colour. Yeah, they let everything bypass and just stereotype them all. You know. 'They don't want to learn' or 'they just want to be disruptive' or it's 'because they come from a single parent family'. And that's not necessarily the case because some of the children, they want to actually know what's wrong with them.'

'And my second son, he was for a long time; why am I so different from everybody else? Now he's read up about it. Oh, okay, I understand now, so I don't feel like an alien. So, in a sense of them understanding that they're still normal, they just have additional stuff, yeah, it's nice. So now they can have conversations and be comfortable. And if anyone asked them a question, like, why did you do that? They can explain'.

Experiences of Transition

'I find that the children who are more active or more sport oriented, orientated or just fidget a lot that have ADHD and what have you, those are the ones that you have to really keep your eye on. Yeah, because those are the ones that tend to attract attention. Not necessarily, purposely Yeah. So, for him, the transition was smooth into secondary school, but once he got there, the problems stemmed from other children where their parents weren't as much in their life as they should be. He was doing a lot. So, I was like, okay, as soon as you want to step into my home at six o'clock, and we live literally 20 minutes, walking from the school: I'm going to change you to a school where you will be coming to my home at six. Yeah. So, he didn't like that, but I feel that it was for the better. Because the school had a bit more structure. Obviously, later on, down the line, he actually got diagnosed with short term attention span. So, you know, the teachers were doing their job at that school to recognise that.'

'I would say there should be like a crossover between year four to year seven for the secondary transition with levelling up with their responsibility so by the time they get to year seven, its second nature.'

Teacher Perceptions

'Every time I went to the school, it was like, oh, gosh, here's mum again. 'Black Mum syndrome' and it's like; no, you're not understanding what I'm telling you. You're just thinking because you're a teacher and you've had years of experience that you know; every child is different. Because (son) disrupts the class you feel that he's looking for attention and you assume he doesn't want to do the work? No. You're not informing him in a way where he can comprehend it. Likewise, for (other son)

you're giving him the work, he understands it, but he just can't get it on paper, and I don't understand how, you know, I feel more teachers need to know. I know they have a lot of workload but I feel that they need to assess things differently. And it's not just what's in the box; a lot of the children are outside the box.'

'A lot of things [were said] like 'you won't pass your SATs' said direct to my son and to quite a few of the young black boys in the class. You know, you would never amount to anything. 'Stop doing this footballers dream'. As a teacher what you should say is, you know, let me tell you football is really saturated. If there's another sport that you know you can do and that you're good at. Maybe channel some of your energy there, not just football. Because you never know the opportunities that can come about; there are different ways to say the things you've got to say'.

The importance of shared cultural experiences

'Because for me, if you have a multitude of teachers from different backgrounds, one teacher can be like, you know, I'm not understanding this, but I can ask my colleague, because they can maybe relate, you know, a lot of teachers don't necessarily understand a lot of fundamentals. You know, so sometimes it's just a little culture clash. It's just about having a bit more understanding. But you have to be willing to want to understand. Yeah, you can't be wanting to be ignorant.'

If they roll their eyes…[Specific teacher] 'So he's got his suit culture. He's got the London culture and then he's got the Caribbean culture and the three merge into one, he's selective in different situations. And I find it works really well. Because I haven't heard him have to shout once.'

Triggers for violence

'It's that when young men do not understand their triggers and their temper and what it can do. So that, I feel would that anxiety every time he goes out with his friends. Remember? I'm like, please, if there's any confrontation, make sure he's not there. I think in schools, [it] would be nice if they could have someone that deals with not just anger management, just knowing your triggers and how you can deflate yourself. Because boys and girls have it, but I feel boys will always get a heavier; what's the word? A heavier punishment especially if you don't look your age.'

C.3 Inequities in educational outcomes between groups

Both national and Lambeth data indicates that significant inequity exists between ethnic groups. In interpreting this data, it is essential to understand the vulnerability of individuals due to system-wide inequity and bias. The outcomes highlighted below reflect the results this inequity.

In Lambeth, children of Black ethnic group were 50% less likely to achieve a good level of development at the end of the Early Years Foundation Stage compared to White British children (2017). Further research can be found in a report commissioned by Lambeth to address the achievement of Black Caribbean young people including good practice recommendations[34]

[34] https://www.lambeth.gov.uk/rsu/sites/www.lambeth.gov.uk.rsu/files/the_achievement_of_black_caribbean_pupils_-_good_practice_2017_0.pdf

Compared to White British children, children of Black ethnic group were similarly likely to achieve grade 4 or higher in GCSE Maths and English, although children of Black Caribbean background were 70% less likely.

Black children and young people were 3.2 x as likely to be a first time entrant to the youth justice system than White British children in Lambeth in 2017/18.

Children of all other ethnic groups were more likely than White British groups to be eligible for free school meals. Children of Black ethnic groups were more than three times as likely to be eligible.

Children of all other ethnic groups were more likely than White British groups to be eligible for free school meals. Children of Black ethnic groups were more than three times as likely to be eligible.

EYFS - Achieving a good level of development		
Ethnic group	Children at Good level of development (GLD)	
	% at GLD 2017	(n)
White British	81%	(526)
White Other	69%	(360)
Black All	67%	(888)
Black Caribbean	64%	(229)
Black African	69%	(427)
Mixed Black	71%	(158)
Black Other	63%	(74)
Mixed Other	79%	(246)
Asian	73%	(141)
Other Ethnic	59%	(80)
Unknown/Not stated	52%	(44)
Lambeth 5 year olds	71%	(2,285)

C.4 Which pupils have been 'persistently absent' from school?

Children eligible for free school meals (FSM) are about twice as likely to be persistent absentees in Lambeth as those not eligible and this was true for both primary and secondary phase.
Primary: 17.7% of children eligible for FSM were persistent absentees, compared with 6.2% of those not eligible for FSM

Secondary: 22.1% of children eligible for FSM were persistent absentees, compared with 11.4% of pupils not eligible for FSM.

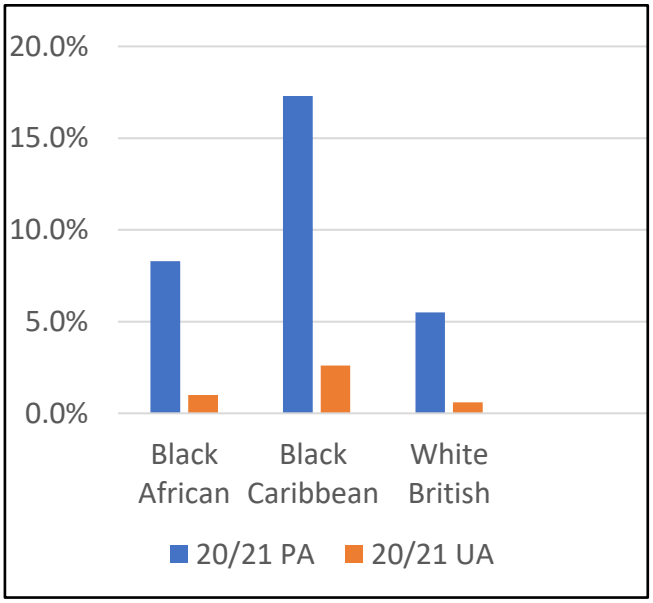
Secondary school children with an EHCP are significantly more likely to be persistently absent than other groups (44.3%)

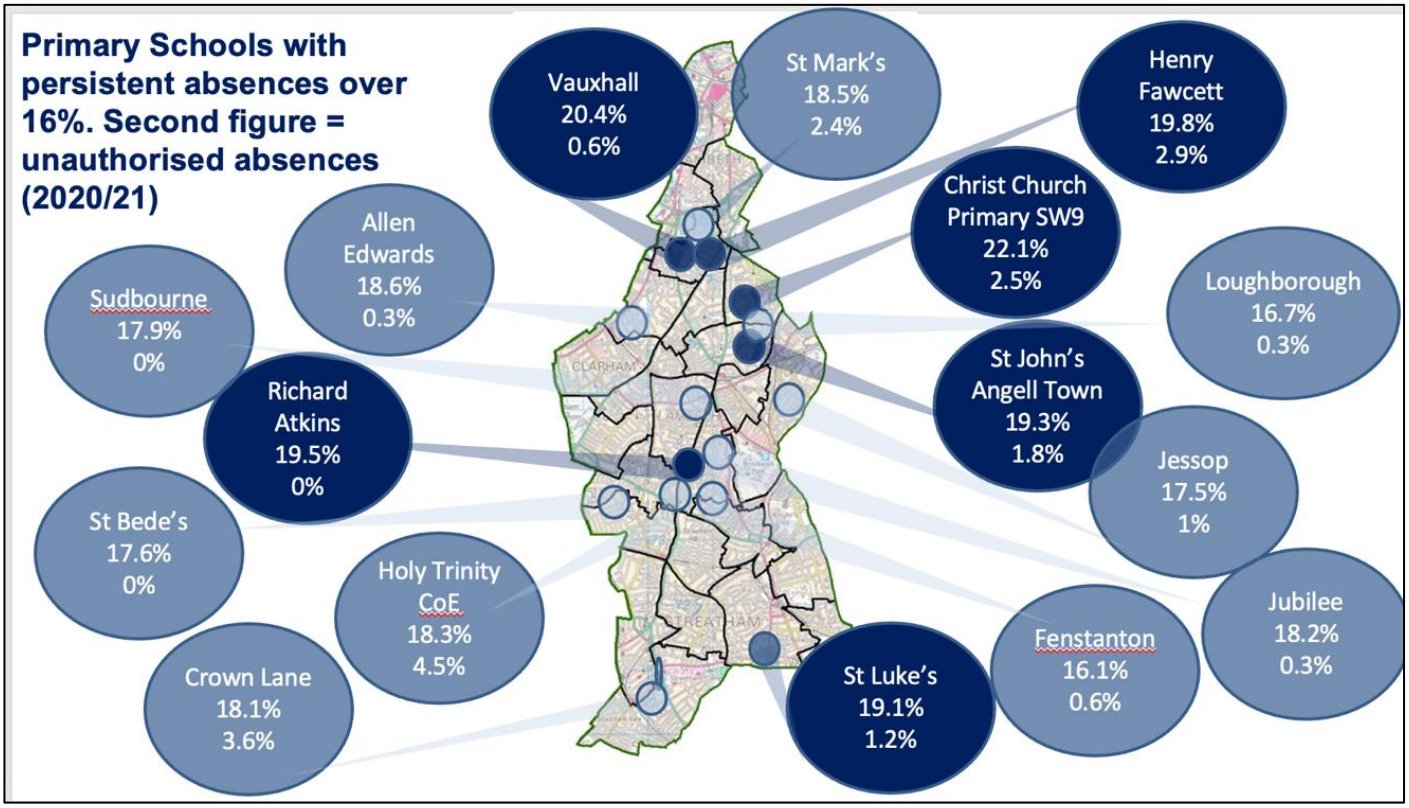
	Lambeth			
	Attend rate	Auth Absence	Unauth Absence	PA (10%)
Primary				
No identified SEN	96.4%	2.4%	1.2%	8.6%
SEN Support	94.8%	3.4%	1.8%	15.2%
Statement or EHCP	92.3%	5.9%	1.8%	22.8%
Secondary				
No identified SEN	95.2%	3.2%	1.6%	12.1%
SEN Support	92.3%	5.0%	2.8%	21.9%
Statement or EHCP	88.2%	9.4%	2.4%	44.3%

C.5 Which pupils have been ‘persistently absent’, and ‘persistently absent unauthorised other’ from Primary school?

There is a significant over-representation of Black British Caribbean children who are persistently absent in primary school, with 17.3% persistently absent.

Significantly more Black British Caribbean children are noted as having unauthorised absences (2.6%), compared to Black British African (1%) and White British (0.6%) children. *While it is likely that Covid has affected this figure, the overall figure of persistent absenteeism only increased by 1.3% in 2020/21 compared to 2018/19. Primary average = 8%





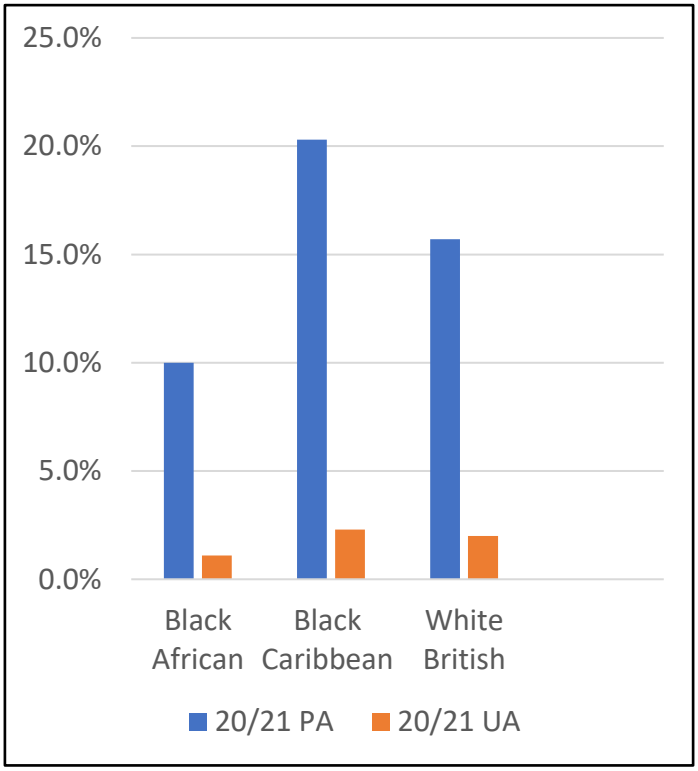
C.6 Which pupils have been ‘persistently absent’, and ‘persistently absent unauthorised other’ from Secondary school?

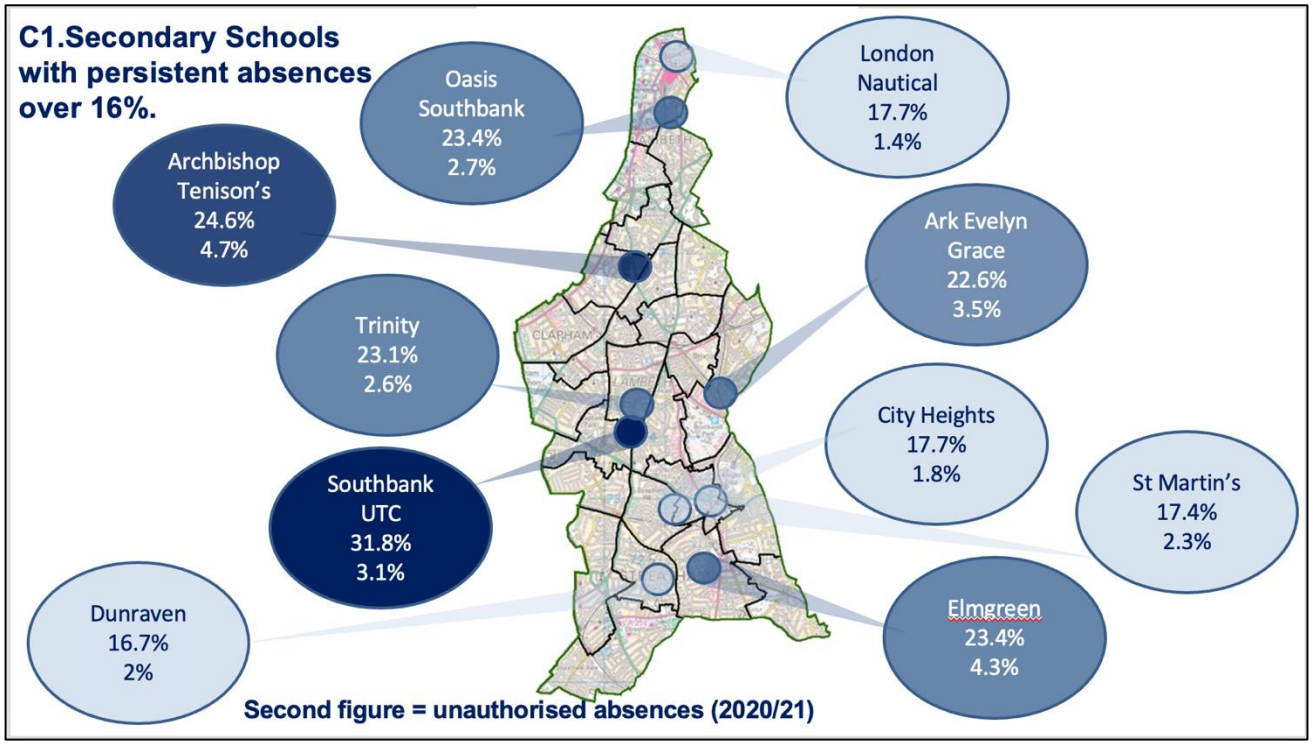
Black British Caribbean children are also more likely to be persistently absent from secondary school (20.3%), closely followed by White British children (15.7%).

Both groups have a similar likelihood of unauthorised absence, 2.3% and 2% respectively. Secondary average = 13%.

Pupil school absence (5-15 yr olds) in Lambeth was similar to national and London averages in 2017/18 and improved from 2010 to 2014. Around 9% of primary school pupils were persistent absentees in 2017/18, similar to the London average.

More than 13% of secondary school pupils were persistent absentees in 2017/18, higher than the London average (12%). Persistent absentee rates in primary schools have generally been static since 2014, but in secondary schools have increased from 2015/16 to 2017/18.





C.7 Which Secondary schools have the most suspensions?

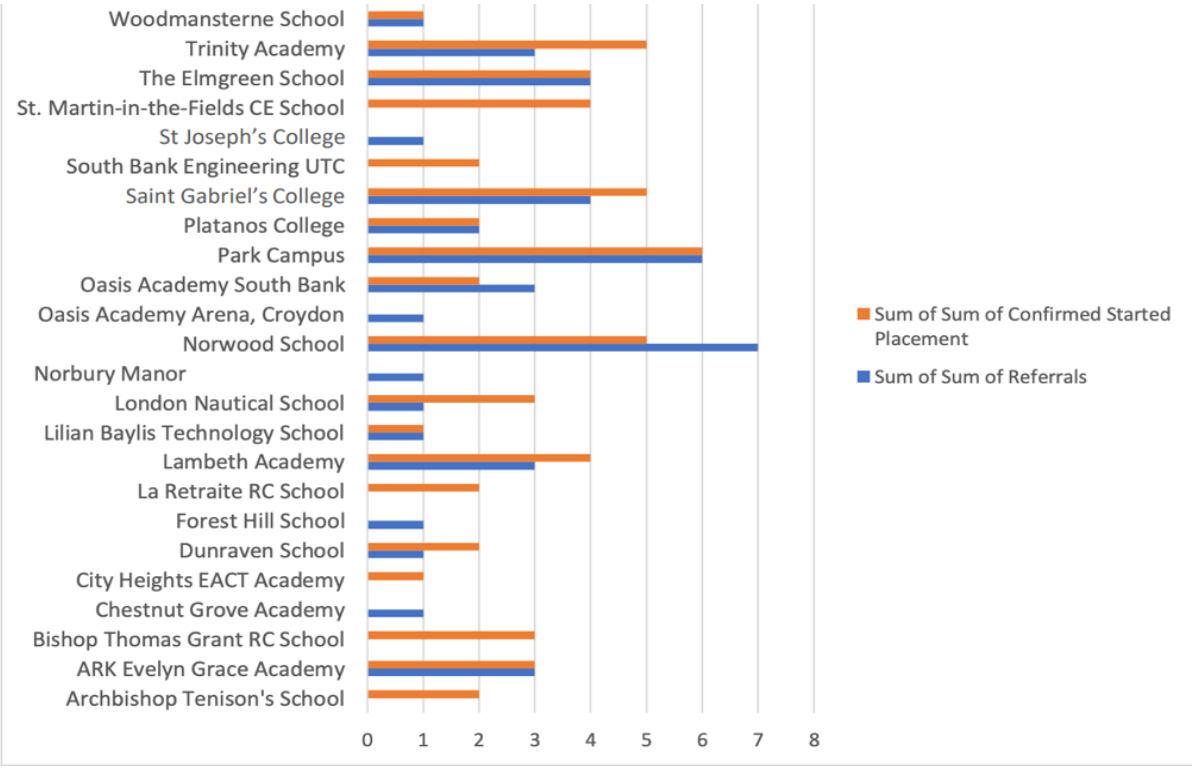
School	Cohort	Number of pupils with Suspension	Number of pupils expressed as a percentage of the school population	Total Number of suspensions	Number of suspensions as percentage of school population
Archbishop Tenison's	328	26	7.93%	33	10.06%
Bishop Thomas Grant R.C.	1,204	4	0.33%	5	0.42%
City Heights	653	1	0.15%	1	0.15%
Dunraven	1,363	8	0.59%	9	0.66%
Elmgreen	1,060	17	1.60%	20	1.89%
Evelyn Grace	511	76	14.87%	113	22.11%
Harris Academy Clapham	193	24	12.44%	30	15.54%
La Retraite RC	1,081	16	1.48%	21	1.94%
Lambeth Academy	810	65	8.02%	85	10.49%
Lilian Baylis Technology	835	28	3.35%	38	4.55%
London Nautical	659	30	4.55%	41	6.22%
Norwood	1,046	18	1.72%	21	2.01%
Oasis South Bank	725	37	5.10%	42	5.79%
Platanos College	955	40	4.19%	59	6.18%
South Bank Engineering UTC	290	35	12.07%	48	16.55%
Trinity Academy	575	29	5.04%	46	8.00%
Woodmansterne	478	29	6.07%	36	7.53%
Secondary Total	**14,012**	**483**	**3.45%**	**648**	**4.62%**

C.8 Which Primary schools have the most suspensions?

School	Cohort	Number of pupils with Suspension	Number of pupils expressed as a percentage of the school population	Total Number of suspensions	Number of suspensions as percentage of school population
Allen Edwards	355	1	0.28%	1	0.28%
Archbishop Sumners	384	1	0.26%	1	0.26%
Ashmole	237	1	0.42%	6	2.53%
Christ Church SW9	193	2	1.04%	2	1.04%
Clapham Manor	433	4	0.92%	4	0.92%
Crown Lane	342	2	0.58%	2	0.58%
Dunraven School	413	4	0.97%	5	1.21%
Elm Wood	417	3	0.72%	4	0.96%
Fenstanton	398	4	1.01%	22	5.53%
Glenbrook	166	4	2.41%	11	6.63%
Heathbrook	366	6	1.64%	12	3.28%
Henry Cavendish	844	5	0.59%	11	1.30%
Hillmead	391	10	2.56%	15	3.84%
Hitherfield	666	1	0.15%	1	0.15%
Jubilee	365	4	1.10%	8	2.19%
Julians	1,000	7	0.70%	7	0.70%
Kings Avenue	235	2	0.85%	5	2.13%
Kingswood	698	2	0.29%	3	0.43%
Loughborough	354	2	0.56%	2	0.56%
Paxton	522	6	1.15%	12	2.30%
Richard Atkins	303	4	1.32%	6	1.98%
Rosendale	682	1	0.15%	1	0.15%
St Helen's	283	1	0.35%	1	0.35%
St John The Divine	172	2	1.16%	2	1.16%
St John's (Angell)	222	3	1.35%	7	3.15%
St Leonard's	336	3	0.89%	3	0.89%
St Luke's	184	9	4.89%	9	4.89%
St Mark's	216	2	0.93%	2	0.93%
St Mary's	318	1	0.31%	2	0.63%
Stockwell	532	1	0.19%	1	0.19%
Streatham Wells	230	1	0.43%	1	0.43%
Sudbourne	329	4	1.22%	6	1.82%
Sunnyhill	414	1	0.24%	1	0.24%
Walnut Tree Walk	308	3	0.97%	3	0.97%
Woodmansterne	793	4	0.50%	16	2.02%
Primary Total	**22,315**	**111**	**0.50%**	**195**	**0.87%**

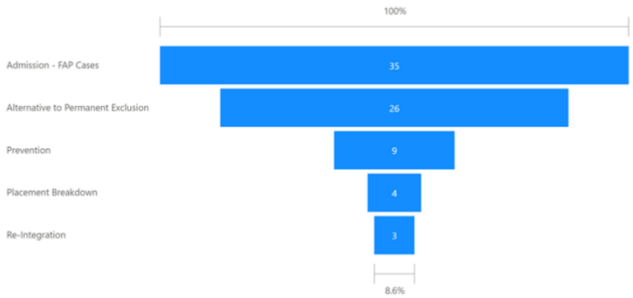
C.9 Where are children being referred to the Secondary Fair Access Panel from?

All Lambeth Secondary Schools engage with the Fair Access Panel process, with all schools having supported at least one child to start a placement within their setting. The Norwood School made the most referrals to the FAP in 2020-21 (n=7), followed by Park Campus Academy (PRU) (n=6). Over this same period, Park Campus Academy (PRU), Norwood School, Saint Gabriel's and Trinity Academy accepted the most children through the FAP process.



C.9.1 What are the reasons for referral?

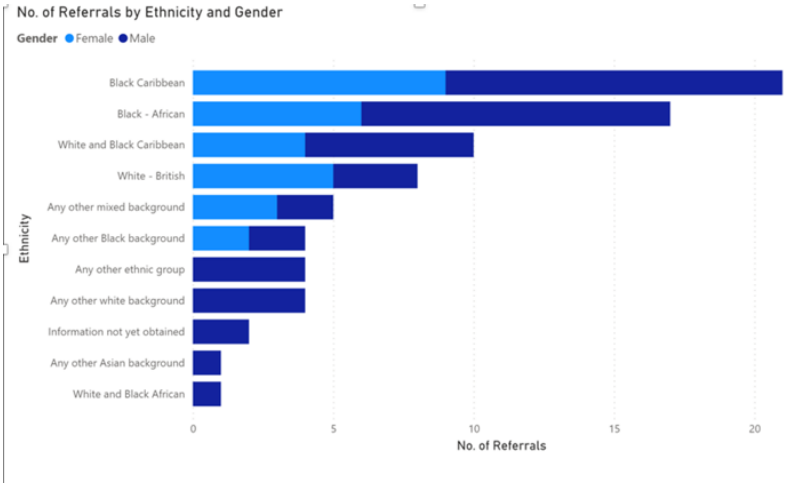
The primary reason children are referred to the FAP is for admissions (35%), identifying school places for children considered more challenging to place. Another significant reason for referral to the FAP is as an alternative to permanent exclusion.



C.9.2 Which children are most likely to be referred?

In line with our understanding of the disproportionate representation of Black children in Lambeth as those mostly likely to have a disrupted education, significantly more Black children (n=42) were referred to the FAP in comparison to children from other ethnic groups, including White children (n=12) in the year 2021/22.

In addition, boys are nearly twice as likely (62%) to be referred to the FAP than girls (38%). This disproportionality is true for all ethnic groups, apart from children from White British and Any Other Mixed background, where more girls than boys were referred.

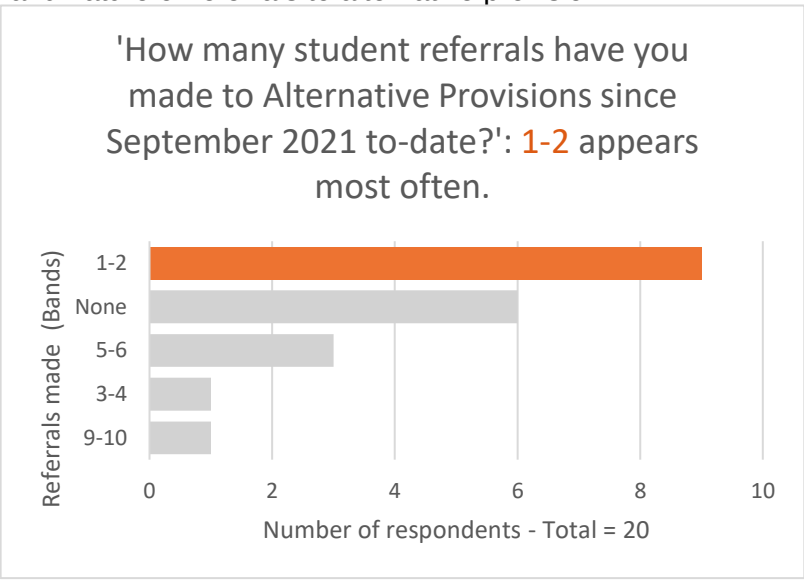


C.10 A higher proportion of children were not in education, employment, or training (NEET) in Lambeth compared to London and England

There were 5,504 young people (aged 16-17) known to be not in employment, education, or training in Lambeth in June 2018. In 2017, 10.1% of 16-17 year olds in Lambeth were NEET, compared to 6% nationally, and 5.7% in London as a whole. Lambeth performed second worst of 16 comparator boroughs on this measure. Of these 16 similar Boroughs, 8 performed significantly better than the national average. The 2017 NEET rate was a significant increase on 2016, when it was 6.4% in Lambeth, and 5.4% in London as whole, i.e., between 2016 and 2017, the NEET rate increased (worsened) in Lambeth but stayed similar for London as whole. Locally, the quality of NEET data recording has improved in recent years, it is therefore expected that the accuracy of NEET data is improving.

C.11 Referrals to offsite Alternative Provision

In order to better understand the frequency and nature of referrals to alternative provision in Lambeth. The Taskforce Chair and school leaders developed a stand-alone anonymous survey which was distributed to all school leaders.



Analysis at an individual level shows that most students referred to alternative provision are still attending. For example, for one school who had referred 9-10 pupils, 7-8 pupils remained in Alternative provision. Only 2 schools (who referred 1-2 pupils to AP) reported no longer having any pupils attending offsite AP.
Two schools reported visiting the students on a weekly basis but most reported visiting at 6-12 week intervals although all of the referring schools were receiving reports

from the AP provider on the child's progress, with some evidence of a disconnect between AP and School metrics for progress.

Providers of offsite alternative provision named by schools;

- Park Campus Academy
- Arco AP
- St Gabriel's AP
- Jus'T'Learn AP
- Kennington Park Academy

Schools rated the quality of offsite provision an average of 3.7 out of a possible 5 marks. The following responses were recorded for the question; *'Suggest how to improve the overall quality of the Alternative Providers you use'*:

- Providers to organise an 'exit report' for pupils returning to school after short term placements so that schools have a view of key aspects of their learning, attendance, punctuality and behaviour for learning
- Need more places to be made available
- Good quality accessible AP with routes back to mainstream is a vital part of the system.
- The current 'market' can be hard to navigate.
- Offer Outreach support to mainstream schools.
- Greater collaboration with Lambeth SEN in supporting students at AP's awaiting specialist placements.
- Limited places at AP's means having to use different placements that can be outside of the borough
- Ability to have blended model or short term respite with more structured route to return to mainstream
- Higher level of therapy support; similar to the model of Francis Barber (Wandsworth based PRU).
- Trauma informed approach to behaviour management
- High quality training for teachers
- Development of excellent curriculums
- Mutual access to curriculum plans and provisions to ensure students are learning in line with their peers.

C.11.1 Reasons for referral to Alternative Provision

There were 15 responses to the question '*What are the three most common reasons for making a student referral to an Alternative Provision?'*

- 100% verbal abuse
- 80% threatening behaviour against an adult
- 73% physical abuse against a pupil
- 13% sexual violence or harassment
- 6% damage
- 6% drug/alcohol

C.11.2 Reintegration in mainstream school

The maximum number of pupils, no longer attending offsite alternative provision was two (across all schools). The survey provides a snapshot, suggesting that once referred to offsite alternative provision students in Lambeth generally do not return to their referring schools.

C.12 What priority cohorts, settings, places, or outcomes have been identified?

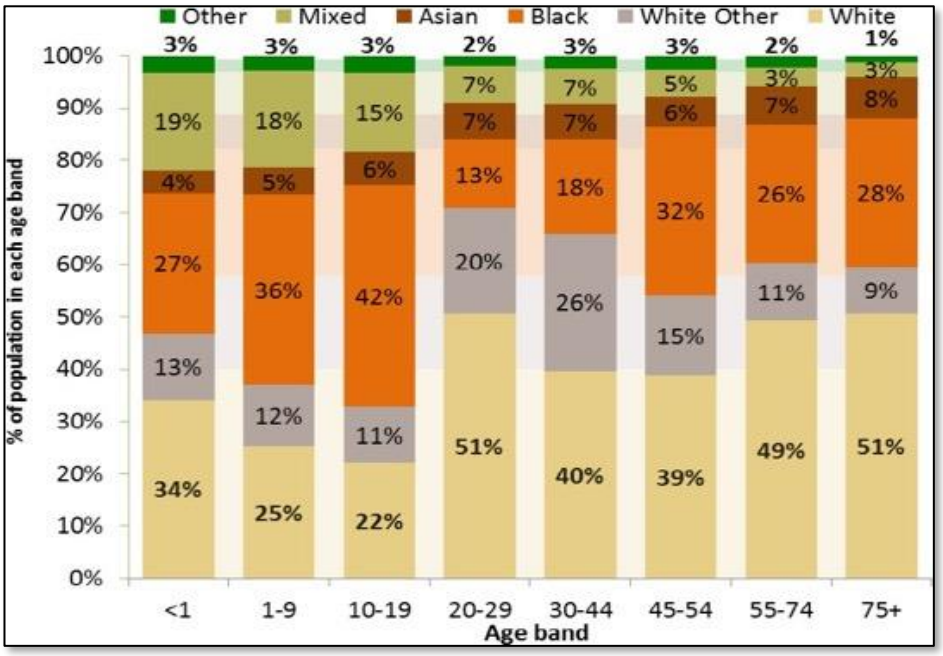
Lambeth data mirrors the wider evidence base on serious youth violence which points to disrupted education as a key factor for serious youth violence. Qualitative research with pupils and teachers has prompted a greater focus on the use of internal provision for exclusions including isolation rooms as a potential factor affecting pupil motivation.

C.13 Limitations

Further research will be needed to understand managed moves, exclusions and the referrals process in Lambeth. It is difficult to reliably measure the role of bias in deciding the outcomes of behaviour sanctions and exclusions. Research carried out on behalf of Lambeth: *'highlights the 'adultification' of black boys in which the intersection of gender and ethnicity reduces their perceived vulnerability whilst increasing their experience of school exclusion, their presence on risk panel agendas, social care and police databases and in the criminal justice system'*[35]

D. Understanding communities impacted by serious violence

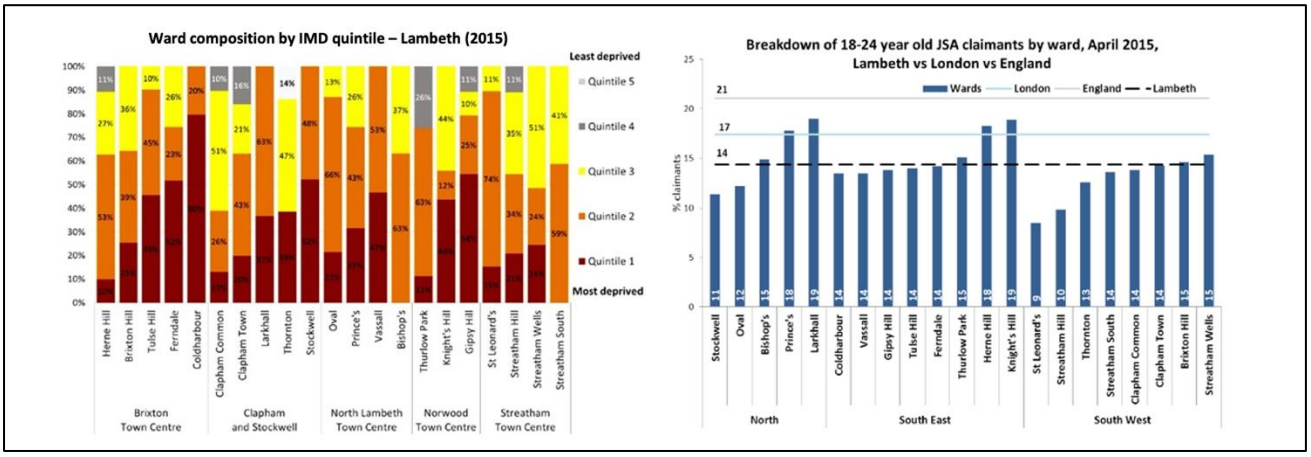
Lambeth has a diverse population, particularly among children, and a lower proportion of the population aged 10-24, compared to London and England. In the 10-19 age group, Black is the most prevalent ethnicity (42%), followed by White (22%); this is reversed for the 20-29 age group.



[35] Building Safety Safeguarding black young men and boys in Lambeth Authors: Carlene Firmin and Lauren Wroe with Jahnine Davis, Brid Featherstone, Anna Gupta, Daniel Morris, Kate Morris, and Yuval Saar-Heiman

D.1 Lambeth and deprivation and poverty

There are many highly deprived areas in Lambeth, and many types of social inequalities and crime are concentrated in these areas. Of particular note are Coldharbour, Stockwell and Vassall wards that have the highest rates of deprivation amongst residents. Nearly a quarter (23.4%) of children aged under 16 in Lambeth were living in low income families in 2016, significantly higher than the London (18.8%) and England.



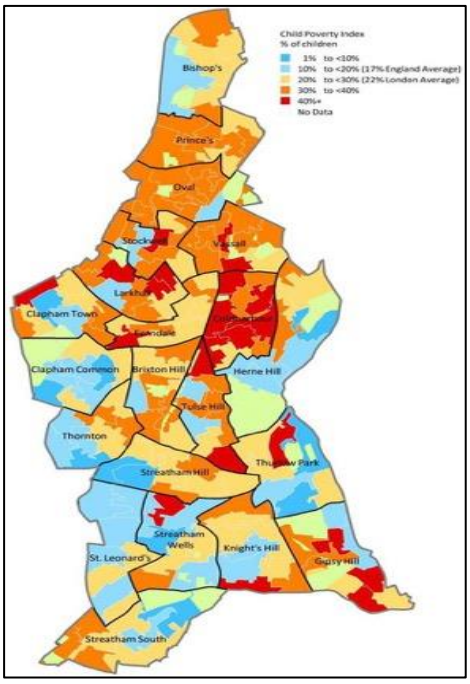
SHEU survey data indicates a rise in free school meal status (proxy for deprivation) between 2016 and 2018 as below:

- 15% ⟹ 24% currently having FSM
- 30% ⟹ 37% eligible or have previously had FSM

Lambeth ranked 13/16 comparator boroughs for the proportion of children living in income deprived households (2015 data).

On family homelessness, Lambeth shows improvement since 2011; currently Lambeth performs similarly to the national average and better than the London average.

Statutory homelessness however shows a slight increase since 2012 and similar figures for Lambeth and London.



D.2 Youth Justice Measures

There are important and unacceptable inequalities in SYV, and the risk factors associated with it. The additional vulnerability of Black children and young people reflect system- wide inequity and bias. There are also inequalities by area of the borough, gender, age group and deprivation. SYV events don't always occur in same locations that victims live. There is also an association between SYV and area deprivation. There are many wide-ranging risk factors for SYV. For many of these Lambeth performs poorly when compared to other similar areas, but for others, Lambeth performs well.

Indicator	Period	Lambeth			England	England		
		Recent Trend	Count	Value	Value	Worst/ Lowest	Range	Best/ Highest
Children in the youth justice system (10-18 yrs)	2016/17	–	-	9.6	4.8	10.5		1.5
Children aged 10 to 14 years in the youth justice system	2015/16	–	53	3.5	2.5	10.7		0.4
Young people aged 15 years in the youth justice system	2015/16	–	68	23.2	9.8	25.6		2.4
First time offenders	2017	↓	817	252.9	166.4	0.0		427.8
First time entrants to the youth justice system	2017	↓	165	687.0	292.5	687.0		104.4

Lambeth performed significantly worse than the England average and comparable Boroughs on several youth justice measures up to 2017 although there have been improvements since 2010.

Lambeth Youth Offending Service Data (young people aged up to 18)

First Time Entrants Rate per 100,000 of youth population (2019/20 data for 2018/19 cohort):
- Lambeth 408
- London 260
- Statistical neighbours 326

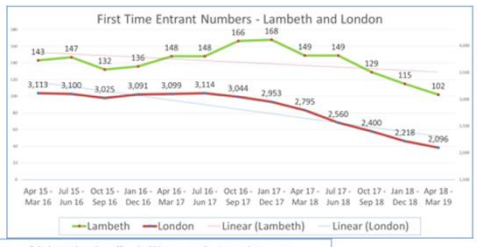
% of cohort that re-offends (2019/20 data for 2016/17 cohort):
- Lambeth 47.6%
- London 43%
- Statistical neighbours 44.6%

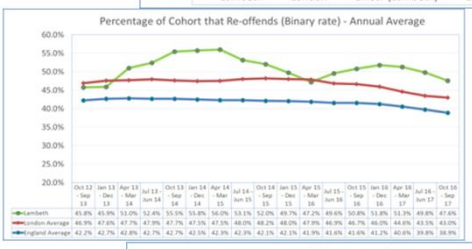
Average Re-offences per re-offender (2019/20 data for 2016/17 cohort):
- Lambeth 3.79
- London 3.68
- Statistical neighbours 3.63

Use of custody: rate per 1000 of youth population (2018/19):
- Lambeth 0.52
- London 0.40
- Statistical neighbours 0.52

% in Education/Training/Employment at the end of Referral Orders, YROs, DTO Licences (2017)
- Lambeth 2016/17 54%
- Lambeth 2017/18 58%
- Lambeth 2018/19 62%

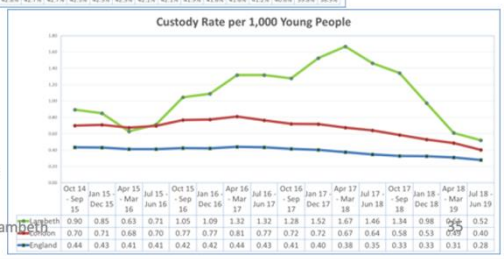
FTE → declining trend whilst London declining more quickly





% Reoffenders → consistently higher rates than London and England averages

Custody rate → significant downwards trend since 2017 whilst London and national rates have declined less quickly

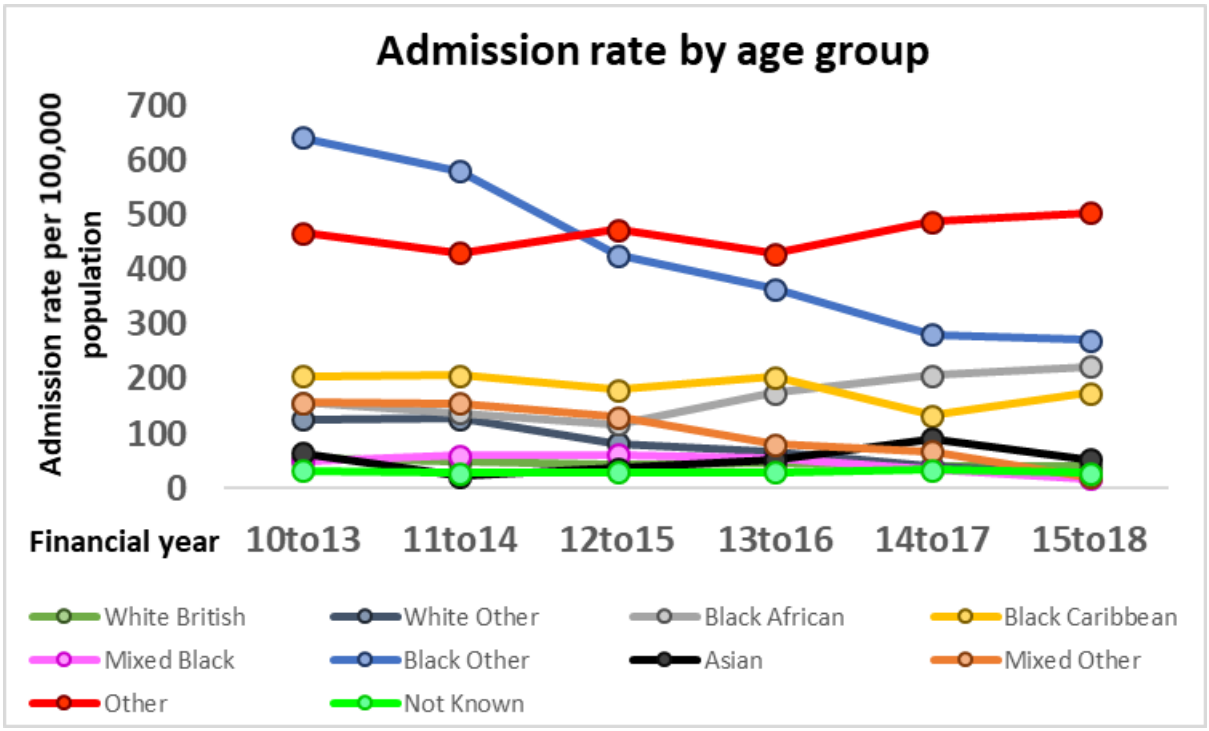


D.3 Hospital Admissions for Serious Violence

Between 2009 to 2018 there were 871 SV-related hospital admissions for young people aged 10-25 and resident in Lambeth, admitted to any hospital in England. The number of admissions fell over this period from a rate of 194.6 to 120.5 per 100,000 population. More SYV incidents occurred around Brixton and Clapham, and residents of some wards were more likely to be admitted to hospital.

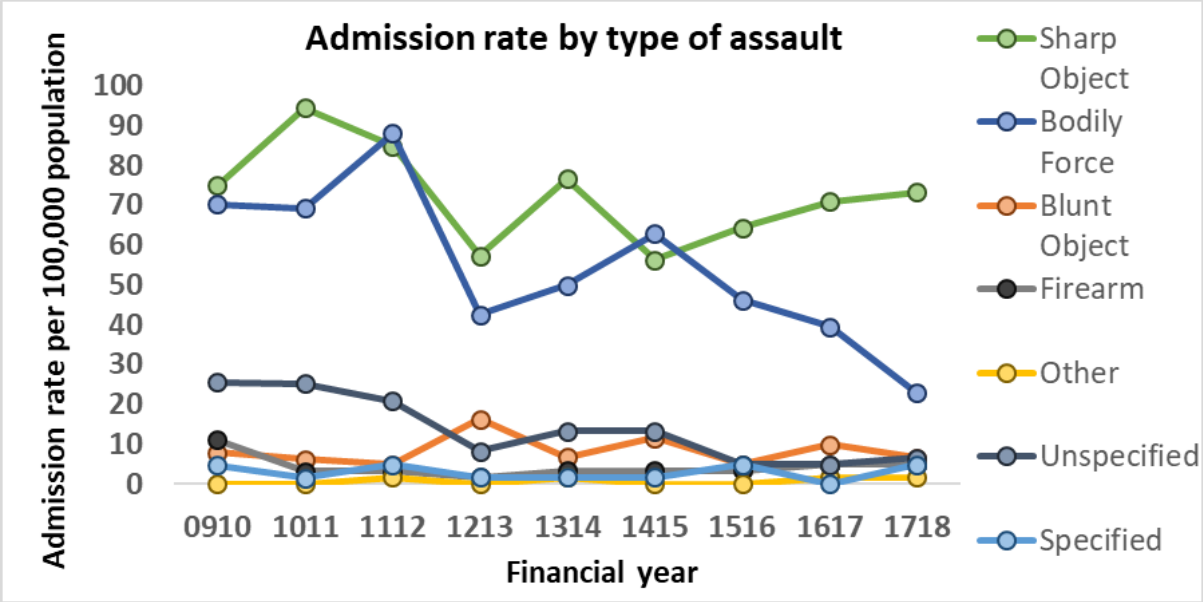
In line with our understanding of the children and young people most likely to be injured in serious violent incidents, admission rates for males are substantially higher than for females: in 2017/18 males had an admissions rate of 217.5 compared to a rate of 28.6 per 100,000 population.

Children and young people aged 16 to 25 years have consistently had the highest rates of hospital admissions compared to other age groups. There is a significantly disproportionate representation of children and young people from “Other” ethnic groups, with a rate of 503 per 100,000 (n=25 admissions in the three years 2016-18).

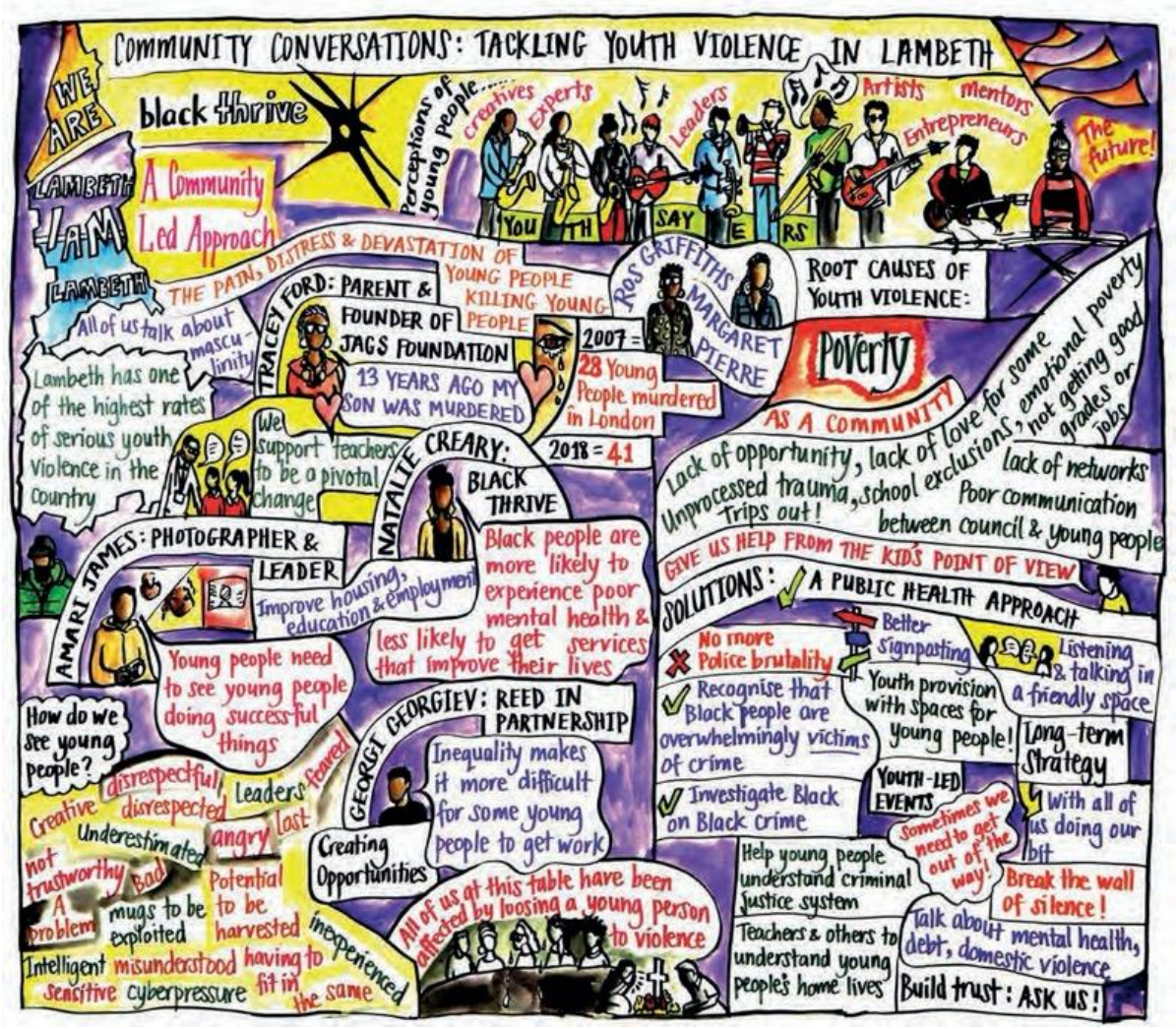


Black children and young people are also disproportionately represented with, for example, an admission rate of 222.9 (n=52). This is in stark contrast to a rate of 40 per 100,000 for White British children and young people over the same period.

While admissions for assault by bodily force have reduced between 2014 and 2018, admissions for assault by a sharp object have increased in direct contrast.



D.4 Wider community perspectives on serious youth violence



D.6. What priority cohorts, settings, places, or outcomes have been identified?

Lambeth sees serious youth violence as a public health issue and as such have a range of immediate priorities linked to the wider community. Listed below, are those that relate directly to the target areas identified as part of this needs assessment[36]:

Becoming a Trauma Informed Council:
Recognising the need to become more aware of the support needed by residents, colleagues and partners, the Council will develop practices to ensure it becomes more Trauma Informed. Training around this theme has already taken place across Children's Services and Community Safety.

Reducing Family Conflict:
We know there is a need to provide support packages for families that can improve relations within their unit, but greater awareness within the Lambeth workforce (and its contractors) of identifying

[36] SERIOUS YOUTH VIOLENCE WORKSTREAM

and addressing family conflict is required. Using the existing packages made available through the commissioned DWP Family Conflict Reduction programme we can increase the number of families being referred to these interventions and use outcome evidence to understand the local picture of family conflict and the root causes in Lambeth (e.g. finances, disciplining of children and intimacy).

Tackling Domestic Violence:
We have to obtain a greater understanding of the links between domestic violence perpetrated by young people on their partners, parents and family members and Serious Youth Violence at a local level and the demands this places on early intervention workers. Having researched this, we will develop a tiered pathway for family conflict and domestic violence based on scale and need.

Reduction in Contextual Harm Experience:
We know that there is a need to develop capacity within the community to address violence, abuse and intimidation outside of the home. More evidence needs to be gathered to identify the gaps in provision and awareness. Once the gap analysis has been completed we will identify the areas of need with a view to developing a pilot project through the Early Help locality model.

Emotional resilience:
The role of families, friends and the local community is key to developing strong support mechanisms when required. Therefore, we are identifying the gaps in provision and reviewing how aware residents and partners are of the services already in place. Once the gap analysis has been completed, we will identify the areas of need with a view to developing a pilot project through the Early Help locality model.

E. Identifying young people in close proximity to serious violence

Below is a list of priority needs with associated risk and protective factors, evidenced in the relevant studies referenced in the body of this report and in the statutory data. It is important to note that risk factors and protective factors are not established as direct causes of violence but rather they are signals of risk for the outcome. The association is based on probability at a population level.

E.1 Exploitation and Modern Slavery:

Data from Lambeth suggests that a portion of SYV is associated with organised crime with a strong link to drug supply. The Met police guidance sees organised crime as distinct from ‘gangs’.

Risk factors include:

- Persistent absence
- Financial pressures within the family (particularly food insecurity)
- Withdrawal from school and from positive peer relationships
- One or more family members know to be involved in organized crime
- Newly arrived in the UK or insecure immigration status
- Family instability

Protective factors include: Positive home school connection, strong school/multi agency relationships including police, ability to recognise and respond to coercive behaviour, knowledge of consent, financial support for families.

E.2 Weapons Possession:

Data suggests that a high proportion of offences relate to weapons possession. The majority of offenders and victims are Black young men, in particular from Caribbean backgrounds with evidence that White British boys and African boys are also involved as either victim/offender.

Risk factors include:

- Previous experiences of violence including but not limited to as the victim of knife crime
- Disrupted education
- Family instability which may include neglect and harsh discipline or hypervigilance
- Dependent relationships observed within the peer group and evidence of bullying
- Presence of anxiety, rumination and internalizing or externalising behaviours
- Sustained persistent absence above and below the 95% threshold

Protective factors include:
School based caregiving relationships, strong home school connection, positive peer group relationships, respect for authority.

E.3 Disrupted Education:

Data from Lambeth and broader academic research supports a strong relationship between disrupted education and youth violence.

Risk factors include:

- Poor primary/secondary transition experience:
- Exclusion, suspension, sanctions, internal isolation and reintegration provision, elective home education
- Managed moves, persistent absence, truancy, emotion-based school avoidance
- Negative school experience, School home/connection, high staff turnover resulting in lack of consistent trusted adult in school

Protective factors include:
School based caregiving relationships, strong goal orientation, strong home school connection, positive peer group relationships, respect for authority, attainment

E.4 SEND Support/Oracy/Communication:

High prevalence of diagnosed SEND 44% in offender cohort particularly ADHD and SLCN.

Risk factors include:

- Difficulty communicating with authority figures not limited to police and school staff
- Difficulty communicating with peers
- Potential for lower attainment
- Vulnerable to exploitation as victim and offender

Protective Factors: Specialist therapeutic support, oracy and literacy support, metacognition, positive peer relationships, boundaries and consent.

E.5 Priority Needs

Priority need	Why has this cohort, place or outcome been prioritised?

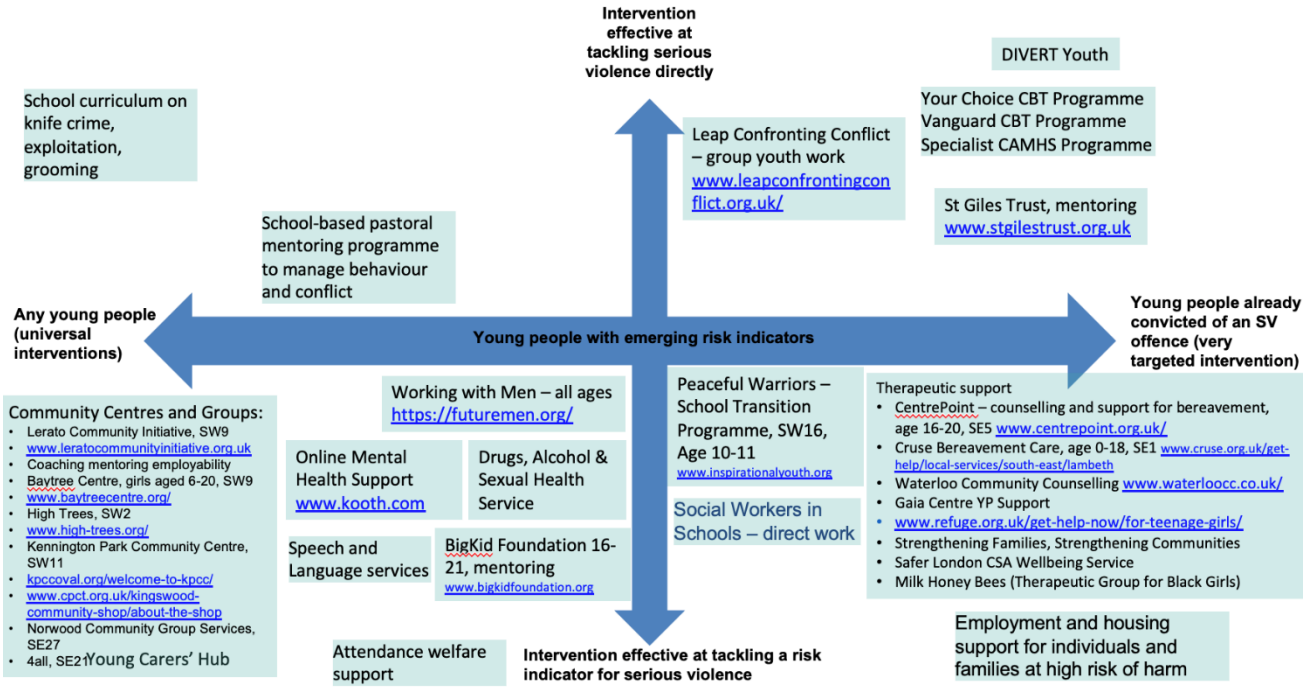
Knife enabled youth violence (including possession)	Over the last year, 88 children and young people (0-24yrs) were victims of a knife injury in Lambeth. In the five month period analysed (November 2021-March 2022), there were a total of 107 SYV victims recorded. In the last year, there were 260 offences for possession of a knife in Lambeth. Schools and Lambeth local authority should also work together to identify offenders and victims who are not currently receiving support from Social Care (41%) and or the Youth Justice Service (37%). The majority of SYV offenders identify as male Black Caribbean (47% n= 22). The second largest groups were male White (British, English, European and Other n= 9) and Black (African and Other n= 7).
Complex needs (Diagnosed and Undiagnosed)	40% of SYV offenders and 44% victims in Lambeth had been diagnosed with SEND 40%, particularly ADHD and Speech and Language. Clegg et al's [37](2005) longitudinal study showed that one third of children with SLCN will develop mental health problems if untreated, with criminal involvement in over half of cases. it is recognised that at least sixty per cent of young people accessing youth justice services, in the UK, have speech, language and communication needs (SLCN)[38]. Meta-analyses of 42 prisons, based on international data derived from symptom-based clinical diagnostic interviews, indicated that 25.5% of the prison population overall met diagnostic criteria for ADHD.
Disrupted education	54% of these children had a disrupted education under age 16, with significant periods of time not attending school/accessing an education. 53% had been to more than one secondary school. Qualitative research from Lambeth demonstrates that the issue is broader than PEX. We recommend the development of a criteria for 'days lost of education' which includes time spent in internal exclusion. Black British Caribbean children are also more likely to be persistently absent from secondary school (20.3%), closely followed by White British children (15.7%). Both groups have a similar likelihood of unauthorised absence, 2.3% and 2% respectively. Secondary average = 13%.
Trauma and instability in family and close relationships	From the case records, it is known that 85% of the children found to have committed offences related to serious violence had experienced previous trauma, including: 43% had previously been injured in violence outside of the home (n= 20), 32% had experienced domestic abuse (n= 15), 23% had a friend of family member seriously injured (n= 11), 15% had a family member with a history of offending. Pupil qualitative interviews and the parent and teacher surveys show a complex picture of anxiety, rumination and poor mental health as well as racism, classism, bias, poverty and other forms of persistent intergenerational trauma.

[37] CLEGG, J., HOLLIS, C., MAWHOOD, L. and RUTTER, M., 2005, Developmental Language Disorders - a follow-up in later adult life. Cognitive, language and psychosocial outcomes. Journal of Child Psychology and Psychiatry, 46, 128-149.

[38] GREGORY, J. and BRYAN, K., 2011, Speech and language therapy intervention with a group of persistent and prolific young offenders in a noncustodial setting with previously undiagnosed speech, language and communication difficulties. International Journal of Language and Communication Disorders, 46, 202-215.

F. Understanding our existing service landscape

It is important to note, that the successful delivery of interventions is contingent on effectively balancing the need for specialist targeted approaches and universal school based provision. The taskforce is aware that this may require going outside of the providers listed below.



Specialist Interventions & Mental Health Support for Children & Young Adults at Risk of Contextual Harm

Mental Health & Counselling

The Well Centre, (11-20) SE24
Mental, physical, sexual health hub
www.thewellcentre.org/referrals

CentrePoint, (16-20) SE5
Counselling and support for bereavement
www.centrepoint.org.uk

Cruse Bereavement Care, (0-18) SE1
www.cruse.org.uk/get-help/local-services/south-east/lambeth

Kooth, (all ages) www.kooth.com
Free & anonymous online counselling

Waterloo Community Counselling, (all ages)
No/low cost psychotherapy & counselling
www.waterloocc.co.uk

Other specialist support

Gaia Centre Young Women's Support
Specialist support for girls (13-17) & support for all victim/survivors of domestic abuse
T: 020 7733 8724
E: lambethvawg@refuge.org.uk

Drug, Alcohol & Sexual Health (DASH) Services (11-21)
T: 07917460749 E: lambeth@brook.org.uk

Young Carers' Hub (5-21)
Tailored support, monthly meetups, weekly clubs www.carershub.org.uk

Contextual Harm Specialist Support

BigKid Foundation, SE24 (16-21)
Mentoring with a focus on transitions. For referrals, email www.bigkidfoundation.org

Juvenis, (11-25)
Mentoring and support. For referrals, email info@juvenis.org.uk

Leap Confronting Conflict (18-25)
Group work, 1:1 coaching & peer mentoring, Referrals:
www.leapconfrontingconflict.org.uk/get-involved/expressions-interest

Milk & Honey Bees, (11-25)
Female led, expressive safe space that aims to allow young women to feel empowered and heal from their experiences. For referrals,
www.milkhoneybees.co.uk/contact

Peaceful Warriors (10-11) & Warrior Mindset (13-15) SW16
Using martial arts to support transitions, Referrals: info@inspirationalyouth.org

Safer London, (11-25)
1:1 support, housing advocacy, emotional wellbeing, parent/carer support, CSA support
referralandassessmentteam@saferlondon.org.uk

St Giles Trust (11-25)
Mentoring and support. For referrals, please email Colin Newman, Community Safety Manager: cnewman@lambeth.gov.uk.

South Central Youth, (12-19)
Activities, specialist interventions, trauma support www.sc-youth.co.uk

Vanguard (11-25)
Referral details coming soon

Your Choice (11-17)
Mentoring using CBT tools to set goals and engage in positive activities. Referrals:
www.lambethsaferchildren.org.uk/yourchoice

Interventions for Reachable Moments

DIVERT (18-25) & Divert Youth (10-18)
Mentoring offered to children or young adults in police custody. Adults: info@divert-partnership.com Children: info@juvenis.org.uk

Oasis Youth Workers, Guy's & St Thomas'
Hospital-based youth work for those injured in violent incidents.
oasisyouthsupport@gstt.nhs.uk

RedThread (11-24) King's College Hospital
Hospital-based youth work for those injured in violent incidents. T: 0203 299 5439

Rescue & Response (up to 25)
Specialist support for those who are being exploited by County Lines Referral form

Support for families

Strengthening Families, Strengthening Communities
13 week group programme, Registration:
www.beta.lambeth.gov.uk/forms/register-with-our-parenting-support-service

Family Group Conferences
Facilitated discussions for wider family networks. Referrals must be made via the Social Worker and on Mosaic.

Not currently commissioned, but funded referrals can be made

Future Men (all ages)
Specialist support for boys & young men
www.futuremen.org

Project 507
Intensive 1-2-1 trauma-informed support for young people who have been sentenced for violence-related offences www.project507.org

Power the Fight
Culturally competent therapeutic, financial and legal support. hello@powerthefight.org.uk

Project YANA (12-25)
Specialist programme to support young people with unresolved trauma.
www.jennisteele.co.uk/yana-project

Summary

It is clear that the escalation of serious youth violence in Lambeth presents a major risk to young people's safety and healthy development, as well as the quality of life and well-being of families and the wider community. Strategic responses have been developed in Lambeth (notably since 2015[39]) with involvement from schools in some existing groups and forums.

A key aim of this needs assessment has been to identify areas in which schools are well placed for intervention, in some cases as first responders, forming part of a longer term multi agency approach. Much of this is premised on schools' unique position to be able to observe risk factors such as SLCN and ADHD, current and historic episodes of violence and bullying and internalised and externalised risk related behaviours.

Schools are also in a strong position to directly influence protective factors against serious youth violence, and it is important that an understanding of protective factors informs any universal (or broadly targeted) element of intervention for example peer mentoring and communication, or sports based cognitive behavioural therapy.

Additional resource will also allow schools to provide highly targeted support to the families most at risk of currently involved in serious youth violence through multi systemic therapy. This method offers considerable potential for longer term positive outcomes by removing the barriers to support across generations and in some cases addressing relationship breakdown with practitioners as well as family members.

Schools also play a direct role in influencing important factors such as 'school connection', motivation' and 'teacher self-efficacy'. These are stand-alone factors which influence school performance and school experience but are also risk factors for disrupted education and school dropout. These risk factors are known to have a strong association with youth violence.

Finally, there is a pressing need to address the disconnect between young people's and some practitioner's perceptions of day to day life in Lambeth. It is clear that young people feel that they are associated with crime regardless of their actual proximity to violence. They perceive this as shaping every day interactions with adults and report that they feel it is disproportionate to the actual prevalence of youth violence in Lambeth.

Both teachers and pupils report sanctions based behaviour management as a factor affecting motivation and school connection and a mechanism for review of this provision has been suggested in the executive summary and body of this report.

Pupils, parents, teachers, and school leaders share a common concern regarding the extent to which race, and socio-economic status are linked to negative long term outcomes for young people including youth violence. It should be noted however, that lack of consideration of families lived experiences of violence, racism, and poverty in the design of interventions and strategy is a factor in unsuccessful delivery.

Much of the statutory data included in this report was collated by Connie Wessels, Contextual Safeguarding Programme Delivery Manager, Lambeth Children's Services who has played a central role in the development of this Needs Assessment. A full data pack, which illustrates each factor in more detail, is included as an appendix to this document and any sources not listed in the footnotes for this report can be found there.

[39] 2015 Violence Needs Assessment for Lambeth