Open Agenda

Health and Wellbeing Board

Thursday 20 July 2023
3.00 pm
Room 225, 160 Tooley Street, London SE1 2QH / HYBRID

Membership

Councillor Kieron Williams (Chair)	Leader of the Council
Dr Nancy Kuchemann (Vice-Chair)	Co-Chair Partnership Southwark and Joint Chair of the Clinical and Care Professional Leadership Group
Councillor Evelyn Akoto	Cabinet Member for Health and Wellbeing
Councillor Jasmine Ali	Deputy Leader and Cabinet Member for Children, Education and Refugees
Councillor Maria Linforth-Hall	Opposition Spokesperson for Health
Anood Al-Samerai	Chair, Community Southwark
Sarah Austin	Chief Executive Integrated and Specialist Medicine for Guy's and St Thomas' NHS Foundation Trust
David Bradley	Chief Executive of South London and Maudsley NHS Foundation Trust
Cassie Buchanan	Southwark Headteachers Representative
Anna Garrod	Guy's and St. Thomas' Foundation, Director of Policy and Influencing
Clive Kay	Chief Executive, King's College Hospital NHS Foundation Trust
Sangeeta Leahy	Director of Public Health , Southwark
Althea Loderick	Chief Executive, Southwark Council
James Lowell	Place Executive Lead
Sheona St Hilaire	Chair, Healthwatch Southwark
David Quirke-Thornton	Strategic Director of Children's and Adults' Services
Alasdair Smith	Director of Children and Families
Martin Wilkinson	Chief Operating Officer, Southwark, NHS SEL Integrated Care Board

INFORMATION FOR MEMBERS OF THE PUBLIC

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Contact

Email: maria.lugangira@southwark.gov.uk
Webpage: Health and Wellbeing Board - Southwark Council

Members of the committee are summoned to attend this meeting
Althea Loderick
Chief Executive
Date: 12 July 2023

PRINTED ON RECYCLED PAPER

Health and Wellbeing Board

Thursday 20 July 2023
3.00 pm
Room 225, 160 Tooley Street, London SE1 2QH / HYBRID

Order of Business

Item No.	Title	Page No.
1.	**WELCOME AND INTRODUCTIONS**	
2.	**APOLOGIES** To receive any apologies for absence.	
3.	**CONFIRMATION OF VOTING MEMBERS** Voting members of the committee to be confirmed at this point in the meeting.	
4.	**NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT** In special circumstances, an item of business may be added to an agenda within five clear days of the meeting.	
5.	**DISCLOSURE OF INTERESTS AND DISPENSATIONS** Members of the committee to declare any interests and dispensation in respect of any item of business to be considered at this meeting.	
6.	**MINUTES** To agree as a correct record the open minutes of the meeting held on 16 March 2023.	1 - 5
7.	**PUBLIC QUESTION TIME (15 MINUTES)** To receive any question from members of the public which have been submitted in advance of the meeting in accordance with the procedure rules.	
8.	**COMMUNITY UPDATE: BUILDING TRUST THROUGH COMMUNITY ENGAGEMENT**	6 - 15

Date: 12 July 2023

Open Agenda Agenda Item 6

HEALTH AND WELLBEING BOARD

MINUTES of the Health and Wellbeing Board held on Thursday 16 March 2023 at 10.00 am at This is a Hybrid meeting

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PRESENT:
Councillor Kieron Williams (Chair)
Dr Nancy Kuchemann (Vice-Chair)
Councillor Evelyn Akoto
Councillor Jasmine Ali
Councillor Dora Dixon-Fyle MBE
Councillor Maria Linforth-Hall
Cassie Buchanan
Nabil Jamshed (substituting for Sarah Austin)
Sangeeta Leahy
James Lowell
Sheona St Hilaire
Alasdair Smith
David Quirke-Thornton
Martin Wilkinson

OFFICER SUPPORT:
Chris Williamson – Head of Health and Wellbeing
Maria Lugangira – Principal Constitutional Officer

1. WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

2. APOLOGIES

Apologies for absence were received from;

- Anood Al-Samerai
- Sarah Austin
- Clive Kay
- Althea Loderick

3. CONFIRMATION OF VOTING MEMBERS

Those listed as present were confirmed as the voting members.

4. NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

There were none.

5. DISCLOSURE OF INTERESTS AND DISPENSATIONS

There were none.

6. MINUTES

RESOLVED - That the minutes of the meeting held on 30 January 2023, be approved as a correct record of the meeting.

7. PUBLIC QUESTION TIME (15 MINUTES)

There were none.

8. COMMUNITY UPDATE: THE NEST

The Board received a presentation from Groundwork's, Hannah Kashman. The focus of the presentation centred on the work of the Nest and the mental health support provided to schools.

Hannah provided the Board with an overview of who the Nest are:

- The aim of the Nest is to provide a service to young people at the point of need, without the need for a professional referral. They offer early intervention and prevention for emotional issues and low-level mental health such as worries, anxieties and stress.

- They also provide young people and families with the opportunities, experiences, and tools to enable them to develop their physical, emotional and social capabilities. Through their non-clinical intervention, they offer support such as youth work, person-centred counselling, psychological wellbeing practices and traditional talking therapies via 1:1 sessions, group work, virtual resources and peer mentoring.

The Board were also presented with a number of key highlights with regards to the support provided by the Nest to pupils who faced school exclusion and the successful outcome of having the decision overturned

The Board thanked Hannah for the insightful presentation and highlighting the much important service provided by the Nest

9. CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH SUPPORT IN SCHOOLS

The Board considered the report, which detailed the mental health support provided to children and young people in schools.

The report covered the four main programmes of support in schools:

1. Improving Mental Health and Resilience in Schools (IMHARS)
2. Youth New Deal
3. Kooth
4. Mental Health Support Team (MHST)

RESOLVED - That the Health and Wellbeing Board note the progress being made to support children and young people's mental health in schools.

10. MENTAL HEALTH AND WELLBEING OF ADULTS

The Board considered the report, which detailed the work being undertaken to ensure that local people have access to mental health and wellbeing services in Southwark.

The Board also received a presentation that, covered in detail the following;

- Programme overview –strategic context and outcome framework
- Achievements to date
- Engagement approach
- Community model and workforce structure
- Current workstreams The Wellbeing Hub plus neighbourhood outreach pilot

RESOLVED - That the Health and Wellbeing Board note the update and progress being made to support and ensure that local people have access to mental health and wellbeing services in Southwark.

11. AIR QUALITY ACTION PLAN 2023 - 2027, AIR QUALITY MANAGEMENT AREA EXTENSION, AND AIR QUALITY JOINT STRATEGIC NEEDS ASSESSMENT

The Board considered the report, which details the Air Quality Joint Strategic Needs Assessment, that aims provide holistic understanding of air quality in the

borough and its impact on the health of local people.

The Air Quality Action Plan 2023 - 2027 was developed through internal and Lead Member consultation that commenced in 2021, and public consultation during 2022. Public Health were a key partner in the consultation, and the emerging JSNA helped to shape the Air Quality Action Plan 2023 – 2027.

The Plan 2023 - 2027 lists the actions that the council will take to reduce air pollution emissions, to reduce exposure to poor air quality, and to educate people on how to mitigate the effects of poor air quality on their health. The actions are assigned to multiple different teams widely across the council.

RESOLVED - The Southwark Health and Wellbeing Board noted the new Air Quality Action Plan 2023 – 2027, extension to the Air Quality Management Area (AQMA), and recently updated Air Quality Joint Strategic Needs Assessment (JSNA)

12. COVID-19 MONITORING REPORT

The Board considered the COVID-19 monitoring report, which presented headline statistics for current local and regional COVID-19 data.

Key headline messages:

- The number of confirmed cases across Southwark, London and England increased over the past fortnight with the Office for National Statistics (ONS) estimating a rise in infections across London.
    - Southwark had 84 confirmed cases of COVID-19 in the week to 25 February.
    - ONS estimated that infections had increased substantially over the past fortnight, with 1 in 35 people in London estimated to have COVID-19 as at 21 February.

- The number of hospital inpatients with COVID-19 across London increased in recent weeks
    - Across London there were around 1,300 hospital impatiens with COVID-19, with the local trusts seeing the number of COVID-19 inpatients stabilise.

- Over 48,000 Southwark GP-registered patients had received their autumn booster does of the COVID-19 Vaccine.

RESOLVED – That the Health and Wellbeing Board note the contents of the COVID-19 Monitoring Report.

13. ANY OTHER BUSINESS

There was none.

Meeting ended at 12.00 pm

CHAIR:

DATED:

Agenda Item 8

Item No. 8	Classification: Open	Date: 20 July 2023	Meeting Name: Health and Wellbeing Board
Report title:		Community Update: Building Trust Through Community Engagement	
Ward(s) or groups affected:		All Southwark wards and population groups	
From:		Sangeeta Leahy - Director of Public Health Southwark Council	

RECOMMENDATION(S)

1. The Southwark Health and Wellbeing Board note the recommendations from the project undertaken by Social Finance and Centric.

2. The Health and Wellbeing Board consider any additional actions that could be taken to embed the recommendations and ensure they are central to future engagement work.

BACKGROUND INFORMATION

3. The disproportionate impact of the COVID-19 pandemic exposed long-standing inequalities that affect Black, Asian and minority ethnic communities. Southwark Stands Together (SST) is Southwark Council's initiative established in response to the killing of George Floyd, the injustice and racism experienced by Black, Asian and minority ethnic communities, and to the inequalities exposed by COVID-19.

4. Initial engagement through SST highlighted that distrust in health and care services can exacerbate existing health inequalities. Through this engagement, local residents shared that distrust can stem from:

    - Poor experiences of services
    - Lack of continuous feedback loops in previous engagement work
    - The long-term impact of colonialism, racist medical practices and racism denial.

5. Southwark Council commissioned Social Finance and Centric to explore how the health and care system can strengthen its engagement work to rebuild trust.

6. Social Finance have experience in projects aimed at bridging the gap between statutory bodies and communities. Social Finance led on the project management and system engagement approach for this work.

7. Centric's model of community research trains up local people as community researchers, empowering them to take ownership of research in their own communities. This allows local people to engage with their networks, maximising the reach of the research. Centric led on the community engagement approach for this work.

8. During this work, Centric recruited six community researchers from Southwark to conduct one-to-one interviews with 30 residents. These interviews explored health and wellbeing issues that matter to residents, with the interview guide shaped by previous engagement and Southwark's Health and Wellbeing Strategy. Results from the interviews were then explored further during two workshops, each attended by 40-50 people. Attendees at the workshops included local residents and representatives from Southwark Council, South East London ICB, South London and Maudsley NHS Foundation Trust and voluntary and community sector organisations. Two further sense-making workshops were held to analyse emerging findings and co-develop recommendations.

9. This work was delivered between April – December 2022.

KEY ISSUES FOR CONSIDERATION

Recommendations

10. Six recommendations were developed through this work. These describe principles to prioritise in engagement work and reflect what local communities said was important to rebuild trust:

    a. Demonstrable commitment to on-going engagement**:** There should be demonstrable commitment to embed continuous engagement with the community at every stage of research, design and delivery. Accountability mechanisms should be explicit within this process, with transparent decision-making.

    b. Connected engagement work: Health and care partners should avoid approaching communities on issues specific to their organisations. Community engagement should be joined-up across organisations, allowing people to engage at a full-system level.

    c. Language and terminology: Health and care organisations should examine the language they use when working with seldom-heard communities. Inclusive and accessible language is a key part of promoting a 'no wrong door' approach to meeting needs. Reducing the use of technical terms can help residents engage as equal partners.

    d. Outreach: People working within health and care organisations should prioritise visiting community spaces and groups to engage, listen and

build relationships with residents.

e. Investment in community capabilities and training: Upskilling people to participate in engagement confidently can help to empower communities. The community-research model is one way to do this.

f. Funding for voluntary and community sector: Measures should be taken to reduce barriers to funding for small organisations that are well-connected to the local community. Involving local communities and the voluntary and community sector in decision-making around funding allocation can help to shift power dynamics.

Next steps

11. This work has been shared with health and care partners through partnership engagement meetings. This should allow individual organisations to consider how the principles can be followed in future engagement work and connect community engagement work across organisations, helping to embed the second recommendation.

12. These recommendations have also helped to shape Partnership Southwark's approach to incorporating lived experience into ways of working. This was an explicit focus of the first workshop. Learning from the work is now being tested through the 1,001 days co-production approach. Five voluntary and community sector organisations were recently paid to sit on the decision-making panel for Partnership Southwark's Neighbourhood Grants panel, testing the final recommendation.

13. Community research forms part of Southwark Council's application for National Institute for Health and Care Research (NIHR) funding to become a research-driven organisation ('Southwark Collaboration for Research and Evaluation'). If the bid is successful, there will be an opportunity to empower communities by further embedding and expanding community research activity within Southwark, and facilitating access to learning opportunities through a wider collaboration with university and community partners.

14. A summary of this work will be published on South East London Integrated Care System's website to ensure learning is shared.

Policy framework implications

15. 'Strong and Connected Communities' is one of the five drive areas in Southwark's Joint Health and Wellbeing Strategy. An aim within the strategy is to, 'Ensure people shape their local areas and services through collaboration and co-design.' The insights from this work should help health and care partners in their on-going engagement work, particularly in work with communities where distrust is a barrier to working together.

16. The South East London ICS People and Communities Strategic Framework sets out three commitments in engagement work – being accountable and transparent, decision-making and priority setting in partnership with people and communities, and working with communities in new ways to transform health and care. This framework mirrors the recommendations from the project.

17. This work is in line with Southwark Council's Delivery Plan, particularly the principle of 'Creating a People-Powered Southwark'.

Community, equalities (including socio-economic) and health impacts

Community impact statement

18. Embedding the recommendations into health and care partners' ways of working should help to give a voice to communities who can be underrepresented in engagement work.

Equalities (including socio-economic) impact statement

19. This work explored how to build trust between local residents and health and care partners through engagement, focusing on Black, Asian and minority ethnic communities in particular. Distrust in services can be a barrier for a number of disadvantaged groups and the recommendations can be embedded across engagement work.

Health impact statement

20. Lack of trust in health and care partners can exacerbate existing health inequalities. This work started from the assumption that building trust is a core part of work to deliver better health outcomes for Black, Asian and minority ethnic communities.

Climate change implications

21. There are no immediate climate change implications.

Resource implications

22. There are no resource implications as a direct outcome of this report.

Legal implications

23. There are no legal implications.

Financial implications

24. There are no financial implications.

Consultation

25. This report summarises the findings of engagement work.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
Southwark Joint Health and Wellbeing Strategy 2022-27 https://www.southwark.gov.uk/assets/attach/177533/Southwark-s-Joint-Health-Wellbeing-Strategy-2022-27.pdf	Public Health Division, Children and Adults Department	Rebecca Harkes, 020 7525 5000

APPENDICES

No.	Title
Appendix 1	Building trust through community engagement – Summary report

AUDIT TRAIL

Lead Officer	Sangeeta Leahy, Director of Public Health
Report Author	Rebecca Harkes, Policy Officer for Health Inequalities
Version	Final
Dated	07 July 2023
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Assistant Chief Executive - Governance and Assurance	No	No
Strategic Director of Finance and Governance	No	No
Cabinet Member	No	No
Date final report sent to Constitutional Team		7 July 2023

APPENDIX 1

Building trust through community engagement

Summary report

Southwark Public Health Division
Children's and Adults' Services

July 2023

BUILDING TRUST THROUGH COMMUNITY ENGAGEMENT – SUMMARY REPORT

Introduction

This report provides a summary of a project to explore how the health and care system can strengthen its engagement work with local communities to build trust.

Background

Southwark Stands Together (SST) is the borough wide initiative established in response to the killing of George Floyd, the injustice and racism experienced by Black, Asian and minority ethnic communities, and to the inequalities exposed by COVID-19.

Engagement through SST explored how loss of trust in services can exacerbate existing health inequalities. This was raised in relation to three broad issues:

- Poor experiences of services – One third of ethnic minority respondents to a survey conducted for SST had experienced racial discrimination in health and care services, compared to 9% of white British respondents[i]. Poor experiences of services can lead to loss of trust from individuals and their networks.
- Lack of continuous feedback loops in previous engagement work – The importance of maintaining engagement with the community and keeping an open line of communication was raised through SST.
- The long-term impact of colonialism, institutional racism and racism denial – Communities emphasised the importance of understanding issues of trust in the broader context of colonialism, institutional racism and racism denial shaping the experiences of people from Black, Asian and minority ethnic communities.

Southwark Council commissioned Social Finance and Centric to develop and test approaches to community engagement and co-production with seldom-heard communities. The purpose of this work was to ensure that work by statutory organisations to address health inequalities embeds the priorities and work of local communities. A focus was to explore long-term engagement methods that build trust in services and decision-making.

Social Finance have experience in projects aimed at bridging the gap between statutory bodies and communities. Social Finance led on the project management and system engagement approach for this work. Centric's model of community research trains up local people as community researchers, empowering them to take ownership of research in their own communities. Centric led on the community engagement approach for this work.

Methods

A steering group was established to shape this work, including members of South East London ICB and Southwark Council's Communities and Public Health teams.

The stages of the project were as follows:

1) One-to-one interviews: Six community researchers were recruited from Southwark to conduct one-to-one interviews with 30 residents. These interviews helped to identify

health and wellbeing issues that were important to local people, with a focus on how they would like to work with the health and care system to address these issues.

2) Workshops: Two workshops were then developed, using themes from the interviews to shape the content. Each workshop was attended by 40-50 people, bringing together local residents and representatives from Southwark Council, South East London ICB, South London and Maudsley NHS Foundation Trust and voluntary and community sector organisations. Workshops were co-designed with community researchers to ensure the agenda, timings, format and location would be conducive to meaningful conversations.

3) Sense-making: Two further sense-making workshops were held to analyse emerging findings and co-develop recommendations.

4) Feedback: Recommendations were fed back to the steering group. Residents who had engaged with this work were invited to a meeting to hear the recommendations and a summary of the next steps.

This work was delivered between April – December 2022.

Findings

Trust

A wide range of reasons for mistrust were surfaced during the interviews and workshops. These included power imbalances between residents and statutory organisations, feedback systems being perceived as inaccessible, the disproportionate impact of COVID-19 and strongly held beliefs that the health (including mental health) of Black communities is less well understood. Issues raised included poor cultural understanding, inappropriate care and experiences of racism. A key reason for mistrust was experiences of residents being consulted for their views with limited feedback loops about what actions had been taken in response.

Engagement on singular issues

During the project, residents typically wanted to speak about multiple issues when given the opportunity to have conversations that are important to them. Issues of health and wellbeing were intertwined with related issues such as housing, cost of living, and employment. Engagement on single issues has less resonance with communities, especially those experiencing multiple disadvantage who had compounding needs. Most participants felt that engagement events should be an opportunity to share their experience of navigating the multiple parts of the system and felt that a single issue focus was constraining.

Language

The workshops reinforced the need to consider the role of language within participatory processes. Participants highlighted that many residents do not speak English as their first language, and even those who do may not be able to understand the terminology used by people working in statutory organisations. Using jargon-free language and explaining key terms was seen as important.

Community spaces

Participants shared that they value efforts by leaders and people within statutory organisations to be present and visible within community settings. They valued opportunities to come together in person, to share diverse conversations and speak directly to those in decision-making roles across health and care.

Community capacity

Participants reflected on the value of building capabilities within the community in areas of health and wellbeing, such as work with faith-based organisations. Where there may be mistrust in statutory services, participants highlighted that there is often strong trust for community-led services, groups and approaches.

Vibrant voluntary sector

Southwark's voluntary sector was identified as a valuable asset that communities and the borough are justly proud of. There was a view that the level of funding for voluntary and community sector organisations, particularly those which are Black, Asian and ethnic minority led, must reflect community needs and the disproportionate inequalities experienced by these communities. Barriers to bidding and procurement processes were raised as a particular issue for smaller organisations closely connected to communities.

Recommendations

Six recommendations were developed through this work. These describe principles to prioritise in engagement work and reflect what local communities said was important to rebuild trust:

1) Demonstrable commitment to on-going engagement**:** There should be demonstrable commitment to embed continuous engagement with the community at every stage of research, design and delivery. Accountability mechanisms should be explicit within this process, with transparent decision-making.

2) Connected engagement work: Health and care partners should avoid approaching communities on issues specific to their organisations. Community engagement should be joined-up across organisations, allowing people to engage at a full-system level.

3) Language and terminology: Health and care organisations should examine the language they use when working with seldom-heard communities. Inclusive and accessible language is a key part of promoting a 'no wrong door' approach to meeting needs. Reducing the use of technical terms can help residents engage as equal partners.

4) Outreach: Officers and decision-makers within health and care organisations should prioritise visiting community spaces and groups to engage, listen and build relationships with residents.

5) Investment in community capabilities and training: Upskilling people to participate in engagement confidently can help to empower communities. The community-research

model is one way to do this. Investment in community-led research and innovations are a way to uplift communities.

6) Funding for voluntary and community sector: Measures should be taken to reduce barriers to funding for small organisations that are well-connected to the local community. Involving local communities and the voluntary and community sector in decision-making around funding allocation can help to shift power dynamics.

Next Steps

Community research

Community research forms part of Southwark Council's application for National Institute for Health and Care Research (NIHR) funding to become a research-driven organisation ('Southwark Collaboration for Research and Evaluation'). If the bid is successful, there will be an opportunity to empower communities by further embedding and expanding community research activity within Southwark, and facilitating access to learning opportunities through a wider collaboration with university and community partners.

Sharing learning

This work has been shared with health and care partners through partnership engagement meetings. This should allow individual organisations to consider how the principles can be followed in future engagement work including connecting engagement work across organisations. A summary of this work will be published on South East London Integrated Care System's website.

Lived experience approach

These recommendations have also helped to shape Partnership Southwark's approach to incorporating lived experience into ways of working. This was an explicit focus of the first workshop. Learning from the work is now being tested through the 1,001 days co-production approach. Five voluntary and community sector organisations were recently paid to sit on the decision-making panel for Partnership Southwark's Neighbourhood Grants panel, testing the final recommendation.

[i] Southwark Stands Together: Findings from listening events, roundtables and an online survey. Southwark Council: London, 2021

Agenda Item 9

Item No. 9	Classification: Open	Date: 20 July 2023	Meeting Name: Health and Wellbeing Board
Report title:		Better Care Fund 2023/24 – 2024/25	
Ward(s) or groups affected:		All	
From:		Martin Wilkinson, Chief Operating Officer, Southwark, NHS SEL Integrated Care Board Genette Laws, Director of Commissioning, Children and Adults, Southwark Council	

RECOMMENDATIONS

1. That the Health and Wellbeing Board agree to the 2023/24 - 2024/25 Better Care Fund (BCF) planning templates (appendices 1 and 2).

2. That the Health and Wellbeing Board agree the BCF 2022/23 year end return submitted to NHSE (appendix 3).

BACKGROUND INFORMATION

3. The Better Care Fund (BCF) was first established in 2015/16 as a national policy initiative to drive forward the integration of health and social care services by requiring local councils and local NHS commissioners to agree a pooled budget and an associated plan for community based health and care services. It is a requirement that the BCF plan is agreed by the Council, Integrated Care Board (ICB) and the Health and Wellbeing Board and submitted to NHSE for assurance and agreement.

4. At its meeting on 30th January 2023 the board received an update on the BCF, including details of the £2.56m Adults Social Care Discharge Fund that had been added to the 2022/23 fund by government in December. The report also updated the board on discussions relating to the BCF strategy for 2023/24, including the option of expanding the BCF on a voluntary basis. It was also noted that pending the formal details of the national 2023/24 planning process there had been in principle agreement to roll forward 2022/23 budgets.

5. The 2023/24 – 2024/25 BCF Policy Framework and planning guidance was issued on April 4th and required submission of a BCF plan meeting the requirements by 28th June 2023. The completed planning templates (appendices 1 and 2) have been agreed through the BCF Planning Group and the respective governance processes of the council and the ICB. They have been submitted on a provisional basis to NHSE, subject to agreement

by this Health and Wellbeing Board meeting. This governance route was agreed with the chair as preferable to the alternative of holding an extraordinary board meeting in June or delegating agreement to the chair or other members of the board.

6. It is also a requirement that the BCF year-end report is agreed by the Health and Wellbeing Board. This is attached for 2022/23 in appendix 3.

KEY ISSUES FOR CONSIDERATION

2023/24 to 2024/25 BCF

7. Key issues for consideration are set out in the BCF plan narrative template (appendix 1). Further detailed information is set out in the BCF Finance and Metrics template (appendix 2).

8. The current BCF is a two year plan, which provides welcome stability in planning terms compared to previous 12 month planning rounds. However, there will be a mid-term refresh of plans before 2024/25 plans are finalised and targets set. Any material changes will be reported to the board in line with BCF governance requirements.

9. The total value of the BCF is £54.2m in 2023/24 and £58.8m in 2024/25, within which the Additional Discharge Fund, ringfenced for supporting transfers of care from hospital, is £3.9m and £7.2m respectively.

10. The plan describes the approach to delivering the twin BCF goals to:

- **Enable people to stay well, safe and independent at home for longer** (focussing on hospital and care home admissions avoidance)

- **Provide the right care in the right place at the right time** (focussing on transfers of care from hospital)

11. Key points to note from the templates include:

- The majority of the budgets and schemes agreed for 2023/24 relate to core community based health and social care services that it has been agreed will roll forward from 2022/23.
- The Additional Discharge Fund in 2023/24 rolls forward a number of the Q4 schemes from the 2022/23 Adult Social Care Discharge Fund.
- Further budget changes, including the use of annual growth, savings and the incorporation of service budgets into the BCF are set out on page 7 of appendix 1. This includes a reduction of £109,000 in the ICB additional contribution relating to the @home nursing budget which has been transferred to the core BCF @home budget.

- The ICB minimum contribution to the core BCF increased by 5.66% (£1.5m).
- The plan contains 5 key metrics and targets as set out in the template, including a new target on admissions to hospital due to falls and existing targets on avoidable admissions (Ambulatory Care Sensitive admissions), discharge to normal place of residence, care home admissions and reablement. A new target on delayed transfers of care from hospital is expected to be announced later in the year.
- The plan includes a capacity and demand analysis relating to intermediate care for step down support from hospital and referrals from community settings to prevent avoidable admissions. This will be further developed during 2023/24 as the issues with our integrated community data set are resolved.

BCF Year-end Report 2022/23 (appendix 3)

12. The 2022/23 year-end report was submitted to NHSE in May following authorisation by the council and ICB. It is a requirement that it is presented to the Health and Wellbeing Board. The report sets out confirmation that national BCF conditions were met, BCF targets were delivered and expenditure was in line with the submitted plan. It also identifies areas of successes and challenges. In addition, it provides detailed information on the application of the Adult Social Care Discharge Fund.

Policy framework implications

13. The Department of Health and Social Care (DHSC) and the Department for Levelling Up, Housing and Communities (DLUHC) published a Policy Framework for the implementation of the Better Care Fund (BCF) in 2023 to 2025 on 4th April 2023. The government issued the document "BCF Planning Requirements 2023/25" to local systems requiring the development of plans at Health and Wellbeing Board level. The document sets out the purpose of the BCF in terms of driving forward the national integration agenda. The BCF plan submitted reflects local policy on integration as set out in the draft Health and Care Plan and is consistent with the national framework.

Community, equalities (including socio-economic) and health impacts

Community impact statement

14. The BCF plan provides funding for essential community support for people with health and social care needs. This has benefit to all people with protected characteristics, particularly services provided for older people, and people with disabilities and mental ill-health. The BCF also funds a range of voluntary sector services promoting community resilience, including the older people's community hub.

15. Other beneficiaries of this investment are the homecare workforce who have been paid the London living wage since April 2018 under Southwark's ethical care charter. This workforce has a high proportion of women and people from the black and minority ethnic communities. This principle is being expanded in the current plan to care home staff through additional funding for the Residential Care Charter.

Equalities (including socio-economic) impact statement

16. The narrative plan sets out how the BCF plan contributes to the equalities and health inequalities objectives of the draft Health and Care Plan and the Health and Wellbeing Strategy (see page 30).

Health impact statement

17. The Better Care Fund provides funding for a range of core community-based health and social care services which have the objective of promoting improved health and wellbeing outcomes of all Southwark residents in need of health or care services. Page 30 of the plan sets out how the BCF aligns to the delivery of the Health and Wellbeing Strategy.

Climate change implications

18. As set out in page 33 of the narrative template the BCF plan will be delivered in line with the Partnership Southwark policy statement on environmental sustainability which incorporates the green policies of partnership organisations.

Resource implications

19. The financial template sets out a detailed schedule of the BCF budgets for 2023/24 to 2024/25 summarised in the table below.

SELICB - Better Care Fund Summary 2023-24 & 2024-25

Better Care Fund	2023/24 £'000	2024/25 £'000
Local Authority Better Care Fund - Core Contribution	20,255	21,401
SELICB Better Care Fund - Core Contribution	7,841	8,285
Local Authority - IBCF	17,847	17,847
Local Authority - DFG	1,686	1,686
Total Better Care Fund - Core	47,629	49,220
Local Authority Additional Contribution	1,287	1,287
SELICB Additional Contribution	1,201	1,201
Total Better Care Fund - Additional Contribution	2,488	2,488
Total Better Care Fund	**50,117**	**51,707**
Local Authority Hospital Discharge Contribution	2,502	4,154
SELICB Hospital Discharge Contribution	1,599	2,971
Total Hospital Discharge Contribution	4,101	7,125
Total Better Care Fund	**54,218**	**58,832**

Consultation

20. As set out in the section “Bodies involved in preparing the plan” of the narrative plan on page 1.

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS

Strategic Director of Finance (20AS2023-24)

21. The Strategic Director of Finance notes the recommendations of this report and the 2022-23 year end position detailed in Appendix 3. The Strategic Director of Finance also notes the provisional 2023-25 BCF plan highlighted in Appendix 2 which provides a comprehensive breakdown of how funds will be allocated alongside the expected outputs for the two financial years.

22. The pooled budget and income streams now represent a significant proportion of the partnerships core funding, in which the Better Care Fund, Improved Better Care Fund and the Discharge Fund contributes in excess of £40m of the council’s Adult Social Care budget. Therefore, it is important for officers to ensure expenditure is in line with the allocated plan and monitored and reported through the respective governance pathways.

23. The Strategic Director of Finance welcomes the newly introduced two year planning template and guidance which provides additional clarity and financial confidence into the budget setting process. Given the financial turbulence present in the system, a longer term view on budget planning is encouraged in future years.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
None		

APPENDICES

No.	Title
Appendix 1	BCF 2023/24 to 2024/25 Narrative Plan Template
Appendix 2	BCF 2023/24 to 2024/25 Finance and Metrics Template
Appendix 3	BCF 2022/23 Year End template

AUDIT TRAIL

Lead Officer	Martin Wilkinson, Chief Operating Officer, Southwark, NHS SEL Integrated Care Board Genette Laws, Director of Commissioning, Children and Adults, Southwark Council
Report Author	Adrian Ward, Head of Place PMO (Southwark), NHS South East London Integrated Care Board
Version	Final
Dated	07/07/23
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Assistant Chief Executive – Governance & Assurance	No	No
Strategic Director of Finance		Yes
Cabinet Member	No	No
Date final report sent to Constitutional Team		7 July 2023

HM Government

NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Integration and Better Care Fund

Cover

Health and Wellbeing Board(s):

Southwark

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

Partnership Southwark members including South East London Integrated Care Board, Southwark Council (Public Health, Children and Adult Services, Housing), VCSE representatives, South London and Maudsley NHS FT, King's College Hospital NHS FT, Guys and St Thomas's NHS FT

How have you gone about involving these stakeholders?

Engagement via Partnership Southwark and Health and Wellbeing Board discussions on strategy, and underpinning engagement on Partnership Southwark strategies and the SELICB Forward View

Governance

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

The BCF is agreed between the council and the ICB prior to approval by the Health and Wellbeing Board. After a draft has been agreed through the BCF Planning Group in consultation with stakeholders it is formally agreed through each organisation's respective governance requirements, then presented to the Health and Wellbeing Board. It is also subject to approval through a national BCF assurance process before being formally agreed.

The pooled budget arrangements are governed by a Section 75 agreement between the council and the ICB which sets out shared responsibilities to implement the planned spending as agreed. This Section 75 agreement is formally signed after the national approval letter. The BCF is subject to quarterly and year end reporting to NHSE, reviewed internally and agreed by the council and ICB before submission. Each scheme in the BCF is assigned a lead organisation responsible for the expenditure on that budget which is managed within the governance arrangements of the lead organisation.

In Southwark the BCF Planning Group has been set up to agree plans and oversee the high-level monitoring of the BCF on behalf of the Health and Wellbeing Board and to agree any changes to the use of funding. This group includes the Director of Adult Social Care, the council's Director of Commissioning for Children and Adults and the ICB's Chief Operating Officer for Southwark on behalf of the Place Executive Lead as well as Finance leads.

The BCF Planning Group is a sub-group of the Joint Commissioning Oversight Group which oversees health, public health, adults and children's social care joint commissioning arrangements.

Governance Arrangements for the Southwark BCF (Schematic)

* Partnership Southwark helps shape the future strategic direction of the BCF as part of the delegation of ICB governance to local care partnerships. It also oversees the Live Well, Age Well and Care Well programmes to which the BCF is aligned.

There are also overlaps with other programme governance arrangements in SEL ICB such as the Urgent and Emergency Care Board that oversees the new ICS discharge improvement plan and winter planning.

1. Executive Summary

This should include:

• Priorities for 2023-25

• Key changes since previous BCF plan.

Background to the BCF

The Better Care Fund (BCF) is a pooled budget held between the council and the NHS that funds a range of core community based health and adult social care services. It was originally formed in 2015/16 by consolidating a range of existing funding streams for health and social care. It is a mandatory pooled budget to which the NHS and Council are required to make stipulated minimum contributions, with minimum ringfenced amounts to be spent on social care and health. The value of the BCF for 2023/24 is £54.2m, including £2.5m additional funding above the minimum required level. The current plan also covers 2024/25 for which the expected budget is £58.8m. The delivery of the pooled budget is underpinned by the associated Better Care Fund plan which sets out how an integrated approach to the delivery of services will secure improved outcomes in line with local and national priorities.

Priorities for 2023/25

The local priorities of the Southwark BCF align strongly to the national statement of the BCF vision and objectives, which are set out as conditions in the planning guidance, 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**

This will help deliver the twin goals of **preventing avoidable admissions to hospitals and care homes** and **supporting safe, timely and effective transfers of care from hospital**.

In addition, achieving these objectives will support the delivery of population health and wellbeing outcomes and help tackle health inequalities as set out in our partnership plans by targeting resources at those most in need of support.

This plan sets out how these objectives will be achieved through the BCF in Southwark.

Local priorities and plans aligned with the BCF

The BCF plan is a key enabler for the delivery of a number of local partnership plans that are closely related, including:

- **The Southwark Health and Wellbeing strategy** – including priorities relating to early identification to stay well and the integration of health and social care
- **The draft Partnership Southwark Health and Care Plan** – including priorities relating to Age Well and Care Well, mental health, integration, collaborative working and neighbourhood working
- **The ICB Joint Forward View –** including priorities relating to strategic system wide collaboration
- **The ICS Integration Strategy –** priorities relating promoting health and well-being, and support for people with long term conditions
- **The ICB Operational Plan –** including its focus on recovery of NHS urgent and emergency services

Key focus areas for 2023/24

As set out in this plan there are a number of areas for development in 2023/24 including:

- Delivery of the South East London ICS Improvement Plan for physical and mental health transfers of care including the development of internal flow hubs and home first/ discharge to assess, reducing delayed transfers of care and avoidable long lengths of stay. This will both improve outcomes for patients and increase acute capacity and support recovery of planned and urgent care services
- Securing data improvements to support capacity and demand planning
- Additional Discharge Funding arrangements to be fully incorporated into BCF and deliver maximum impact on delays
- Development of step down options including facilities to reduce delayed transfers for pathway 2 and 3
- Development of a refreshed Market Position Statement in 2023, which for the first time will be joint, relating to care and related health services

Broader system priorities influencing our BCF approach include

- Continuing to support system recovery from the pandemic
- Strengthening the alignment of resources and shared understanding of collective budgets across Partnership Southwark - including a focus on developing collaborative approaches to mental health services in 23/24
- Support further development of the neighbourhood model to promote integrated multi-disciplinary working focussed on outcomes and community needs
- Strengthen whole system resilience in the face of anticipated intensive pressures, including pressures arising from demand in numbers and complexity of need (in particular due to possible flu, covid and cost of living pressures), industrial action, cost pressures, workforce recruitment and retention and funding issues.
- Ensuring a good quality and sustainable provider market that can meet demand, particularly in care homes, home care and community health therapy services
- Supporting the ongoing bedding in of the South East London Integrated Care System, including the Integrated Care Board Southwark borough team and the Partnership Southwark arrangements, which were formally established in July 2022.
- Supporting a reduction in health inequalities in line with the refreshed Health and Wellbeing Strategy, and aligned to the Southwark Health and Care Plan (due to be signed off in July 2023)
- Ensuring all services in Southwark contribute to the goal of reducing environmental impact in line with the Partnership Southwark sustainability policy statement as set out on page 33.

Key Changes since previous BCF Plan

Increased national focus on discharge from hospital

There has been a nationally driven increase in the focus of the BCF on tackling delayed transfers of care from hospital. This is reflected by the incorporation of the Additional Discharge Fund into the BCF plan, and a focus on contributing to the delivery plan for recovering urgent and emergency care services, reflecting the ministerial priority to tackle

immediate pressures in delayed discharges. There has been a significant level of system and place level improvement work on discharge as set out in more detail in the section on national condition 3.

At a local level Southwark has responded to this agenda but admission avoidance remains a key focus of the BCF plan that is given equal weight to discharge.

Additional Discharge Fund

The Additional Discharge Fund (previously called the Adult Social Care Discharge Fund) was first incorporated into the BCF in December 2022 as a variation to the core BCF plan. It provided £2.56m non-recurrent funding for a range of Q4 initiatives that directly supported timely and effective discharge, with year-end reporting highlighting a significant impact supporting 817 transfers of care. This has now been made a core part of the BCF allowing for a number of the schemes to roll forward including council led schemes relating to reablement, homecare, double-handed care, extra care and sheltered accommodation, residential and nursing care, recruitment and retention, VCS, step down flats, brokerage and the transfers of care assessment team. The ICB element includes a strong focus on mental health discharge, in particular the provision of supported housing, and on the support required to co-ordinate these discharges. It is also focussed on supporting discharges from acute settings via the provision of increased therapy support where required to enable discharge and the provision of a social worker in ED who can work on pre-admission discharge planning. Additional resources are also allocated to provide a budget for flexible commissioning of services required to assist complex discharges of people on pathways 2 and 3**.** A scheme to support discharges of homeless people has also been funded.

New schemes for 23/24, for which the full year budget increases to £3.9m, include the development plans for intermediate care step down beds provision initiative outlined below and include investments in residential care to increase capacity. It is anticipated that on the basis of national funding growth figures the discharge fund will increase to £7.1m in 2024/25. Plans described for 2024/25 are provisional and will be reviewed later in Q4 23/24.

Development of more specialist bed based intermediate care services

Southwark has one of the highest rates of discharge to normal place of residence in London, reflecting a strong home first approach supported by a range of intensive community based health and care services funded by the BCF. However, an identified capacity gap in our intermediate care offer relates to people who cannot be discharged home as they require specialist bed based rehabilitation services. These patients frequently experience delayed transfers of care, some with a high number of delayed days in hospital after being clinically ready for discharge, due to waiting for a place to be free in a suitable bed based service.

The Council has transferred the running of four older people residential care homes to a new provider who will be a strategic partner to repurpose some of the rooms across the four homes to provide nursing care so that people can ‘age in place’. As part of the redesign of provision, a floor that has been vacant in the lead up to the transfer is being furnished to provide D2A or reablement for up to 17 people from the autumn of 2023. This expansion of provision will support complex pathway 2 step down from acute settings, particularly with multi-disciplinary work within the community to support safe and sustainable transfers of care where people can live safely and successfully in community settings, whether at home (private residential or extra care) or in a regulated setting such as a care home or supported living.

In addition, the ICB are in system wide discussions around options for developing health funded capacity for complex pathway 2 and 3 discharges from additional discharge funding.

Key Budget Changes 2022/23 to 2023/24

Although the BCF predominantly consists of schemes and budgets that have rolled forward from previous years, there are new features to note for 2023/24 relating to the discharge funding, use of 5.66% uplift and some internal funding changes:

Council scheme budget changes:

- The incorporation of the Additional Discharge Fund (council grant element) totalling £2.502m into the BCF as a full year budget

- Net growth in Core BCF budget for council services funded from ICB contribution to BCF of £1.085m (5.66%)* to £20.255m
    - Annual uplifts for a range of council contracts and services (+ £1.152m)
    - New mobilisation funding for intermediate and nursing care contracts (+ £0.1m)

      Less:

    - Efficiency savings relating to voluntary sector hub model (- £0.167m)

- Repurposing of contingency and cost pressure budgets to residential and nursing care (£0.574m)

Note: there is no growth in council IBCF grant funded provision (£17.847m) or DFG (Disabled Facilities Grant) funded provision (£1.686m), although it has been indicated that DFG grant is expected to be increased mid-year.

ICB scheme budget changes:

- The incorporation of the Additional Discharge Fund (ICB devolved amount) totalling £1.599m into the BCF as a full year budget

- Net Growth of £415k (5.66%) in Core BCF budget for ICB services funded from the ICB minimum contribution to £7.841m:
    - Actual growth of £0.450m includes:
    - Annual uplift of NHS Community & Mental Health Contracts (+£0.277m)
    - New investment in GSTT community services (Occupational Therapy, Tissue Viability, Foot Health Therapies) (+£0.173m)

      Other changes (-£0.035m) include:

    - Funding for Speech & Language Therapist for GSTT Community Services (+£0.065m)
    - Consolidation of @home services by including Palliative Care @ Home service (+£0.326m)
    - Transfer of @home nursing budget from additional funding element to core BCF funding (+£0.109m)

      Less:

- Projected contract savings arising from re-procurement and change of provider to Integrated Community Equipment Service (-£0.15m)
- Self-management reductions reflecting 2023/24 contract values (-£0.054m)
- Service Development budget absorbed into ICB running cost budget (-£0.331m)

Changes to 2024/25

The assumed growth for Year 2 is summarised in the table, including a further 5.66% uplift in the ICB minimum contribution, and forecast draft increase in Additional Discharge Fund. These budgets will be subject to review prior to 2024/25 to take into account planning guidance, service evaluation and latest demand pressures.

Note: A full analysis of the BCF budgets is included in the Finance template

Other changes

Falls prevention – new metric and target

A new target has been introduced on admissions to hospital due to falls in over 65 year olds, which aligns with our long standing local priority around falls prevention. Although Southwark's rate on this indicator is close to the London average it is recognised that there is scope for improvement, and a target to reduce the headline rate by 5% has been agreed. A number of BCF services are focussed strongly on falls prevention including the GSTT community falls service, telecare, community equipment (ICES), reablement and rehabilitation, home care, care homes. Falls prevention strategy is part of the Age Well frailty workstream in the Partnership Southwark programme.

Note: Delayed transfers of care – new metric expected to be introduced during 2023/24

It is expected that a new target will be introduced mid-year reflecting patient delays, based on data provided by trusts which will incorporate the delay since "discharge ready date" into mainstream reporting. Plans for this target will be developed as part of mid-year reporting on the BCF.

National Condition 1: 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 2023-25

• Approaches to joint/collaborative commissioning

• How BCF funded services are supporting your approach to continued integration of health and social care.

Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

Joint priorities 2023-25

As set out in the Executive Summary (p.4) the key joint priorities reflected in the BCF relate to avoiding admissions to hospital and care homes and supporting safe and effective transfers of care from hospital, and a number of related areas of focus.

In broader terms as a partnership our priorities are summarised in the Joint Forward Plan which the BCF is an enabler for:

Approaches to joint/collaborative commissioning

Southwark council and the ICB have a joint commissioning structure with teams responsible for delivering programmes to improve outcomes and address health inequalities for the population: older people and adults with complex needs; children and young people; and healthy populations. The team is jointly funded by the LA and ICB. The primary care commissioning team is part of the overall structure (led by a joint-funded post) to help ensure

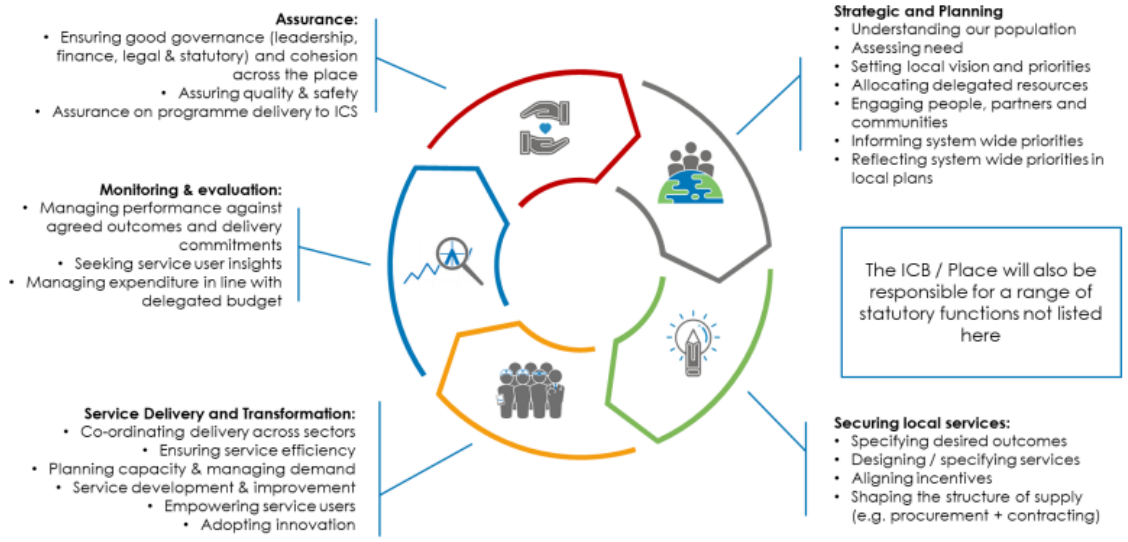
cohesion, although the team is not jointly funded. These arrangements are, of course, subject to the Hewitt Review recommendations.

The joint commissioning teams work closely with the Partnership Southwark programme team that leads integrated programmes under the Start Well, Live Well, Age Well and Care Well programmes which are focussed on facilitating improved joint working between providers.

There is a continued commitment to deepening the approach to integrated commissioning. . This includes building on our agreed key principles, our common framework for joint commissioning and planning progress against agreed “road map” milestones on an integration maturity matrix, and the development of integration demonstrator projects (see fig. 1).

Fig 1: Joint Commissioning Principles and common framework for joint commissioning

We agreed a set of principles which would underpin the development of future joint commissioning arrangements and how we plan services



…..and discussed a common framework for joint commissioning, with the development of LCP functions underway to underpin the process and provide the necessary inputs

Key principles of the Bridges to Health and Wellbeing Approach

Partnership Southwark has previously agreed an approach to joint commissioning for improved population outcomes referred to as the Bridges to Health and Wellbeing model that was developed following extensive engagement. Whilst it was decided not to take a prescriptive approach to applying the methodology to all programmes, the model provides guiding principles that apply to all integrated workstreams:

1	**Organising the population into coherent groups –** grouping the population according to similar patterns of health and care need ('population segments') and associated relevant outcomes is a sound basis for developing a population based approach
2	**Agreeing outcomes for population groups** - the development of an agreed outcomes framework for each population group/ segment, like the approach used for the frailty, dementia and end of life segment, provides partners with a common focus
3	**Whole system approach to deliver the outcomes -** population health and wellbeing outcomes can only be fully achieved by all partners working together as a single Southwark system.
4	**The integrated service models need to be holistic and person focused** – health, care and universal services focussed on working together on the whole need of a person or population rather than service focused. Co-production of new service models with the public and the use of personalised outcomes for individuals in their multi-disciplinary plans is a key element of this.
5	**Prevention -** we need to shift resources to prevention if outcomes are to improve. This will mean sharing the costs, risks and rewards of investment in prevention opportunities we have identified.
6	**Providers and commissioners will need to work together in new ways -** with formal and informal alliances where necessary to deliver outcomes on which they are

	jointly accountable. This will include high levels of collaboration, trust, and data and intelligence sharing.
7	**Workstreams to be aligned to outcomes frameworks –** we need a structured approach to incorporating the delivery of improved outcomes into the way services are developed. This covers not just existing and proposed Partnership Southwark workstreams, but any relevant workstreams and "business as usual" services.
8	**Evidence based and driven by shared data –** The new integrated service models need to be based on in depth needs analysis using shared data on individuals and populations, mapping of existing services, gaps and opportunities, knowledge of best practice etc.
9	**Aligning resources and commissioning -** We need to consider all resources available for populations to improve outcomes and consider the best way of configuring them that is the best use of the "Southwark £".
10	**Commissioning for outcomes and contractual changes -** There will inevitably be a need over time for the approach to contractual specifications and payment mechanisms to shift to reflect the focus on outcomes – however the need for these to be evolutionary rather than revolutionary is recognised, with clear mechanisms in place to address system risks

How BCF funded services are supporting your approach to continued integration of health and social care.

A number of BCF funded services work closely with partners in a MDT approach, for example:

- The new Transfer of Care Service hospital discharge teams funded via the BCF work in close collaboration with acute and community health teams as part of the discharge process.
- Intermediate Care Southwark is fully funded by the BCF. It is an integrated service model incorporating council staff, council commissioned reablement provider and ICB commissioned intermediate care and community health services under a single management structure
- The Intensive Support Service (previously called Enhanced Intervention Service) is a BCF funded multi-disciplinary team supporting people with learning disabilities and challenging behaviour to remain in lower intensity community based placements. The team includes psychologists from SLAM, a social worker and a therapist from GSTT community team.

Changes to the services being commissioned through the BCF for 2023-25 are set out in the executive summary, and the following sections on National Condition 2 and 3

National Condition 2

Use this section to describe how your area will meet **BCF objective 1: Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

The Southwark BCF will enable people to stay well, safe and independent at home for longer through the funding of person centred community based services that prevent the deterioration of health and wellbeing and help reduce avoidable admissions to hospital or care homes as part of personalised care plan. These are part of the wider neighbourhood MDT approach with primary care to preventing admissions for people identified as at risk of admission. Relevant BCF funded schemes include:

- Home care
- Step up reablement and intermediate care
- Urgent Community Response (with increased direct self-referral in 23/24)
- Support to carers
- Telecare and community equipment
- VCS funding – e.g. older people's hub, social prescribing
- Falls service
- Self-management funding for people with long term conditions
- Flexi care/ Extra care
- Mental health and learning disability personal budgets
- Mental health reablement
- Lower limb wound care/ Tissue Viability
- Disabled Facilities Grant

These services will support the wider system in delivering the Fuller report recommendations. The Southwark Fuller Delivery Group has objectives for 2022/23:

- To enable all Primary Care Networks (PCNs) to evolve into integrated neighbourhood teams, supporting better continuity, preventive healthcare and access
- To ensure proactive healthcare and support, targeted at people of all ages living with frailty, multiple long-term conditions and/or complex needs, to help them stay independent and healthy for as long as possible at home, in the place they call home or in their local community
- To improve the management and experiences of people with LTCs.

- To develop strategies to develop high intensity user services and address UEC demand management.
- To ensure patients have access on the day for urgent problems.

This will be in the context of improved access to primary care services in line with primary care recovery plan, which is identified as a key factor in avoidable admissions.

In addition, the objective is supported by our broader prevention strategy such as the focus on hypertension as part of our Vital 5 screening initiative.

Link to discharge strategy: it should be noted that in order to ensure a rounded view on patient flow the system discharge improvement plan set out on page 18 includes a key objective around prevention of admissions, including re-admissions.

National Condition 2 (cont)

Demand and Capacity

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community.

See commentary on demand and capacity planning for national condition 3 on page **21.**

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

BCF funded services play a vital role in enabling people to stay well, safe and independent at home for longer. Examples of how these impacting on the key metrics include.

Unplanned admissions to hospital for chronic ambulatory care sensitive conditions:

- BCF funded community health services including Urgent Community Response enabling referrals for intensive support to prevent admission and the @home service as an alternative to admission, including palliative care at home
- Self-management courses for people with long term conditions, including Self Management UK and Walking Away from Diabetes
- Services such as home care play a key role in supporting the health and wellbeing of people with long term conditions and escalating concerns about health conditions at an early stage, and BCF funded social care services will play a key role in the emerging neighbourhood model with integrated multi-disciplinary working focussing on admissions avoidance objectives.

Emergency hospital admissions following a fall for people over the age of 65

- The BCF provides £857k funding for the Southwark Community Rehab and Falls service. This service specialises in preventing falls, caring for people who have had a fall or fracture or if there are concerns about the risk of falling. The service includes a falls clinic, strength and balance classes and information advice and support to patients and carers.
- Addressing the risk of falls is a key theme running through a range of BCF funded services. Falls risk assessments underpin the provision of reablement and rehab, community equipment, minor adaptations and major adaptations through the Disabled Facilities Grant.
- The telecare services provides specific services enabling falls to be responded to, including specialist staff and equipment for lifting people after a fall rather than calling an ambulance.

The number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

- The BCF provides funding for an extensive range of personalised home based services that enable people to live independently and safely at home in the community for as long as possible, avoiding or delaying the need for permanent admissions to care homes. This is a key objective of our home care, extra care,

reablement, intermediate care, rehab, housing adaptations, equipment, voluntary sector hub and carers support services.

- Discharge related services are focused on a home first approach rather than transfer to a care home as set out in this plan
- A number of these areas have been strengthened through the use of the additional discharge fund, including schemes to fund step down flats and strengthen supported housing options in mental health

National Condition 3

Use this section to describe how your area will meet **BCF objective 2: Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered 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, in line with the Government's hospital discharge and community support guidance.

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

Additional Discharge Fund: The Additional Discharge Fund has provided significant investment for this objective as set on page 6.

South East London Integrated Care System – in depth review of discharge and 2023-2025 improvement plan for transfers of care

The key development in terms of planning for improving transfers of care relates to the development of this ICS plan which Southwark intends to actively deliver with partners.

Building on the outputs of a number of system and place level discharge related workstreams, in March 2023 the ICS held a Discharge Summit to enable system leaders to come together and discuss how to improve both timeliness and quality of discharge from our acute and mental health providers. A wealth of suggestions came from that discussion and, as a system, it was agreed to develop a SEL Discharge Plan that all partners in the ICS can commit to delivering. This System Plan has been developed in conjunction with the Discharge Solutions Improvement Group (DSIG) and the SEL MH Discharge Group (sub-group of DSIG) and aims to define our mission, objectives and the measures by which we will deliver improvement over the next two years (2023-2025), aligning to BCF improvement plans.

A mission statement for the plan was agreed as follows:

"When medically and therapeutically ready, our residents will receive good, safe and timely transfer of care from hospital to home. Irrespective of whether they have mental or physical health needs, they will feel that the care on offer is to help them recover as quickly as possible with no hospital stay longer than needed".

High level objectives were agreed and detailed action plans for each objective is set out in full overleaf.

Discharge Improvement Plan Objective 1: We will work to a **common framework** to deliver transfer of care standards

South East London Integrated Care System

Standards: a) Complimentary model for TOC Hubs with agreed language and definitions; b) Home first wherever possible (within a D2A process); c) Standardised discharge policies where appropriate across acute providers (physical and mental health)

Actions		Measures	Evidence Base	Who *(Place, SEL level, Sub-group)*	When	Governance
A)	Implement 10 immediate actions and 7 recommendations from SEL TOC review with initial focus on priorities 1-3: **1) SEL discharge plan owned by all system partners with shared ambition** **2) SEL operating model for TOC/Flow hubs (including agreed common language and definitions)** **3) Significantly increased focus on P0 with dedicated P0 co-ordinators in hubs** 4) Regular discharge audit programme across SEL 5) Review of data captured to align and expand current data and review targets to improve performance 6) Strategic review of most efficient TOC/Flow hub model for SEL 7) Hub access to Social Care management IT systems	TOC Review Delivery Tracker Oversight and collection and monitoring of P0 data including complexity and delay reasons Non CTR by Pathway, number of patients discharged, TOC LoS by pathway and borough	SEL TOC Review	1) DSIG 2) Sub-group: TOC leads (SEL co-ordinated) 3) Acute DOOs	Q1 23/24 Q3 23/24 Q3 23/24	DSIG DSIG AFIG
B)	Commission demand and capacity planning and associated reviews for key areas (e.g. intermediate care, weekend working/extended hours and mental health)	Base-line audit HICM maturity assessment	TOC – HICM – Change 5	SEL commissioned	Q2 23/24	DSIG & BCF
C)	Embed the Mental Health Discharge Framework and improve delivery against baseline assessment	Base-line audit	100 day MH challenge	SEL MH Discharge Group	Q4 23/24	DSIG

9

Discharge Improvement Plan Objective 2: We will secure pathways that are **safe, personalised and promote independence and recovery**

South East London Integrated Care System

Standards: Clear processes for transferring patient care to give all patients opportunity to recover in the community: a) before an assessment for their reablement and long-term care needs takes place (physical health); b) through shared lives and stepdown accommodation options with psychosocial support (mental health). Where recovery is not an option c) to maximise quality of life in final months, weeks or days of a person's life.

Actions		Measures	Evidence Base	Who *(Place, SEL level, Sub-group)*	When	Governance
A)	Improve, promote and enable through the transfer of care model: • Greater access to intermediate care and reablement services for our patients • Providing these services at the right time to maximise the patient's recovery. Achieving successful outcome for the patient around wellbeing and living as independently as they can with no ongoing or minimum levels of on-going support. Place-based funding and investment plans aligned to this action to evidence where local investment will support delivery	Reablement ADASS monthly return (SALT) AND BCF 91-day Intermediate Care Metrics SEL Discharge Dashboard		Place-based	23/24	DSIG
B)	Implement evidence based best practice, including discharge to assess and home first models as our embedded approach to transfer of care e.g. SEL Policy and action cards on how to transfer care for out of borough patients without delay	ASC outcome framework BCF indicator dashboard	Discharge guidance TOC – HICM Bromley policy & action cards	Place-based improvement spread across SEL	23/24	DSIG & PELS
C)	Develop the range of supported housing and shared lives initiatives for fragile mental health patients stepping down into the community with psychosocial support enabling residents to regain their skills to cope with activity around daily living (independence).	Place based BCF metrics	Review PSSRU Outcome measure	Place based and MH Discharge Group/BCF	23/24	DSIG and PELS
D)	Early planning for patients requiring end of life services that supports the aims of dying well. Training of all staff working in discharge to proactively identify patients who are approaching the end-of-life care phase to support earlier access to palliative care services. Making advanced care planning and use of universal care plan the norm.	Audit of use of universal care plan Reduction in number of people dying in hospital EoL national data set	SEL Joint Forward View for PEOLC care (pg. 200)	AFIG, place based and EoL steering group		DSIG, AFIG & EOL steering group

Discharge Improvement Plan Objective 3: We will **meet complex patient needs**

Standards: SEL has clear processes for transferring patient care into the community to: a) continue treatment/ recovery that enables longer term planning; b) meets planned and unplanned health needs and c) enables where possible a patient to die in the most suitable setting (of their choice)

Actions		Measures	Evidence Base	Who *(Place, SEL level, Sub-group)*	When	Governance
A)	Developing safe and appropriate pathway for patients with complex clinical or discharge challenges: • dementia & delirium pathways • transfer of care to bed-based services for patients with complex needs Recognising that these will be developed at SEL level where possible for local adoption based on population need	Readmission rates	Good practice evidence base to be gathered	D&D sub-group Place-based leads linking with CH group	Q3 Q3	DSIG
B)	Develop a SEL approach to patient deterioration escalation and pre-crisis planning (mental and physical health)	Readmission rates		Identified clinical leads (tbc)	Q3	DSIG
C)	For patients with complex needs reaching end of life engaging the range of services (e.g. health and care support, hospice care, accommodation and equipment) to enable a dignified and comfortable death wherever possible	Audit of delivery of care against universal care plan	SEL Joint Forward View for PEOLC care (pg. 200)	AFIG, place based and EoL steering group		DSIG, AFIG & EoL Steering Group
D)	Maximising the opportunities to adopt pooled funding and risk/gain share approaches to reduce TOC delays	TOC delays		Sub group	Q2	DSIG
E)	Place-based funding and investment plans aligned to the SEL discharge plan to evidence where local investment will support delivery of SEL objectives	Local discharge improvement plans and delivery updates		Place-based	Q2	DSIG

11

Discharge Improvement Plan Objective 4: We will focus on **avoiding unnecessary admissions**

Standard: To ensure people are only admitted to hospital when their care can no longer be managed at home. People requiring access to urgent and emergency care are not admitted unless their clinical condition requires it

Actions		Measures	Evidence Base	Who *(Place, SEL level, Sub-group)*	When	Governance
A)	Consistent community offer to support people staying independent at home for as long as possible. Involving voluntary sector services, strength-based support systems (including social prescribers) and active interventions such as intermediate care and reablement as a step-up service.	ASCOF - The proportion of older people (aged 65 and over) at home 91 days after discharge from hospital into reablement / rehabilitation services				Community Provider Network
B)	Admission avoidance/ACPs for ambulance service and hospital front door, with a front door discharge to assess approach. Adhering to any end-of-life plans in the universal care plan where the patient has chosen to die at home or other non-hospital setting.					Local UEC Board
C)	Understanding patient behaviours and how this drives their decision making in times of urgent need					Local UEC Board
D)	Review our key existing pathway to avoid admissions e.g. urgent community response (UCR) offer, reablement, MH crisis offer, virtual wards to ensure we are optimising available capacity. Clear access criteria and can be referred from ED.					Local UEC Board

Patient experience of discharge project

An innovative multi-agency project has been established to gain in-depth intelligence about patient experience of discharge. This will help partners understand how best to improve discharge, with a focus on effective communication and consultation with patients. Community researchers recruited by the voluntary sector have been trained in ethnographic interviewing techniques by a specialist research company. They will accompany a sample of patients during their discharge from hospital and ask them about how they are experiencing the process, what they have been told and understand about what is happening and interview two weeks later to understand what actually happens. The report is expected to be available in July.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as

- where number of referrals did and did not meet expectations
- unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
- patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);

- approach to estimating demand, assumptions made and gaps in provision identified - planned changes to your BCF plan as a result of this work.

- where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
- how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Estimates for demand and capacity in intermediate care services are based on latest service data projected forward.

The learning from 2022/23 is that we are currently not able to populate the data fields in the national Capacity and Demand template in a consistent and accurate manner. For example, discharge information at a borough level by pathway and service received is not generated by acute data systems. In addition, the local community health provider has had major IT/IS system failures during the year and has been unable to report. This remains an area for development during 2023/24 that is expected to be resolved in the autumn of 2023.

The main source of information used for assessing gaps between demand and capacity for intermediate care is real time operational data of the internal flow hubs, which provides details on all currently delayed patients including the identified reason for the delay. This tells us for the acute delays the key delay reasons relating to care packages (as opposed to delays relating to ongoing NHS care) are as follows:

- availability of suitable care home placement able to meet high levels of acuity in patients
- availability of bed based rehabilitation for those with highest needs who cannot be supported at home
- capacity of community health services to take discharge referrals for therapy at home

Discharges from mental health inpatient settings are most frequently caused by lack of capacity in supported housing providers who are able to support high needs individuals upon discharge. Homelessness and NRPF is also a common factor.

It is a known risk that the lack of capacity in specific areas may result in discharges into services that are not the ideal match for assessed needs, as well as delays in the discharge itself.

These identified gaps are in the process of being addressed through the BCF funding, in particular the Additional Discharge Fund and associated commissioning strategies including:

- Commissioning of new nursing home in borough and initiatives to maximise capacity across the nursing home and residential home bed base
- Development by council of more specialist bed based reablement care services as set out on page 6
- Extra care / flexi care / step down flats
- ICB commissioning plans for rehab beds for pathway 2 and 3 discharges for both acute and mental health under development
- Funding of Kings Outreach Therapy service to provide additional therapy support to discharge when the local community health provider is unable to accept a referral
- Recruitment and retention initiatives (Care Home Charter)
- Homelessness discharge scheme

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

Southwark has the highest rate of discharges to usual place of residence in London. To support our strong home first ethos, the following BCF funded services will actively support discharge to normal place of residence, providing options for care packages that make returning home a safe and effective transfer.

- Internal flow hubs pursuing home first discharge to assess approach
- Reablement services including double handed care
- Community Health @home service and rehabilitation/ intermediate care
- Home care, including overnight intensive home care (Night Owls)
- Residential care and nursing care and flexi care/ extra care
- Step down flats
- 7 day hospital discharge team
- ICES and Telecare
- VCS services such as Hospital Buddies
- DFG including handy person service
- Palliative care at home service

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these

High Impact Changes Model for transfers of care

The High Impact Changes Model is a framework for identifying potential improvements across key aspects of the hospital discharge process. Aspects of the model are included in the SEL ICS improvement plan, and the model is used in Southwark as a tool to benchmark for good practice and to help identify service improvement priorities. A recent update against the criteria confirmed that current arrangements still fall into the mature or established banding for each change area. Areas for potential further improvement to be explored include:

Change 1: Early discharge planning

- Ensure people at high risk of admission have discharge plans in place
- Internals flow hubs to ensure full compliance with the setting of expected dates of discharge and an MDT plan, ensuring effective discussion and communication of this, including with family/friends, with preparation during hospital stay to effectively provide a safe discharge
- Ensure new providers implement the red bag scheme promptly

Change 2: Monitoring and responding to system demand and capacity

- Further develop analysis of demand and capacity to enable more sophisticated and long range forecasting
- Develop data systems to enable effective use of intermediate care capacity and demand model
- Maintain contracting with 10 core providers of home care for the borough to ensure capacity to respond to pathway 1 packages of care in a timely manner.

Change 3: Multi-disciplinary (MDT) working

- Primary care involvement in the MDT for discharge planning where required

Change 4: Home first / discharge to assess

- Ensure nursing capacity in the community to do complex assessments
- Further develop reablement and rehabilitation offer in terms of response times and level of care
- Ensure continuation of strong home first approach despite pressures on system, commissioning additional capacity as required from discharge funding
- Review Intermediate Care Southwark pathway to ensure appropriate patients are referred and receive care within best practice timeframes

Change 5: Flexible working patterns

- Build an integrated 7 day service model, increasing the number of patients leaving with packages of care at weekends
- Ensure the internal flow hubs at both acute hospital sites working seven days a week, with access to clinical and social care colleagues to support decision making regarding discharge arrangements.

- Review need and costs/ benefits of expanded 7 day working across more teams in trusts, providers and community health
- Enable more care packages to start at weekends

Change 6: Trusted assessment

- Ensure Trusted Assessor (TA) model is fully embedded with continued use of TA documentation as standard practice by discharge hubs in format agreed with care homes

Change 7: Engagement and choice

- Ensure choice protocol (Safe to Transfer Discharge Policy) that was signed off across SEL in April 2023 is fully embedded and operating effectively

Change 8: Improved discharge to care homes

- Respond to recommendations from Care Home listening event in early 2023
- Development of Transfer of Care (TOC) Passport which provides essential information about a patient for care homes, so they are confident in receiving the admission with all necessary information on arrival.
- Enable more weekend discharges to care homes
- Maximise commissioning options to increase care home capacity to accommodate complex needs, including options from use of discharge fund

Change 9: Housing and related services

- Ensure expected dates of discharge incorporate housing related needs
- Continuation of homeless health project to facilitate discharges
- Extend model of housing advice workers with discharge teams to mental health

These changes will be picked up under workstreams including the Lambeth and Southwark Discharge Operational Delivery Group, the ICS Discharge Solutions Group and mental health discharge group, and specific discharge related workstreams. The changes will be absorbed into the SEL ICS discharge improvement plan monitoring

National Condition 3 (cont)

Care Act and Supporting Unpaid Carers

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

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.

Funding from the BCF for carers and Care Act duties

A total of £1.95m of BCF funding is targeted at carers and Care Act duties.

The BCF from its inception in 2015/16 has included an allocation of £1m from the NHS minimum contribution to the council to meet additional costs arising from the Care Act.

In addition, £400,000 is allocated to the local VCS (Southwark Carers) for the provision of respite and £450,000 for the costs of carers assessments and services. From 2021/22 an additional £100,000 of annual uplift was targeted at the identified priority area of supporting carers of people with dementia.

Supporting unpaid carers.

Services

There are currently estimated to be 25,700 carers in Southwark

The Voluntary Community Sector (VCS) support for carers, provides information and advice on carers rights, advocacy, accessing grants, legal advice, employment information and advice, accessing statutory services and contingency planning. Carers can access one to one emotional support, as well as enjoy a range of activities and groups, trips and outings, for wellbeing, social interaction and peer support.

There is a dedicated service for young carers, which provides emotional and practical support to young carers with caring responsibilities. This service is funded from the council's general fund to support (currently) 223 young carers registered in Southwark, 53 of which have been supported through one to one activities (workshops, respite, etc) in the past year.

Both commissioned services help to improve identification of "hidden" carers and to raise awareness of the impact of caring.

Southwark has commissioned ADASS Proud to Care online scheme to provide a wide range of discounts to paid and unpaid carers in Southwark amongst other boroughs. Southwark is able to add local businesses to the scheme. Unpaid carers receive assistance from the Voluntary Community Sector to access the scheme.

As of February 2022, carers and foster carers in Southwark have access to a 24 hour helpline which offers confidential, professional support and advice around; health and wellbeing, money worries, self-care and respite, consumer and legal issues, family and home, work and life.

Carer training

In 2022 The Institute of Public Care completed carer training for staff across ASC, Ageing Well Southwark and Commissioning. The workshops were co-produced with carers and representatives from the voluntary sector. The newly designed carer pathway will embed the ethos, principles and approach in order to further:-

- Understand and overcome the challenges to carer identification.
- Have skilled strengths based conversations, supporting carers to access resources to sustain the caring relationship and their own wellbeing.
- Use a more creative and person centred approach to support planning and use of direct payments

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

The DFG service is based within Southwark Council's Private Sector Housing & Adaptations Team and delivered through the Home Improvement Agency (HIA). It is funded by a ring-fenced grant paid to the council for the discharge of its statutory duties to administer a DFG scheme. The DFG supports people with disabilities who are owner-occupiers (who may be asset rich and cash poor) and tenants of private rented/housing association housing by funding physical adaptations to their homes that enable them to remain long term in their own home in the community, avoiding admissions to hospital and care homes. As well as major adaptations the DFG also funds a handyperson service which works closely with the hospital discharge teams to enable people to return home from hospital when their house needs minor repairs. Under the Regulatory Reform Order flexibilities Southwark also provide a range of small repairs grants and loans to help vulnerable people carry out repairs and improvements to their homes.

The Disabled Facilities Grant has been awarded a budget of £1.686m for 23/24, which is the same allocation funding for 22/23. In real terms this can be seen to be a decrease in funding with the rise in costs of materials etc. Growth has been focussed on securing an increase in senior occupational therapist capacity to reduce delays and increase the number of people accessing DFG's.

In 22/23 the focus has been working on clearing the backlog of cases and dealing with any urgent / emergency cases. The financial means test for DFG applications continues to be temporarily waived. The overall delivery process has also been reviewed and improvements implemented. Financial counsellors continue to support applicants and provide assurance with safety etc. For 23/24 we will continue to focus on clearing our backlog of cases, which currently stands at 51 cases on the waiting list, and ensuring emergency cases are dealt with immediately. The team continues to reduce the number of people on the waiting list by reducing the time clients are waiting, which currently stands at 6 months, we intend to reduce this to four months, by working through cases more efficiently. We received a total of 93 referrals from OT, on average 8 per month, during April 22 to March 23.

From April 22 to April 23, we have completed 123 major adaptations, which compromised of:

- 82 Level access showers
- 22-bathroom alterations
- 12 step/ stairlift installations
- 3 Closomat installations
- 3 building alterations
- 1 Door entry system

We have set a target of 150 major completions in 2023/24.

The DFG Service works with adult social care by having joint meetings bi-monthly to specifically discuss complex cases and every 3 months to discuss the progress of cases and complex cases, staffing etc

Other specific areas of improvement:

- The DFG service has now gone to advertising to recruit a Senior Occupational Therapist. The role will work across new homes, the HIA service and voids. This will

help increase the number of OT assessments, improve communication/queries with adaptations on site and build stronger links with ASC and Health colleagues.

- The DFG service continues to work with a fast track system that has been put in place to ensure cases assessed as urgent or end of life are prioritised.
- The Housing team have been trained in falls prevention and provide advice, support and practical help when visiting older, frail and vulnerable people to help prevent the risk of falls and potential hospitalisation.
- The service has updated reporting on Case manager, the IT system used to record adaptation works, this is to monitor progress of cases and ensure progress is made in a timely manner.
- The service implemented satisfaction surveys for completed works. From April 22 to March 23, 46 satisfaction surveys were completed for HIA, respondents said they were happy with the service. Some of the comments were

'I would recommend the service', 'the HIA provided an excellent service'.

The case studies below illustrate how DFGs can benefit service users:

CASE A

Client is female in her 60's and a Housing Association tenant living by herself. Client receiving palliative care at home. Client was referred to the Home Improvement Agency following an Occupational Therapists assessment, the outcome of the assessment recommended the provision for level access shower facilities with wall mounted drop down seat and grab rails.

The adaptations installed had a positive effect allowing the client to maintain her independence, dignity and privacy. Client was very happy with her new bathroom and was satisfied with the overall service. Client stated that the contractor's work was excellent, they were polite and very helpful. Client had a positive experience therefore felt able to recommend the service to others.

CASE B

Client has a range of health issues including multiple sclerosis, collagenous colitis, kidney failure, lupus, breast and lung cancer. The client was assessed by Occupational therapy to replace the bath with a shower, these works were carried out. The client responded to say that the works enabled her to maintain her independence and she was able to shower.

Handy person service.

The handyperson service has been assisting residents, regardless of tenure, (aged 60 or over, or with a disability of any age) with a range of works. The number of works completed between April 22 to March 23, was 1457, which is broken down as follows:

- 444 minor repairs
- 746 Key safes
- 238 Lightbulb changing
- 29 other (decorating, smoke alarms)

Minor repairs include putting up shelves, assembling furniture, moving furniture, which has enabled a new bed or other furniture to be delivered to the persons property.

75% of the key safes installed, approximately – 560 homes, were to enable someone to be discharged from hospital, with approximately just under 200 cases to enable them to receive care in the community. In all cases to enable the resident to remain living in their home.

For 2023/24 our aim is to increase the number of works we carry out across the borough, by promoting the handyperson service to more people including residents living in their own home. We are working with the communication team to put out several adverts across a range of mediums including online newsletters, inserts in council tax and rent statements etc.

From April to March 23, the handyperson service carried out a total of 123 satisfaction surveys. Total satisfaction for the year was at 100%. The consensus from all *'clients was that they trusted the service, happy to get works done, they felt that the service was wonderful and reliable, it enabled them to feel safe, secure at home and enabled them to maintain their independence'.*

Additional information (not assured):

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services?.

No (focus has been on recovering core DFG waiting list)

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan

- How equality impacts of the local BCF plan have been considered

- How these inequalities are being addressed through the BCF plan and BCF funded services

- Changes to local priorities related to health inequality and equality and how activities in the document will address these

- Any actions moving forward that can contribute to reducing these differences in outcomes

- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

Supporting the Southwark Health and Wellbeing Strategy

The drive areas included in the refreshed Southwark Health and Wellbeing Strategy agreed by the Health and Wellbeing Board are set out below. These are underpinned by a commitment to ensure tackling inequalities is embedded across all our policy making, service design and delivery.

The key areas in which the BCF will support the refreshed Health and Wellbeing Strategy are as follows:

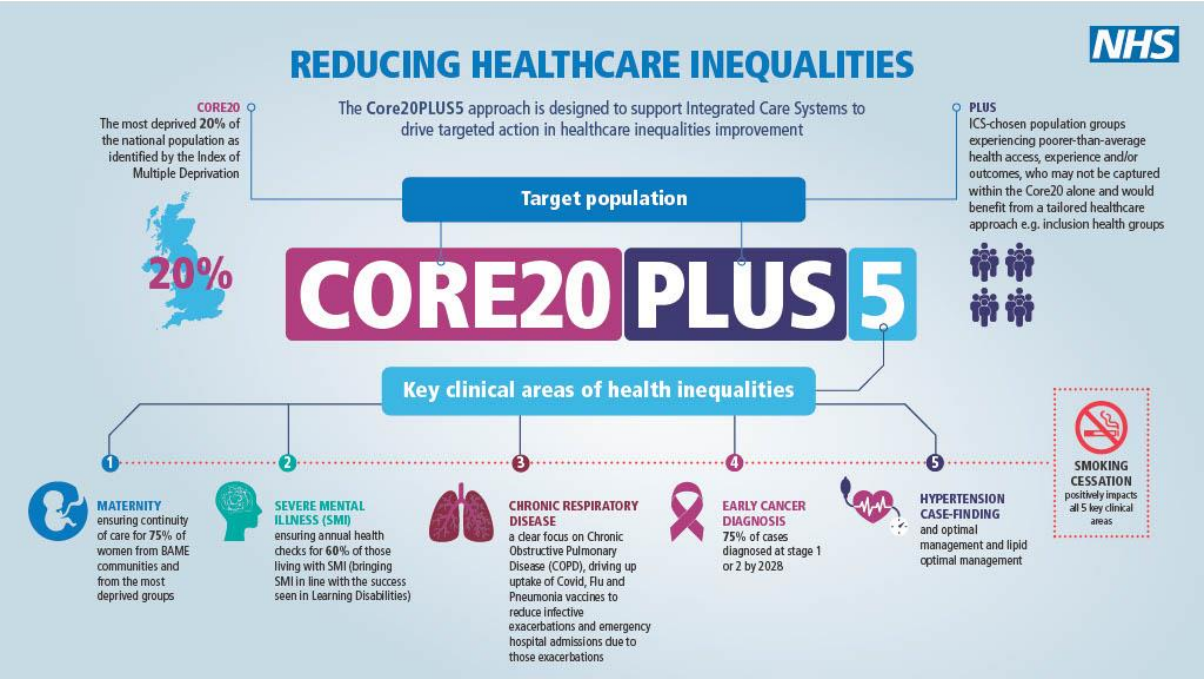
Drive 2: Healthy employment and good health for working age adults across the health and wellbeing economy: the BCF provides funding for costs associated with the Southwark ethical care charter, which helps ensure good employment practices in commissioned services.

Drive 3: Early identification and support to stay well: The BCF funds a number of services that have preventative value including the voluntary sector hub, falls prevention, self-management for people with long term conditions and telecare. Also captured under this heading is a range of core out of hospital services funded through the BCF such as rehab and reablement, carers support and hospital discharge support.

Drive 4: Strong and connected communities: BCF funding supports the voluntary sector hub which play a key role supporting strong communities. The vision for integration which the BCF supports includes the development of a strong neighbourhood model which would help promote community resilience.

Drive 5: Integration of Health and Social Care: The BCF is a key pooled budget providing a foundation for the alignment of resources as an enabler of integration. It funds services that have become more integrated e.g. Reablement and Community Health enhanced rapid response have integrated as Intermediate Care Southwark. The draft **Health and Care Plan** and an associated outcomes framework will be developed during 2023/24 and provide detail on the delivery of this drive area. The BCF will be fully aligned with this plan.

Core20PLUS5: It is a priority to develop the capacity to support a Core20PLUS5 approach in 2023/24, working with NHS analytics teams and public health to identify key population groups to target improvements in heath inequalities. This will complement the current Vital 5 programme which focuses on people with key risk factors for poor health outcomes. The Core20PLUS5 approach is illustrated in the diagram below:



The draft Health and Care Plan sets out a commitment to embedding an approach to tackling health inequalities across all our policy-making, services and delivery, including BCF development. It builds on the Partnership Southwark Recovery Plan which sets out the wide range of inequalities in outcomes experienced by Southwark's population which were highlighted and exacerbated by the differential impact of COVID-19 on communities. Addressing inequalities is at the heart of the partnership's 4 key population-based programmes.

The BCF funding is a key enabler of the adult's focused workstreams: live well, age well and care well workstreams, funding a significant range of community based health and care services that are working together to deliver the objectives of the plan.

Contribution to Equalities Act requirements

The BCF funds services that provide a range of essential personalised support for people with health and social care needs. This has important benefits for people with protected characteristics under the Equalities Act, many of whom are reliant on these services, in particular older people, people with disabilities and people with mental health problems. Other beneficiaries of BCF investment are the homecare workforce who have been paid the London living wage since April 2018 as a result of BCF investment in our ethical home care policy. This workforce is mainly made up of women and those from the black and minority ethnic communities. The Additional Discharge fund has provided resources to extend these principles to the care home workforce through the Residential Care Charter.

Environmental impact of the BCF

Partnership Southwark is committed to developing its approach to sustainability to minimise the adverse impact services have on the environment, particularly in relation to climate change and air quality. This is reflected in the Partnership Southwark Environmental Sustainability Policy Statement in January 2023 which gives a commitment to developing a mutually supportive approach to delivering organisational sustainability plans and ensuring all partnership decisions consider sustainability implications.

According to the Sustainable Development Unit, the NHS is the biggest public sector contributor to climate change in the whole of Europe. Hospitals have a major role to play in this as they have such a high carbon footprint. The BCF has an indirect role in this as it supports the overall strategy of developing a neighbourhood model with health and care closer to home, reducing admissions and minimising length of stay in hospital - which in the long term will shift the balance of resources away from hospital activity. In addition, it is recognised that all community based service providers funded by the BCF have a role to play and will be supported to minimise their environmental impact. For example, the community equipment service has a strong focus on increasing recycling and re-use of equipment.

BCF Planning Template 2023-25

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

2. Cover

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).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, 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'.

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

8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

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 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. 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.

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

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

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

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, 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 Condition 4 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 6b.
- 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. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. 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 eligible expenditure on social care under National Condition 4.
- 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.

7. 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 on NHS commissioned out of hospital services under National Condition 4. 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.

8. 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.

9. 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.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

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

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

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 2023-25. 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 2023-24.

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 2023-24. 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 (2021)
- Actual performance for each quarter of 2022-23 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.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- 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. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. 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 2022-23, 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 2023-24 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 2022-23 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.

4. Residential Admissions:
- 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 2022-23. 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.

5. Reablement:
- 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 2022-23. 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.

8. Planning Requirements

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 Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 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.

HM Government

NHS England

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

			Complete:
Health and Wellbeing Board:	Southwark		Yes
Completed by:	Adrian Ward		Yes
E-mail:	adrian.ward@selondonics.nhs.uk		Yes
Contact number:	0208 176 5349		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No		Yes
If no please indicate when the HWB is expected to sign off the plan:	Thu 20/07/2023	<< Please enter using the format, DD/MM/YYYY	Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Kieron	Williams	kieron.williams@southwark.gov.uk	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Andrew	Bland	andrew.bland@selondonics.nhs.uk	Yes
	Additional ICB(s) contacts if relevant		Martin	Wilkinson	martin.wilkinson@selondonics.nhs.uk	Yes
	Local Authority Chief Executive		Althea	Loderick	althea.loderick@southwark.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)		David	Quirke-Thornton	david.quirke-thornton@southwark.gov.	Yes
	Better Care Fund Lead Official		Adrian	Ward	adrian.ward@selondonics.nhs.uk	Yes
	LA Section 151 Officer		Clive	Palfreyman	clive.palfreyman@southwark.gov.uk	Yes
*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 -->						

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. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Southwark

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£1,686,144	£1,686,144	£1,686,144	£1,686,144	£0
Minimum NHS Contribution	£28,095,959	£29,686,191	£28,095,959	£29,686,191	£0
iBCF	£17,847,349	£17,847,349	£17,847,349	£17,847,349	£0
Additional LA Contribution	£1,287,225	£1,287,225	£1,287,225	£1,287,225	£0
Additional ICB Contribution	£1,200,520	£1,200,520	£1,200,520	£1,200,520	£0
Local Authority Discharge Funding	£2,502,171	£4,153,604	£2,502,171	£4,153,604	£0
ICB Discharge Funding	£1,599,000	£2,971,000	£1,599,000	£2,971,000	£0
Total	**£54,218,368**	**£58,832,033**	**£54,218,368**	**£58,832,033**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£7,984,075	£8,435,974
Planned spend	£8,264,564	£8,708,382

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£19,508,213	£20,612,377
Planned spend	£20,254,645	£21,401,059

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	222.0	187.0	225.0	195.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,940.0	1,843.0
	Count	473	450
	Population	25997	25997

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 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)	96.8%	96.8%	96.8%	96.8%

Residential Admissions

		2021-22 Actual	2023-24 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	562	540

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	90.0%

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 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Southwark

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:
- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.
The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:
- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.
You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:
- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, please select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	Analysis gives best estimates, caweated due to data issues including limitations in reporting on requested data items. Rehab, UCR and at home estimates only based on last available 12 months data before system outage. Capcity and demand data to be built on during the year as community health provider implements new data system. Discharge data reflects estimated apportionment of ICB Operating Plan trajectories to borough level. Estimated 5% pathway zero receive some form of social or VCS support. Demand for intermediate care from the community for vol sector services is zero as VCS do not provide formal Intermediate Care. Short term domiciliary care / other social care incorporated into reablement. Unmet need data not available hence capacity reflects demand in baseline data and projections. Mental health not included as comparable data not available.	Complete:	
		3.1	Yes
		3.2	Yes
		3.3	Yes
		3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

Trust Referral Source (Select as many as you need)	Demand - Hospital Discharge: Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	Social support (including VCS) (pathway 0)	42	44	44	42	43	40	44	42	39	42	39	41
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		34	36	35	34	35	32	36	34	31	33	31	33
OTHER		7	7	7	7	7	6	7	7	6	7	6	7
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	Reablement at home (pathway 1)	18	21	17	11	14	32	23	36	27	26	26	39
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		14	17	14	9	11	25	19	29	22	21	21	31
OTHER		3	3	3	2	2	5	4	6	4	4	4	6
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	Rehabilitation at home (pathway 1)	61	61	61	61	61	61	61	61	61	61	61	61
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		49	49	49	49	49	49	49	49	49	49	49	49
OTHER		9	9	9	9	9	9	9	9	9	9	9	9
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
OTHER		0	0	0	0	0	0	0	0	0	0	0	0
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	Reablement in a bedded setting (pathway 2)	1	1	1	1	1	1	1	1	1	1	1	1
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		1	1	1	1	1	1	1	1	1	1	1	1
OTHER		0	0	0	0	0	0	0	0	0	0	0	0
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	Rehabilitation in a bedded setting (pathway 2)	9	9	9	9	9	8	9	9	8	9	8	9
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		7	7	7	7	7	7	7	7	7	7	7	7
OTHER		1	1	1	1	1	1	1	1	1	1	1	1
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement	10	11	11	6	8	7	10	10	7	11	9	9
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	(pathway 3)	8	9	9	5	6	5	8	8	6	9	7	7
OTHER		2	2	2	1	1	1	2	2	1	2	1	1
Totals	**Total:**	276	288	280	255	265	290	291	312	280	293	281	312

3.2 Demand - Community

Demand - Intermediate Care: Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	120	120	120	120	120	120	120	120	120	120	120	120
Reablement at home	39	56	56	35	21	17	23	29	22	22	22	12
Rehabilitation at home	54	54	54	54	54	54	54	54	54	54	54	54
Reablement in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge: Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly) ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	83	87	86	82	85	79	87	82	76	82	76	81	0%	100%	0%
Reablement at Home	Monthly capacity. Number of new clients.	35	42	34	22	27	62	46	70	53	50	50	76	0%	100%	0%
Rehabilitation at home	Monthly capacity. Number of new clients.	119	119	119	119	119	119	119	119	119	119	119	119	100%	0%	0%
Short term domiciliary care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Reablement in a bedded setting	Monthly capacity. Number of new clients.	2	2	2	2	2	2	2	2	2	2	2	2	100%	0%	0%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	17	17	17	17	17	17	17	17	17	17	17	17	100%	0%	0%
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	20	22	22	12	15	13	20	20	14	22	17	17	100%	0%	0%

3.4 Capacity - Community

Capacity - Community: Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly) ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Urgent Community Response	Monthly capacity. Number of new clients.	120	120	120	120	120	120	120	120	120	120	120	120	100%	0%	0%
Reablement at Home	Monthly capacity. Number of new clients.	39	56	56	35	21	17	23	29	22	22	22	12	0%	100%	0%
Rehabilitation at home	Monthly capacity. Number of new clients.	54	54	54	54	54	54	54	54	54	54	54	54	100%	0%	0%
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Southwark

Local Authority Contribution			Complete:
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2	
Southwark	£1,686,144	£1,686,144	Yes
DFG breakdown for two-tier areas only (where applicable)			
Total Minimum LA Contribution (exc iBCF)	**£1,686,144**	**£1,686,144**	

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2	
Southwark	£2,502,171	£4,153,604	Yes

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2	
NHS South East London ICB	£1,599,000	£2,971,000	Yes
Total ICB Discharge Fund Contribution	£1,599,000	£2,971,000	

iBCF Contribution	Contribution Yr 1	Contribution Yr 2	
Southwark	£17,847,349	£17,847,349	Yes
Total iBCF Contribution	**£17,847,349**	**£17,847,349**	

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	Yes	Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding	
Southwark	£1,287,225	£1,287,225	Council's core budget	Yes
Total Additional Local Authority Contribution	**£1,287,225**	**£1,287,225**		

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS South East London ICB	£28,095,959	£29,686,191
Total NHS Minimum Contribution	**£28,095,959**	**£29,686,191**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	Yes	Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding	
NHS South East London ICB	£1,200,520	£1,200,520	Additional ICES budget	Yes
Total Additional NHS Contribution	**£1,200,520**	**£1,200,520**		
Total NHS Contribution	**£29,296,479**	**£30,886,711**		

	2023-24	2024-25
Total BCF Pooled Budget	**£54,218,368**	**£58,832,033**

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

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

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Southwark

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£1,686,144	£1,686,144	£0	£1,686,144	£1,686,144	£0
Minimum NHS Contribution	£28,095,959	£28,095,959	£0	£29,686,191	£29,686,191	£0
iBCF	£17,847,349	£17,847,349	£0	£17,847,349	£17,847,349	£0
Additional LA Contribution	£1,287,225	£1,287,225	£0	£1,287,225	£1,287,225	£0
Additional NHS Contribution	£1,200,520	£1,200,520	£0	£1,200,520	£1,200,520	£0
Local Authority Discharge Funding	£2,502,171	£2,502,171	£0	£4,153,604	£4,153,604	£0
ICB Discharge Funding	£1,599,000	£1,599,000		£2,971,000	£2,971,000	£0
Total	**£54,218,368**	**£54,218,368**	**£0**	**£58,832,033**	**£58,832,033**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£7,984,075	£8,264,564	£0	£8,435,974	£8,708,382	£0
Adult Social Care services spend from the minimum ICB allocations	£19,508,213	£20,254,645	£0	£20,612,377	£21,401,059	£0

Checklist

Column complete:

Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

										Planned Expenditure										
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1	Enhanced Intervention Services - ICB	MDT providing enhanced psycholgical support for people with learning disabilities and challenging behaviour	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution	Existing	£228,404	£241,331	100%
2	Admissions avoidance - ERR and @home	Community health services enhanced rapid response and @home service	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		2100	2100	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£5,044,499	£5,330,018	49%
3	GP Support @ Home Acuity	Service provides acute clinical care @ home. Multidisciplian team providing quality care at the persons ow home	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£264,654	£279,633	3%
4	@Home Geriatric Assessment	Service providing geriatric assessment and advance care planning in a persons own home	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£31,320	£33,093	0%
5	@Home Integrated Care Fellows	At home integrated Clinical Care Fellows expertise	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£86,130	£91,005	1%
6	Falls service	Southwark community rehab and falls service: specialising in preventing falls, supporting people who have previously had	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£856,949	£905,452	54%
7	Occupational Therapy-Southwark	OT working with falls service supporting people who after an injury or illness have functional, cognitive and phsychological	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£48,936	£51,706	39%
8	Tissue Viability - Community	Service providing treatment, advice and education on treatment of wounds and pressure ulcers in community	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£58,415	£61,722	39%
9	Therapies - Foot Health Community	Assess, treat and advise people with foot conditions. Podiatrists who support foot and lower limb care.	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£65,489	£69,195	39%
10	Palliative Care @ Home	Service provides palliative nursing care at home, also support for families of people who are seriously ill.	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£326,236	£350,360	29%
11	Self-management	Self-management for people with long term conditions	Prevention / Early Intervention	Other	Self-management courses/resource				Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£163,031	£172,259	100%
12	EIS - Speech & Language Therapist	GSTT therapist working in EIS team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£65,133	£68,820	100%
13	Neuro-rehab team - GSTT	Support workers for GSTT community neuro-rehab team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£205,691	£217,333	100%
14	Community Equipment Service	ICES Contract - CCG costs - BCF additional contribution	Assistive Technologies and Equipment	Community based equipment		2862	3120	Number of beneficiaries	Community Health		NHS			Private Sector	Additional NHS Contribution	Existing	£1,200,520	£1,200,520	100%
15	Community Equipment Service	ICES Contract - CCG costs - BCF core contribution	Assistive Technologies and Equipment	Community based equipment		807	880	Number of beneficiaries	Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£296,427	£313,205	100%
16	Behavioural Support - LD and autism	Community team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			Local Authority	Minimum NHS Contribution	Existing	£100,000	£100,000	100%
17	Dementia - Enhanced Neighbourhood	Integrated Care Planning and Navigation	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£184,177	£184,177	53%
18	Homecare Quality Improvement	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care packages		107309	113699	Hours of care	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£2,114,000	£2,330,840	11%
19	Residential & Nursing	Residential and Nursing Placements	Residential Placements	Care home		55	55	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£2,691,939	£2,943,455	12%

20	Protect Adult Social Care - Residential Care	Residential Care	Residential Placements	Care home		48	48	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£2,254,877	£2,479,452	22%
21	Mobilisation - Intermediate and Nursing Care	Nursing and reablement placements	Residential Placements	Care home		2	2	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	New	£100,000	£100,000	1%
22	Discharge to Assess - Council Costs	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£540,600	£573,036	100%
23	Reablement - OT Team ICS	Intermediate Care Services	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£467,250	£490,613	100%
24	Hospital discharge Team	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,879,976	£1,973,974	90%
25	Housing Worker Discharge Team	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£52,500	£55,125	100%
26	Intermediate Care	Intermediate Care Services	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		300	300	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,205,817	£1,278,166	84%
27	Night Owls - overnight intensive	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		13000	13000	Hours of care	Social Care		Joint	50.0%	50.0%	Local Authority	Minimum NHS Contribution	Existing	£241,000	£241,000	99%
28	Reablement Team	Intermediate Care Services	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		525	525	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£2,033,575	£2,135,254	100%
29	Community Mental Health Services	Community Based Schemes	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£694,300	£735,958	61%
30	Enhanced Psychological Support for those	LD clients	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£29,000	£29,000	5%
31	Learning Disability - Personal Budgets	Personalised Budgeting and Commissioning	Personalised Care at Home	Physical health/wellbeing					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£223,660	£237,080	6%
32	Mental Health Reablement	Community Based Schemes	Reablement in a persons own home						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£160,730	£170,374	8%
33	Mental Health - Personal Budgets	Personalised Budgeting and Commissioning	Personalised Care at Home	Mental health /wellbeing					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£636,000	£674,160	42%
34	Mental Health Broker	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£63,000	£66,150	100%
35	Mental Health Complex Cases Worker	Community Based Schemes	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£52,500	£55,125	100%
36	Mental Health Discharge Worker	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£52,500	£55,125	100%
37	Psychiatric Liaison (AMHPs and reablement)	Community Based Schemes, admissions avoidance	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£315,000	£330,750	36%
38	Care Act Funding	Care Act Implementation Related Duties	Care Act Implementation Related Duties	Other	Carers				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,000,000	£1,000,000	100%
39	Service Development and Change	Funding for integration projects	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£45,000	£45,000	4%
40	Carers Strategy	Carers Services	Carers Services	Respite services		125	125	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£450,000	£450,000	87%
41	Unpaid Carers	Support for carers of people with dementia	Carers Services	Respite services		30	30	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£100,000	£100,000	100%
42	Community Equipment	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Community based equipment		250	280	Number of beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£562,000	£562,000	22%
43	Telecare	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Assistive technologies including telecare		98	105	Number of beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£623,995	£623,995	59%
44	Voluntary Sector Prevention Services	Prevention / Early Intervention	Prevention / Early Intervention	Social Prescribing					Social Care		Joint	28.0%	72.0%	Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£1,081,251	£1,081,251	87%
45	Voluntory Sector Carers work	Prevention / Early Intervention	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£400,000	£400,000	100%
46	iBCF funding plans - home care	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care packages		523990	521608	Hours of care	Social Care		LA			Private Sector	iBCF	Existing	£10,327,850	£10,327,850	42%
47	iBCF funding plans - nursing care homes	Residential Placements	Residential Placements	Nursing home		79	79	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£4,174,334	£4,174,334	17%
48	iBCF funding plans - Transformation fund to improve	Community Based Schemes	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Social Care		LA			Local Authority	iBCF	Existing	£250,000	£250,000	100%
49	IBCF Reablement and Intermediate bed based care	Intermediate Care Services	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with reablement accepting step up and step down users		151	151	Number of Placements	Social Care		LA			Private Sector	iBCF	Existing	£999,749	£999,749	100%
50	Residential care for older people	Residential Placements	Residential Placements	Care home		8	8	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£400,000	£400,000	2%

51	Nursing Care for older People	Residential Placements	Residential Placements	Nursing home		6	6	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£300,000	£300,000	3%
52	Home care for older people	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care packages		44420	44083	Hours of care	Social Care		LA			Private Sector	iBCF	Existing	£870,648	£870,648	4%
53	Flexicare - Housing Based Scheme	Extracare - Flexi-care	Residential Placements	Extra care		22	22	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£524,768	£524,768	24%
54	Disabled Facilities Grants	DFG Related Schemes	DFG Related Schemes	Adaptations, including statutory DFG grants		150	150	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG	Existing	£1,686,144	£1,686,144	100%
55	Community Equipment	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Community based equipment		250	280	Number of beneficiaries	Social Care		LA			Local Authority	Additional LA Contribution	Existing	£246,850	£246,850	10%
56	Telecare	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Assistive technologies including telecare		98	105	Number of beneficiaries	Social Care		LA			Local Authority	Additional LA Contribution	Existing	£444,626	£444,626	42%
57	Voluntary Sector Prevention Services	Prevention / Early Intervention	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Local Authority	Additional LA Contribution	Existing	£482,749	£482,749	39%
58	Voluntory Sector Carers work	Prevention / Early Intervention	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Local Authority	Additional LA Contribution	Existing	£113,000	£113,000	28%
59	Further investment into Nursing Care	Further investment into the Nursing Care sector to allow for a new care home within the borough to populate their beds faster	Residential Placements	Nursing home		22	22	Number of beds/Placements	Social Care		LA			Local Authority	Local Authority Discharge	Existing	£713,000	£713,000	3%
60	Improvements in Reablement Outcomes	Further investment into reablement packages to improve outcomes. This would increase the speed and accessibility of	Home-based intermediate care services	Reablement at home (to support discharge)		44	44	Packages	Social Care		LA			Local Authority	Local Authority Discharge	Existing	£200,000	£200,000	10%
61	Enhanced resources into Homecare	Enhanced investment into double handed care placements to allow for more effective discharge to an “at home” setting and to	Home Care or Domiciliary Care	Domiciliary care packages		9238	9328	Hours of care	Social Care		LA			Local Authority	Local Authority Discharge	Existing	£220,673	£220,673	1%
62	Maximising the use of Extra Care and sheltered	Investment in Extra Care Housing, Sheltered and Alms housing to facilitate higher acuity discharges from hospital – additional	Housing Related Schemes						Social Care		LA			Local Authority	Local Authority Discharge	Existing	£77,000	£77,000	4%
63	Residential Care Charter	Accelerated investment in to the LA's in-borough provider's in providing a supplement which would impact front line	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge	Existing	£150,000	£150,000	50%
64	Hospital Buddies	Supports to those who are due to be admitted to hospital for elective surgery, with discharge preparation.	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess pathway 0)					Social Care		LA			Local Authority	Local Authority Discharge	Existing	£20,000	£20,000	100%
65	Double Handed Care	Occupational Therapist based in the ToC Review team to look at all new residents being discharged with double handed care	Other						Social Care		LA			Local Authority	Local Authority Discharge	Existing	£55,000	£55,000	100%
66	Transfer of Care Assessment Team	Community based team to complete assessments in the community as a part of the D2A model to facilitate quick and safe	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	Local Authority Discharge	Existing	£175,000	£175,000	10%
67	Cost of Living Crisis Worker	Non-qualified staff member to support people who are due to be discharged from Hospital or recently discharged with the	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess pathway 0)					Social Care		LA			Local Authority	Local Authority Discharge	Existing	£35,000	£35,000	100%
68	Step Down Flats	To fund 7 step down flats in extra care sheltered housing. This will enable pathway 1 discharges where people cannot return	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with rehabilitation (to support discharge)		35	35	Number of Placements	Social Care		LA			Local Authority	Local Authority Discharge	Existing	£188,998	£188,998	25%
69	Increased Brokerage Support	This additional funding helped to provide the right care and the right time for the right people and speed up pathway 1 and 3	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes					Social Care		LA			Local Authority	Local Authority Discharge	Existing	£27,500	£27,500	4%
70	Retention initiative for OT Workers	Investment into earmarked initiative for Occupational Therapists retention payment to assist in retaining staff please	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge	Existing	£40,000	£40,000	0%
71	Further Investment into Residential Care	Further investment into the Residential Care sector to allow for a new provider within the borough to populate their beds faster than	Residential Placements	Care home		11	11	Number of beds/Placements	Social Care		LA			Local Authority	Local Authority Discharge	New	£600,000	£600,000	2%
72	LA Discharge Fund to be allocated	2024/25 growth to finalise notional commitments	Other						Social Care		LA			Local Authority	Local Authority Discharge	New	£0	£1,651,433	100%
73	ICB discharge fund to be allocated	To be allocated end 23/24: Pathway 2&3, Mental Health support, bed based intermediate care, Community based schemes	Other						Community Health		NHS			NHS	ICB Discharge Funding	Existing	£0	£2,971,000	100%
74	Mental Health Discharge Housing Workers	MH Discharge workers to support MFFD homeless on the ward and those currently in B&B. Facilitate discharge from the ward and	Housing Related Schemes						Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding	Existing	£40,000	£0	100%
75	Expand step down housing	step down flats - Create capacity in complex care placement for MFFD patients currently on the ward	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with reablement (to support discharge)		48	0	Number of Placements	Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding	Existing	£144,500	£0	100%
76	Expand step down housing options	placement review workers	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding	Existing	£36,000	£0	100%
77	Additional Home Treatment Team (HTT) capacity	HTT advanced practitioners to support individuals discharged to step down accommodation	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding	Existing	£40,000	£0	100%
78	Shared lives support	Step down service for people discharged from hospital. Increase housing capacity for discharge to the community and offer psychosocial support to users	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding	Existing	£20,100	£0	100%
79	Outreach Service	Kings Outreach Therapy Service (KCH led across Lambeth & Southwark)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	ICB Discharge Funding	Existing	£153,711	£0	100%
80	Pathway 2 & 3 Discharges	Placements, hotels, equipment inc homeless and NRPF	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with rehabilitation (to support admission avoidance)		10	0	Number of Placements	Community Health		NHS			NHS Community Provider	ICB Discharge Funding	Existing	£350,000	£0	100%
81	Pathway 2 & 3 Discharges	Placements, and bed based intermediate care	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with rehabilitation (to support admission avoidance)		3	0	Number of Placements	Community Health		NHS			NHS Community Provider	ICB Discharge Funding	Existing	£150,000	£0	100%

82	Pathway 2 & 3 Discharges	Placements, and bed based intermediate care	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with rehabilitation (to support admission avoidance)		6	0	Number of Placements	Community Health		NHS			Private Sector	ICB Discharge Funding	Existing	£468,689	£0	100%
83	Homeless discharge service	Accommodation and support to enable discharge of homeless patients ready for discharge	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	ICB Discharge Funding	New	£196,000	£0	100%

Further guidance for completing Expenditure sheet

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'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. 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. Independent Mental Health Advocacy 2. Safeguarding 3. 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. Carer advice and support related to Care Act duties 3. 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 social 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 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. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. 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. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. 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 (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. 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.

12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	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.
16	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.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 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	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	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.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Southwark

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	234.0	196.7	236.8	205.0	The ambition is for a 5% reduction in 23/24, reflecting a continuation of progress made in 22/23. Benchmarking suggests this is achievable given 22/23 position is top quartile for London, and if key conditions such as COPD, heart failure,asthma & diabetes can be managed more in the community. Note Q4 actual 22/23 rate 205 in line with target.	A range of BCF services and related partnership improvement workstreams directly and indirectly support the objective of reducing avoidable admissions. e.g. Urgent Community Response, Self-Management, Age Well, neighbourhood working and PCN development, Core 20+5, Vital 5, SDEC, primary care access, risk stratification, long term condition management including diabetes and hypertension mgt, anticipatory/ proactive care.	Yes
	Number of Admissions	502	422	508	-			
	Population	318,830	318,830	318,830	318,830			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Indicator value	222	187	225	195			Yes

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

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition	
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,299.0	1,940.0	1,843.0	Draft proposal is for a 5% annual reduction in falls admissions which benchmarking suggests is achievable given the 21/22 rate was around 5% above the London average and draft data suggests on course for delivering a 5% reduction on 21/22. Waiting for 22/23 falls data from BCF team before finalising.	Falls prevention is a key focus of the Partnership Southwark Age Well frailty workstream and agencies working with older people are focussed on this objective. The GSTT community falls service is funded from the BCF. Services such as ICES and telecare have a strong falls prevention/admission element.	Yes
	Count	560	473	450			Yes
	Population	25,997	25997	25997			Yes

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	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 (SUS data - available on the Better Care Exchange)	Quarter (%)	96.5%	96.9%	96.9%	97.1%	Benchmarking shows that Southwark had the highest rate on this measure in London in 22/23. This reflects very strong services that support a home first approach. The 96.8% target reflects a continuation of this high level of performance. A target to further increase the rate is not considered appropriate as current performance is optimal.	The BCF continues to fund the provision of high intensity home based support services enabling an effective and safe home first approach in the vast majority of discharges from hospital. For example, home based reablement and intermediate care, intensive home care, double handed care, overnight home care.	Yes
	Numerator	5,009	4,883	5,070	5,098			
	Denominator	5,189	5,041	5,230	5,252			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Quarter (%)	96.8%	96.8%	96.8%	96.8%			
	Numerator	5,571	5,344	5,343	5,201			Yes
	Denominator	5,755	5,521	5,520	5,373			Yes

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 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	562.0	538.8	498.9	539.7	The target is 22/23 planned activity and 4% increase to reflect the population and acuity. Dealing with increasing complexities and must ensure forecasting accommodates those sudden fluctuations and the long term impact of the pandemic.	To maintain people's independence in the community as long as possible using care packages and reablement.	Yes
	Numerator	157	162	150	169			Yes
	Denominator	27,938	30,064	30,064	31,312			

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

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 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 (%)	86.6%	83.0%	92.4%	90.0%	The new target is based on 22/23 activity and considers monthly fluctuation.	Streamlining care and support via the new transfer of care team (new team that transfers patients from hospital to home). Intermediate Care Southwark working hard to ensure the right people receive reablememt at the right time.	Yes
	Numerator	161	760	871	849			Yes
	Denominator	186	916	943	943			Yes

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

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

Better Care Fund 2023-25 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Southwark

	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	Complete:
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 all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* 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? *Paragraph 11* 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? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan	Yes		The plan will be presented to the Health and Wellbeing Board meeting on 20/7/23. In the interim it was agreed with the chair that this draft, approved by senior ICB and Council lead officers, would be submitted.	20/07/2023	Yes
	PR2	**A clear narrative for the integration of health, social care and housing**	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 integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • 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 *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* 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. *Paragraph 15*	Narrative plan	Yes				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? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • 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? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan	Yes				Yes
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	PR4	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan	Yes				Yes
Additional discharge funding	PR5	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans	Yes				Yes

NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan	Yes				Yes
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**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 to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan	Yes				Yes

Agreed expenditure plan for all elements of the BCF	**PR8**	**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? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* 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? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan	Yes				Yes
Metrics	**PR9**	**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 based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan	Yes				Yes

Better Care Fund 2022-23 End of Year Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) To confirm actual income and expenditure in BCF plans at the end of the financial year
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICB's, local authorities and service providers) for the purposes noted above.

BCF reports submitted by local areas are required to be signed off by HWBs as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website in due course.

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 grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To more optimally 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 tab for readability if required.
The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste Values only.

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

ASC Discharge Fund-due 2nd May

This is the last tab in the workbook and must be submitted by 2nd May 2023 as this will flow to DHSC. It can be submitted with the rest of workbook empty as long as all the details are complete within this tab, as well as the cover sheet although we are not expecting this to be signed off by HWB at this point. The rest of the template can then be later resubmitted with the remaining sections completed.

After selecting a HWB from the dropdown please check that the planned expenditure for each scheme type submitted in your ASC Discharge Fund plan are populated.
Please then enter the actual packages of care that matches the unit of measure pre-specified where applicable.
If there are any new scheme types not previously entered, please enter these in the bottom section indicated by a new header. At the very bottom there is a totals summary for expenditure which we'd like you to add a breakdown by LA and ICB.

Please also include summary narrative on:
1. Scheme impact
2. Narrative describing any changes to planned spending – e.g. did plans get changed in response to pressures or demand? Please also detail any underspend.
3. Assessment of the impact the funding delivered and any learning. Where relevant to this assessment, please include details such as: number of packages purchased, number of hours of care, number of weeks (duration of support), number of individuals supported, unit costs, staff hours purchased and increase in pay etc
4. Any shared learning

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF 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

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.

3. 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:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2022-23 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.

https://www.england.nhs.uk/publication/better-care-fund-planning-requirements-2022-23/

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: NHS contribution to adult social care is maintained in line with the uplift to NHS Minimum Contribution
National condition 3: Agreement to invest in NHS commissioned out-of-hospital services
National condition 4: Plan for improving outcomes for people being discharged from hospital

4. Metrics

The BCF plan includes the following metrics: Unplanned hospitalisation for chronic ambulatory care sensitive conditions, Proportion of discharges to a person's usual place of residence, Residential Admissions and Reablement. Plans for these metrics were agreed as part of the BCF planning process.

This section captures a confidence assessment on achieving the plans for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes that have been achieved.
The BCF Team publish data from the Secondary Uses Service (SUS) dataset for Dischaege to usual place of residence and avoidable admissions at a local authority level to assist systems in understanding performance at local authority level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric plans and the related narrative information and it is advised that:
- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.
- In providing the narrative on Challenges and Support needs, and Achievements, most areas have a sufficiently good perspective on these themes and the unavailability of published metric data for one/two of the three months of the quarter is not expected to hinder the ability to provide this useful information. Please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration observed or anticipated and any associated comments to explain.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. Income and Expenditure

The Better Care Fund 2022-23 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and NHS. The mandatory funding sources are the DFG (Disabled Facilities Grant), the improved Better Care Fund (iBCF) grant, minimum NHS contribution and additional contributions from LA and NHS. This year we include final spend from the Adult Social Care discharge fund.

Income section:
- Please confirm the total HWB level actual BCF pooled income for 2022-23 by reporting any changes to the planned additional contributions by LAs and NHS as was reported on the BCF planning template.
- In addition to BCF funding, please also confirm the total amount received from the ASC discharge fund via LA and ICB if this has changed.
- The template will automatically pre populate the planned expenditure in 2022-23 from BCF plans, including additional contributions.
- If the amount of additional pooled funding placed intothe area's section 75 agreement is different to the amount in the plan, you should select 'Yes'. You will then be able to enter a revised figure. Please enter the **actual income** from additional NHS or LA contributions in 2022-23 in the yellow boxes provided, **NOT** the difference between the planned and actual income.
- Please provide any comments that may be useful for local context for the reported actual income in 2022-23.

Expenditure section:
- Please select from the drop down box to indicate whether the actual expenditure in your BCF section 75 is different to the planned amount.
- If you select 'Yes', the boxes to record actual spend, and explanatory comments will unlock.
- You can then enter the total, HWB level, actual BCF expenditure for 2022-23 in the yellow box provided and also enter a short commentary on the reasons for the change.
- Please include actual expenditure from the ASC discharge fund.
- Please provide any comments that may be useful for local context for the reported actual expenditure in 2022-23.

6. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2022-23 through a set of survey questions
These questions are kept consistent from year to year to provide a time series.
The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 5 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund

There are a total of 3 questions in this section. Each is set out as a statement, for which you are asked to select one of the following responses:

- Strongly Agree
- Agree
- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2022-23
3. The delivery of our BCF plan in 2022-23 had a positive impact on the integration of health and social care in our locality

Part 2 - Successes and Challenges
This part of the survey utilises the SCIE (Social Care Institue for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic Model.

Please highlight:
4. Two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2022-23.
5. Two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2022-23?

For each success and challenge, please select the most relevant enabler from the SCIE logic model and provide a narrative describing the issues, and how you have made progress locally.
SCIE - Integrated care Logic Model

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rurual factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

Department of Health & Social Care | Department for Levelling Up, Housing & Communities | Local Government Association | NHS England

Better Care Fund 2022-23 End of Year Template

2. Cover

Version 1.0

Please Note:

- *The BCF end of year reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.*
- *At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.*
- *All information will be supplied to BCF partners to inform policy development.*
- *This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.*

			Checklist: Complete:
Health and Wellbeing Board:	Southwark		Yes
Completed by:	Adrian Ward		Yes
E-mail:	adrian.ward@selondonics.nhs.uk		Yes
Contact number:	0208 176 5349		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No		Yes
If no, please indicate when the report is expected to be signed off:	Thu 20/07/2023	<< Please enter using the format, DD/MM/YYYY	Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC

Please see the Checklist on each sheet for further details on incomplete fields

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Income and Expenditure actual	Yes
6. Year-End Feedback	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 End of Year Template

3. National Conditions

Selected Health and Wellbeing Board: Southwark

Confirmation of Nation Conditions			Checklist
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in 2022-23:**	Complete:
1) A Plan has been agreed for the Health and Wellbeing Board area that includes all mandatory funding and this is included in a pooled fund governed under section 75 of the NHS Act 2006? (This should include engagement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes		Yes
2) Planned contribution to social care from the NHS minimum contribution is agreed in line with the BCF policy?	Yes		Yes
3) Agreement to invest in NHS commissioned out of hospital services?	Yes		Yes
4) Plan for improving outcomes for people being discharged from hospital	Yes		Yes

Better Care Fund 2022-23 End of Year Template

4. Metrics

Selected Health and Wellbeing Board: Southwark

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2022-23 planning	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements	Checklist Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	899.0	On track to meet target	Despite the strong reduction the rate of ASC admissions remains above the London average and that of comparable boroughs. There remains a high level of variation between population and GP practices	12% reduction in the year compared to 21/22 exceeding target of 5% . Notable reductions in heart failure, asthma, COPD & diabetes, the main conditions reflecting the majority of admissions.	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	96.9%	On track to meet target	not applicable	The target has been met and Southwark has the highest rate in London on this measure, reflecting the current home first based model of care.	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	539	On track to meet target	Try to maintain people's independence in the community as long as possible using care packages and reablement.	The rate of permanent admission is 498.9, equating to 12 fewer placements than predicted. We have embedded a Home First Model at the point of discharge which has resulted in fewer admissions.	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	83.0%	On track to meet target	Streamlining care and support via the new transfer of care team (a new team that transfers patients from hospital to home).	We expected 83% in 2022/23 but achieved 92.4%. A reduced weighting list and stable staff cohort with minimal vacancies has contributed to better outcomes for residents.	Yes

Better Care Fund 2022-23 End of Year Template

5. Income and Expenditure actual

Selected Health and Wellbeing Board: Southwark

Income

	2022-23	
Disabled Facilities Grant	£1,686,144	
Improved Better Care Fund	£17,847,349	
NHS Minimum Fund	£26,590,914	
Minimum Sub Total		£46,124,407

	Planned		Actual			
NHS Additional Funding	£1,309,308		Do you wish to change your additional actual NHS funding?	No		
LA Additional Funding	£1,287,225		Do you wish to change your additional actual LA funding?	No		
Additional Sub Total		£2,596,533				£2,596,533

	Planned 22-23	Actual 22-23
Total BCF Pooled Fund	£48,720,940	£48,720,940

	ASC Discharge Fund					
	Planned		Actual			
LA Plan Spend	£1,308,873		Do you wish to change your additional actual LA funding?	No		
ICB Plan Spend	£1,251,893		Do you wish to change your additional actual ICB funding?	No		
ASC Discharge Fund Total		£2,560,766				£2,560,766

	Planned 22-23	Actual 22-23
BCF + Discharge Fund	£51,281,706	£51,281,706

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2022-23	

Checklist
Complete:

Yes
Yes
Yes
Yes
Yes

Expenditure

	2022-23
Plan	£48,720,940

Do you wish to change your actual BCF expenditure?	Yes	Yes

Actual	£49,225,725	Yes

	ASC Discharge Fund
Plan	£2,560,766

Do you wish to change your actual BCF expenditure?	No	Yes

Actual	£2,560,766	Yes

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2022-23	Additional costs were incurred as a result of increased activity in our Integrated Community Equipment service and residential and nursing care.	Yes

Better Care Fund 2022-23 End of Year Template

6. Year-End Feedback

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF.
There is a total of 5 questions. These are set out below.

Selected Health and Wellbeing Board: Southwark

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate to what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response	Checklist Complete:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	The BCF Planning Group that oversees the pooled budget is an effective integrated forum, and the BCF has prompted discussions at the Health and Wellbeing Board and Partnership Southwark about further pooling and alignment of resources to improve outcomes.	Yes
2. Our BCF schemes were implemented as planned in 2022-23	Agree	There were areas of overspend and slippage that were managed within the budget in line with the S75 agreement, but in overall terms the plan was implemented as agreed.	Yes
3. The delivery of our BCF plan in 2022-23 had a positive impact on the integration of health and social care in our locality	Agree	The BCF provided funding for areas of integrated working including hospital discharge, reablement, intermediate care and community health, including the integrated Intermediate Care Southwark service. The BCF has increased investment into the integrated community equipment service, which had faced substantial growth pressure.	Yes

Part 2: Successes and Challenges

Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing.
Please provide a brief description alongside.

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2022-23	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes	
Success 1	6. Good quality and sustainable provider market that can meet demand	Commissioning new nursing home, re-tendering of former Anchor residential care homes to new provider, commissioning of extra care. Use of discharge fund to strengthen providers.	Yes
Success 2	2. Strong, system-wide governance and systems leadership	Development of local care partnership as part of wider ICS development since Jul 22. Development of revised Health and Wellbeing Strategy informing Joint Forward Plan and Southwark Health and Care Plan. Flexible and agile joint planning for short terms use of discharge fund despite the challenges. Improved whole system focus on discharge and patient flow, including Transfers of Care Team, SEL workstream on discharge improvement.	Yes

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2022-23	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges

Challenge 1	6. Good quality and sustainable provider market that can meet demand	Capacity of nursing care home sector to take referrals for patients with high levels of acuity remains key driver of delayed transfers relating to community based care. In mental health a key driver relates to supported housing. Our largest provider of nursing care rated inadequate by CQC. Recruitment and retention, continuing impact on capacity of providers e.g. Community Health capacity to take hospital referrals, Physiotherapist, social care workforce	Yes
Challenge 2	8. Pooled or aligned resources	Discharge Fund – challenging nature of national process due to short notice one off funding with restrictive conditions, makes it difficult to take a strategic integrated approach to root causes of discharge delays. The BCF delayed process 22/23, with letters of agreement only issued in January, makes it more difficult to link to annual budget planning	Yes

Footnotes:

Question 4 and 5 are should be assigned to one of the following categories:

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

Other

Better Care Fund 2022-23 End of Year Template

ASC Discharge Fund

Selected Health and Wellbeing Board: Southwark

Please complete and submit this section (along with Cover sheet contained within this workbook) by 2nd May

For each scheme type please confirm the impact of the scheme in relation to the relevant units asked for and actual expenditure. Please then provide narrative around how the fund was utilised, the duration of care it provided and and any changes to planned spend. At the very bottom of this sheet there is a totals summary, please also include aggregate spend by LA and ICB which should match actual total prepopulation.
The actual impact column is used to understand the benefit from the fund. This is different for each sheme and sub type and the unit for this metric has been pre-populated. This will align with metrics reported in fortnightly returns for scheme types.
1) For 'residential placements' and 'bed based intermediary care services', please state the number of beds purchased through the fund. (i.e. if 10 beds are made available for 12 weeks, please put 10 in column H and please add in your column K explanation that this achieve 120 weeks of bed based care).
2) For 'home care or domiciliary care', please state the number of care hours purchased through the fund.
3) For 'reablement in a person's own home', please state the number of care hours purchased through the fund.
4) For 'improvement retention of existing workforce', please state the number of staff this relates to.
5) For 'Additional or redeployed capacity from current care workers', please state the number of additional hours worked purchased through the fund purchased.
6) For 'Assistive Techonologies and Equipment' , please state the number of unique beneficiaries through the fund.
7) For 'Local Recruitment Initiatives', please state the additional number of staff this has helped recruit through the fund.

If there are any additional scheme types invested in since the submitted plan, please enter these into the bottom section found by scrolling further down.

Scheme Name	Scheme Type	Sub Types	Planned Expenditure	Actual Expenditure	Actual Number of Packages	Unit of Measure	Did you make any changes to planned spending?	If yes, please explain why	Did the scheme have the intended impact?	If yes, please explain how, if not, why was this not possible	Do you have any learning from this scheme?
Additional Home Treatment Team (HTT) capacity	Other		£53,360	£40,000		N/A	Yes	Diverted projected surplus to other schemes	Yes	Trained professionals focused on safe patient discharge. Combined impact of 32 extra acute beds created - this is equivalent to 3800 occupied bed days (OBD) (schemes 1,9,15)	Early planning and disbursement of funds necessary for recruitment
Administration	Administration		£25,607	£21,837		N/A	No		Yes	Resource enabled administration of discharge scheme planning and reporting	no
CHC	Other		£250,000	£0		N/A	Yes	After further planning considerations budget redirected to other schemes within the fund with demand	No	Scheme did not need to be mobilised - budget redirected to other schemes within the fund with excess demand.	Ensure time in planning process to fully test proposals
Cost of Living Crisis Worker	Other		£35,000	£35,000		N/A	No		Yes	The post is an invaluable resource within the community.	New initiatives take time to bed in. Short term funding can make long term
Discharge reserve	Contingency		£100,000	£0		N/A	No	This was a contingency redirected to schemes with excess demand	Yes	This was a contingency applied to schemes with excess demand	no
Double Handed Care	Assistive Technologies and Equipment	Other	£55,000	£55,000	54	Number of beneficiaries	No		Yes	The scheme has the potential to be more successful once recruitment of qualified Occupational Therapists is achieved . (54 clients)	Investment in training of Occupational Therapists is required nationally to
Enhanced resources into Homecare	Home Care or Domiciliary Care	Domiciliary care packages	£177,375	£177,375	9,238	Hours of care	No		Yes	Yes, enhanced investment into double handed care has enabled us to maintain community care capacity and avoid nursing home placements wherever possible.	Investing in our community care provision has meant that over times where
Expand step down housing options (a)	Bed Based Intermediate Care Services	Other	£33,600	£273,418	8	Number of beds	Yes	Agreed to scale up successful model funded by schemes with slippage	Yes	Accommodation available to facilitate patient discharge. 8 step down flats	Step downflats model is effective
Expand step down housing options (b)	Other		£53,360	£36,000		N/A	Yes	Diverted surplus to step down scheme (a) (flats)	Yes	Trained professionals focused on safe patient discharge. Combined impact of 32 extra acute beds created - equivalent to 3800 occupied bed days (OBD) (schemes 1,9,15)	Early planning and disbursement of funds is necessary for recruitment
Further investment into Nursing Care	Residential Placements	Nursing home	£263,000	£263,000	22	Number of beds	No		Yes	Yes, the increased investment into the nursing care sector has helped the new care home to populate their beds.	The demand for Nursing home placements leads to our longest delays for
Hospital Buddies	Other		£20,000	£20,000		N/A	No		Yes	Yes, the scheme offers more than just practical support for residents. This covers residents in need of care services and those that are not.	New schemes take time to embed into systems and to generate work. Sometimes
Improvements in Reablement Outcomes	Reablement in a Person's Own Home	Reablement service accepting community and discharge	£100,000	£100,000	5,063	Hours of care	No		Yes	Yes, further investment in the reablement package of care has enabled ICS to access increased numbers of cases. (44 clients).	Increased volume of cases does not necessarily mean increased appropriate cases
Increased Brokerage Support	Other		£27,500	£27,500		N/A	No		Yes	Additional Brokerage support has enabled additional resources to enable timely discharge for client on pathways 1 and 3 discharges.	Short term funding means it is difficult to recruit and retain the right staff and
Maximising the use of Extra Care and sheltered accomodation	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	£77,000	£77,000	8	Number of beds	No		Yes	Additional Investment has enabled more timely discharges into Extra Care, reducing the burden on Residential Care. (Note : packages column: 4400 hours of additional support)	Investing in our community care provision has meant that over time where other
Mental Health Discharge Housing Workers	Other		£106,720	£80,000		N/A	Yes	Actual spend lower than budget, surplus diverted to alternative scheme	Yes	Trained professionals focused on safe patient discharge. Combined impact of 32 extra acute beds created - equivalent to 3800 occupied bed days (OBD) (schemes 1,9,15)	Early planning and disbursement of funds necessary for recruitment

Older Adults Care Navigators (mental health)	Other		£38,265	£0		N/A	Yes	Scheme could not be mobilised (recruitment)	No	Scheme not able to be mobilised as a result of difficult recruiting into post	Early planning required
Residential Care Charter	Improve retention of existing workforce	Incentive payments	£150,000	£150,000	300	number of staff	No		Yes	The funding enabled us to work with providers to improve the working conditions of care staff, to boost recruitment and retention.	Investing in our community care provision has meant that over time where others
Retention initiative for OT Workers	Improve retention of existing workforce	Incentive payments	£40,000	£40,000	60	number of staff	No		Yes	We are starting to see the benefit of this scheme as ASC are now attracting more OT's into the workforce.	Investing in our staff leads to overall improved numbers and morale.
Shared lives support (Q4 2022/23)	Reablement in a Person's Own Home	Reablement to support to discharge – step down	£20,100	£20,100	804	Hours of care	No		Yes	Accommodation available to facilitate patient discharge - 804 hrs est tbc	
Social worker in Denmark Hill ED	Other		£60,000	£60,000		N/A	No	There was recruitment slippage but post was filled per plan	Yes	Too early to evaluate fully due to recruitment slippage	We have spent time developing pathways and referral routes out of
Spot purchasing budget Pathway 2 & 3 discharges	Other		£201,286	£310,538		N/A	Yes	Budget was scaled up by absorbing projected underspends on other ICB schemes	Yes	It was useful to have a flexible spot purchasing budget to help resolve funding for some complex patients with lengthy delays	
Step Down Flats	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	£188,998	£188,998	16	Number of beds	No		Yes	Step down flats offer an alternative for someone who is able to leave an acute hospital setting when they are unable to return home temporarily.	On-going provision of step down flats offer a least restrictive option for people
Supported housing investment to enable discharge	Other		£160,767	£350,000		N/A	Yes	Scheme was scaled up.	Yes	Accommodation available to facilitate patient discharge. Six supported housing units.	Early planning necessary to maximise impact and cost efficiency
Tenancy (Retainment) Support	Other		£48,828	£0		N/A	Yes	Scheme could not be mobilised in time due to capacity	No	Scheme could not be mobilised.	Joint working between MH provider (SLAM) and LA to be enhanced. Early planning
Therapy input discharge support (a)	Reablement in a Person's Own Home	Reablement to support to discharge – step down	£50,000	£0	0	Hours of care	Yes	Was not possible to mobilise the scheme in short timeframe - budget redirected to other schemes with excess demand	No	Scheme could not be commissioned within timescales - budget redirected to other schemes with excess demand	Ensure sufficient time and capacity to mobilise schemes with complex set
Therapy input discharge support (b)	Reablement in a Person's Own Home	Reablement to support to discharge – step down	£50,000	£60,000	2,000	Hours of care	Yes	Additional costs incurred and agreed. The team comprised of a band 7 OT, Band 7 PT and Rehab support worker.	Yes	The service prevented hospital admissions and reduced demand to urgent community services. Casseload 32 clients, estimated bed day saving of 144 days (2000 hrs est tbc)	Imperative to have a flexible approach to accepting referrals including
Transfer of Care Assessment Team	Residential Placements	Discharge from hospital (with reablement) to long term care	£175,000	£175,000		Number of beds	No	see note on scheme type and units	Yes	The team have been invaluable at supporting the transition back into the community and supporting the known risky discharges. 105 residents supported. Note: scheme type should be "other"	Short term funding makes it difficult to sustain a team and support long term

Planned Expenditure	£2,560,766
Actual Expenditure	£2,560,766
Actual Expenditure ICB	£1,251,893
Actual Expenditure LA	£1,308,873

Item No. 10	Classification: Open	Date: 20 July 2023	Meeting Name: Health and Wellbeing Board
Report title:		Joint Forward Plan 2023/24 South East London Integrated Care Board	
Ward(s) or groups affected:		All	
From:		Martin Wilkinson, Chief Operating Officer, Southwark, NHS SEL Integrated Care Board	

RECOMMENDATION(S)

1. The Board notes the South East London Integrated Care Board Joint Forward Plan 2023/24.

2. The Board notes the letter dated 14 June 2023 from the Chair of the Health and Wellbeing Board to the Chief Executive of South East London Integrated Care Board confirming the Joint Forward Plan takes 'proper account' of the priorities and actions outlined within the Southwark Joint Health & Wellbeing Strategy.

BACKGROUND INFORMATION

3. The Health and Care Act 2022 introduced integrated care boards (ICBs) and integrated care partnerships (ICPs) as part of new Integrated Care Systems (ICSs), which were established on 1st July 2022.

4. NHSE national planning guidance for 2023/24 requires that ICBs publish a Joint Forward Plan by 1st July 2023.

5. It is a requirement of the planning process for the Joint Forward Plan that each Health and Wellbeing Board in the ICS provide a statement to confirm that the plan takes proper account of the borough's health and wellbeing strategy. To meet the requirements this statement had to be made prior to the publication of the plan on 1st July. As the Health and Wellbeing Board was not scheduled to meet during this period it was agreed that the Chair would provide a letter to the ICB confirming this, based on the advice from Public Health (see **appendix 1**).

6. The plan is now being presented to the board for information.

7. The Joint Forward Plan will be refreshed annually to take account of implementation and outcomes over the previous year, including any

learning to be applied to future plans, and reflect any changes required due to new or emerging issues or requirements. This will be subject to consultation and discussion with the Health and Wellbeing Board.

KEY ISSUES FOR CONSIDERATION

8. The full Joint Forward Plan is a very large document (299 pages) and is more easily viewed in a navigable format on the ICS website www.selondonics.org/joint-forward-plan.

9. The key issues for consideration for this board relate to the Southwark borough section of the plan (see **appendix 2**). This section was developed by Partnership Southwark and forms the basis of the Southwark Health and Care Plan approved by the Partnership Southwark Strategic Board on 6th July 2023.

Key points of Joint Forward Plan

10. The Joint Forward Plan provides a strategic overview of key priorities and objectives for the medium term (3 to 5 years) at SEL and borough level, and a summary of short term actions to deliver these. The plan covers a wide range of planning requirements to ensure that services are being developed that:

- Meets the needs of our population.
- Demonstrates and makes tangible progress in addressing the core purpose of our wider integrated care system - improving outcomes in health and healthcare, tackling inequalities in outcomes, experience and access, enhancing productivity and value for money and helping the NHS support broader social and economic development.
- Delivers national NHS Long Term Plan and wider priorities.
- Meets the statutory requirements of our Integrated Care Board.

11. The plan builds on the work been done as a wider system and is driven by:

- The SEL Integrated Care Partnership integrated care strategy (as presented to the Health and Wellbeing Board on 17th November 2022)
- Borough based Local Health and Wellbeing Plans
- Local Care Partnerships plans
- SEL-wide pathways and services transformation work

12. The plan reflects commitments to:

- Improving population health and reducing inequalities.
- Improving and standardising our core service offer, quality and outcomes across primary care, community, mental health and acute services, plus across our key care pathways such as urgent and emergency care.
- Taking action to secure a sustainable health system, with a particular

focus on finance, workforce, quality and performance.
- Developing the supporting system architecture and infrastructure required to secure success and embed sustainable change.
- Pushing the boundaries with regards evidence based innovation and transformation.
- Doing so in partnership with our communities, patients and service users to ensure coproduced approaches and solutions that are patient and service user centred.

Key points - Southwark borough section

13. The Southwark section (see page 93 of full plan, extracted in **appendix 2**) sets the five key objectives underpinning the local plan, which correspond exactly to the Health and Wellbeing Strategy presented to this board in November 2022, namely:

- A whole family approach to give children the best start in life
- Healthy employment and good health for working age adults
- Early identification and support to stay well
- Strong and connected communities
- Integration of health and social care

14. Focus areas for the term of plan include:

- Strategic collaboration, with an initial focus on mental health
- The Start Well, Live Well, Age Well and Care Well workstreams focusing on specific priorities for joint working across the partnership including 1001 days, mental health in Children and Young People, community mental health transformation, Vital 5, cancer, and prevention
- Enablers such as workforce, estates, finance and digital

15. Underpinning key principles include:

- Embedding an approach to tackling health inequalities across all our policymaking, services and delivery.
- Making sustainability and tackling climate change an integral part of protecting and improving health.
- Targeted place-based approach and population groups.
- Community empowerment and co-production.
- Delivering high quality, joined-up and person-centred health and social care.

This section forms the basis of the Southwark Health and Care Plan and its delivery will be overseen through Partnership Southwark governance arrangements.

Policy framework implications

16. As set out in para 3 the requirement for a Joint Forward Plan arises from NHSE planning requirements established for Integrated Care Boards for 2023/24.

17. Health and Wellbeing Boards remain responsible for producing both joint strategic needs assessments and joint local health and wellbeing strategies which future iterations of the Joint Forward Plan are required to take into account.

Community, equalities (including socio-economic) and health impacts

Community impact statement

18. The core purpose of the Joint Forward Plan underpinning the detailed workstreams is “improving outcomes in health and healthcare, tackling inequalities in outcomes, experience and access, enhancing productivity and value for money and helping the NHS support broader social and economic development”.

Equalities (including socio-economic) impact statement

19. The plan aims to tackle health inequalities that lead to differences in health and life expectancy within the borough. The strategy takes a community and place focus, which involves providing additional support to the population groups that have the poorest outcomes and focusing on the most disadvantaged neighbourhoods.

Health impact statement

20. As stated within the plan the key population health and inequalities challenges it seeks to address are:
    - High levels of health need, with a clear link across to the relatively high levels of deprivation and population diversity found in south east London.
    - Life expectancy for south east Londoners is below the London average for all boroughs except Bromley.
    - Differences in life expectancy are more marked for those born in the least and most deprived areas across south east London.
    - These factors drive significant inequalities, with a variance across boroughs including higher levels of need, challenge and opportunity across our inner south east London boroughs, but with clear inequalities and an inequalities gap evident within each of our six boroughs.
    - Known risk factors that drive poor health outcomes plus drive inequalities.
    - Inequalities evident in terms of access, experience and outcomes.

Climate change implications

21. As set out in the Sustainability section of the plan (page 262) the ICB Green Plan underpins actions for making progress towards NHS carbon neutral targets.

22. The Southwark section of the plan confirms individual organisations will be supported to implement their green plans in line with the Partnership Southwark environmental sustainability policy statement.

23. The stated ambition is to have made clear progress towards the NHS targets of a net zero carbon footprint by 2040 and the interim target of 80% reduction by 2028, and the council's climate change plan and target for a carbon neutral Southwark by 2030. This will be measured in part through progress on key domains of the ICS Green Plan including workforce and system leadership, air quality, travel and transport (staff and patients), estates and facilities, sustainable models of care (including prevention and lean service delivery), digital, medicines (20% of NHS carbon footprint), supply chain and procurement, food and nutrition, adaptation, green spaces.

Resource implications

24. Officer time from all partners will be required to support the continued development and delivery of the Southwark section of the Joint Forward Plan.

25. Any new projects/initiatives that arise through the action plan that require additional or reallocation of funding would need to be considered through the appropriate budget, monitoring and governance processes.

Legal implications

26. The production of the Joint Forward Plan fulfils one of the statutory obligations of the Integrated Care Board.

Financial implications

27. Any financial decisions that relate to the delivery of the action plan will be taken separately and through the relevant partner governance mechanisms.

Consultation

28. The Joint Forward Plan has been subject to consultation as set out on page 14 of the plan.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
None		

APPENDICES

No.	Title
Appendix 1	Letter from Chair of Health and Wellbeing Board on Joint Forward Plan
Appendix 2	Southwark section of Joint Forward Plan, South East London ICB 2023/24

AUDIT TRAIL

Lead Officer	Martin Wilkinson, Chief Operating Officer, Southwark, NHS SEL Integrated Care Board
Report Author	Adrian Ward, Head of Place PMO, Southwark, NHS SEL, Integrated Care Board
Version	Final
Dated	7/7/23
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Assistant Chief Executive Governance and Assurance	No	No
Strategic Director, Finance	No	No
List other officers here		
Cabinet Member	No	No
Date final report sent to Constitutional Team		7 July 2023

Cllr Kieron Williams
Chair of Southwark's Health & Wellbeing Board
Leader of Southwark Council

kieron.williams@southwark.gov.uk
Tel: 0752 691 5287

Date: 14 June 2023

Ref: ICB Joint Forward Plan 2023

Dear Mr Bland

ICB Joint Forward Plan

I am writing to you in my capacity as chair of the Health & Wellbeing Board. I understand the ICB seeks our view on whether the South East London Joint Forward Plan takes proper account of the Southwark Joint Health & Wellbeing Strategy.

Our Joint Health & Wellbeing Strategy was published earlier this year and sets out our local commitment to improving the health and wellbeing of all residents in Southwark, with a focus on reducing inequalities that have been exacerbated by the COVID-19 pandemic, and more recently the rising Cost of Living Crisis.

The strategy was developed in close collaboration with the South East London Integrated Care Board, as well as through our local care partnership, Partnership Southwark which is our key delivery vehicle for many aspects of the Joint Health & Wellbeing Strategy. Our five drive areas set out the key areas of focus for our board, including:

- A whole-family approach to giving children the best start in life
- Healthy employment across the health and wellbeing economy and good health for working age adults
- Early identification and support to stay well
- Strong and connected communities
- Integration of Health and Social Care

Within the draft Joint Forward Plan we welcome the recognition of historic under-resourcing of mental health services, and the commitment to expanding the provision of support to both children and young people and adults.

In addition, we share the commitment to prevention and tackling inequalities in access, experience and outcomes and support the increased investment in this area. However,

as the Joint Forward Plan is implemented we would like to see greater emphasis within the NHS on primary prevention.

We also acknowledge the ICB commitment to co-production with local communities, however we believe this is an area that requires strengthening within the plan. The COVID-19 pandemic underscored the importance of working with residents to design services and programmes together in order to best reflect their needs. Only in doing so will we be able to make a meaningful and lasting impact on health inequalities.

Overall, the draft Joint Forward Plan for South East London takes 'proper account' of the priorities and actions outlined within the Southwark Joint Health & Wellbeing Strategy. We look forward to working with the ICB on the implementation of the plan and welcome on-going involvement of the Health & Wellbeing Board.

Yours sincerely

Cllr Kieron Williams
Chair of Southwark's Health & Wellbeing Board
Leader of Southwark Council

South East London Integrated Care System

NHS South East London

South East London

2023/24 Joint Forward Plan – Southwark Section for Health and Wellbeing Board 20/07/23

For the full Joint Forward Plan see www.selondonics.org/joint-forward-plan.

June 2023 – V2.5

Partnership Southwark Overview

Our population

We have 307,000 residents. Our population is comparatively young, with the average age (32.4 years) almost two years younger than London, and almost seven years younger than England. 39% of residents are aged 20-39, compared to 26% in England. We have a large Lesbian, gay, bisexual, transgender, queer or questioning and others (LGBTQ+) population – over 8% of our adults compared to 4% in London and 3% nationally. Latest estimates indicate that 51% of people living in Southwark have a white ethnic background compared to 81% nationally. Our diversity is greater among our children and young people, with roughly equal proportions of young people from white and black ethnic backgrounds. The latest population projections suggest that the population will continue to grow, with over 17,000 additional people living in the borough by 2030. Population growth is set to take place across almost all parts of the borough, but the largest increases are expected in redevelopment areas around Old Kent Road, Canada Water, and Elephant and Castle.

Health outcomes for our population

Strengths

- Residents are living longer and healthier lives than ever before, with life expectancy comparable or better than the national average.
- Levels of relative deprivation in the borough continue to reduce.
- Key risk factors such as smoking, alcohol and physical inactivity are comparable or better than the national average.
- Preventable mortality has reduced by half since 2001, narrowing the gap with England.

Challenges

- 1 in 4 children in reception are overweight
- 15,000 emergency attendances by children under 5 per year
- Second highest level of STIs and HIV in Eng.
- Around 2,400 admissions for ambulatory care sensitive conditions per year
- 55% of cancers diagnosed at stage 1 or 2
- Around 55,000 adults have a common mental health condition
- ASC provides support to 1500 unpaid carers
- Amongst the highest rate of emergency admissions for falls in London
- Highest rate of emergency admissions for dementia in London

Inequalities within our borough

- Approximately 21% of Southwark's population live in communities ranked within the most deprived nationally. This increases to 23% among those aged under 18.
- Across a wide range of health, social and economic measures, from child poverty through to obesity, hospital admissions and life expectancy, outcomes are poorer in central and northern parts of Southwark particularly communities in Faraday and Peckham wards.
- Residents from a Black African and Black Caribbean background are more likely to live in communities with high levels of deprivation, develop a greater number of long-term conditions, have poorer mental health, and experience discrimination and racism when accessing services
- Southwark has the fourth highest LGBTQ+ population in the country, and we know that this group can suffer discrimination for access to services, as well as poorer health outcomes
- Southwark has the highest number of asylum seekers in accommodation centres in SEL. The population may have experienced conflict, violence, multiple losses, torture, sexual assaults, and/or risk of exploitation, as well as experiencing issues accessing health and care services.

Partnership Southwark

What we've heard from the public

- Engagement has been undertaken through:
  - Southwark Stands Together
  - South London Listens
  - Southwark 2030
  - Partnership Southwark workshops around the 'Lived Experience Assembly' (working title)
  - Partnership Southwark outreach work
  - Centric and Social Finance work with both Partnership Southwark and public health

- The high level feedback has been as follows:
  - Discrimination and structural racism are impacting access and experience of services
  - Vulnerable people are falling through gaps in support
  - Mental health and wellbeing for children, young people and adults is a priority
  - Services need to be culturally appropriate and accessible for all
  - Concern regarding rising cost of living, food poverty and affordable housing
  - Local communities and community autonomy is high valued
  - Power sharing between communities and services is needed when considering, designing and testing plans and services

Southwark - Our objectives

Our key objectives - what we want to achieve over the next five years

The top things that we want to achieve over the next five years are outlined in our Joint Health and Wellbeing Strategy, 2022-2027. These have been committed to by all Partnership Southwark members:

A whole family approach to give children the best start in life	Healthy employment and good health for working age adults	Early identification and support to stay well	Strong and connected communities	Integration of health and social care
We want to ensure all families in Southwark receive access to good-quality maternity care, reducing differential outcomes between population groups. We want to build resilient families through holistic care in pregnancy and early years, improve mental health for the whole family and keep children safe through early identification and support for families at risk of adverse childhood experiences.	Across the health and wellbeing economy, we want to increase access to good quality jobs, promote health through employment support, enable people to lead healthy lifestyles, building on the already strong work on the Vital 5, and promote and maximise access to leisure and physical activity.	We want to ensure services prevent ill-health through early detection. We want to help people stay well through falls prevention, support for recovery from hospital admission, and wellbeing support for carers and families. We will have an enhanced focus on communities and neighbourhoods with poorer health to ensure better uptake of prevention and services to manage long-term conditions	We want to ensure local people shape their local areas and services. We want to ensure that services are accessible to the most excluded groups and reduce social isolation and loneliness. We will develop strong collaborations between statutory services and the voluntary and community sector, undertake targeted work to remove barriers to services and focus work on addressing loneliness.	The opportunities to deliver better outcomes for Southwark residents will be optimised through strengthening joined up care, exploring where care can be delivered at a neighbourhood level and strengthening how we involve local people in delivery of our work. By bringing NHS, council and voluntary and community organisations together, we can define the shared outcomes we want for our population and ensure the right leadership, accountability and oversight to support our work.

Southwark - Our priority actions

Our priority actions

The following priority actions demonstrate how we will deliver our objectives, and will also be detailed in our local Health and Care Plan.

Strategic collaboration

- Our most fundamental step towards true integration and better outcomes is embedding a new way of working. By this, we mean that we will be designing and producing services together with our community and across providers, to provide holistic and sustainable solutions
- We will start to explore what a "collaborative model" for Mental Health could be, including capitated budgets, and how this would fit with the agreed approach that we are taking, as outlined above.

Wells workstreams

- Our Wells workstreams reflect the life course of our residents – start, live and age well, with some relying on care homes when they can no longer live in their own homes. As part of the Health and Care Plan development, we have focused the delivery of the Wells to align with the ambition within the Health and Wellbeing Strategy and identify the areas with the most potential for integration.
- Start Well: First 1001 days and Children & Young People's mental health
- Live Well: Adults Community Mental Health Transformation, Cancer and Vital 5 (exploring a family approach)
- Age & Care Well: Local Jobs for Local People, Neighbourhood Integrated Care and Deprived Neighbourhood Outreach

Principles

- Embedding an approach to tackling health inequalities across all our policy-making, services and delivery.
- Making sustainability and tackling climate change an integral part of protecting and improving health.
- Targeted place-based approach and population groups.
- Community empowerment and co-production.
- Delivering high quality, joined-up and person-centred health and social care.

Southwark priority 1: Strategic Collaboration

Strategic collaboration – Mental Health

In Partnership Southwark, we are committed to reaching a place of true integration across the system. We recognise that this will not happen instantly, and will require significant work from all our partners in order to achieve our goals. We want to embed ourselves in communities, working at a neighbourhood level to support residents, identified populations and tackle inequalities. Residents are telling us that the system is too fragmented, with conflicting priorities and inequalities in terms of access and experience. As the demand for services increases, a lack of integration between services is going to exacerbate these concerns and mean that we are not giving the right focus on the outcomes for residents. We are already in a collaborative space for Children & Young People and Adults (particularly CMHT) due to the work which is being delivered by partners. Additionally other areas such as BCF are starting to examine how they could help to drive integration/joint working in the MH space. We want to make the most of this momentum to explore how a strategic collaborative could work.

How we will secure delivery

Actions for 23/24

- Undertake engagement workshops with key system partners. The aim of this work is to map what is already taking place, consider what we could do differently and think about a more formalised strategic form that could overset this, leading to better performance and outcomes across the system. This will help to set our level of ambition for the strategic collaborative and create a delivery structure for getting there (e.g. an overarching steering group with a number of strands underneath this which feed in, such as MH Placements and substance misuse).

Actions for 24/25

- TBD depending on outcome of above conversations

Intended outcomes in 5 years time

- To reduce numbers of people reaching crisis point and give prompt and appropriate support for people in crisis
- To increase the number of people able to live independently
- To increase numbers of people living in stable and appropriate accommodation
- To improve mental health outcomes for people from black communities in Southwark
- To improve physical health for people with mental health issues
- To increase numbers of people in education, training, volunteering or employment

Southwark priority action 2: Start Well | 1001 Days Programme

1001 Days Programme

Within the overall Start Well workstream covering residents aged 0-25 years old, a specific programme focused on the first 1001 days of life (conception to 2 years old) has been identified as a priority within Southwark. The programme is specifically targeted at families in the Camberwell Green area and is utilising a neighbourhood approach to allow for tailored and creative approaches to meeting need. Camberwell Green has been selected as the initial area of focus as it is an area of high deprivation (most of the area is in the second most deprived quintile nationally) and:

- evidence shows that socioeconomic deprivation increases the risk of maternal perinatal mental illnesses,
- 16% of mothers living in Camberwell Green did not breast milk feed at all, 31% partially breast fed compared with 11% and 24% respectively for mothers in the second least deprived quintile (maternal population in the least deprived quintile is very small),
- Camberwell Green has the highest prevalence of obesity in Reception aged children in the borough.

Camberwell is also a community asset rich area with strong, well embedded, and trusted community groups and leaders making this an ideal area to trial the resident led, neighbourhood targeted programme approach. Proposed focuses for the programme are perinatal, parental and infant mental health; looking at local workforce development; and breast feeding and infant nutrition.

How we will secure delivery

Actions for 23/24

- Map current programmes that have interdependencies and relationships with 1001 Days programme.
- Develop and deliver a coproduction plan to shape the future of the programme
- Develop & maintain a learning log to track learning from neighbourhood working & resident led approach.
- Asset mapping of Camberwell Green in collaboration with residents and partners.
- Continue to expand the delivery group membership as necessary to ensure all relevant partners and teams are part of the programme. Continue to build relationships with residents and community groups in Camberwell Green and across system partners.
- Prioritise referrals from 1001 day workforce at Camberwell Green
- Coproduce outcomes framework with residents and system partners.
- Explore needs and opportunities for data sharing between system partners.
- Link with existing planning around workforce development to align plans.

24/25

We will use the learning from the Camberwell Green 1001 days pilot to spread and scale across the borough. Further plans and actions to be coproduced with residents and partners as the programme develops.

Intended outcomes in 5 years time

Through the areas of focus that have been proposed, our aim is that:
By 2027, all women and their partners who live in Southwark will feel equipped and empowered to provide the best start in the first 1001 days of their children's lives through the provision and access of family-centred, integrated support and services that meet their specific needs.

Specific outcome measures will be determined through coproduction with partners and residents within the first half of 23/24.

Southwark priority action 2: Start Well | CYP Mental Health

CYP Mental Health

The Southwark Partnership is known to serve children and young people at an elevated risk of mental health issues. Southwark young people are at a higher risk than the national rate of being first time entrants to the Youth Justice system, of homelessness and of attendance at Accident and Emergency. There are high rates of prevalence of being at risk of the 'toxic trio' (adult mental health, domestic abuse, alcohol / substance misuse) being amongst the highest rates in the country where all three risk factors are present.

How we will secure delivery

Actions for 23/24

- Active management of waiting lists and reduction in waiting times for service users
- Improving equality of access
- Supporting 16-25 year olds to access the right support
- Improving parental mental health to keep families strong
- Support for Southwark schools – universal and targeted offer for pupils, staff and parents
- Supporting children responding to trauma and distress and crisis stepdown
- Supporting the emotional and mental wellbeing of young offenders (including prevention)
- Develop a seamless pathway for children and young people with eating disorders
- Ensure that the mental health needs of those attending Accident and Emergency are better met
- Improving the responsiveness of perinatal mental health support

24/25

- On going delivery of 2023/24 programmes

Intended outcomes in 5 years time

- Young People are able to access holistic services which are structured around need rather than age
- Southwark system can demonstrate seamless, system wide collaboration in a joined up vision and clear, sustainable investment through transparent decision making and collective accountability
- Families are able to access support for their mental health and wellbeing in a way that supports improved family outcomes
- Resilient and representative groups able to improve service users experience
- Improved connectivity and pathways between SEL commissioned services and local services to increase uptake
- Improve the mental health and wellbeing of families, children and young people, ensuring 100% of children and young people who need support can access emotional wellbeing or mental health services
- Keep children and young people safe through early identification and support for families at risk of adverse childhood experiences

Southwark priority action 3: Live Well - Community Mental Health Transformation

Community mental health transformation

Working collaboratively with residents, Voluntary, community and social enterprise sector (VCSE) and local authorities, expand the provision of early intervention and community-based mental health support offers for adults through both statutory and non-statutory organisations, and across health and care services.

How we will secure delivery

Actions for 23/24

Delivery of year 3 of the adult community mental health transformation programme:

- Embed service user and carer involvement into service design and review across the system e.g. through the launch of a Service Users Network.
- Neighbourhood team structures designed, tested and implemented, incorporating multi-disciplinary teams and capitalising on the combined resource of MH professionals across primary care, secondary care and local VCSE professionals.
- Review of referral processes between CMH services and secondary care with a view to streamline and reduce rates of unsuccessful referrals. Work with service users and residents with lived experience to ensure simple points of access across the system for self referrals and referrals from other professionals.
- Develop improved relationships and systems for SMI health checks to take place with the most appropriate health care team.
- Finalise a proposal to measure outcomes across the system using the national outcomes framework metrics and existing system measures.
- Link with CYP Emotional, Wellbeing & Mental Health Steering and Delivery Groups to join up work around young people's transition from CAMHS to adult services

Actions for 24/25

- Current funding until ends March 2024

Intended outcomes in 5 years time

- Each neighbourhood in Southwark to have a fully established integrated community mental health teams bringing together health and social care and VCSE providers.
- Contacts through community mental health to have increased 5% on average every year, with contacts representing the demographics and need of the local population.
- Reduction in the inequality of service users' access, experience and outcomes around CMH services. In particular Southwark's Black, Asian and Minority Ethnic communities and other groups that have previously been underserved.
- Care is continuous: service users have an 'easy in, easy out' experience when stepped up/down between primary and secondary care and vice versa.
- Mental health care is largely preventative and reduces the number of residents experiencing a mental health crisis.
- Links with the VCSE are improved, service-users are able to get support with wider issues such as housing.
- Improved mental and physical health and reduction in mortality, particularly among residents with SMI.

Southwark priority action 3: Live Well - Vital 5

Vital 5 – exploring a whole family approach

The starting focus of the Live Well programme is hypertension; one of the Vital 5. Hypertension cuts across and impacts all the other Vital 5 areas and is also one of the five clinical areas within the Core20Plus5. Hypertension is the most important risk factor for premature cardiovascular disease, being more common than smoking, dyslipidaemia, and diabetes and accounting for an estimated 54% of all strokes and 47% of all ischemic heart disease events globally. Evidence also suggests there are significant numbers of residents with undiagnosed hypertension. Our aim is to ensure residents have the best possible blood pressure, and 80% of those with high blood pressure are detected and treated to recommended guidelines, in line with the national ambition.

How we will secure delivery

Actions for 23/24

- A review of local intelligence regarding the prevalence and management of hypertension including an analysis on health inequalities across our boroughs.
- Identify where blood pressure is taken across the system, and how these measurements are being fed back appropriately.
- Undertake a gap analysis of work already underway surrounding the vital 5 to diagnose and manage hypertension in the borough and identify future opportunities and actions.
- Ensure alignment at a borough level with Vital 5 programme at GSTT and KCH
- Ensure alignment a borough level with Vital 5 programme across South East London
- Evaluation of digital health kiosks in the community
- Incorporate awareness and screening of the Vital 5 in the public health promotion and campaign programme

Actions for 24/25

- An equivalent approach for the other Vital 5 areas (smoking, alcohol, mental health, obesity) will be adopted once work on hypertension begins to advance, building on the iterative and developmental model of working.
- Building on previous year's work, lessons learnt and round up

Intended outcomes in 5 years time

Local ambition:

- A minimum of 50% of NHS Healthchecks are undertaken by residents from Black, Asian and other ethnic minority backgrounds.
- All residents in Southwark to be aware of what the vital 5 is, and what their own measurements are.
- Fully embedded 'Making Every Contact Count' approach to maximise interactions with patients.

National ambitions:

- 80% of the expected number of people with high BP are diagnosed by 2029
- 80% of the total number of people diagnosed with high BP are treated to target as per NICE guidelines by 2029

Southwark priority action 3: Live Well - Cancer

Cancer

The reduction of cancer screening inequalities across the borough of Southwark, with a particular focus on cohorts of patients with low uptake and engagement rates. We have been successful in securing cancer inequalities funding, which we plan to spend on numerous project and pilots. Our key target cohorts are patients with learning disabilities, SMI and patients who choose to not engage with screening programmes for a variety of reasons.

We also aim to improve quality of care in the community for those living with cancer by promoting community services, social prescribing and the importance of physical activity.

How we will secure delivery

Actions for 23/24

- Utilising the inequalities funding over the next financial year, to ensure a targeted approach to inequalities reduction.
- Working with public health colleagues to align project aims to their JSNA documents.
- Ensure we use a people centred approach, conducting community engagement when necessary for successful project delivery.
- Work with South East London Cancer Alliance colleagues to ensure we are aligning with their forward view and strategic aims to ensure a joined up approach.
- Working through project actions and forward view in our council and ICB cancer working group.
- Working closely and sharing learning with other boroughs in SEL.

Actions for 24/25

- As above

Intended outcomes in 5 years time

Our 5 year aim, is to ensure that Southwark is benchmarked similar to SEL, London and national levels of uptake. Furthermore, we hope to be well underway to achieving national targets for cancer screening across the breast, bowel and cervical programmes. Whilst we aim for screening rates to increase, we are keen to ensure an even coverage of uptake across Southwark with a greater reduction of inequalities across the borough.

In addition, we hope for high quality cancer care reviews to be conducted routinely in the community. The promotion of local services, support and the importance of physical activity will be a routine part of cancer care in the community.

Southwark priority action 4: Age & Care Well (1)

Age & Care Well

With an eye to Prevention, Strength based approaches and self-management, the aim is to help older people to remain active, productive, independent and socially connected for as long as possible and recognising whether it's between hospital and home or from one community services to another, services need to be consistently joined up and responsive to the individual needs of older people. The specific areas of focus will be developing a lower limb wound care model for Southwark, improving care and support for people with frailty through an integrated model, and better coordination of services for those living with dementia. We also want to align with the ambitions of the Community Mental Health Transformation model to address mental health of older people, aligned with neighbourhood development initiatives.

How we will secure delivery

Actions for 23/24

- Strengthening strategic alignment for planning and delivery across Age and Care Well workstreams, bringing community and care homes closer together
- Embedding service user and carer involvement to the design of new models of care and approaches
- Developing outcomes framework to be developed which takes the system / workforce and individual service users into account
- Developing a system led, more comprehensive model of practice for lower limb wound care. Currently working with Accelerate on a needs analysis to inform a detailed business case.
- Refreshing the Dementia strategy and delivery plans in partnership with residents and service users.
- Working with colleagues across SEL and in Southwark to understand good practice around integrated frailty pathways and develop recommendations for piloting locally

Actions for 24/25

- To be agreed Q3
- Working with CMHT leads to explore a developing programme with Older People

Intended outcomes in 5 years time

- There is improved access to specialist and comprehensive physical and mental healthcare & wellbeing services/support and to community activities where required.
- We have an integrated lower limb wound care pathway which achieves better outcomes, including:
    - Better quality of care
    - Proactive management
    - Higher detection rates
    - Early intervention approach and reduction in crisis management
    - Fewer hospital admissions
- We have developed the Community Mental Health model to include older people, stopping people reaching crisis and ensuring they receive care closer to home
- An agreed frailty definition and pathway in Southwark

Southwark priority action 4: Age & Care Well (2)

Age & Care Well – Workforce Development

The workforce across the health and care sector is a major priority and challenge for our local system, including individual providers as well as the large institutions. There is a keenness to optimise interprofessional practice and integration opportunities through neighbourhood approaches, also working innovatively to develop new and diverse roles and career pathways, apprenticeships and connecting further with communities and capitalising on the skills and passion of local people in Southwark.

How we will secure delivery

Actions for 23/24

- Establishing links with wider Workforce planning strategies and collaborate where it makes sense to do so
- Work in partnership with Bermondsey and South London Mission to explore opportunities to develop an apprenticeship programme
- Developing neighbourhood champions to support healthy living initiatives and develop skills/professional opportunities for the community

Actions for 24/25

- To be agreed Q3
- Working with CMHT leads to develop programme with Older People

Intended outcomes in 5 years time

- We have implemented our workforce initiatives which include a range of Voluntary and Community Sector partners to create a sustainable local workforce.
- There is proactive collaboration and recruitment into local care & health sector with local people (placements, apprenticeships, local training/engagement opportunities, tailored support in deprived neighbours to support into work)
- We have established neighbourhoods champions who outreach into their local communities.
- There is evidence of interprofessional practice – which moves beyond multi disciplinary approaches.

Partnership Southwark: local delivery of SEL priorities

Partnership Southwark delivery of SEL pathway and population group priorities

It is recognised that delivery of our local forward view priorities depends on a combination of place level and system-wide plans. For a number of key pathways, population groups and enablers the benefits of geographical scale are recognised and SEL programmes are in place, and Southwark is committed to ensuring its place based plans are fully aligned to these. This alignment is particularly important where there are substantial system level and place level workstreams such as in mental health, CYP and primary care. All of our priorities are partnership focused and resident centred, working across Partnership Southwark to understand the best outcomes for the borough.

Learning Disability & Autism

Southwark has a Learning Disabilities and Autism local lead role that supports the local delivery of the SEL programmes objectives, by, for example:

- supporting cases where mental health has deteriorated and there is a risk of admission to an inpatient unit
- operation of Dynamic Support Registers to identify risks of admission
- discharge planning for people who are inpatients in mental health hospitals back into community living with range of appropriate support
- inputting into SEL operational and strategic LeDeR pathways

Cancer

Our focus is reducing late diagnosis rates through the reduction of cancer screening inequalities across the borough of Southwark, with a particular focus on cohorts of patients with low uptake and engagement rates. We have been successful in securing cancer inequalities funding, which we plan to spend on numerous project and pilots. Our key target cohorts are patients with learning disabilities, SMI and patients who choose to not engage with screening programmes for a variety of reasons.

Urgent and Emergency Care

Southwark has a key role to play in helping maximise system capacity by reducing the number of preventable admissions, and ensuring the prompt discharge of people from hospital who are medically fit for discharge. Southwark's Better Care Fund and the associated Adult Social Care Discharge fund will be expanded in 2023/24 and set out the approach to providing integrated out of hospital health and care services that deliver these objectives. A discharge improvement programme will be part of the approach. Southwark will also seek to ensure we consistently meet or exceed the 70% 2-hour urgent community response standard.

Primary care

Working in neighbourhoods has provided the population of those practices access to specialist care from the different roles in an accessible way , both in the local area and within a short waiting time. Practices working together in the neighbourhoods and PCN have enabled a supportive environment for staff, clinical supervision and development pathways and opportunities within the workplace. This in turn has meant that that staff retention has increased and bolstered the workforce. An example from a patient perspective would be presenting at the practice with a musculoskeletal symptom and being offered an appointment within 1 week with a first contact physio. Being seen by the right person at the right time would then prevent further decline in symptoms and with an early treatment plan lead to better outcomes for the patient.

Southwark enabler requirements (1)

Workforce

Our Local Care Partnership has a demonstrated record of developing new roles that drive forward integration, for example our mental health support workers that bring together primary and secondary care. The individual members of our partnership are also at the leading edge of educating and training our future workforce.

As a partnership our aim is to continue to develop innovative roles and ways of working that support integration, including multi-disciplinary teams, and make best use of our constrained resources. We also have an ambition to explore areas of staff development that might benefit from doing more together, for example apprenticeships, where each partner has a successful programme.

However, workforce is one of our system's most pressing issues and for important practical reasons, many of our partners look beyond our borough-level arrangements for collaboration and joint working on workforce. We would welcome a productive dialogue between the partnership and system wide forums on workforce plans, we would also like to see system collaboration inculcating a supportive environment for the cross organisational ways of working that are at the heart of integration. Issues relating to key worker housing also to be considered.

Estates

The 2021 ICS South East London Estates Strategy update and SEL PCN Estates Reviews identify our current priorities and baseline for the NHS community and primary care estate in Southwark. As a rapidly growing borough these priorities include development opportunities arising from regeneration and renewal.

The Local Care Partnership has a Local Estates Forum with wide engagement from partners and the SEL Estates team work alongside the Forum to maintain relationships and seek out opportunities for joint working.

The focus for development for Partnership Southwark is to use this work and priorities to support integration and effective use of the Southwark estate. This includes making the best use of the opportunities presented by the Tessa Jowell Health Centre, where a Lead Integrator is being appointed, and to make use of wider opportunities from the availability of parts of the Council's estates portfolio.

Southwark enabler requirements (2)

Digital

Partnership Southwark will work closely with the emerging ICS Digital Programme to ensure place level delivery. Priority requirements for Southwark include:

(1) developing a single view of the digital estate;

(2) replacing outdated digital infrastructure so that our workforce have the ability to access a person's health and care record, and other data and information, with ease and from any location;

(3) investing in our analytics expertise and information governance processes, including data sharing arrangements, to ensure the optimal use of data to inform population health programmes, research programmes, strategic planning, clinical improvement and prevention schemes, and new payment mechanisms;

(4) embedding fully integrated approaches across our local care partnership including when developing new digital solutions, digital delivery plans, and financial investment and cost saving strategies;

(5) identifying shared workforce training opportunities;

(6) developing shared digital exclusion strategies; and

(7) ensuring compliance with information governance across the estate.

Finance

Partnership Southwark has an ambition to have an integrated financial plan and a strong financial standing that will enable us to deliver our collective priorities. Ensuring a collaborative approach to planning and contracting, as well as delivery, the Partnership recognises the very real challenges the local health and care economy faces and the need to work together to find solutions to jointly manage these issues across the LCP.

We are working to ensure Partnership Southwark LCP members (ICB, council and provider partners) plan and delivery services together in transparent ways as close to local people's homes as possible to deliver social value and mitigate our collective and individual financial risks for the benefit of the whole system.

We are working to increase ownership and accountability at a local level to achieve our shared priorities. We will aim to ensure there is flexibility to develop, test and implement new contracting and delivery models to support integrated care. This will provide opportunities for improvements by working in collaboration to redesign services, including with our local VCSE and residents.

We are currently looking at a local provider collaborative model for Mental Health. We will use the new NHS payment scheme mechanisms in line with guidance ensuring payment arrangements support productivity and efficiency.

Southwark enabler requirements (3)

Sustainability

Individual organisations will implement their green plans in line with the Partnership Southwark Environmental Sustainability policy statement agreed at the strategic board in January 2023. For the ICB this specifically includes the commitments in the ICS Green Plan and the Primary Care Green Plan.

A Partnership Southwark green champions network will be established for sharing best practice and identifying opportunities for collective working. A commitment to ensuring that sustainability implications are systematically considered in all decision making will be implemented.

Our ambition is to have made clear progress towards the NHSE targets of a net zero carbon footprint by 2040 and the interim target of 80% reduction by 2028 and the council's climate change plan and target for a carbon neutral Southwark by 2030. This will be measured through progress on key domains of the ICS Green Plan including: workforce and system leadership, air quality, travel and transport (staff and patients), estates and facilities, sustainable models of care (including prevention and lean service delivery), digital, medicines (20% of NHS carbon footprint), supply chain and procurement, food and nutrition, adaptation, green spaces.

Quality

Place based quality arrangements and joint working with system-level quality forums still require development to reach full maturity, taking into account the different loci of capacity, work and influence as well as the move away from the traditional assurance-based approach to quality to a collaborative quality improvement approach.

Our ambition is to build a community of learning and shared focus on quality that takes full advantage of the experience and skills of our diverse partners to help quality improvement drive our programme of integration and that supports a shared accountability for the wellbeing and experience of the population in their interactions with our services.

Partnership Southwark requires a range of support to make this change, including subject matter expertise for facilitation and development, the flow of intelligence to support quality improvement as well as a clear strategic steer representing the ambitions of the ICP as a whole.

Additionally, our ICS's response to quality escalations has yet to be tested. Partnership Southwark would appreciate a discussion about the role that Local Care Partnerships can play when areas require additional focus on quality so that we have established ways of working in the event that such systems are needed.

Southwark enabler requirements (4)

Medicines optimisation

Medicines prevent, treat and manage many illnesses and conditions and are the most common intervention in healthcare. Successful implementation of medicines optimisation relies on close collaboration and engagement, with shared-decision making between the residents in Southwark and all partners involved in medicines including all of our providers and community pharmacists who can play an important role in optimising adherence and reducing waste. Patient safety is paramount and should not be compromised at the expense of other factors influencing medicines choice. Clear communication is needed between SEL and place regarding delegation of this budget at place level.

Safeguarding

Safeguarding Adults at Risk and Children and Young People should be the golden thread that runs through all activities of the ICB/ICS. The above cannot be done in isolation; it is only truly effective when we work collaboratively and restoratively with our partner agencies to 'Think Family' and protect all those at risk of harm, abuse or neglect. This approach is being embedded across all of our services, whilst focusing on developing evidence based approaches to safeguarding practice that balances the rights and choices of an individual, with the Trust duties to act in their best interest to protect the patient, the public and the organisation from harm. Safeguarding is complex and challenging and our plans for the 5 years ahead within this Joint Forward Plan year are ambitious but they are achievable and underpinned by strong partnership working across the health economy and wider system.

Communications and engagement

Public engagement is a key cornerstone of our approach in Southwark. Ensuring we dedicate resource and time to public engagement to work towards a co-production approach will be vital in securing the best services for people and communities in the borough. We will seek to have people and communities within the partnership at every level to support involvement at the Strategic Board and Executive team to ensure we are able to listen to and learn from lived and learned experience as we develop, maintain and monitor services.

We will use the information from this meaningful engagement to inform our work to provide health and care services. We will also apply it to our communications activity to support the development of Partnership Southwark and to make sure that people across the borough are aware of, and understand what support is available to them. Our communications and engagement activity will also strive to support our work to tackle health inequalities in the borough by involving people from a broad range of communities and tailoring our communications to communicate effectively with our key audiences using the channels most suited to their expectations and needs.

Item No. 11	Classification: Open	Date: 20 July 2023	Meeting Name: Health and Wellbeing Board
Report title:		JSNA Annual Report 2023	
Ward(s) or groups affected:		All Southwark wards and population groups	
From:		Sangeeta Leahy - Director of Public Health Southwark Council	

RECOMMENDATION(S)

1. That the board note the findings of the JSNA Annual Report 2023, and agree an annual update.

2. That the board note the population groups and communities identified with the poorest outcomes.

3. That the board note and agree the JSNA projects recommended for the coming months.

BACKGROUND INFORMATION

4. Joint Strategic Needs Assessment (JSNA) is a process designed to inform and underpin the Joint Health and Wellbeing Strategy (JHWS) by identifying areas of unmet need, both now and into the future. It is a statutory requirement for Local Authorities and their partners (under both the Health and Social Care Act 2012 and the Local Government and Public Involvement in Health Act 2007 s116 and s116A).

5. Local areas are free to undertake JSNAs in a way best suited to their local circumstances. There is no template or format that must be used and no mandatory data to be included.

6. In Southwark, prior to the COVID-19 pandemic we had an annual work programme for the JSNA that aligned to four themes, ensuring it covered the breadth of issues affecting health and wellbeing:
   - Domain 1 - population groups
   - Domain 2 - behaviours and risk factors
   - Domain 3 - wider determinants of health
   - Domain 4 - health conditions and healthcare

7. This report has two main objectives:
   - To update the board on the JSNA Annual Report 2023, undertaken as part of the JSNA programme.
   - To outline next steps for the JSNA.

KEY ISSUES FOR CONSIDERATION

JSNA Annual Report

8. The JSNA Annual Report provides an update on health and wellbeing in Southwark. It seeks to provide an analysis of our population, along with details of the health inequalities that exist in the borough.

9. The report forms part of the borough's Joint Strategic Needs Assessment (JSNA) work programme, and informs the Joint Health & Wellbeing Strategy (JHWS) and it is envisaged other local action to improve health and wellbeing in Southwark.

10. The report provides an overview of our changing population, bringing together data released from the 2021 Census:

    - The average age (32.4 years) is more than two years younger than London, and almost seven years younger than England.

    - Around half (51%) of people living in Southwark have a White ethnic background compared to 81% nationally.

    - The largest ethnic group other than White is 'Black, Black British, Caribbean or African', accounting for one-quarter (25%) of Southwark residents.

    - For the first time the 2021 Census provided data on the number of residents identifying as Hispanic or Latin American. In total, 9,200 people in Southwark recorded this as their ethnicity.

    - Southwark has the 4th largest LGB+ population in England, with 8% of residents (nearly 21,000 people) aged 16+ identifying as non-heterosexual. Southwark also has the 5th largest trans/non-binary population in England.

    - Over 18,000 residents provide some level of unpaid care, equivalent to 6% of Southwark's population.

11. Across the borough there have been significant improvements in health and wellbeing over the last decade, and there are many areas of success that should be celebrated:

    - Our residents are living longer lives than ever before, with life expectancy comparable or better than the national average.

    - Levels of relative deprivation in the borough continue to reduce.

    - Child vaccination rates are generally comparable or higher than the London average.

- Key risk factors such as smoking, alcohol and physical inactivity are comparable or better than the national average.

- Preventable mortality has reduced by almost half since 2001, narrowing the gap with England.

12. Southwark also benefits from a wide range of social and physical assets that help our communities to maintain and sustain good health and wellbeing, from our extensive network of community, voluntary and faith organisations through to our libraries, leisure centres, parks and green spaces.

13. Although there have been substantial improvements in health outcomes in Southwark, many challenges remain. The COVID-19 pandemic and the on-going Cost of Living Crisis continue to exacerbate the inequalities that too many people experience. These inequalities are both avoidable and unfair.

14. Across a wide range of health, social and economic measures, from child poverty through to obesity, hospital admissions and life expectancy, outcomes are poorer in central and northern parts of Southwark. In particular, communities in Faraday and Peckham wards. However, it is important to acknowledge that pockets of deprivation also exist within areas of affluence.

15. There are also significant gaps in outcomes between population groups in Southwark. These often mirror the inequalities we see at a national level, with those from Black, Asian and minority ethnic groups experiencing poorer outcomes compared to those from a White ethnic background. In particular, residents from a Black African and Black Caribbean background are more likely to live in communities with high levels of deprivation, develop a greater number of long-term conditions, have poorer mental health, and experience discrimination and racism when accessing services.

16. Southwark has one of the largest LGBTQI+ communities in the country. There is increasing academic evidence that key public health challenges disproportionately impact this population group, with higher levels of smoking, alcohol use, incidence of some cancers and mental ill-health. LGBTQI+ individuals also experience discrimination and homophobia when accessing health, care and other services.

17. As we plan interventions, services and strategies to improve outcomes and reduce inequalities within the borough it is important to consider how different demographic and social characteristics overlap and intersect, magnifying disadvantage.

JSNA Programme

18. In addition to the JSNA Annual Report, a number of in-depth projects are recommended for the JSNA programme over the coming months, including:

    - Children & Young People's Mental Health & Wellbeing: this needs assessment is currently being finalised and focuses on children and young people under 25.

    - LGBTQI+: This proposed needs assessment will build on the new demographic data released through the 2021 Census and seek to establish the health and wellbeing needs of this population group.

    - Neighbourhood Profiles: A series of neighbourhood profiles are proposed to supplement this annual report. They will provide summaries of demographics, health and wellbeing for communities across the borough and support neighbourhood work.

    - On-going monitoring of the cost of living crisis: It is proposed the monitoring of the cost of living crisis continues to support the local response.

Policy framework implications

19. The JSNA process should underpin the development of the Joint Health & Wellbeing Strategy of the Health & Wellbeing Board and other local plans and policies designed to improve health and wellbeing in the borough.

20. The JSNA should inform plans of borough the Council and NHS partners, including the emerging South East London Integrated Care System.

Community, equalities (including socio-economic) and health impacts

Community impact statement

21. Lead authors for each JSNA project included within the future programme are encouraged to engage with partners, community and voluntary organisations, and residents in the development of their reports.

Equalities (including socio-economic) impact statement

22. A key component to the JSNA programme is to develop our understanding of health inequalities in the borough. All JSNA reports consider how different population groups and communities are affected by the issue being considered. This includes the protected characteristics outlined in the Equality Act 2010, along with other factors such as socio-economic status.

Health impact statement

23. The JSNA programme is designed to consider the direct and indirect influences on health and wellbeing in the borough i.e. health and its wider determinants.

Climate change implications

24. The JSNA programme will include work assessing the wider determinants of health, including environmental impacts e.g. air quality.

Resource implications

25. The JSNA is undertaken in-house and led by the Public Health division on behalf of the Health & Wellbeing Board. While the majority of the resource for producing the JSNA will come from within Public Health, co-production is an important aspect to the development of JSNA projects. There is an expectation that partners will play an active role in the development of projects within their area of expertise. Through this co-production process the JSNA can better reflect the local picture and ensure recommendations for future action have the support of all partners.

Legal implications

26. Local authorities and the NHS have equal and joint duties to prepare the Joint Strategic Needs Assessment, through the Health & Wellbeing Board, outlined in the Health and Social Care Act 2012.

Financial implications

27. There are no financial implications. The JSNA programme delivered in-house, led by the Public Health division with contributions from partners.

Consultation

28. The JSNA work programme will be developed following the engagement of key partners across Southwark Council, NHS and other partners. Lead authors for each project included within the programme are encouraged to engage with partners and residents in the development of their reports.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
None		

APPENDICES

No.	Title
Appendix 1	JSNA Annual Report 2023 – Southwark's Joint Strategic Needs Assessment

AUDIT TRAIL

Lead Officer	Sangeeta Leahy – Director of Public Health
Report Author	Chris Williamson – Head of Health & Wellbeing
Version	Final
Dated	11 July 2023
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Assistant Chief Executive - Governance and Assurance	No	No
Strategic Director of Finance	No	No
Cabinet Member	No	No
Date final report sent to Constitutional Team		12 July 2023

JSNA Annual Report 2023

Southwark's Joint Strategic Needs Assessment

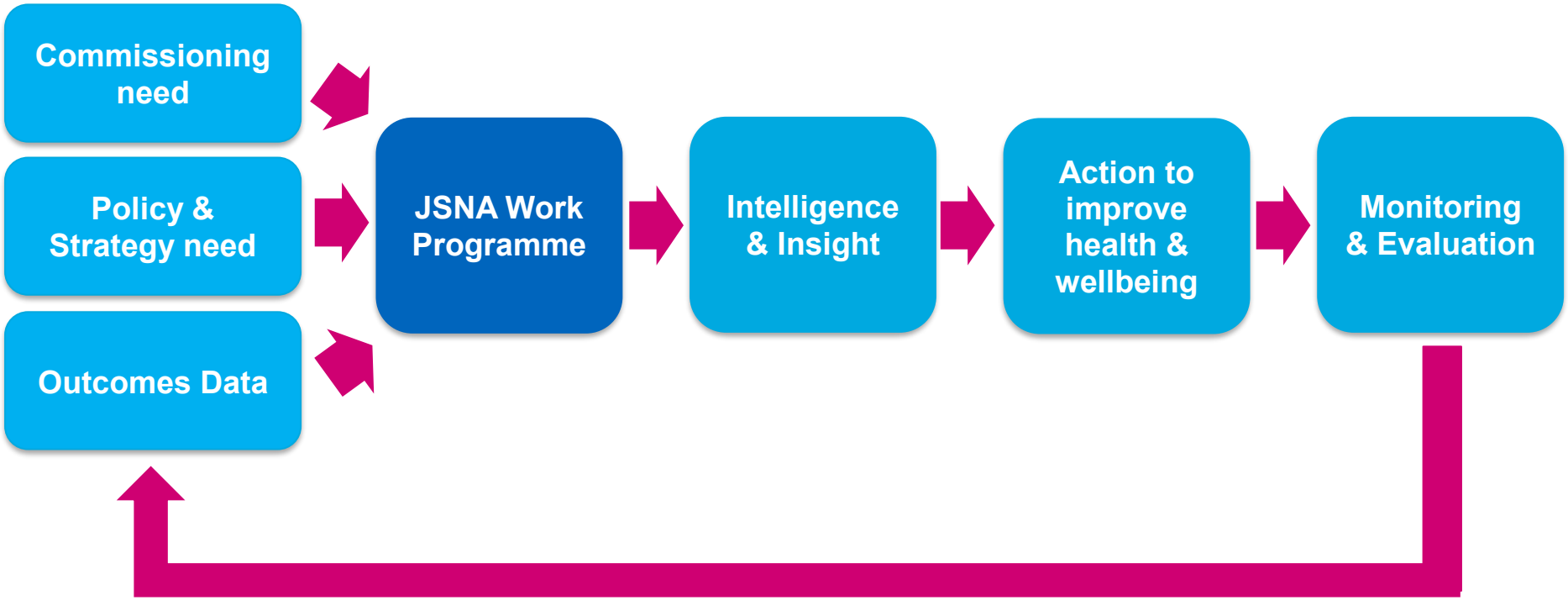
OVERVIEW OF HEALTH & WELLBEING
PUBLIC HEALTH DIVISION
CHILDREN & ADULTS DEPARTMENT
LONDON BOROUGH OF SOUTHWARK

Southwark Council
southwark.gov.uk

1. BACKGROUND

The JSNA Annual Report provides a broad overview of health and wellbeing in Southwark. It seeks to provide an analysis of our changing population, along with details of the health inequalities that exist in the borough. These quantitative data are intended to complement the Annual Public Health Report (APHR), which this year focuses on the impact of poor air quality on health. The APHR is available via: www.southwark.gov.uk/aphr.

This report forms part of the borough's Joint Strategic Needs Assessment (JSNA) work programme, and supports the monitoring of key health and wellbeing outcomes set out in the Joint Health & Wellbeing Strategy (JHWS) and other local strategies and plans.



2. CONTENTS

3. SUMMARY

3.1 Overview of Southwark

Southwark is a densely populated and diverse inner-London borough situated on the south bank of the River Thames, with Lambeth to the west and Lewisham to the east. The borough is made up of a patchwork of communities: from leafy Dulwich in the south, to bustling Peckham and Camberwell, and the rapidly changing Rotherhithe peninsula. Towards the north, Borough and Bankside are thriving with high levels of private investment and development. Yet there remain areas affected by high levels of disadvantage, where health outcomes fall short of what any resident should expect.

Our population is a young, diverse and growing, with large numbers of young adults and residents from a wide range of ethnic and social backgrounds.

- The average age (32.4 years) is more than two years younger than London, and almost seven years younger than England.
- Around half (51%) of people living in Southwark have a White ethnic background compared to 81% nationally.
- The largest ethnic group other than White is 'Black, Black British, Caribbean or African', accounting for one-quarter (25%) of Southwark residents.
- Over 80 languages are spoken in the borough, with 79% of the population speaking English as their main language.
- There were over 40 distinct religions identified among Southwark residents.
- Southwark has the 4th largest LGB+ population in England, with 8% of residents (nearly 21,000 people) aged 16+ identifying as non-heterosexual. Southwark also has the 5th largest trans/non-binary population in England.
- Over 18,000 residents provide some level of unpaid care, equivalent to 6% of Southwark's population.

3.2 Achievements

Across the borough there have been significant improvements in health and wellbeing over the last decade and there are many areas of success that should be celebrated:

- Our residents are living longer lives than ever before, with life expectancy comparable or better than the national average.
- Levels of relative deprivation in the borough continue to reduce.
- Child vaccination rates are generally comparable or better than the London average.
- Key risk factors such as smoking, alcohol and physical inactivity are comparable or better than the national average.
- Preventable mortality has reduced by almost half since 2001, narrowing the gap with England.

3.3 Assets

Southwark benefits from a wide range of social and physical assets that help our communities to maintain and sustain good health and wellbeing.

- The borough has an active and large range of community, voluntary and faith organisations working to support local residents. Embedded within our communities, these groups are key partners in efforts to tackle the inequalities we see in Southwark.

- There are a diverse range of high quality open spaces in Southwark, from the Thames pathway, to our extensive network of parks and community gardens. These outdoor spaces are complimented by a range of modern leisure facilities such as the Castle Centre and Peckham Pulse. Such assets provide opportunities for physical activity, sport and play, helping reduce stress and prevent the development of long-term conditions.

- Southwark also has a network of modern libraries located across the borough. These facilities provide spaces for the whole community to use, whether that be through baby sensory sessions, community group activities, or accessing local council services.

- The borough is also home to a number of world-class health and care facilities, from our large hospital trusts, through to our community based clinics and hubs. These services provide our residents with access to high quality support and care for those in need.

These are just some examples of the social and physical assets in Southwark that partners and residents can draw on as we seek to improve health and reduce inequalities in our borough.

3.4 Challenges

Although there have been substantial improvements in health outcomes in Southwark, many challenges remain. The lasting impact of the COVID-19 pandemic and the on-going cost of living crisis continues to exacerbate the inequalities that too many people experience. These inequalities are both avoidable and unfair. While inequalities vary across different issues, there are a number of communities and population groups within the borough that consistently experience poorer outcomes than others.

Geographic Inequalities

Across a wide range of health, social and economic measures, from child poverty through to obesity, hospital admissions and life expectancy, outcomes are poorer in central and northern parts of Southwark. In particular, communities in Faraday and Peckham wards. However, it is important to acknowledge that pockets of disadvantage also exist within areas of affluence, such as the Kingswood estate in Dulwich Wood and Downtown estate in Surrey Docks.

Population Inequalities

There are also significant gaps in outcomes between population groups in Southwark. These often mirror the inequalities we see at a

national level, with those from Black, Asian and minority ethnic groups experiencing poorer outcomes compared to those from a White ethnic background. In particular, residents from a Black African and Black Caribbean background are more likely to live in communities with high levels of disadvantage, develop a greater number of long-term conditions, have poorer mental health, and experience discrimination and racism when accessing services.

While we have indications and examples of the inequality in outcomes between different ethnic groups, there remain gaps in our understanding at a local level. A number of national reviews have identified the continued need to improve the recording and the analysis of ethnicity data. Locally, as nationally, additional work is required to improve the quality of ethnicity data, to ensure we support those most in need and reduce inequalities. This is particularly the case for groups that are too often excluded from national data collections, such as residents with a Latin American background.

Southwark has one of the largest LGBTQI+ communities in the country. There is increasing academic evidence that key public health challenges disproportionately impact this population group, with higher levels of smoking, alcohol use, incidence of some cancers and mental ill-health. LGBTQI+ individuals also experience discrimination and homophobia when accessing health, care and other services. An in-depth needs assessment for this population group will be undertaken in 2023, building on the new data released through the 2021 Census. As with ethnicity, additional work is required to collect data on sexual orientation within local services to enable better monitoring and tackle local inequalities.

There are also a number of notable health inclusion groups in Southwark. These are groups that are often socially excluded, have multiple risk factors for poor health, and experience stigma and discrimination, including:

- People with learning disabilities
- Carers
- Rough sleepers
- Asylum seekers and refugees

In-depth needs assessments for these groups are accessible via www.southwark.gov.uk/jsna.

Intersectionality

The national and local evidence base regarding the health inequalities experienced by different population groups continues to improve. However it is important to acknowledge that these groups are not homogenous. The experiences and outcomes of specific ethnic groups, or those with the same sexual orientation are not equal. As we plan interventions, services and strategies to improve outcomes and reduce inequalities within the borough it is important to consider how different demographic and social characteristics overlap and intersect, magnifying disadvantage.

Further work will be undertaken this year to understand the extent of the intersection and overlap between vulnerable population groups in the borough.

Wider Determinants of Health

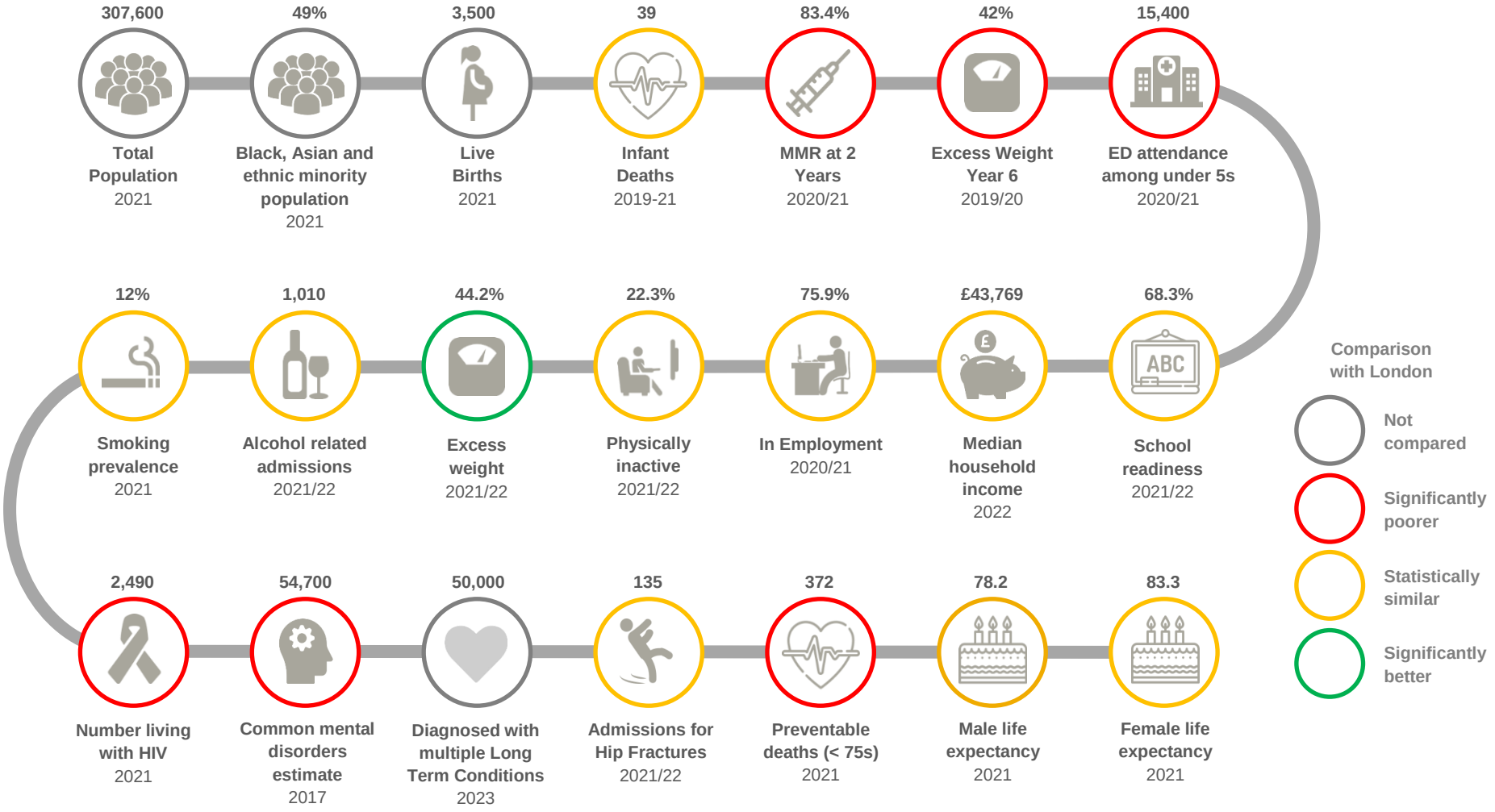
Despite the COVID-19 pandemic and cost of living crisis, many of the socio-economic outcomes in Southwark are comparable to the either the London or national average. However, this masks significant inequalities experienced by many of our residents. A third of our children live in poverty, and significant numbers live in homes suffering from food insecurity – exacerbated by the cost of living crisis.

The importance of addressing the wider determinants of health was clearly outlined in the Marmot Review in 2010: "*This link between social conditions and health is not a footnote to the 'real' concerns with health – health care and unhealthy behaviours – it should become the main focus*." What was true in 2010 remains true today. Only by improving the social and economic conditions in which our residents live can we make meaningful and sustainable improvements in health and reduce inequalities.

The following sections of this report provide and update on health and wellbeing outcomes in Southwark, along with the inequalities in the borough. In addition to this summary report additional in-depth needs assessments are underway, or planned this year, including:

- Children & Young People's Mental Health & Wellbeing
- LGBTQI+
- Neighbourhood Profiles
- On-going monitoring of the cost of living crisis

4. SOUTHWARK HEALTH & WELLBEING INFOGRAPHIC



5. HEALTH & WELLBEING GEOGRAPHIC INEQUALITY INFOGRAPHIC

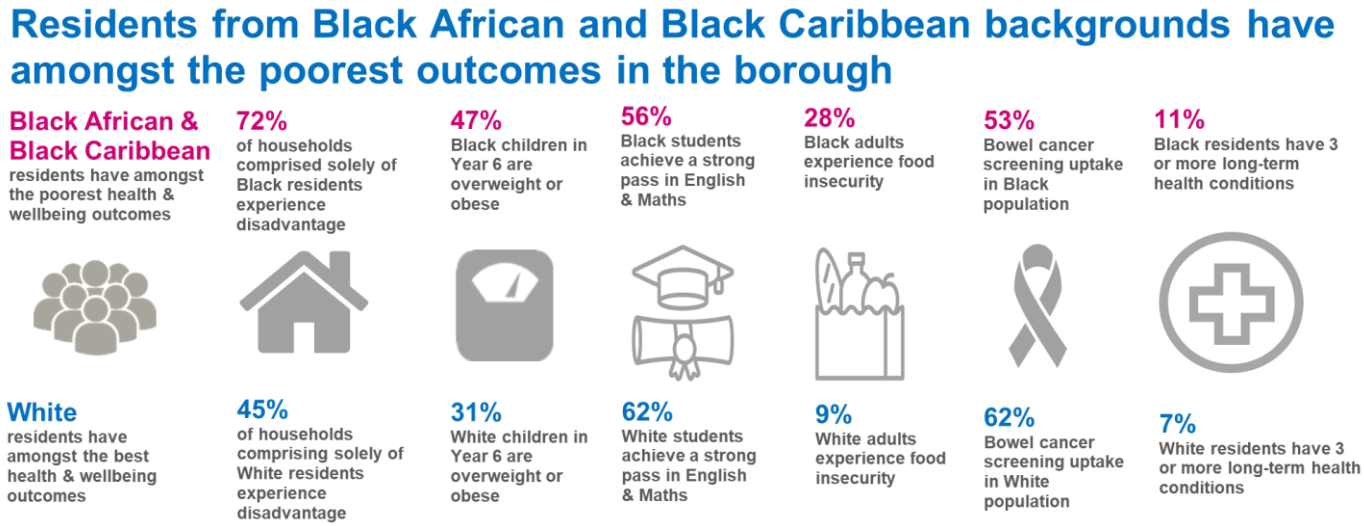
There is a wide and growing range of data that highlight the geographical inequality in health and wellbeing outcomes in the borough, often linked to socio-economic disadvantage.

Our poorest outcomes are concentrated in our most deprived neighbourhoods

Faraday has the highest level of socio-economic deprivation	**64%** are from a non-White ethnic background	**£35,000** median income	**33%** of children under 16 live in poverty	**9.6%** of adults are unemployed	**52%** social renters	**25% above** the average crime rate for London	**71 per 1000** residents have 3 or more long term health conditions	**4% above** the national average for emergency hospital admissions	**78.8** male life expectancy **84.5** female life expectancy
									
Dulwich Village has the lowest level of socio-economic deprivation	**21%** are from a non-White ethnic background	**£74,000** median income	**5%** of children under 16 live in poverty	**2.6%** of adults are unemployed	**13%** social renters	**23% below** the average crime rate for London	**34 per 1000** residents have 3 or more long term health conditions	**45% below** the national average for emergency hospital admissions	**87.1** male life expectancy **89.5** female life expectancy

6. HEALTH & WELLBEING ETHNICITY INEQUALITY INFOGRAPHIC

Local data on inequalities between demographic groups highlight the poorer outcomes among those from Black African and Black Caribbean backgrounds. However this data is limited at a local level, often relying on bespoke data collection or research projects.



HEALTH & WELLBEING WARD MATRIX

Ward Code	Multi Ward Area	Electoral Ward	People								Place				Start Well			Live Well				Age Well						
			Total Population	Population aged under 20	Population aged 20-64	Population aged 65+	Non White-British Population	Residents unable to speak English well or at all	Residents providing unpaid care	Residents with a disability	IMD Score	Fuel Poverty	Unemployment	Long-term unemployment	Breast Feeding Continuation	Emergency admissions in under 5s	Excess Weight - Year 6	Cancer Incidence	Emergency hospital admissions	Emergency hospital admissions for	Emergency hospital admissions for	Emergency hospital admissions for	Deaths from all causes	Deaths from cancer	Deaths from CVD	Deaths from resp. diseases	Male L.E.	Female L.E.
			2021	2021	2021	2021	2021	2021	2021	2021	2019	2020	2021/22	2021/22	2018/19-2021/22	2018/19-2020/21	2019/20-2021/22	2015-2019	2016/17-2020/21	2016/17-2020/21	2016/17-2020/21	2016/17-2020/21	2016-2020	2016-2020	2016-2020	2016-2020	2016-2020	2016-2020
			Number	Number	Number	Number	%	%	%	%	Score	%	%	%	%	Rate per 1,000	%	Ratio	Ratio	Ratio	Ratio	Ratio	Ratio	Ratio	Ratio	Ratio	Years	Years
E05011106	North East	North Bermondsey	15,300	2,600	11,400	1,300	60.0	2.3	5.9	13.5	22.4	8.6	4.9	0.6	81.1	93	42.9	89	91	104	259	93	103	102	97	85	79.0	83.2
E05011112		Rotherhithe	15,600	3,000	11,500	1,200	66.8	2.8	5.7	13.4	24.6	9.1	5.6	1.3	79.6	92	40.3	97	91	90	265	103	97	87	81	105	79.9	83.5
E05011116		South Bermondsey	15,900	3,300	11,400	1,300	64.6	4.1	7.4	15.4	28.3	11.6	7.9	1.3	80.2	113	42.4	102	107	87	213	80	91	95	96	100	79.1	85.3
E05011117		Surrey Docks	13,000	2,000	10,100	900	60.6	1.9	5.6	11.0	16.8	4.1	4.9	0.6	85.5	118	37.0	98	83	72	70	79	78	104	74	69	83.2	85.5
E05011095	North West	Borough & Bankside	9,000	1,700	6,600	700	64.8	1.8	5.6	13.6	21.1	9.2	4.6	0.8	81.8	113	37.0	120	97	74	169	113	87	118	80	72	81.2	84.3
E05011098		Chaucer	15,000	3,100	10,800	900	74.6	3.5	5.8	12.4	26.4	12.1	6.3	0.6	86.0	121	40.8	94	97	94	157	46	75	99	70	72	83.8	85.3
E05011104		L.Bridge & W.Berm.	15,100	2,400	11,700	1,000	65.4	2.2	5.5	12.3	23.3	9.7	5.1	1.1	85.2	92	44.3	107	99	82	157	139	128	118	107	143	75.6	80.0
E05011114		St George's	8,500	1,600	6,300	500	69.3	2.8	6.1	14.1	32.6	13.1	7.5	1.8	83.3	145	42.9	81	126	91	94	67	106	82	138	70	78.3	84.0
E05011108	East Central	Nunhead & Q. Road	15,600	3,200	10,900	1,500	64.6	3.0	7.5	17.3	33.9	15.2	8.2	0.8	85.4	82	43.8	98	98	86	165	122	143	106	133	143	75.3	80.4
E05011109		Old Kent Road	19,000	4,600	12,900	1,500	76.7	7.0	6.7	14.4	32.0	12.8	9.7	1.8	79.1	99	50.0	105	105	79	166	95	100	120	95	107	78.8	83.3
E05011110		Peckham	14,800	3,400	10,200	1,200	81.2	5.1	7.2	14.6	34.0	14.1	11.1	1.6	84.3	89	47.2	97	101	73	128	64	112	109	92	99	77.2	81.3
E05011111		Peckham Rye	10,200	2,600	6,700	900	50.0	1.6	7.3	13.1	21.3	11.3	6.3	1.1	91.5	72	28.8	105	71	65	104	68	86	99	84	83	79.5	86.3
E05011113		Rye Lane	14,500	3,000	10,200	1,300	59.3	3.1	6.6	14.9	27.2	12.5	7.5	1.1	89.2	79	42.5	109	79	67	136	57	88	100	97	98	79.7	85.3
E05011096	West Central	Camberwell Green	15,500	3,200	11,000	1,400	73.0	5.2	6.1	13.9	31.2	15.4	9.2	1.9	85.6	81	47.4	108	88	76	115	77	97	100	114	76	79.3	84.3
E05011102		Faraday	12,500	3,100	8,400	1,000	76.6	7.2	6.1	12.4	34.3	14.3	9.6	1.8	82.9	93	47.8	101	104	74	183	104	91	101	84	87	78.8	84.5
E05011105		Newington	13,400	2,900	9,300	1,300	71.7	3.6	7.7	16.7	30.0	11.0	9.0	2.4	81.2	111	40.9	109	109	64	203	99	91	107	87	80	78.0	85.8
E05011107		North Walworth	15,800	3,000	11,800	1,000	72.0	4.4	5.7	13.3	33.6	14.0	7.7	1.7	83.7	124	50.0	110	112	93	178	110	102	99	125	122	77.9	84.1
E05011115		St Giles	15,900	3,400	11,200	1,300	64.7	4.2	6.0	13.2	27.2	11.6	7.7	0.9	87.7	81	49.4	108	85	73	126	47	92	108	103	79	79.4	85.0
E05011097	South	Champion Hill	9,200	2,100	6,400	800	62.7	2.6	6.4	12.9	18.2	11.0	5.7	1.9	89.9	101	34.5	105	70	49	66	82	68	91	61	49	82.0	89.8
E05011099		Dulwich Hill	9,600	2,100	6,600	900	43.8	2.1	6.8	12.5	18.1	9.2	5.4	0.8	88.8	82	27.7	99	78	76	134	103	97	101	84	106	80.0	83.6
E05011100		Dulwich Village	10,300	2,800	6,000	1,500	34.8	0.9	7.3	11.1	9.8	7.1	2.6	0.5	90.9	67	19.4	90	55	42	46	59	54	67	55	39	87.1	89.5
E05011101		Dulwich Wood	10,600	2,800	6,500	1,300	56.9	1.7	7.3	13.5	20.3	9.2	6.1	1.8	90.5	64	38.2	98	72	56	62	105	82	100	86	79	80.1	86.4
E05011103		Goose Green	13,600	2,800	9,600	1,200	43.4	1.4	6.6	12.4	16.4	7.4	4.9	1.1	88.6	83	22.8	102	67	59	82	62	78	90	76	65	80.8	87.5
E09000028	**Southwark**		**307,600**	**64,700**	**217,300**	**25,700**	**64.5**	**3.4**	**6.0**	**18.0**	25.8	11.1	6.9	1.2	84.6	93	41.2	102	91	75	148	85	94	101	92	90	79.4	84.3

Outcome significantly poorer than Southwark	Outcome poorer than Southwark, but not significantly	Outcome better than Southwark but not significantly	Outcome significantly better than Southwark	Statistical significance not applicable

7. PEOPLE

Southwark is a densely populated and diverse inner London borough situated on the south bank of the River Thames, with Lambeth to the west and Lewisham to the east. The borough is made up of a patchwork of communities: from leafy Dulwich in the south, to bustling Peckham and Camberwell, and the rapidly changing Rotherhithe peninsula. Towards the north, Borough and Bankside are thriving with high levels of private investment and development. Yet there remain areas affected by high levels of socio-economic disadvantage, where health outcomes fall short of what any resident should expect.

7.1 Current population

Home to some 307,600 people, Southwark has a comparatively young population. The average age (32.4 years) is more than two years younger than London, and almost seven years younger than England.

307,600
Population in 2021

32.4 years
Average age in 2021

Figure 1: Southwark census population estimate, 2021
Source: ONS 2022. Census 2021 - Population and household estimates, England & Wales

Figure 2 shows the age structure of Southwark compared to England (black outline). The chart demonstrates that the low average age in the borough stems not from a large number of children, but from a large number of young working age residents: 41% of the Southwark population is aged 20 to 39.

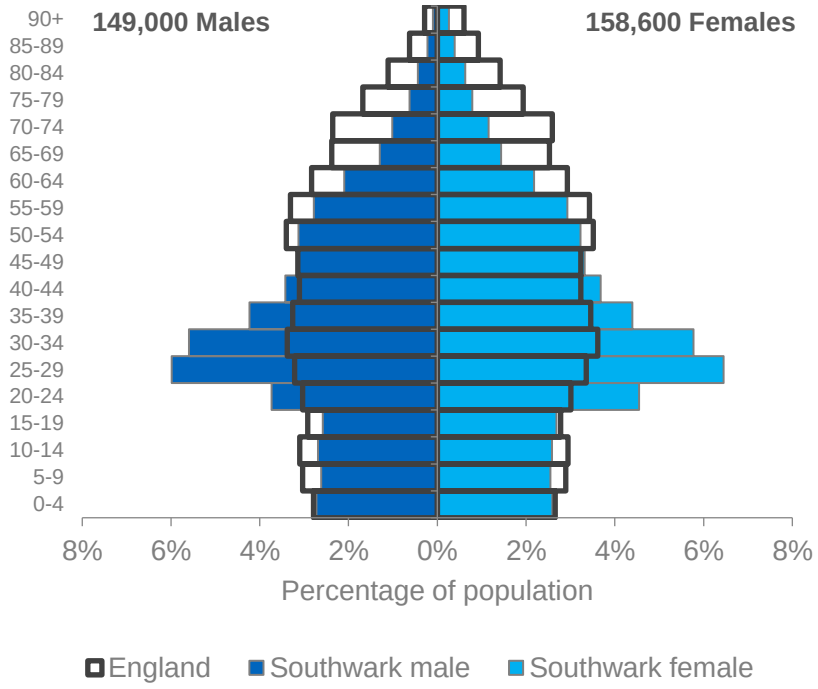


Figure 2: Age structure of Southwark compared to England, 2021
Source: ONS 2022. Census 2021 - Population and household estimates, England & Wales

7.2 Population Change

The population of Southwark grew by 7% between 2011 and 2021, in line with both the London and national average. However, the change over the decade has not been uniform. Over the ten-year period, the most significant changes in the age structure within Southwark has been among adults aged between 55 and 70, and children aged under 5.

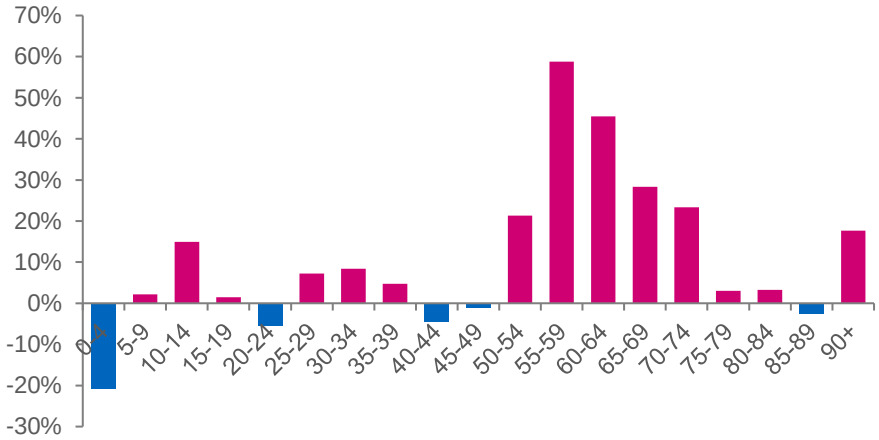


Figure 3: Percentage change in Southwark population by age, 2011 to 2021
Source: ONS 2022. Census 2021 – Population and household estimates, England & Wales

The latest population projections suggest that our population will continue to grow over the next decade. Population growth is set to take place across almost all parts of the borough, but the largest increases are expected in redevelopment areas around Old Kent Road, Canada Water, and Elephant and Castle.

7.3 Ethnicity, languages and country of birth

Southwark is a diverse borough with residents from a wide range of ethnicities and backgrounds.

Data from the 2021 Census shows that 51% of people living in Southwark have a White ethnic background compared to 81% nationally. Just over a third (36%) of residents identify as 'White: English, British, Welsh, Scottish or Northern Irish' ethnicity.

The largest ethnic group other than White is 'Black, Black British, Caribbean or African', with one-quarter (25%) of Southwark residents reporting this as their ethnicity compared to only 14% of residents across London and 4% of residents nationally. Almost one-fifth (16%) reported 'African' ethnicity and 6% reported a 'Caribbean' ethnicity.

For the first time the 2021 Census provided data on the number of residents identifying as Hispanic or Latin American. In total, 9,200 people in Southwark recorded this as their ethnicity.

The diversity of Southwark is much greater among our children and young people, with roughly equal proportions of young people from White and Black ethnic backgrounds, and 14% with mixed or multiple ethnicities.

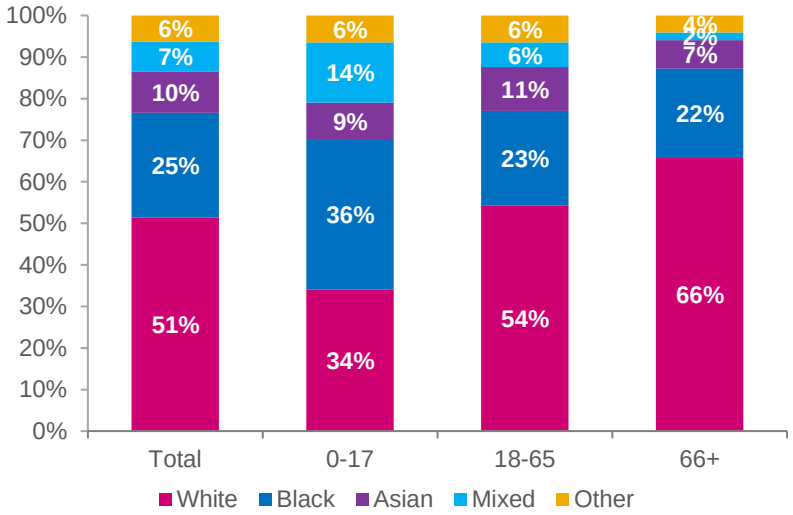


Figure 4: Southwark population by broad ethnic group and age, 2021
Source: ONS 2023. Census 2021 – Age and ethnic group

Over 80 languages are spoken as main languages in Southwark, with 79% of the population speaking English as their main language. The most common language after English was Spanish, which has almost doubled since 2011 and spoken as a main language by over 13,000 residents. Somali was the most common African language spoken.

The top five main languages (other than English) spoken at the time of the 2021 Census were:

- Spanish (13,000)
- Italian (4,300)
- Portuguese (3,600)
- French (3,500)
- Chinese (excl. Cantonese and Mandarin) (2,200)

Of the 53,700 Southwark residents whose main language is not English, 10,200 (19%) cannot speak English well or have no English proficiency.

A large proportion of our residents were also born overseas, with 40% of Southwark's residents born outside the UK, Channel Islands and Ireland. The top country of birth outside the UK and Ireland was Nigeria, making up around 4% of Southwark residents. Italy, Jamaica, Spain and Ghana also made up a notable proportion of Southwark's population. Around 8% of residents were born in the Americas or the Caribbean, with over half of these residents being born in countries in South America.

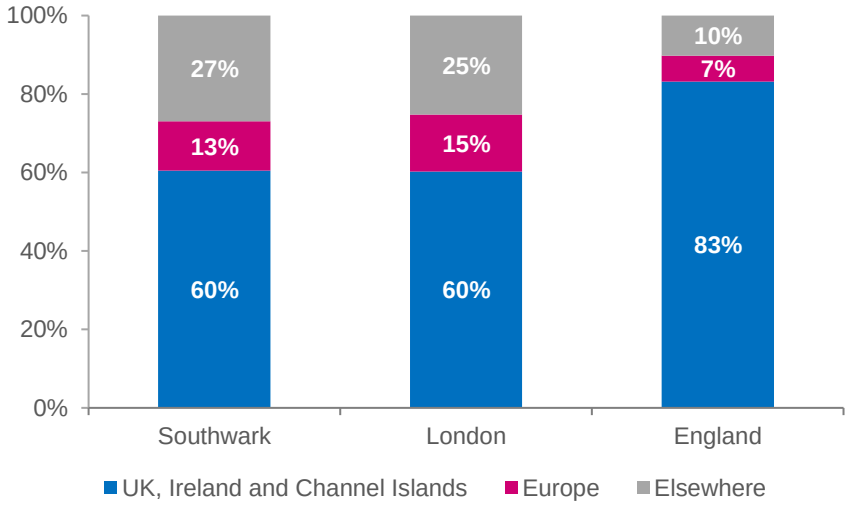


Figure 5: Residents' country of birth as a proportion of total population, 2021
Source: ONS 2022. Census 2021 - International migration, England and Wales

7.4 Religion & Faith

There were over 40 distinct religions identified among Southwark residents by the 2021 Census.

In 2021, 43% of residents reported their religion to be Christian, a drop of 10% since the 2011 Census.

'No religion' was the second most common option reported among Southwark residents, representing over one third (36%) of the population, substantially larger than across London (27%), but similar to the proportion nationally (37%).

Over 29,600 Southwark residents reported their religion to be Muslim, equating to approximately 10% of the population. Those with Muslim or Hindu religion made up a notably smaller proportion of the population in Southwark than was seen across London.

7.5 Sexual Orientation

New, voluntary, questions in the 2021 Census on sexual orientation provide the most recent local data on residents' sexual orientation.

Southwark is ranked the 4th in England for residents identifying with a non-heterosexual orientation, frequently lesbian, gay or bisexual. In Southwark, 8% of residents (nearly 21,000 people) aged 16+ have a non-heterosexual sexual identity. Within this population, 56% identified as lesbian or gay and 40% identified as bisexual or pansexual. 6% of Southwark women identify as LGB+ overall, though this reaches 12% within the 16-24 age bracket. More men identify as LGB+: 10% of male residents overall, peaking at 13% within the 35-44 age bracket. The Burgess Park area of Southwark has the largest LGB+ population within the borough.

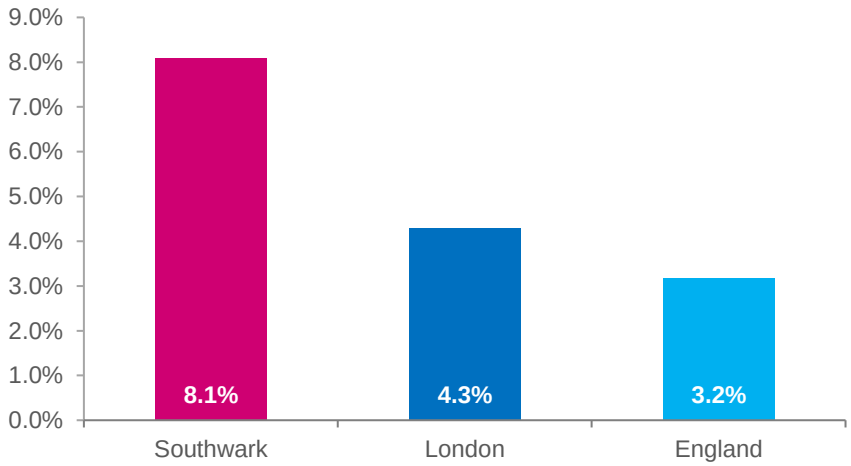


Figure 6: Residents identifying with a non-heterosexual sexual identity
Source: ONS 2023. Census 2021 - Sexual orientation, England and Wales

7.6 Gender Identity

The 2021 Census also asked residents optional questions about their gender identity. Southwark ranked the 5th highest local authority in England for trans or non-binary identities. Within the borough 3,200 residents reporting a gender identity different from their sex registered at birth. Half of these used no specific gender identity term, the rest used 'trans woman', 'trans man' or 'non binary'. Despite having a relatively high proportion of the population with gender identities that differed from sex assigned at birth, the numbers are likely to be underestimates as many residents declined to answer the question.

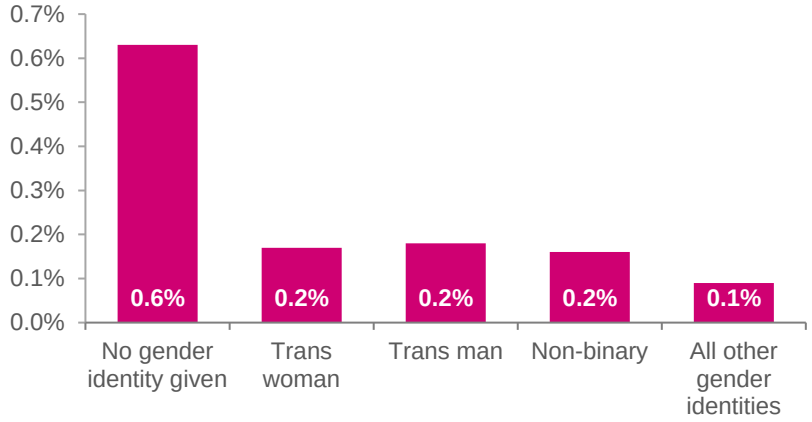


Figure 7: Proportion of Southwark residents who reported a gender identity different to their sex assigned at birth.
Source: ONS 2023. Census 2021 – Gender identity, England and Wales

7.7 Disability & Impairment

The 2010 Equality Act defines a disability as a physical or mental impairment which has a substantial and long-term negative effect on a person's ability to do normal daily activities.

The 2021 Census collected information on residents' disability status, with over 42,000 Southwark residents (14%) recording a disability. This is a similar proportion to London but slightly less than the national average of 17%. Almost a quarter of households (33,000) had at least one resident with a disability.

The neighbourhoods with higher proportions of disability are Old Kent Road, South Bermondsey and Nunhead & Queen's Road, where in some areas 17-23% of residents were disabled.

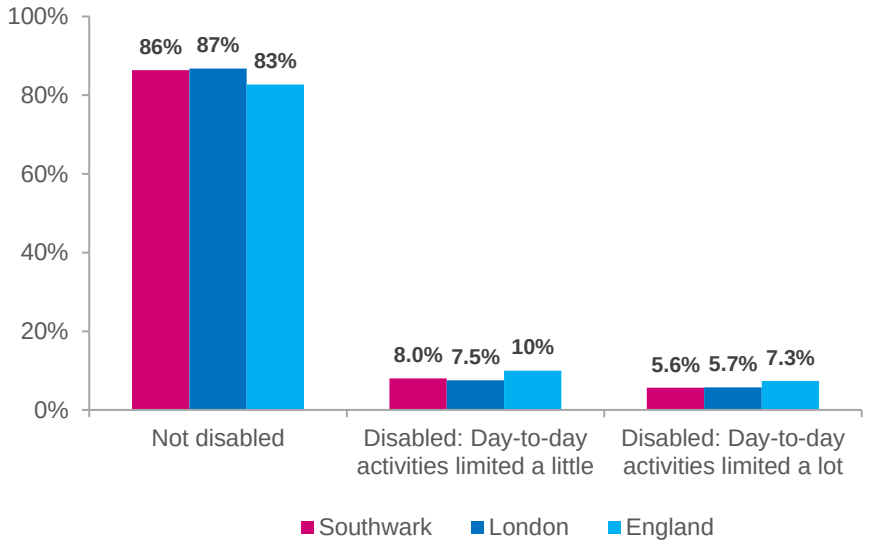


Figure 8: Proportion of Southwark, London and England residents who were disabled at the time of the census.
Source: ONS, 2023. Census 2021 – Health, disability and unpaid care, England and Wales.

Of those in Southwark who were disabled at the time of the Census, half were aged 50 or over. Levels of disability among residents of different ethnicities broadly mirror that of the general population in the borough.

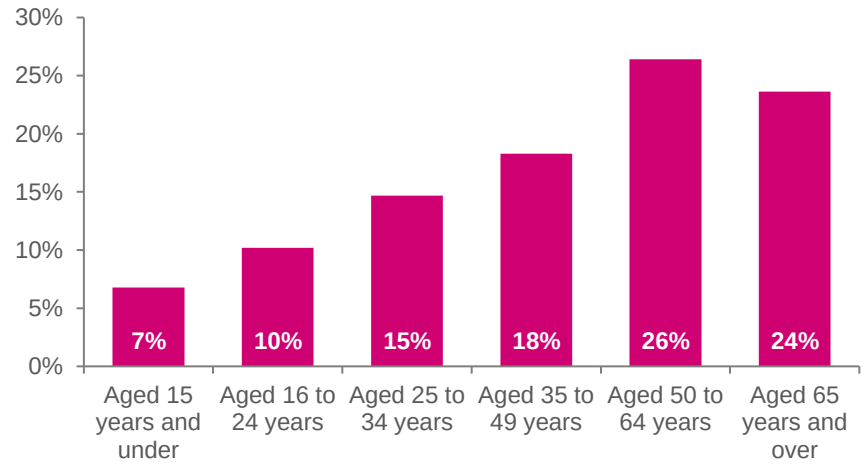


Figure 9: Disabled residents of Southwark by age group.
Source: ONS 2023. Census 2021 – Age and disability

The Family Resource Survey by the Department of Work and Pensions, collects data on what disability/disabilities people have. The most common disabilities reported in inner-London in 2021/22 were:

- Mobility Issues (23% of all disabilities)
- Mental Health (17%)
- Stamina / Fatigue (16%)

These are likely to be the top issues within Southwark's disabled population.

7.8 Carers

Unpaid or informal carers play an integral role in supporting the family members and friends they care for. According to data gathered by the 2021 Census, over 18,000 residents provide some level of unpaid care, equivalent to 6% of Southwark's population.

While this is similar to the 2011 Census, there has been an increase in the hours of care provided over the decade. In 2021, around a quarter (26%) of unpaid carers provided 50+ hours of care per week, equivalent to nearly 5,000 residents.

Never has the importance of carers been emphasised more than during the COVID-19 pandemic. The increased demand for care during the pandemic disproportionately affected women, people from Black African ethnic backgrounds, and those who themselves live with disability and complex care needs.

7.9 Housing and households

A 'household' is defined as one person living alone, or a group of people living at the same address who share cooking facilities and a living room or dining area. In Southwark, there are approximately 130,800 households, an increase of over 10,000 since 2011.

Data from the 2021 Census recorded data on housing tenure: Southwark ranks highest out of all local authorities in England for the proportion of households which are rented from the council, at 27%. When including households rented from the council and housing associations, (i.e. all socially rented households) this increases to 40%. This totals to 52,000 socially rented households in the borough.

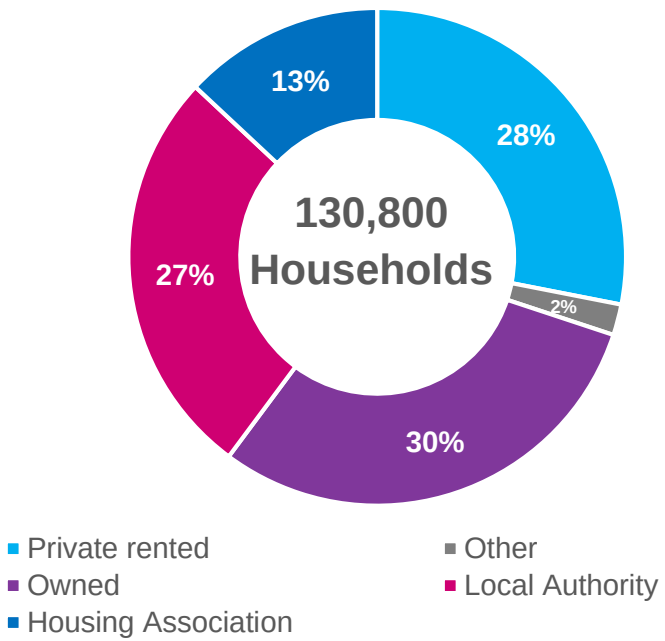


Figure 10: Housing tenure profile in Southwark in 2021
Source: ONS 2023. Census 2021 – Housing, England and Wales

There has been an increase of 9,000 privately rented households since 2011, making up 28% of households in the borough.

At the time of the 2021 Census around one-third of Southwark residents were living alone; slightly higher than both the London and national average. This includes over 9,500 households (7%) of a person aged 66 or over living alone.

One quarter of households included at least one dependent child with a tenth of households being lone parent households with dependent children, equivalent to 12,000 households.

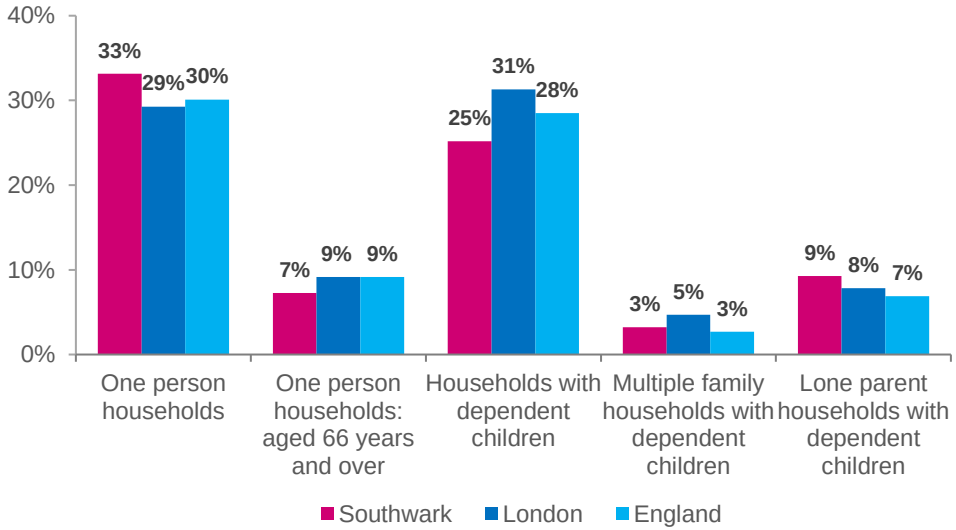


Figure 11: Proportion of households with selected household compositions, in Southwark, London and England.
Source: ONS 2022. Census 2021 – Household and resident characteristics, England and Wales.

Household disadvantage measured by taking a number of factors into account, including employment, education, health and disability and housing quality (overcrowding, shared dwelling or no central heating). At the time of the 2021 Census, 51% of Southwark households were classed as disadvantaged, similar to the London and England averages. In Southwark, 12% of households (approximately 16,000) are classed as overcrowded, higher than the London and England averages.

8. PLACE

8.1 Deprivation

The Indices of Deprivation (IoD) is the official measure of relative deprivation in England, encompassing a wide range of indicators assessing living conditions.

Southwark has seen an improvement in its' ranking relative to other local authorities since 2015, yet remains one of the most deprived in the country.

Table 1: Indices of Deprivation – Southwark ranking in 2015 & 2019
Source: Ministry of Housing, Communities & Local Government

Measure	Ranking out of 317 local authorities	
	IoD 2015	IoD 2019
Rank of average rank	23rd	43rd
Rank of average score	40th	72nd

It is important to acknowledge that the Indices of Deprivation measures relative deprivation. While the ranking of Southwark has improved relative to other local authorities, this does not necessarily indicate that there has been a reduction in absolute levels of deprivation.

Approximately 21% of Southwark's population live in communities ranked within the most deprived nationally. This increases to 23% among those aged under 18.

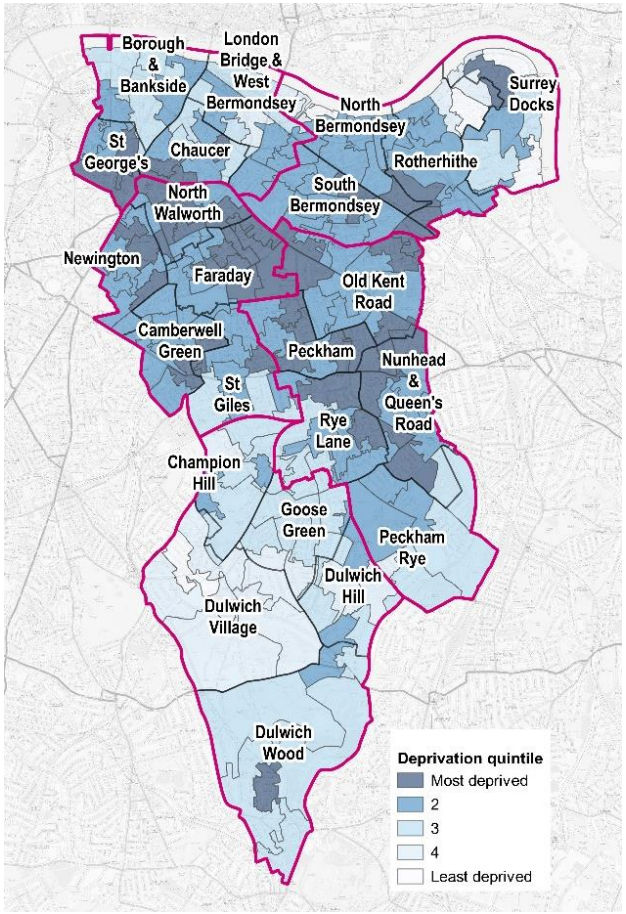


Figure 12: Indices of Multiple Deprivation across Southwark 2019.
Source: Ministry of Housing, Communities and Local Government 2019. English Indices of Deprivation. © OS crown copyright and database rights 2021. Ordnance Survey (0)100019252.

8.2 Employment & Income

The 2021 Census shows that economic activity levels in Southwark are higher than both London and England. At the time of the Census in March 2021, just over 70% of the population aged 16+ were economically active, 92% of whom were in employment.

Economic inactivity in Southwark is below regional and national levels. The main group of those who are economically inactive and not seeking work are students, with 16,500 in the borough, followed by those who are long-term sick, with over 10,000 in this group.

Table 2: Economic activity of the population aged 16+ in Southwark, London and England 2021
Source: ONS 2022. Census 2021 – Economic activity status, England and Wales.

Measure	Southwark		London	England
	Number	%		
Economically active	**181,200**	**71%**	**66%**	**61%**
In employment	167,000	65%	61%	57%
Unemployed	14,200	6%	5%	4%
Economically inactive	**74,900**	**29%**	**34%**	**39%**

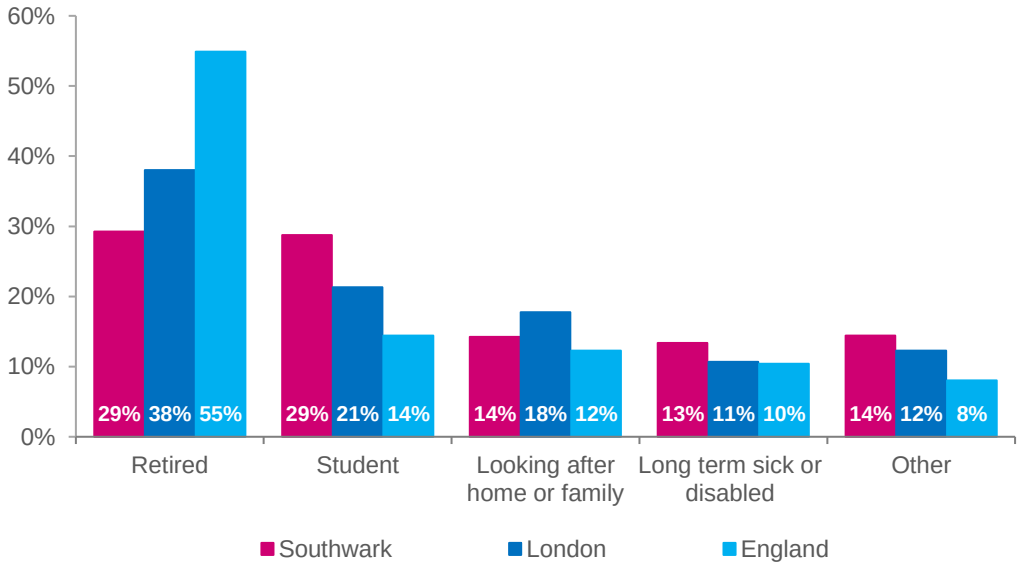


Figure 13: Reasons for economic inactivity across Southwark, London and England, as a proportion of the economically inactive population.
Source: ONS 2022. Census 2021 – Economic activity status, England and Wales.

At the time of the 2021 Census, one third of Southwark residents who were economically inactive had never worked, similar to the proportion across London; this was equivalent to 31,000 residents.

The median (average) household income in Southwark in 2022 was £43,769 broadly comparable to the national average of £38,984. However, there is a wide range of incomes in Southwark with around 1 in 10 households in the borough having a total income of less than £15,000 per year.

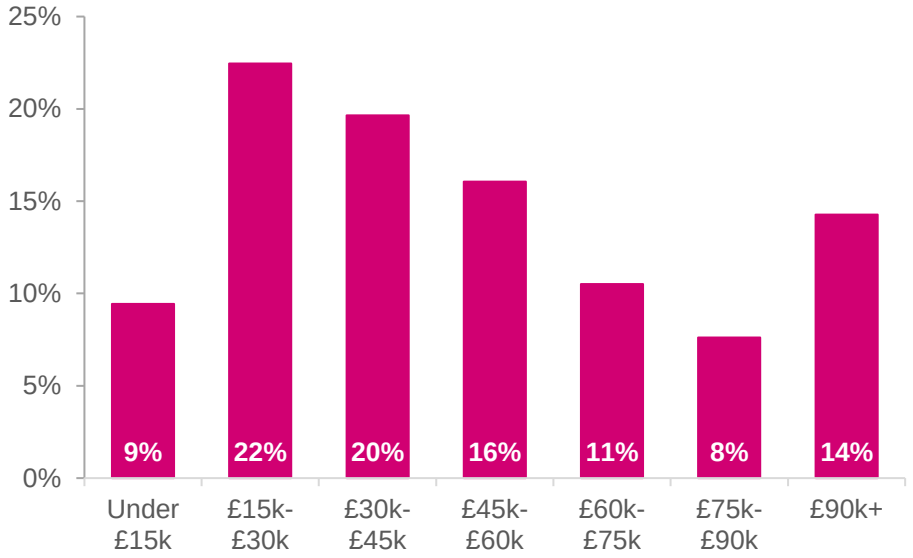


Figure 14: Percentage of Southwark households by income bracket, 2022
Source: CACI Paycheck Directory, 2023.

While average income in Southwark is in line with national levels there are significant geographical inequalities within the borough, with median income highest in Dulwich Village (£73,990) and lowest in Old Kent Road (£32,731).

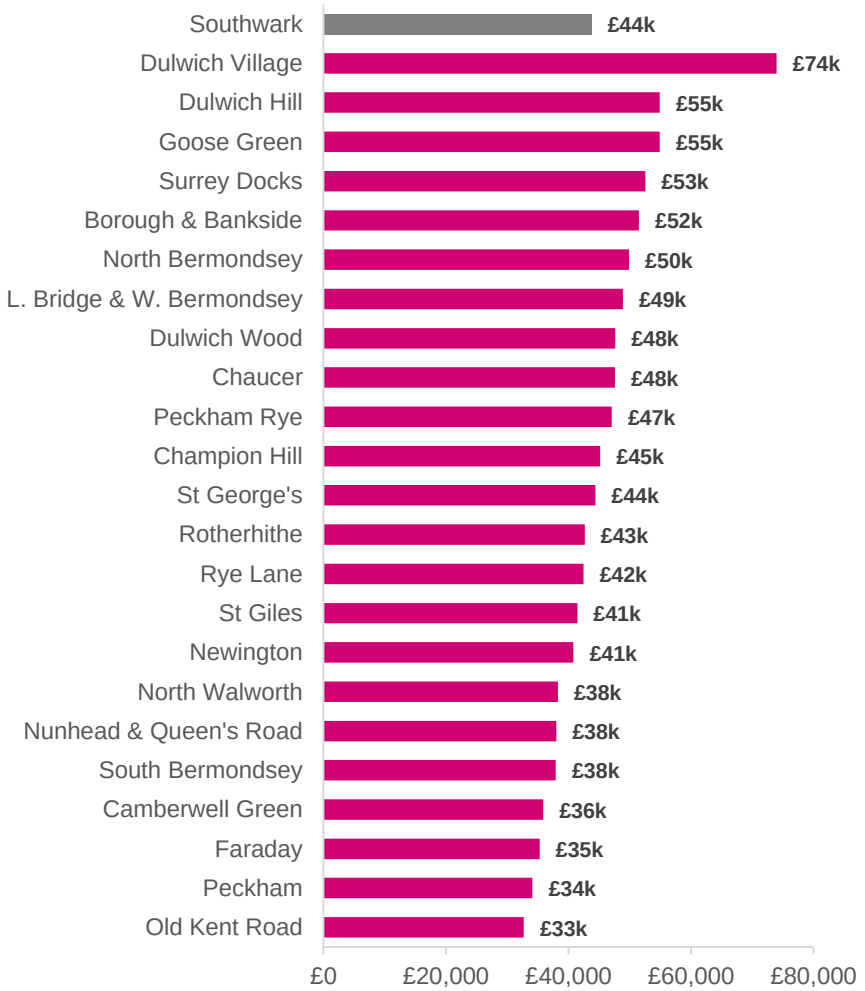


Figure 15: Median gross household income by ward, 2022.
Source: CACI Paycheck Directory, 2023.

8.3 Child Poverty

Children are classed as growing up in poverty if their family income is below the poverty line: earning 60% below the median income. The data here examines child poverty after housing costs of rent, water rates, mortgage interest payments, buildings insurance payments, ground rent and service charges are taken into account.

In 2021/22 approximately 23,000 children aged 0-15 in Southwark were living in poverty, after housing costs were factored in, equating to 36% of children in the borough. This is higher than the London average of 33%. Southwark ranked 8th highest of the London boroughs for child poverty after housing costs in 2021/22.

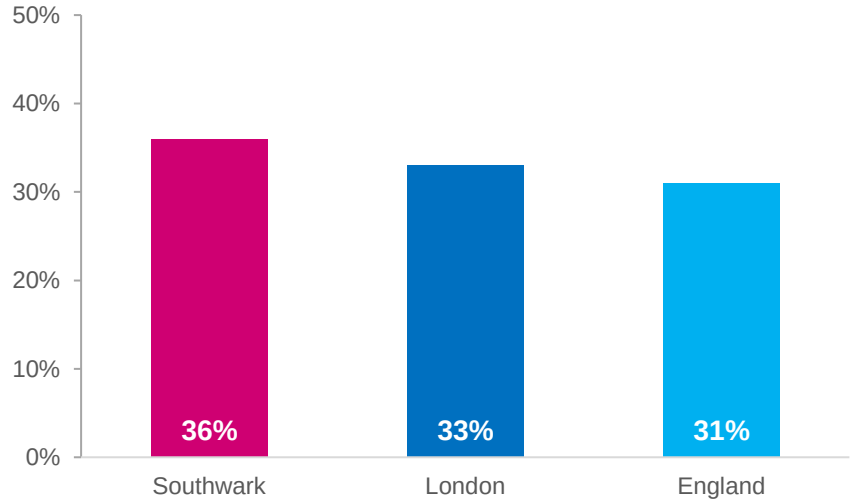


Figure 16: Percentage of children (aged 0-15) living in poverty after housing costs are taken into account, in Southwark, London and England, 2021/22.
Source: End Child Poverty, 2023. Local child poverty rates, After Housing Costs.

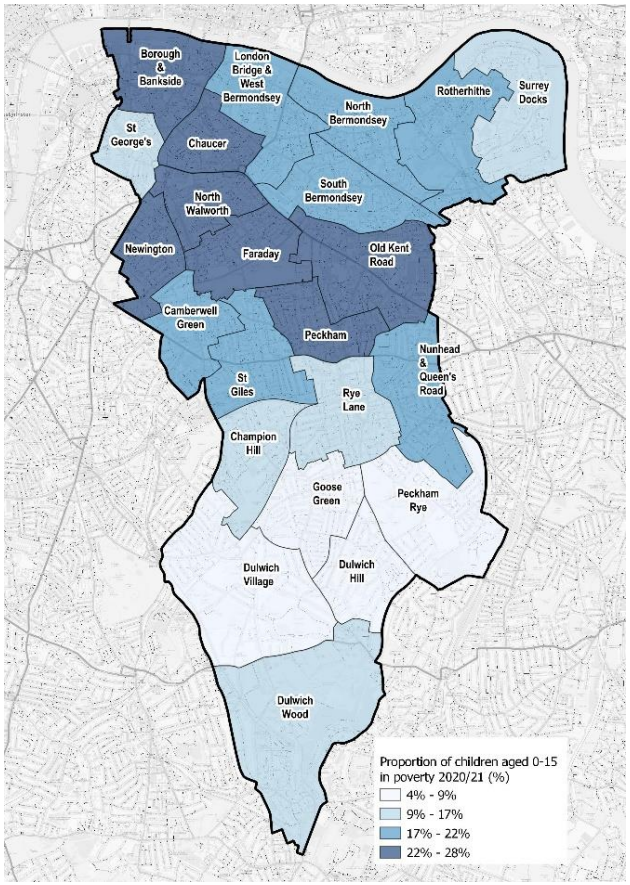


Figure 17: Percentage of children aged 0-15 living in poverty (relative low income families) by ward, before housing costs 2020/21
Source: Department for Work and Pensions 2023. Children in low income families: Relative low income 2021/22. Accessed via StatXplore.
ONS, 2022. 2021 Census – Population and household estimates, England and Wales.

8.4 Cost of Living Crisis

What is the cost of living crisis?

The on-going cost of living crisis has been defined by large and rapid increase to peoples' day-to-day costs across almost all spending categories, most notably housing, fuel and food costs.

Russia's invasion of Ukraine and subsequent sanctions limited supply of gas across Europe. This contributed to a rise in fuel costs for transport, homes and businesses. Increased fuel costs have since had a knock-on effect, increasing prices of goods and services across multiple industries.

Who is most affected by the crisis?

While prices have risen for everyone, those on lower incomes are more affected, as a greater proportion of their expenditure is spent on essentials such as household bills and food. Furthermore, fuel and food have also seen some of the highest price rises, above the average inflation rate. Those on low incomes are less likely to have room to cut back, as many will have already been limiting their spending before the cost of living crisis. Within Southwark, Old Kent Road, Faraday, Peckham and Camberwell Green wards have the highest proportions of residents on low incomes. Polls by the Greater London Authority have found that those on incomes of less than £20,000; those who are deaf or disabled and those who live in socially rented properties are more likely to be struggling financially than the average Londoner. Those who are on low-incomes but above the threshold for means-tested cost of living support as well as those without recourse to public funds are also likely to have been impacted more heavily by the crisis.

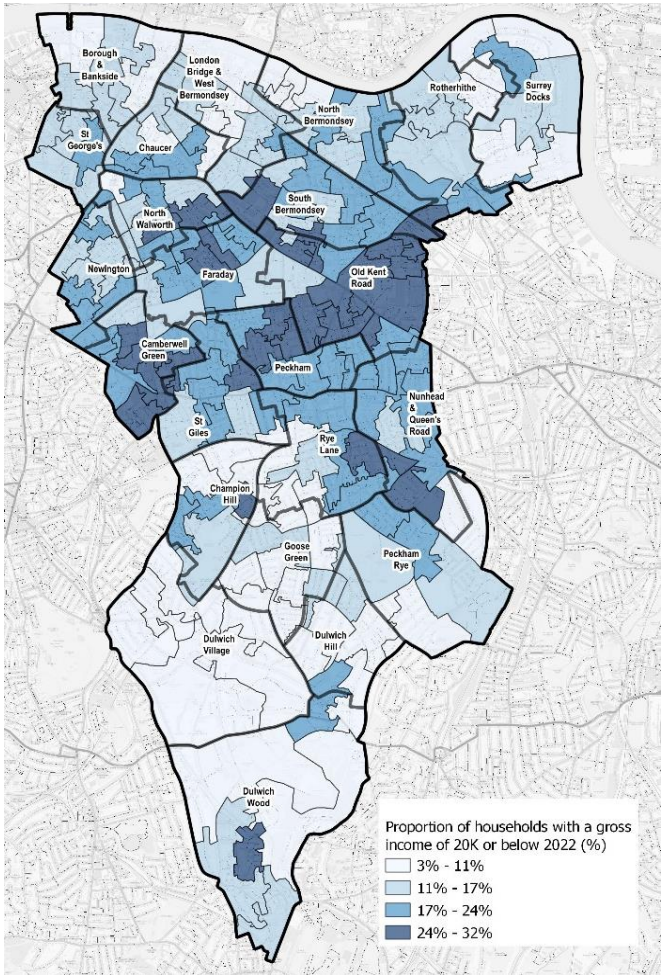


Figure 18: Proportion of households with a gross annual income of 20K or below in 2022.
Source: CACI Paycheck Directory, 2023.

What is the impact on food security?

The cost of living crisis has exacerbated food insecurity, with food prices rising by an average of 25% between March 2021 and March 2023. This is likely to have impacted low income households the most, as they spend a greater proportion of their income on essentials such as food.

A study by Trust for London estimated that on average, low income households spend 17% of their weekly expenditure on food compared to only 8% of high income households. Furthermore, costs have risen above the average inflation rate for many essentials such as milk, bread, oils and fats making higher costs unavoidable for many.

Surveys by the Greater London Authority provide insights on how the cost of living crisis is affecting Londoners. Of respondents who report as financially struggling, 60% said they were buying less food and essentials to manage living costs. 13% of Londoners in January 2023 said they had regularly or occasionally gone without food or relied on outside support such as from food banks.

The Survey for Londoners estimated adult food insecurity to be 16% in Southwark in 2021/22, equivalent to 41,000 residents aged 16+. The survey also found that approximately 2% of residents across Southwark and Lambeth had used a food bank in the past 12 months to collect food, and 1% had used food banks for other services such as counselling.

Product	Average price March 2022	Average price March 2023	Annual growth
A dozen eggs	£2.42	£3.19	↑ 32%
White sliced bread	£1.07	£1.38	↑ 29%
Butter	£1.81	£2.36	↑ 30%
Baked beans	£0.76	£1.05	↑ 39%
Semi-skimmed milk (2 pints)	£0.96	£1.33	↑ 39%

Table 3: Cost of common grocery items in March 2022 and March 2023, plus percentage change in price.
Source: ONS 2023. Shopping prices comparison tool.

8.5 Homelessness

Southwark has the sixth largest population of rough sleepers in London. Over the year 2021/22, 388 individuals were identified by outreach teams as rough sleepers in the borough, a decrease of 32% compared to 2020/21. Of the rough sleepers identified, 61% were new rough sleepers, 13% were returners and 26% were classed as living on the street, having been seen for a minimum of two consecutive years. Levels of rough sleeping are generally highest in the north west of the borough, around London Bridge, with pockets around Burgess Park and Peckham.

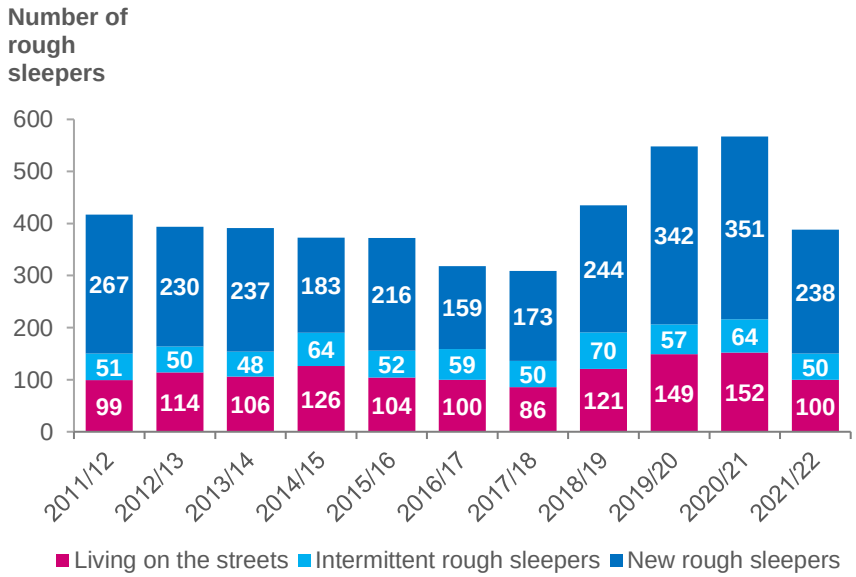


Figure 19: Numbers of rough sleepers identified by outreach teams in Southwark 2011/12 to 2021/22.
Source: GLA, 2022. Rough sleeping in London (CHAIN reports), Borough Annual Reports: Southwark 2021/22.

The majority of rough sleepers identified in Southwark in 2021/22 were male (87%). About a third (30%) were 26-35 years old, with a further third (34%) aged 36-45 years old. The main ethnic groups were White (59%, including 36% White-British) and Black (23%).

Support needs related to alcohol, drugs and mental health were recorded by needs assessments of rough sleepers. Over three-quarters (78%) of rough sleepers had one or more support need recorded, and 43% had more than one of alcohol, drugs and mental health support needs. It is worth noting that 29% of rough sleepers did not have a support needs assessment recorded.

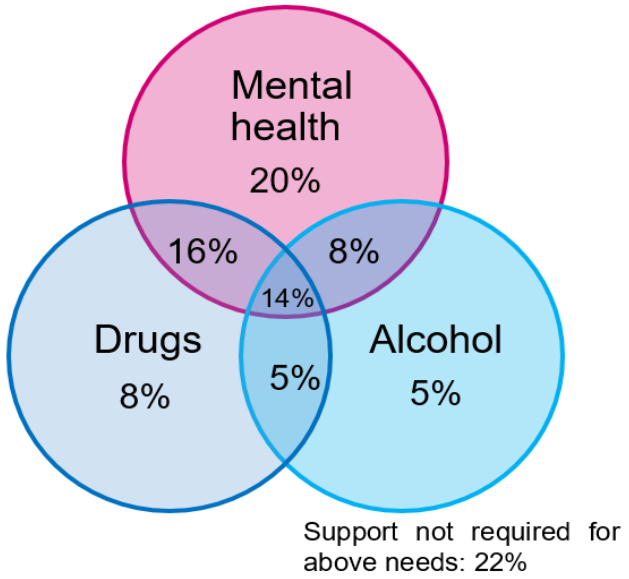


Figure 20: Recorded support needs of rough sleepers in Southwark, 2021/22
Source: GLA, 2022. Rough sleeping in London (CHAIN reports), Borough Annual Reports: Southwark 2021/22.
Note: Percentages are taken of those who have been assessed

8.6 Crime

Crime can have a significant impact on the health and wellbeing of our residents and communities. From April 2022 to March 2023, there were nearly 40,000 recorded offences in Southwark. This was equivalent to 124 offences per 1,000 population, a rate significantly higher rate than the London average of 110 offences per 1,000 population.

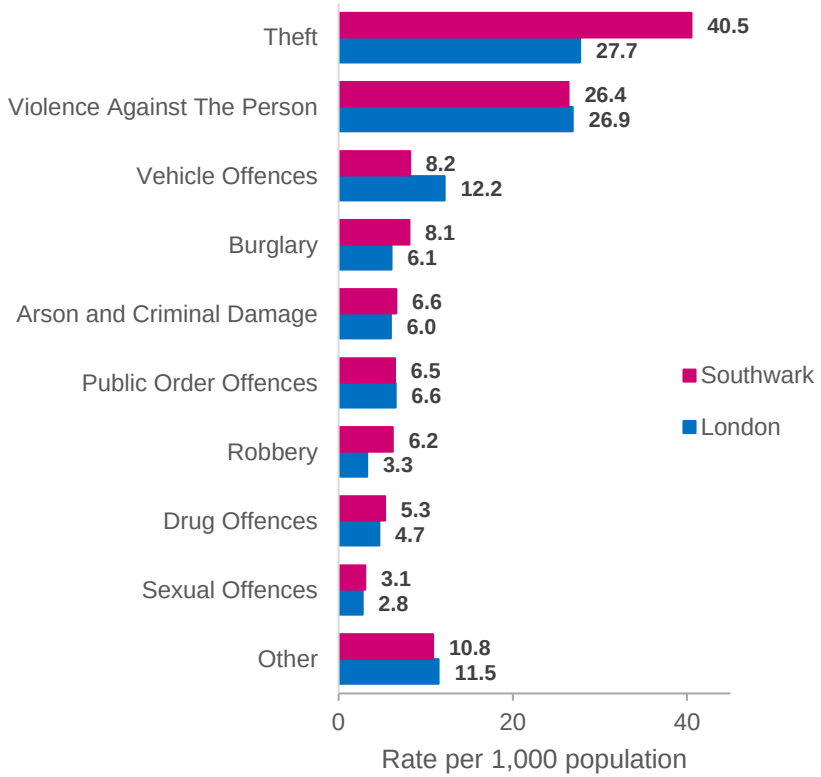


Figure 21: Top ten recorded offences by Southwark 2022-23
Source: Metropolitan Police, 2023. Crime Dashboard- Overview of Crimes

The pattern of recorded offences in Southwark mirrors that for London as a whole, with violence against the person and theft being the most common.

In 2022/23 there were 13,000 recorded cases of theft in Southwark and 8,500 cases of violence against the person. Across the borough, the highest crime rates are in London Bridge and West Bermondsey, Borough and Bankside and North Walworth.

Emergency hospital admissions for violence (including sexual violence) are comparable to the London and England average. Over the three-year period 2018/19 to 2020/21, there were 450 such emergency admissions in Southwark.

8.7 Air Quality

There is strong evidence to show the impacts of air pollution on health. This ranges from exacerbation of respiratory conditions such as asthma and chronic respiratory disease, through to an increase in emergency admissions to hospital.

Across London, the pollutants nitrogen dioxide (NO_2) and particulate matter (PM_{10}) exceed the levels set as the national air quality standards. The largest single source of air pollution in Southwark is road transport, contributing around a third of $PM_{2.5}$ emissions. Domestic and commercial fuels, which come mostly from cooking and heating, also contribute to levels of NO_2, PM_{10} and $PM_{2.5}$.

Figure 22: Main sources of outdoor air pollution

While short-term exposure to air pollution is known to adversely affect health, the relative risk associated with long-term exposure is much greater, contributing to the initiation, progression and exacerbation of disease. NO2 is linked to lung irritation and damage, while particulate matter is linked to increased risk of respiratory disease, lung damage, cancer and premature death.

As well as impacting health conditions, long-term exposure to air pollution can increase the risk of premature death. It is estimated that the average reduction in UK life expectancy associated with air pollution is six months. The effect of particulate matter $PM_{2.5}$ on mortality is higher in Southwark than in London or England, but rates have fallen since 2010 following reductions in emission rates.

Southwark has seven Air Quality Focus Areas which have specific targets set for air pollution levels.

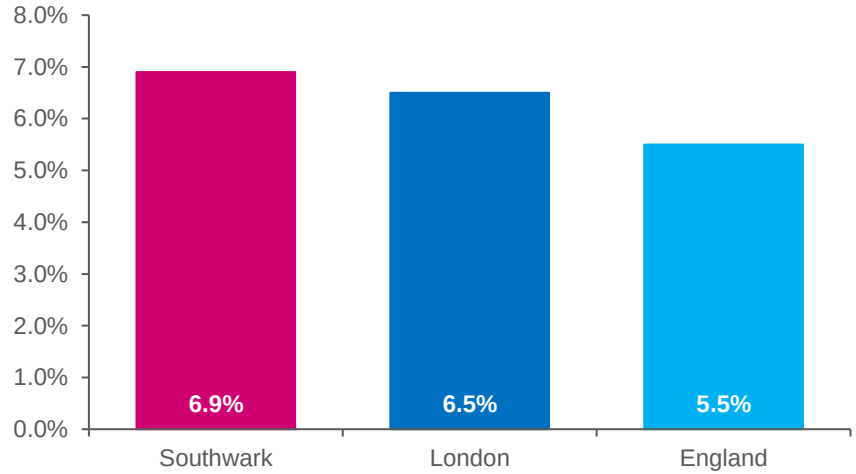


Figure 23: Percentage of adult deaths attributable to particulate air pollution (PM2.5) in 2021
Source: OHID, 2023. Public Health Profiles

Further information on the impact of air quality on health is available in the 2023 Annual Public Health Report, available via: www.southwark.gov.uk/aphr.

9. COMMUNITY VOICE

There has been a wide range of community engagement over the course of the last two years, through which local residents have raised their views and concerns regarding health and wellbeing in the borough.

This on-going engagement has highlighted a number of common themes, building on those identified in the last JSNA Annual Report. These include:

- Residents continue to experience discrimination and structural racism when accessing local services.
- Residents want to be meaningfully involved and for their voices, insight and experience to be valued in the development of plans and local services.
- Services must be culturally appropriate and accessible to all.
- Residents often struggle to access services, such as GP appointments; due to demand, or because they feel excluded, unsure of where to go or unable to interact with services.
- Residents want to be able to access services in their neighbourhoods as much as possible.
- There is ongoing concern regarding rising cost of living, food poverty and affordable housing.
- Mental health and wellbeing for children, young people and adults is a priority.
- There is a concern that vulnerable people continue to fall through gaps in support.

Partners across the health and care system must ensure the concerns and priorities raised by residents are addressed through development of local services and plans. Partners need to work together and with communities, to address the extent of inequalities that exist in health care and health outcomes.

9.1 Rebuilding Trust through Community Engagement and Empowerment

Southwark Council commissioned Social Finance and Centric to develop and test approaches to community engagement and co-production with seldom-heard communities. A focus of this work was on building trust with Black, Asian and minority ethnic communities through community engagement, reflecting that this is necessary to reduce health inequalities in Southwark.

A set of recommendations were developed through one-to-one engagement and workshops, led by community researchers. This work re-iterated the importance of:

- Embedding community engagement throughout the work of health and care organisations, with processes that prioritise accountability and transparency.
- Connecting engagement across organisations, meaning residents can engage with the wider health and care system.
- Helping communities to engage through prioritising accessible language and outreach to existing community spaces.

9.2 Southwark Stands Together

Southwark Stands Together is a borough wide initiative, established in 2020 in response to the killing of George Floyd and the Black Lives Matter movement. It aims to put tackling racial inequalities at the forefront of our work to deliver a fairer and more equal society for all.

The initiative made a number of recommendations, including some centred on addressing inequalities faced by Black, Asian and minority ethnic groups in the health and care sectors. These were:

- Develop a strong partnership approach across the whole health sector addressing the wider health inequalities that disproportionally impact Black, Asian and minority ethnic communities, and their physical, mental and emotional wellbeing.
- Recognise that discrimination can occur in many different ways, from front line to backroom functions; adopt and embed organisation wide approaches to improve the experience of Black, Asian and minority ethnic communities.
- Work with key partners to ensure health services and initiatives are culturally appropriate and accessible for Black, Asian and minority ethnic residents.
- Increase uptake of preventative programmes such as screening, health improvement and education (i.e. awareness, myth busting and health literacy) amongst Black, Asian and minority ethnic communities.

In March 2023, a workshop was held between health and care partners and local residents to reflect on what improvements they had seen in their communities and workplaces and where further work is required. Positive changes included the introduction of community health ambassadors, a network of local volunteers that provide accurate health information and resources to their local communities. A common discussion point throughout the workshop revolved around the need to strengthen communication about Southwark Stand Together, and identifying opportunities to do this.

9.3 Southwark 2030

Southwark 2030 is an engagement programme aimed at gathering views of Southwark residents on their vision for the future of Southwark. The programme has sought views from a wide range of groups, providing opportunities for local people, community groups, business and public services to share their ambitions for the borough.

The engagement work to date has taken place through a range of formats including a survey with over 1,200 respondents, who could raise topics important to them, including family, health, housing, services, green spaces, money and having a say.

A wide range of community groups have also hosted listening events focused on hearing from friends, neighbours and communities about how they felt Southwark could be made a better place. There have been 38 listening sessions, attended by over 800 people. In addition, a school toolkit was developed to involve children and young people in the process.

One of the emerging themes from this engagement relates to the importance of health & wellbeing, ensuring residents are supported to live longer, healthier lives. Further testing of themes and ambitions with the public and partners will take place through the rest of 2023.

10. STARTING WELL

10.1 Births

The total number of babies born in Southwark has been decreasing year on year over the past 10 years. There were 3,250 live births in 2022, down from over 5,000 in 2011, a 35% decrease. The birth rate in Southwark was 38.4 births per 1,000 women aged 15-44 in 2022.

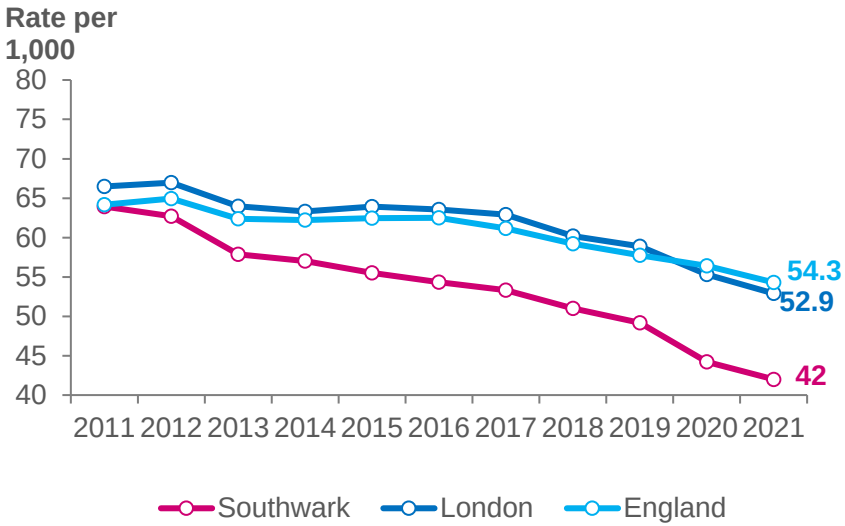


Figure 24: General fertility rate: birth rate per 1,000 females aged 15-44
Source: OHID, 2022. Child & Maternal Health Profiles

The decline in the fertility rate in Southwark is seen across all age groups, but particularly among younger women. The average age of mothers giving birth in Southwark in 2022 was around 33 years. Across the borough there is substantial variation in the number of births each year, with rates highest in Dulwich and Peckham Rye.

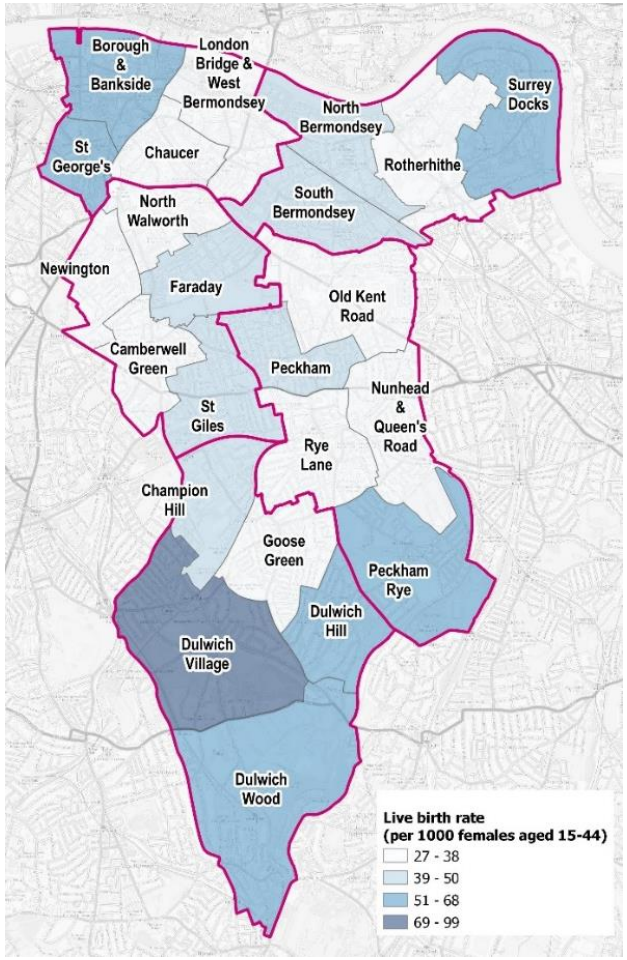


Figure 25: General fertility rate by ward, 2021.
Source: NHS Digital: Local birth files.

New mothers in Southwark come from a diverse range of backgrounds, with 55% being from outside the UK. The most common non-UK countries of birth of mothers are Nigeria, Sierra Leone, Ghana, Poland and Somalia.

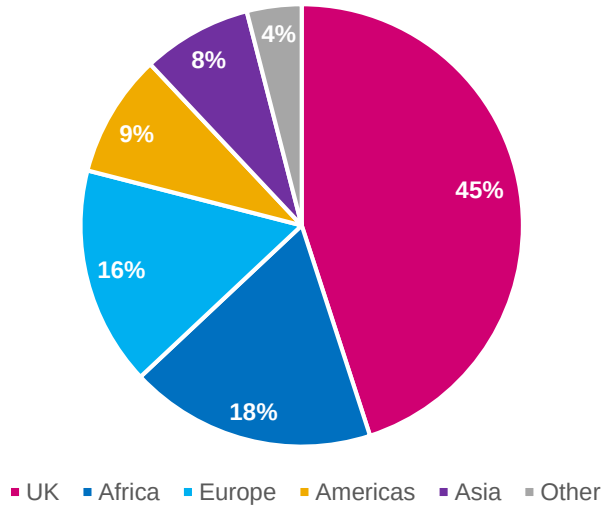


Figure 26. Births in Southwark (2018-2020) by maternal country of birth (%).
Source: NHS Digital: Local birth files

Stillbirths are thankfully rare, with 52 cases in the three-year period 2019-21 and rates comparable to London and England. However, there are significant inequalities, with almost two-thirds (62%) of stillbirths among women and people not born in the UK, and almost half of these were to mothers and people born in African countries.

10.2 Infant mortality

Infant mortality refers to deaths within the first year of life. It includes:

- Perinatal mortality - deaths within the first 7 days
- Neonatal mortality - deaths under 28 days
- Post-neonatal mortality - deaths between 28 days and one year.

There has been a significant reduction in infant mortality in Southwark since 2001, though improvements have slowed in recent years. Levels of infant mortality in the borough are similar to those of London and England overall.

Between 2019 and 2021 there were 39 infant deaths registered in Southwark, a rate of 3.5 infant deaths per 1,000 live births, the same as the rate across London. The majority of these deaths occurred within the first 7 days of life.

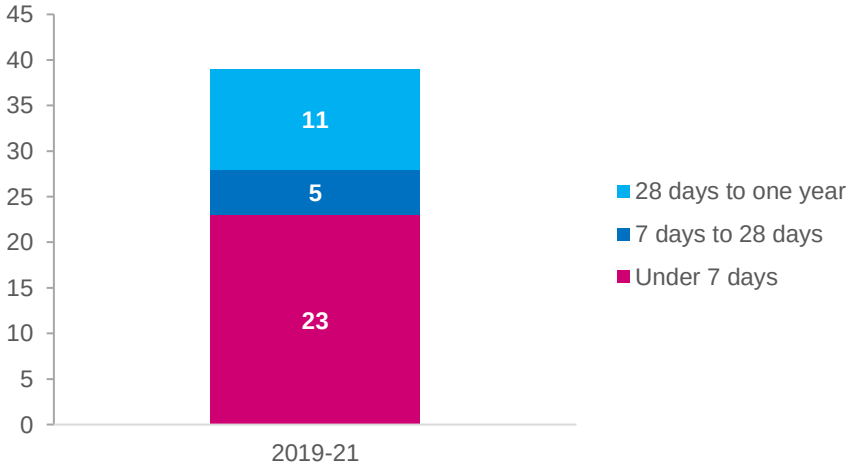


Figure 27: Infant deaths in Southwark, by age of infant, 2019-2021
Source: ONS, 2022. Deaths Registered in England & Wales

10.3 Childhood vaccinations

Vaccination is the safest and most effective way of protecting individuals and communities from vaccine preventable diseases. National immunisation programmes have led to exceptional reductions in the incidence of previously common disease, and related deaths.

Uptake of childhood vaccinations in Southwark is generally above London as a whole, although fall below target and England levels.

Vaccination	Southwark	London	England
DTaP/IPV/Hib/HepB at 1yr	**88.2%**	86.5%	91.8%
MMR1 at 2yrs	**83.4%**	79.9%	89.2%
MMR1 at 5yrs	**88.7%**	87.8%	93.4%
MMR2 at 5yrs	**82%**	74.2%	85.7%
DTaP/IPV/Hib at 5yrs	**90%**	90%	94.4%

Table 4: Childhood vaccination coverage, 2021/22
Source: NHS Digital, 2022. Child Vaccination Coverage Statistics 2021/22

Whilst efforts have been made to improve uptake among vulnerable groups, inequalities may remain: children with additional health, social or safeguarding needs; new migrants to Southwark, and later-born children of large families are all thought to be at risk of going unimmunised.

10.4 Healthy weight

Excess weight in childhood typically persists into adulthood and is associated with increased risk of a range of health consequences such as type 2 diabetes, hypertension and heart disease. Levels of excess weight in Southwark are consistently above London and national levels. In Southwark schools, approximately 1 in 4 children in Reception are overweight or obese, with levels increasing significantly by Year 6.

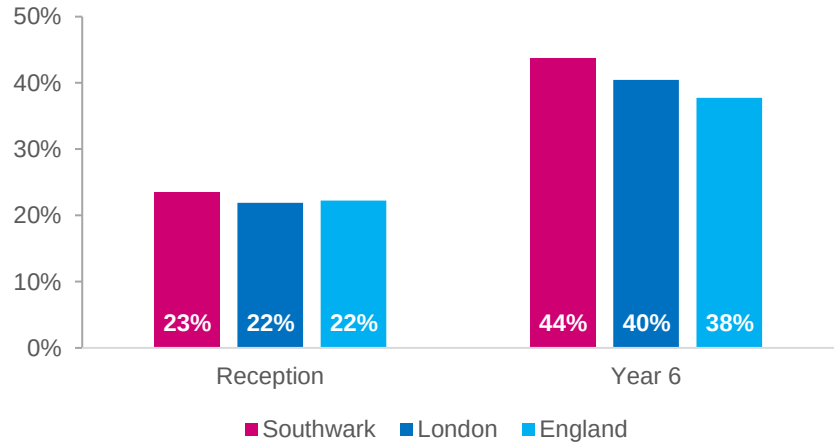


Figure 28: Prevalence of excess weight (overweight or obesity) in Reception and Year 6 pupils across Southwark, London and England 2021/22.
Source: NCMP Enhanced Datasets 2021/22.

Within the borough there are significant inequalities in the prevalence of excess weight, with children from Black ethnic groups significantly more likely to be overweight or living with obesity compared to the Southwark average. Those living in more disadvantaged areas are also more likely to be overweight or living with obesity than those living in more affluent communities.

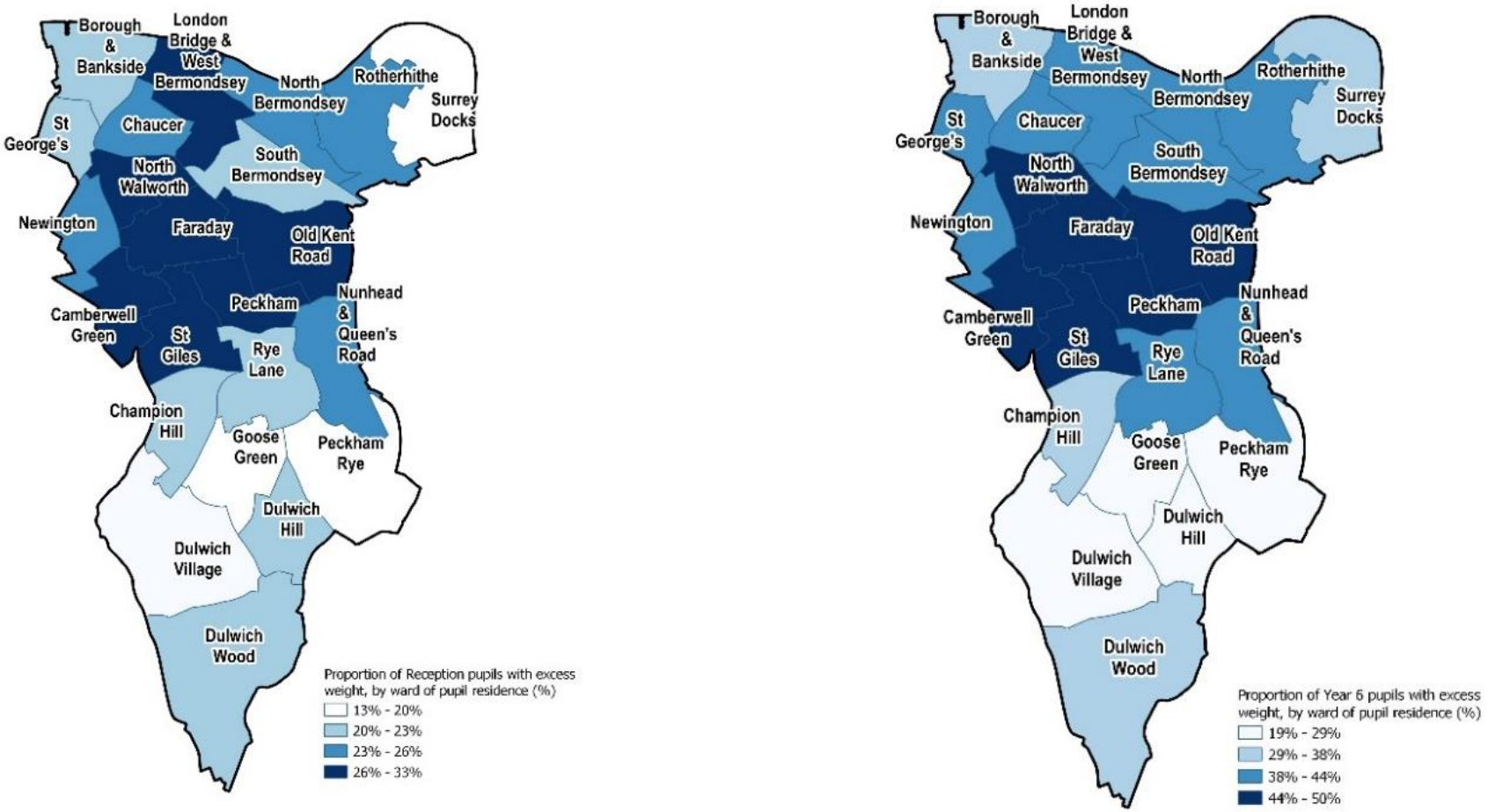


Figure 29: Excess weight (overweight or obese) prevalence in Reception (left) and Year 6 (right), 2017/18 to 2021/22.
Source: NCMP Enhanced Datasets 2017/18 - 2021/22.

10.5 Vulnerable Children

Children in Need

A child in need is defined as "*…a child who is unlikely to reach or maintain a satisfactory level of health or development, or their health or development will be significantly impaired without the provision of services, or the child is disabled.*"

At the end of March 2022 there were 2,800 children in need in Southwark, with levels above both London and England. This is up slightly from 2,771 at the end of March 2021. The most common primary need of assessed children in Southwark was abuse or neglect, mirroring the national picture. The graph opposite shows the different primary needs at assessment; in addition to the needs below a small number of children were identified as being in need due to low income.

In addition to the primary need, a range of factors that contribute to the child being in need are recorded as part of the assessment. The top five factors identified in Southwark in 2022 were:

- Domestic Abuse (1,490 cases)
- Mental Health (1,280 cases)
- Drug or Alcohol Misuse (685 cases)
- Emotional Abuse (590 cases)
- Physical Abuse (560 cases)

Each factor can be linked to the child themselves, a parent or another person but have an effect on the child's wellbeing and therefore is recorded on the child's in need assessment.

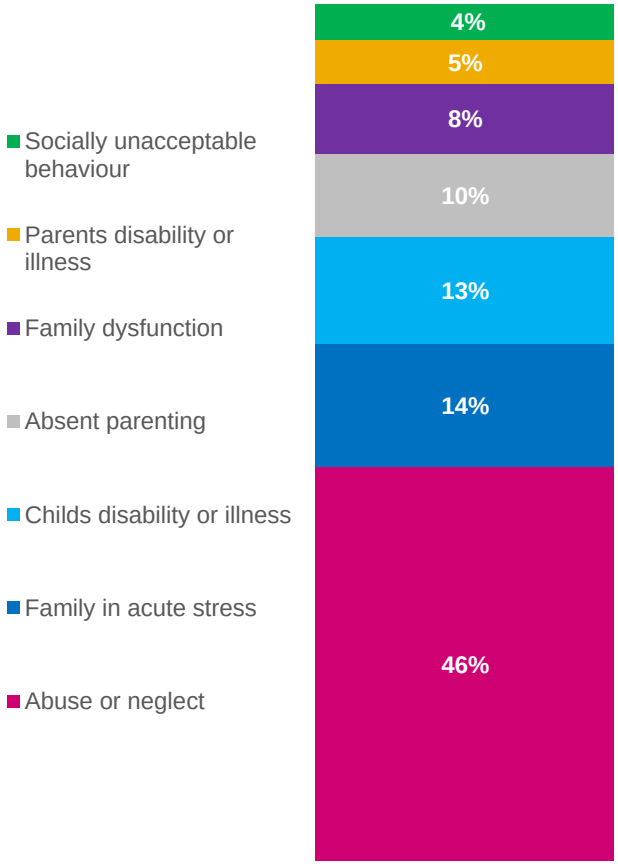


Figure 30: Percentage of children in need in Southwark, March 2022, by primary need at assessment
Source: Department for Education, 2022. Characteristics of Children in Need, Reporting year 2022.

Child Protection Plans

Children at risk of significant harm have a child protection plan, the aim of which is to:

- To ensure the child is safe and prevent any further significant harm by supporting the strengths of the family, by addressing the risk factors and vulnerabilities and by providing services to meet the child's assessed needs
- To promote the child's welfare, health and development
- Provided it is in the best interests of the child, to support the family and wider family members to safeguard and promote the welfare of their child.

At the end of March 2022 there were 329 children in Southwark with a child protection plan. The most common underlying cause was emotional abuse, followed by neglect, mirroring the national pattern.

Locally and nationally, three factors have combined to place children at greater risk of abuse: increase in stressors to parents and care givers, increase in children's vulnerabilities and changes in access to universal services as a result of the COVID-19 pandemic.

10.6 Healthcare use

Over the five-year period 2016/17 to 2020/21 there were 5,575 emergency hospital admissions among Southwark children under the age of 5. Admission rates in the borough are significantly lower than the averages for London and England. However, there are substantial inequalities, with significantly higher levels seen in the north of the borough.

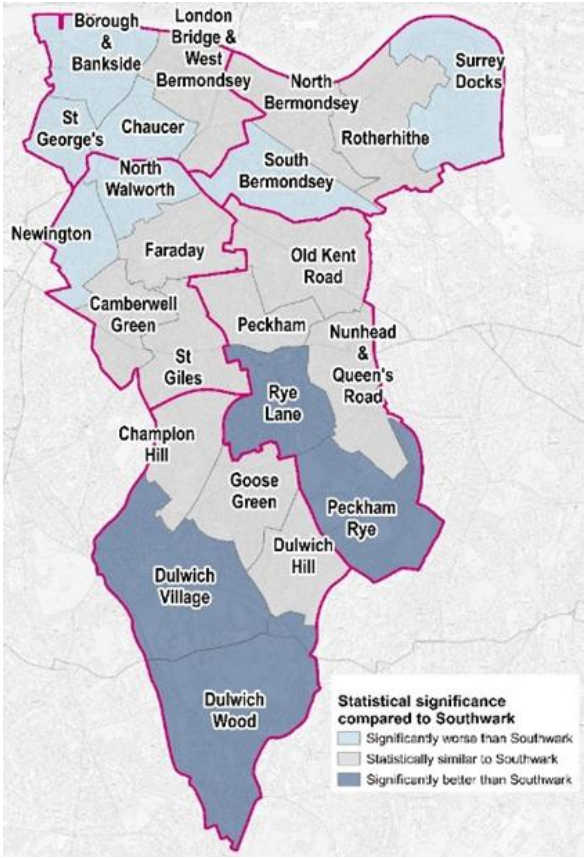


Figure 31: Emergency admissions among under 5s, 2019/20.
Source: OHID 2023. Local Health - Small Area Public Health Data.

A&E attendances in young children are often preventable, and commonly caused by accidental injury or by minor illnesses which could have been treated in primary care. In 2021/22, there were 15,410 attendances to A&E by Southwark children aged 0-4, with rates significantly worse than both London and England.

11. LIVING WELL

11.1 Risk factors

Data from the Global Burden of Disease study outlines the top ten risk factors for poor health. Southwark mirrors the national picture, with smoking, obesity, poor diet among the top risks impacting on healthy life in our borough.

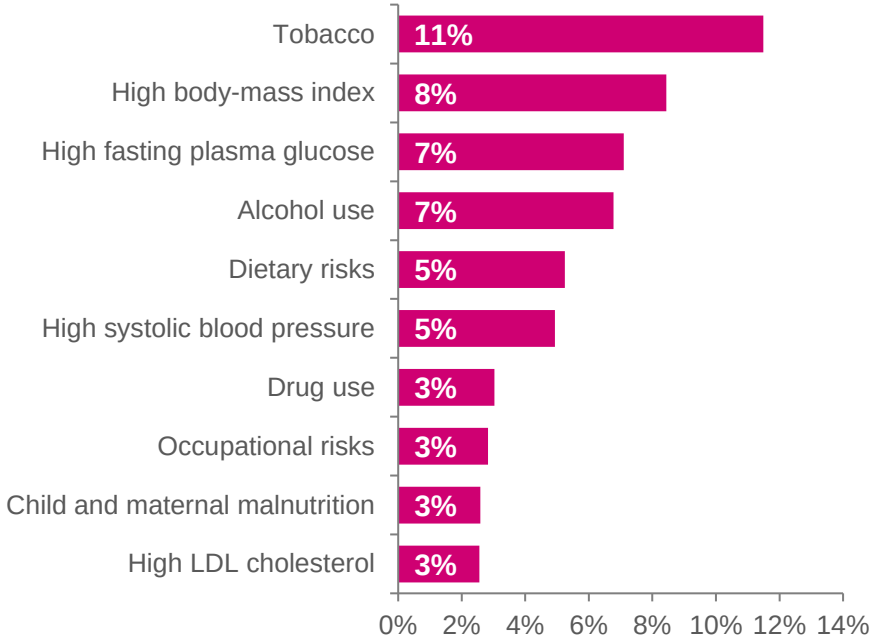


Figure 32: Percentage of years of life lost to disability or premature death (DALYs) in Southwark by risk factor, 2019.
Source: IHME 2019. Global Durden of Disease Compare

The figure opposite illustrates the latest prevalence of key risk factors among adults in Southwark compared to London and England.

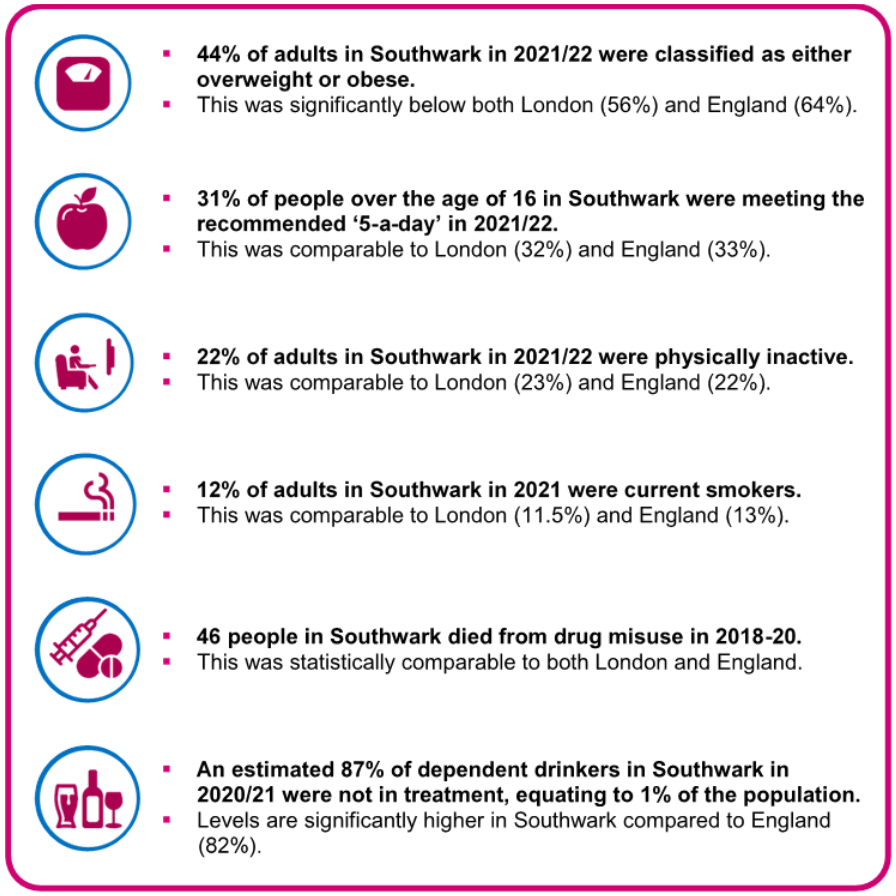


Figure 33: Behavioural risk factors associated with poor health in Southwark
Source: OHID 2023. Public Health Profiles.

11.2 Sexual health

In addition to obesity, poor diet and smoking, poor sexual and reproductive health has a significant impact on health and wellbeing in Southwark. The borough has the second highest levels of sexually transmitted infections in England, just behind Lambeth. Levels of diagnosed infections Southwark are over twice the London average and more than four times the national average.

In 2022 there were nearly 9,300 new STI diagnoses among residents, a 24% increase compared to 2021. Within the last year in Southwark there has been:

- 37% increase in gonorhorrea diagnoses
- 28% increase in syphillis diagnoses
- 19% increase in chlamydia diagnoses
- 37% increase in genital herpes

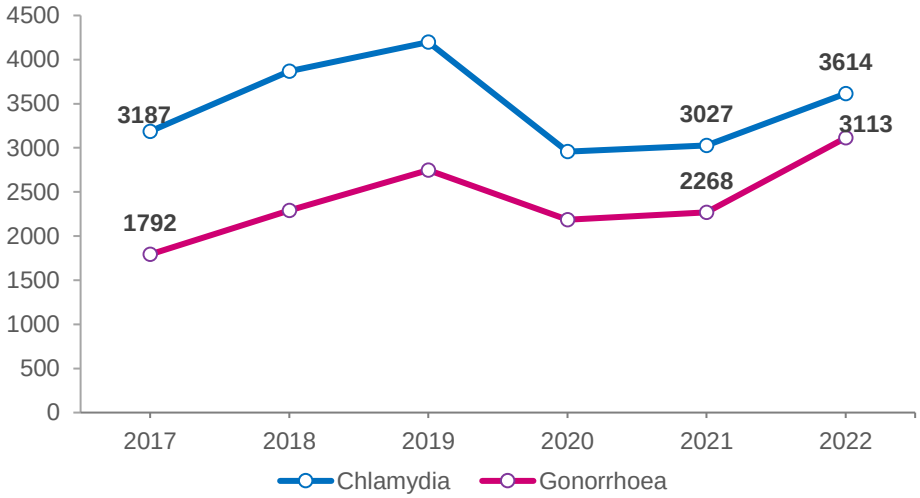


Figure 34: Number of diagnosed cases per year of Chlamydia and Gonorhorrea of Southwark residents 2017-2022
Source: OHID 2023. Sexual and Reproductive Health Profiles.

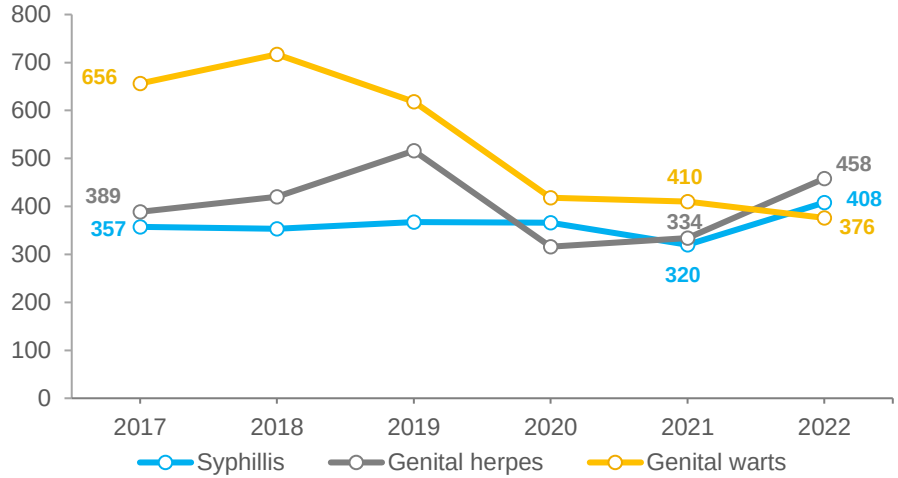


Figure 35: Number of diagnosed cases per year of Syphilis, Genital herpes and Genital warts of Southwark residents 2017-2022
Source: OHID 2023. Sexual and Reproductive Health Profiles.

There was a 17% increase of STI testing in the borough between 2021 and 2022 (excluding testing for chlamydia in those under 25), however the increased diagnosis of STI's cannot be attributed to higher rates of testing alone, and does suggest an increasing population prevalence of STI's to pre-pandemic levels.

When looking at inequalities in sexual health, infection rates in Southwark are highest in the following groups:

- Men: accounting for almost 70% of cases
- 15-24 year olds: accounting for over a quarter of cases
- Gay, bisexual and men who have sex with men: accounting for two-thirds of cases

Rates of new diagnoses are also unequal across the borough, with the highest levels seen in the north-west corner of the borough.

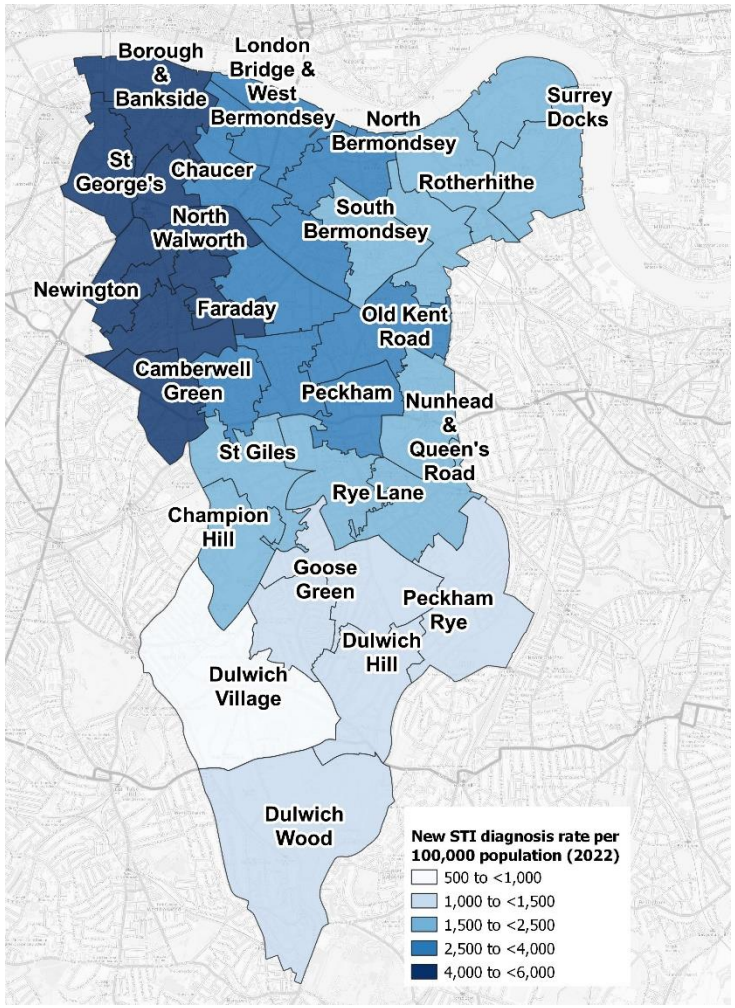


Figure 36: Rate of new STI diagnoses across the borough, per 100,000 resident population in 2022.
Source: UKHSA 2023.

HIV

In addition to high levels of sexually transmitted infections, levels of HIV in Southwark are also high, with the borough having the second highest prevalence in England, behind neighbouring Lambeth. Rates of diagnosis of HIV in Southwark are over double the London average and 4.5 times higher than the England average.

Figures for 2021 show there are 2,881 people currently living in the borough who have been diagnosed with HIV, with the highest prevalence in the north-west of the borough. There were 71 new diagnoses in 2021, the highest in London.

Levels of HIV testing in the borough are comparable to London and higher than across England as a whole, with 56% of eligible attendees at specialist sexual health services accepting a HIV test in 2021.

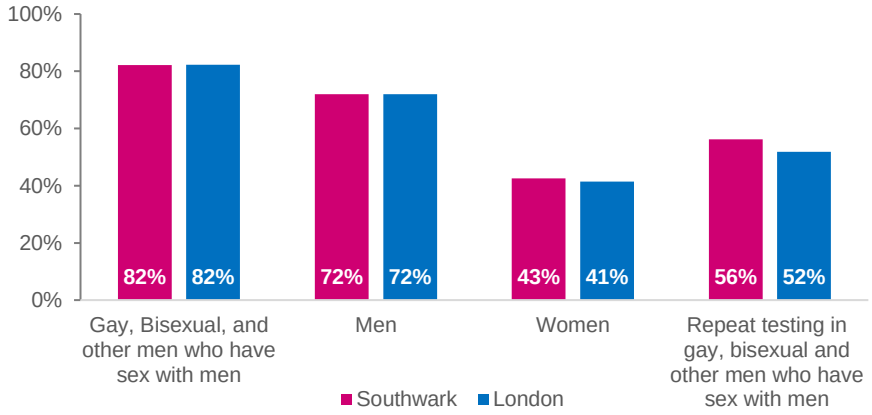


Figure 38: HIV testing coverage out of those considered eligible for an HIV test when attending specialist sexual health services.
Source: OHID 2023. Sexual and Reproductive Health Profiles.

Late diagnosis of HIV is an important predictor or poor health and premature death. Recent figures that 40% of adults (aged 15+) diagnosed with HIV received a late diagnosis. Levels of late diagnosis in Southwark are comparable to London (39%) and England (43%).

Just over a quarter (27%) of gay, bisexual and other men who have sex with men received a late diagnosis, lower than for heterosexual and bisexual women (53%) and heterosexual men (60%).

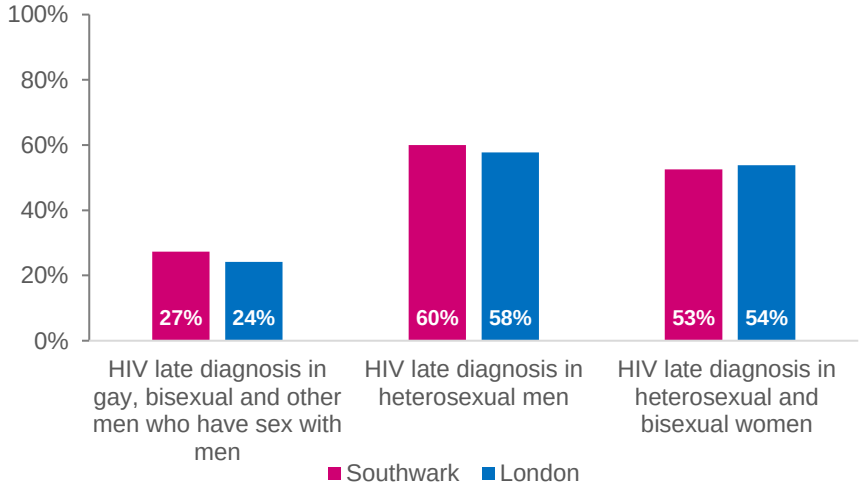


Figure 37: Percentage of HIV cases with a late diagnosis, 2019-21. Only counts those aged 15+ and who were first diagnosed in the UK
Source: OHID 2023. Sexual and Reproductive Health Profiles.

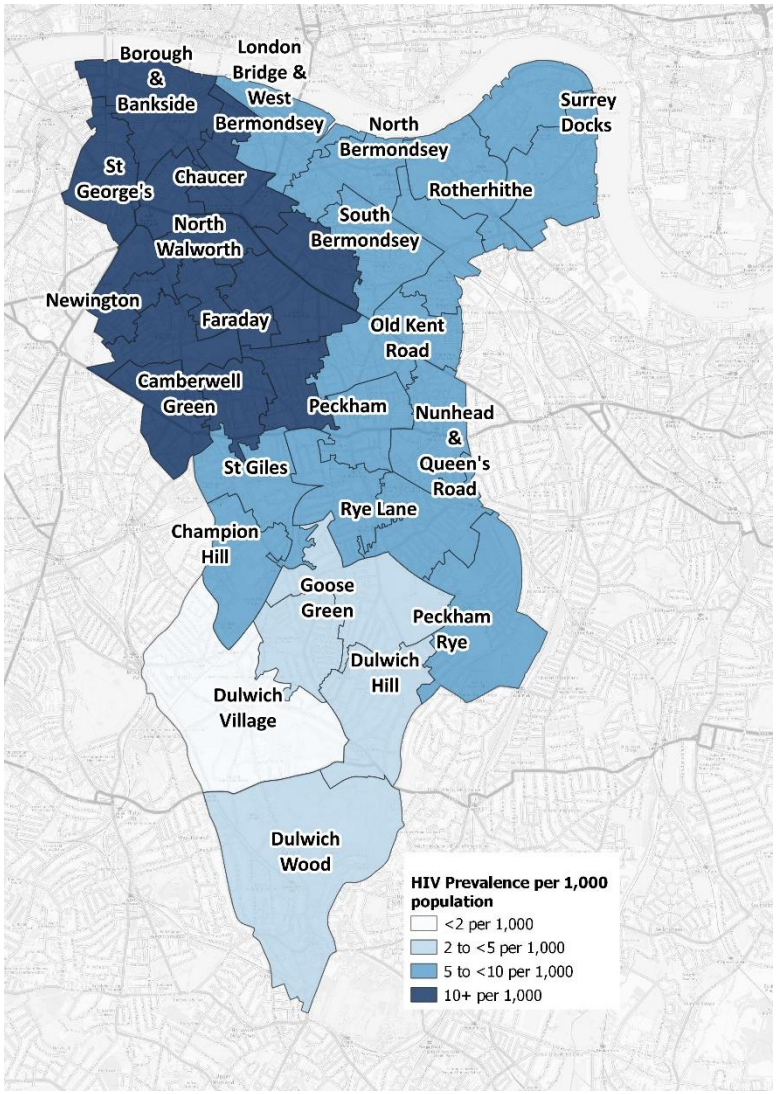


Figure 39: Diagnosed HIV prevalence among people of all ages, 2021. Source: UKHSA 2023.

11.3 Long-term conditions

The Department of Health & Social Care defines a long-term condition as: "*…one that cannot currently be cured but can be controlled with the use of medication and/or other therapies.*"

Long-term conditions are the main driver of cost and activity in the NHS, and have a significant impact on people's health and wellbeing.

Using data gathered from Southwark GP's, we know that there are over 107,000 patients registered at Southwark GP's who are living with one or more long-term condition, 25,000 of these patients are living with three or more conditions.

The most commonly diagnosed long-term conditions are hypertension, depression and obesity. These are the most prevalent conditions in both the North and South Primary Care Networks in Southwark, as well as being the most diagnosed conditions across England.

Hypertension (high blood pressure) is the most prevalent long-term condition in the borough, and is a key risk factor for life threatening conditions such as heart attacks and strokes. Hypertension disproportionately affects those from a Black ethnic background: 18% of the GP registered population who are Black have hypertension, compared to 9% of the White population, 8% of the Asian population, 5% of the mixed ethnicity population and 4% of those from other ethnicities.

Non-diabetic hyperglycaemia (elevated blood sugar levels) and diabetes mellitus are the next most prevalent conditions. Diabetes mellitus covers those with a diabetes diagnosis of both types 1 and 2, and cases where the type is yet to be determined. Within Southwark, there are over 900 patients registered with a Southwark

GP's with type 1 diabetes, and 17,700 patients with type 2 or other forms of diabetes. Type 2 diabetes disproportionately affects those from a Black ethnic background, 45% of diabetic patients are from a Black ethnic background, despite only 25% of the overall population being Black. Type 2 diabetes also disproportionately affects those living in more deprived areas in the centre of the borough.

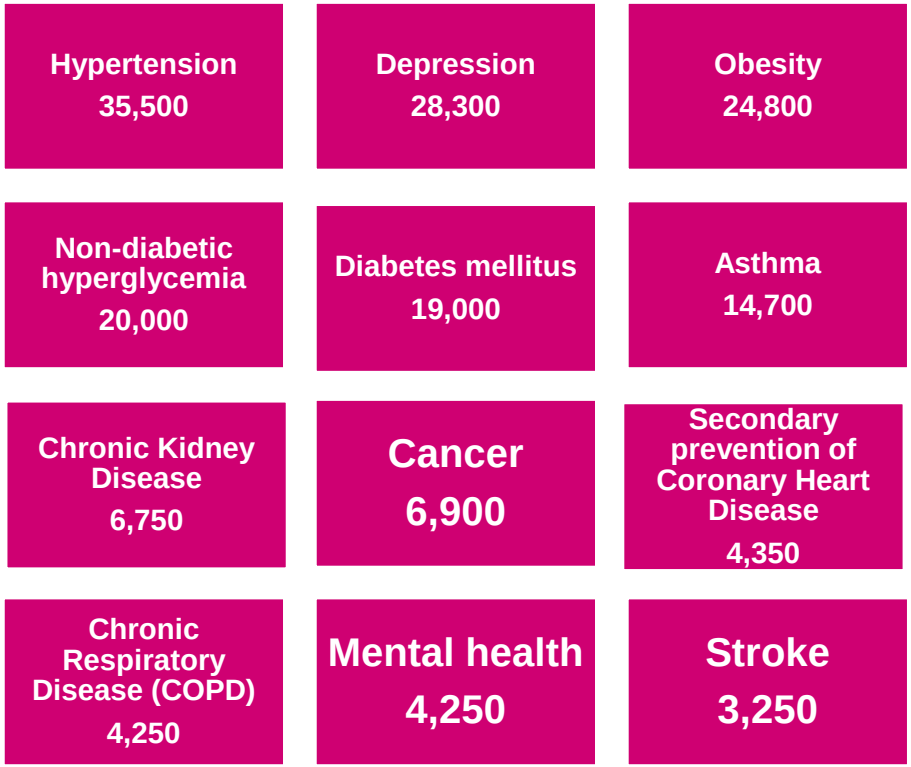


Figure 40: Most common diagnosed conditions in Southwark, 2021/22
Source: NHS Digital 2021, Quality & Outcomes Framework, 2021/22

Multi-morbidity

Multi-morbidity refers to those living with multiple conditions. Our knowledge of development and progression to multiple long-term conditions continues to develop, however key findings from national and local research indicates that:

- People in the UK are developing multiple long-term conditions at an increasingly younger age.
- Nationally, those from a Black, Asian and minority ethnic backgrounds are more likely to develop multiple long-term conditions, and develop them at a younger age than those from a White background.
- Multiple long-term conditions are more common in communities experiencing higher levels of socio-economic disadvantage. Those living in the most disadvantaged areas of the country can expect to develop two or more long-term conditions up to 10 years earlier than those living in the most affluent communities.
- Certain long-term conditions are linked, so having one increases the likelihood of developing multiple conditions.

Locally, 55% of those with one or more long-term conditions are female and 45% are male. Of those with three or more long-term conditions, 57% are female and 43% are male.

Those from a Black ethnic background in Southwark are overrepresented among those with long-term health conditions. Black patients make up 33% of those with one or more long-term conditions and 39% of those with 3 or more long-term conditions, despite making up only 25% of the population.

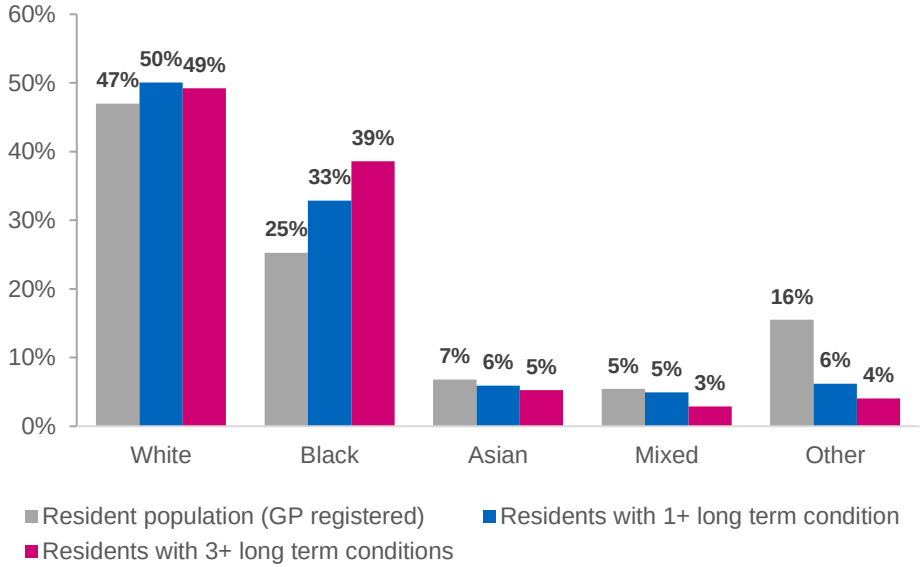


Figure 41: Proportion of GP registered Southwark residents with long-term conditions, by ethnic group, compared to Southwark's GP resident population by ethnic group.
Source: South East London Integrated Care System 2023. Comorbidities Dashboard.

An ageing population means there has been an increase in the number of people with multiple long-term conditions. This change requires a greater shift towards co-ordinated and holistic care, rather than the provision of unconnected episodes of care. Research increasingly points to the importance of addressing both the social and economic context in which residents live in order to prevent and slow the progression to multiple long-term conditions.

Ambulatory care sensitive conditions

The term '*ambulatory care sensitive conditions*' refers to long-term conditions that should not normally require hospitalisation. These include conditions such as diabetes and high blood pressure, which can effectively be managed within the community.

Reducing the number of hospital admissions for ambulatory care sensitive conditions is a key ambition of the NHS. Figures for 2022/23 show there were 1,950 unplanned hospital admissions in Southwark for these conditions. This was higher than the average for South East London of 809 admissions per 100,000 residents.

The rate of admissions for London was 548 in 2020/21 compared to 662 per 100,000 in England.

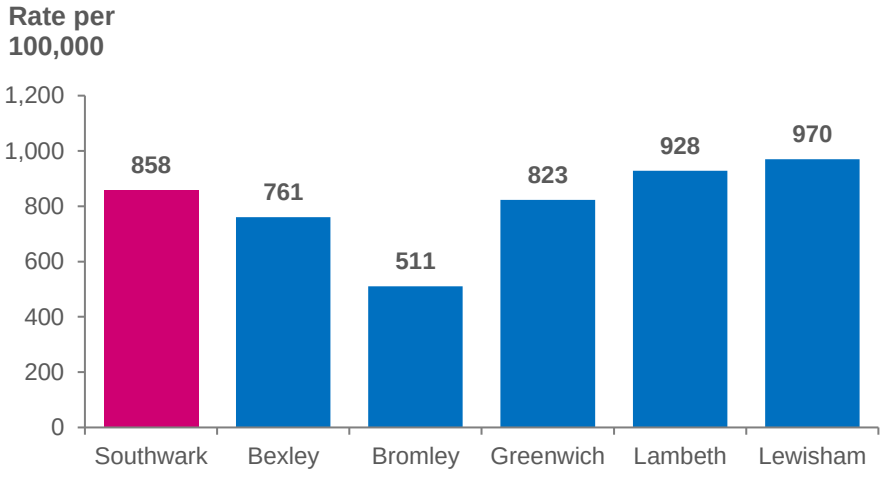


Figure 42: Unplanned admissions for ambulatory care sensitive conditions per 100,000 residents, indirectly standardised rates, 2022/23.
Source: South East London Integrated Care System 2023. Unplanned ACSC Admissions Report Dashboard.

11.4 Hospital Waiting Times

'Incomplete pathways' are the waiting times for patients waiting to start treatment. These patients will be at various stages of their care, for example, waiting for diagnostics, an appointment with a consultant, or for admission for a procedure. These are sometimes referred to as the NHS waiting list. The NHS Constitution standard states that 92% of patients on 'incomplete pathways' should be seen within 18 weeks from time of referral.

While the number of people on hospital waiting lists was increasing before the pandemic, we know the situation has deteriorated further over the last few years. Figures for March 2023 published by NHS England show there are over 7 million patients waiting to start treatment, with 59% of patients wait times being 18 weeks or less.

Our local hospital trusts perform better than the national average for waiting times, with a much larger percentage of patients waiting within the standard set out in the NHS Constitution. However, over 180,000 people are waiting for treatment at our two main hospital trusts, Kings College and Guy's & St Thomas' hospitals.

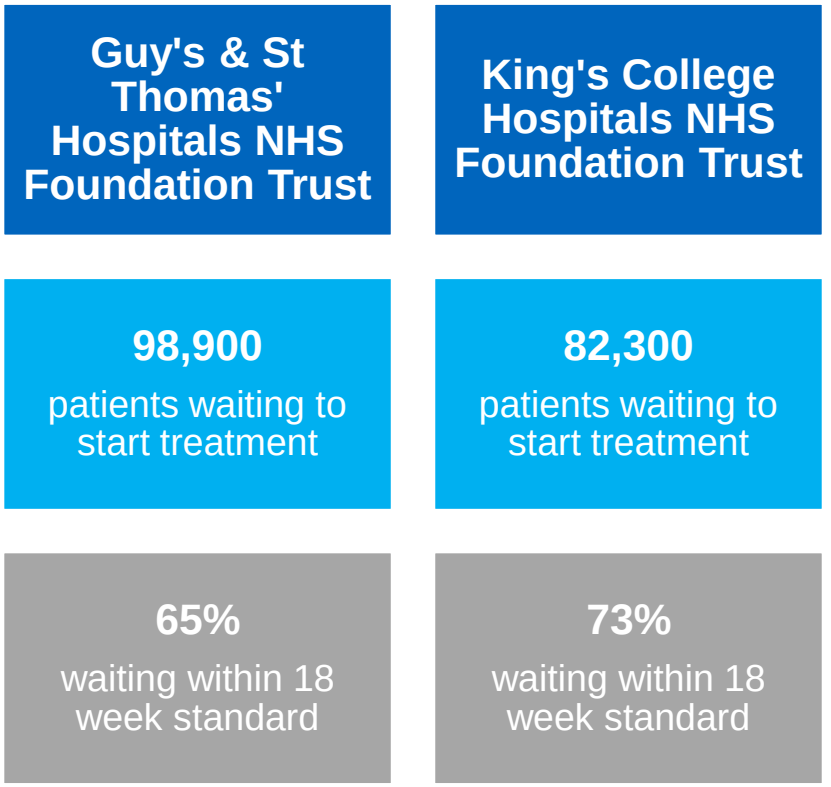


Figure 43: Consultant-led Referral to Treatment Waiting Times Data, for King's College and Guy's and St Thomas' hospital trusts, March 2023
Source: NHS England, 2023. Consultant-led Referral to Treatment Waiting Times Data 2023/24

11.5 Cancer

In 2020, there were approximately 8,350 people in Southwark who were diagnosed or had previously been diagnosed with cancer (living with or beyond cancer). This was lower than the rates nationally and across South East London. Cancer prevalence has been increasing since 2010, when fewer than 5,000 residents of Southwark were living with or beyond cancer.

It is important to know how many people are both living with and beyond cancer, in order to plan for ongoing care needs. Within the South East London, the majority (15,000 people) were first diagnosed 5-9 years ago, while a further 12,000 people were diagnosed between 2-4 years ago.

Within Southwark, the most prevalent forms of cancer are breast (26%) and prostate (21%). The prevalence of cancers differed between men and women, however blood and colorectal cancer had a high prevalence in each.

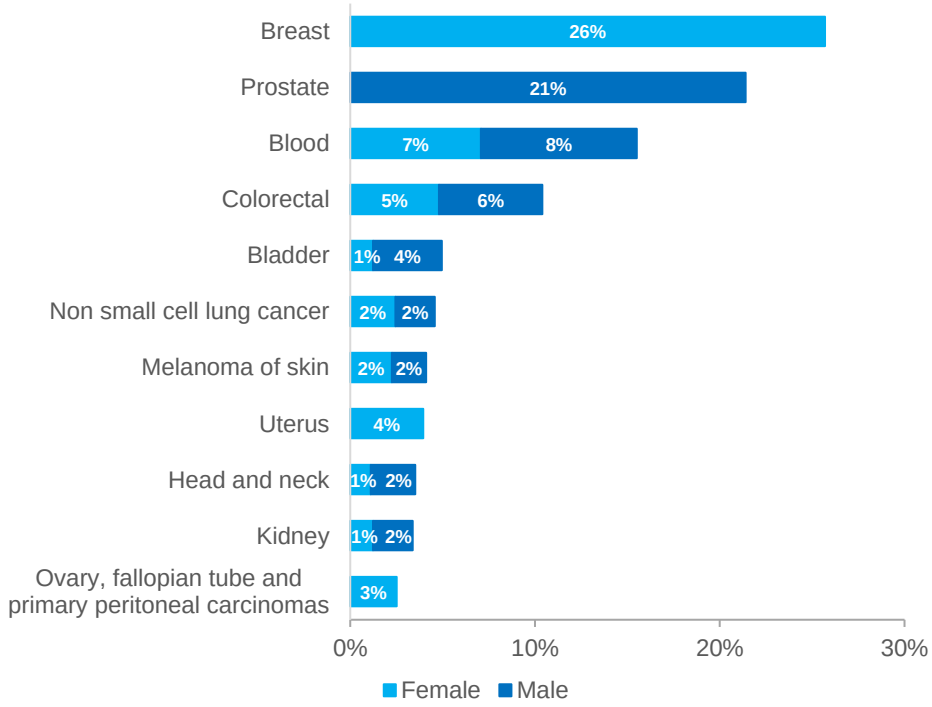


Figure 44: Percentage prevalence of cancers by site, in men and women living with and beyond cancer in Southwark 2020.
Source: National Cancer Registration & Analysis Service 2020. Cancer Prevalence.

The overall incidence of new cancer cases in Southwark is comparable to England, however rates of both lung cancer and prostate cancer are significantly higher than the national average.

National evidence shows that age is one of the largest risk factors for the development of cancer, with more than a third of all cancers occurring in those aged 75 and over. There is also a strong association between cancer incidence and socio-economic

disadvantage. Evidence from Cancer Research UK points to almost 17,000 additional cases of cancer each year in England due to socio-economic inequalities.

There are also disparities in cancer prevalence between different ethnic groups. In 2023, 64% of cancer patients registered at Southwark GP's are White, 23% are Black, 4% are Asian, 3% Mixed ethnicity and 7% are listed as 'Other' ethnicity.

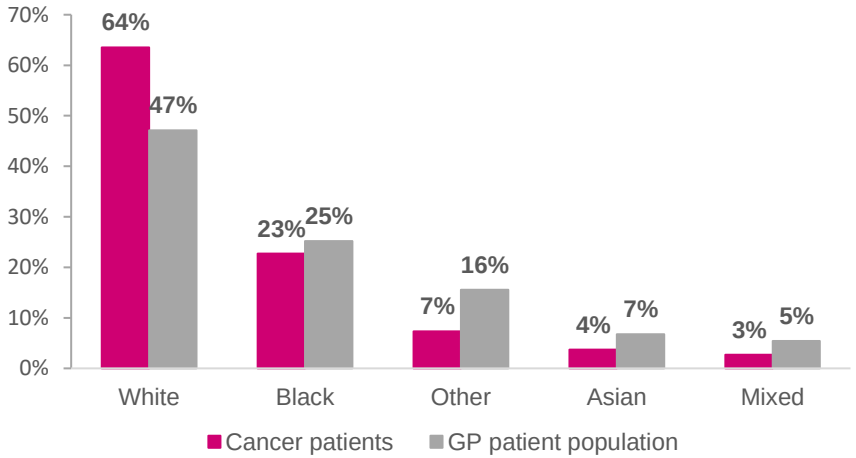


Figure 45: Prevalence of cancer by ethnicity of patient, among patient's registered at Southwark GP's, compared to the overall GP patient population by ethnicity.
Source: South East London Integrated Care System 2023. Cancer population insights dashboard.

Cancer screening is a vital tool to diagnose cancers in early stages. Currently, screening is available for bowel, breast and cervical cancers. Uptake of screening in Southwark is highest for cervical cancer.

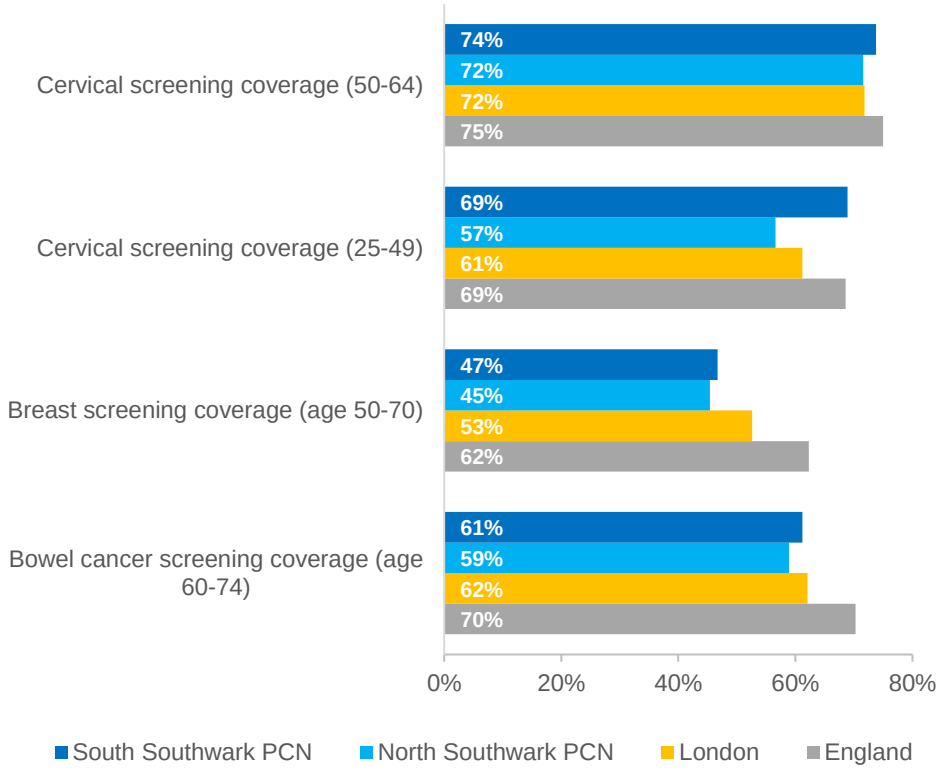


Figure 46: Coverage of cancer screening programmes in 2021/22 by Primary Care Network
Source: OHID, 2023. Cancer Services Profile.

When examining screening uptake by ethnic group, uptake is highest among those of a White ethnic background for bowel and breast cancer, and those of a Black ethnic background for cervical cancer. Breast cancer has the lowest uptake, with less than 50% coverage for each of the ethnic groups.

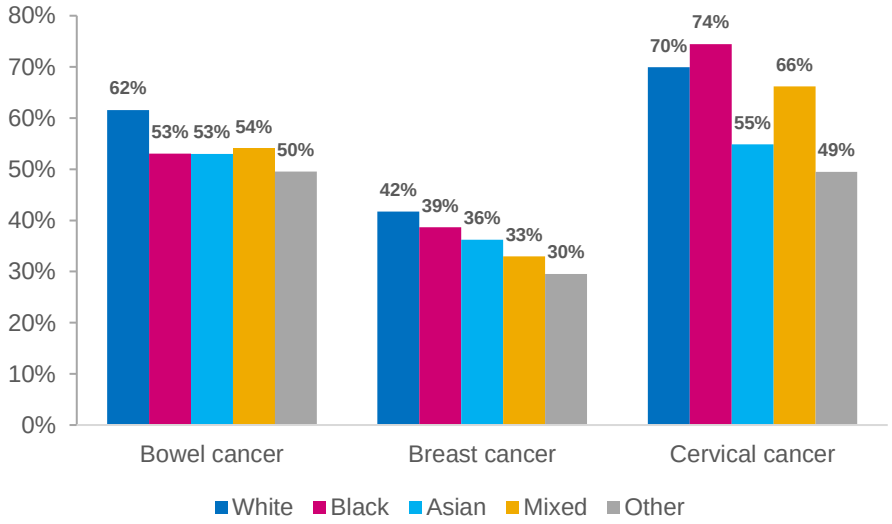


Figure 47: Percentage of eligible patients from each major ethnic group, who have been screened for bowel cancer in the last 2.5 years, breast cancer in the last 2.5 years and cervical cancer in the past 3.5 years (for those aged 25-49) or 5.5 years (for those aged 50-64).
Source: South East London Integrated Care System 2023. Cancer population insights dashboard.

The early diagnosis of cancer is an important factor in ensuring the best health outcome. There is a national ambition for 75% of cancers in England to be diagnosed at Stage 1 or Stage 2 by 2028. Figures for 2019 show 55% of cancers in South East London are diagnosed at this point, though this varies by cancer type. For example, percentages for the following cancers diagnosed in stage 1-2:

- Breast cancer: 84%
- Bladder cancer: 78%
- Cervical cancer: 70%
- Prostate cancer: 59%
- Colon cancer: 42%

11.6 Mental Health

Mental illness covers a wide range of conditions such as depression, anxiety disorders and obsessive compulsive disorders, through to more severe conditions like schizophrenia. It is thought one in four people will experience a mental health problem in any given year.

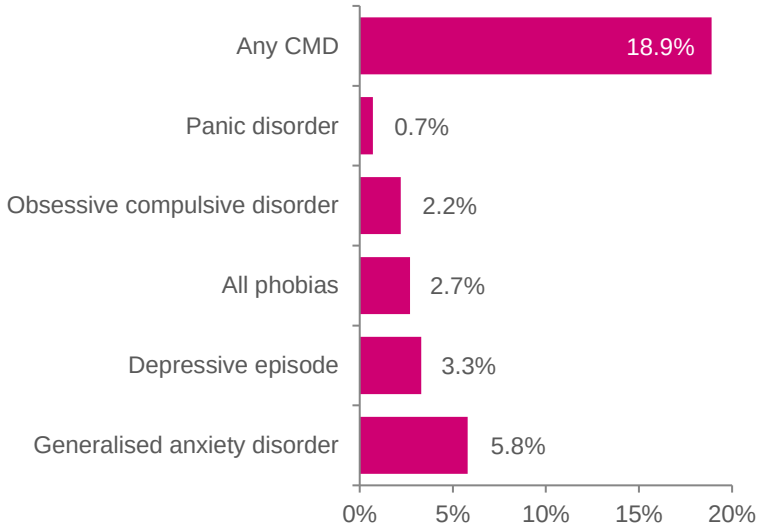


Figure 48: Prevalence of common mental disorders among adults in London
Source: NHS Digital, 2016. Adult Psychiatric Morbidity Survey, 2014.

Results from the 2014 Adult Psychiatric Morbidity Survey show that 1 in 6 adults had a common mental disorder (CMD) in the week prior to the survey, rising to almost in 1 in 5 adults in London. Applying the London prevalence to Southwark would equate to almost 48,700 adults in the borough experiencing a CMD.

All types of common mental disorders are more prevalent in women than among men: 1 in 5 women report experiencing CMD, compared to 1 in 8 men. The gender gap is particularly pronounced among those aged 16-24, where more than three times the number of women have a common mental disorder than men.

Figures for 2021/22 show that just over 13,000 people in Southwark were referred to psychological therapy services. Of those referred, 52% were from a White ethnic background, 19% from a Black ethnic background, 7% from a mixed ethnic background and 6% from an Asian ethnic background.

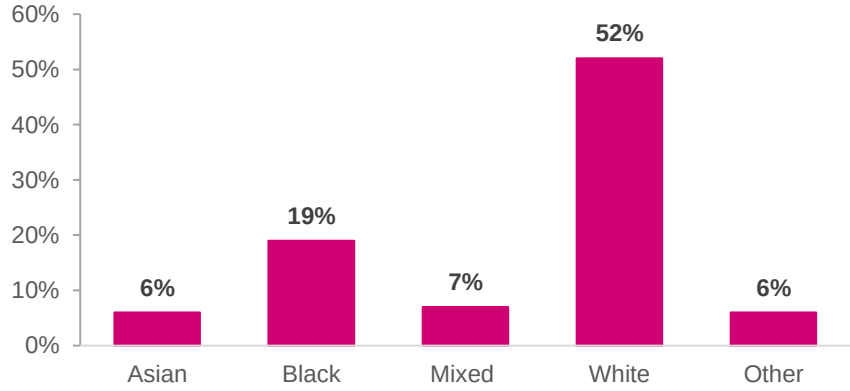


Figure 49: Referrals to Southwark psychological therapy services (IAPT), by major ethnic group.
Source: NHS Digital, 2022. Psychological Therapies, Annual Reports on the use of IAPT services 2021/22.

The most represented groups referred in terms of gender and age were females aged 26 to 64 (49% of referrals); men aged 26-64 (23% of referrals) and females aged 18-25 (17% of referrals).

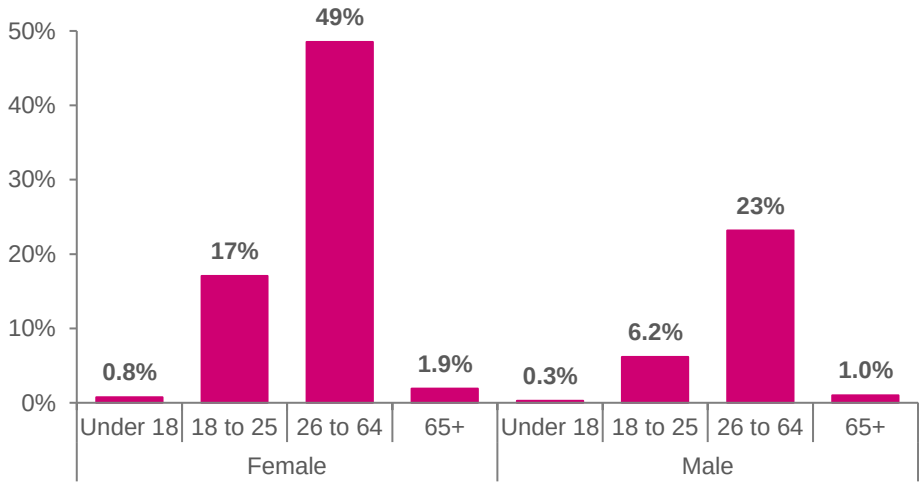


Figure 50: Number of referrals to Southwark IAPT in 2020/21 by group
Source: NHS Digital, 2022. Psychological Therapies, Annual Reports on the use of IAPT services 2021/22.

Severe Mental Illness (SMI) refers to a range of conditions which include schizophrenia, bipolar affective disorder and depression with psychosis. Figures for 2022/23 show nearly 4,000 patients registered with a Southwark GP have been diagnosed with severe mental illness.

This cohort has significant health needs and also experiences great socio-economic disadvantage, with 63% of those with severe mental illness living in areas in the highest 30% of deprivation in the borough.

There are also strong ethnic inequalities in severe mental illness prevalence, with 39% of severe mental illness patients being of a Black or Black British ethnicity; those from a Black ethnic background make up 25% of Southwark's general population. In terms of age, severe mental illness is most prevalent in the 41-60 age range, making up 45% of all severe mental illness patients.

In 2018-2020, the rate of premature mortality in adults with severe mental illness in Southwark was 127 per 100,000 population. This was worse than both the London rate (103) and the England rate (104).

12. AGEING WELL

12.1 Adult Social Care

Adult Social Care provide information, advice and services to local residents to support them to remain independent. In 2022/23 there were 251 people who requested and started using a service.

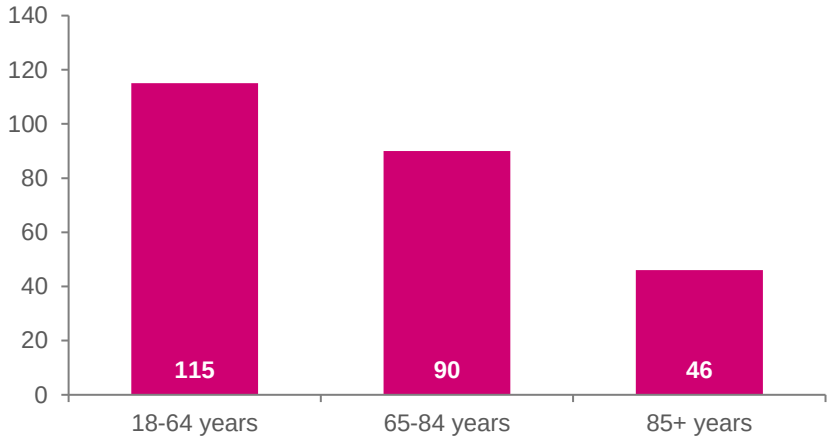


Figure 51: New service users who started between April 2022 and March 2023, by age group
Source: Southwark Adult Social Care Division

In 2022/23, slightly more new users were over the age of 65 (136 users) compared to under 65 (115 users).

Adult Social Care provided support to nearly 3,340 long-term service users in 2022/23. The most common primary support reason was for older people and physical disability (67%). The next most common reason for support was learning disability, with the majority of these service users being in the 18-64 age category.

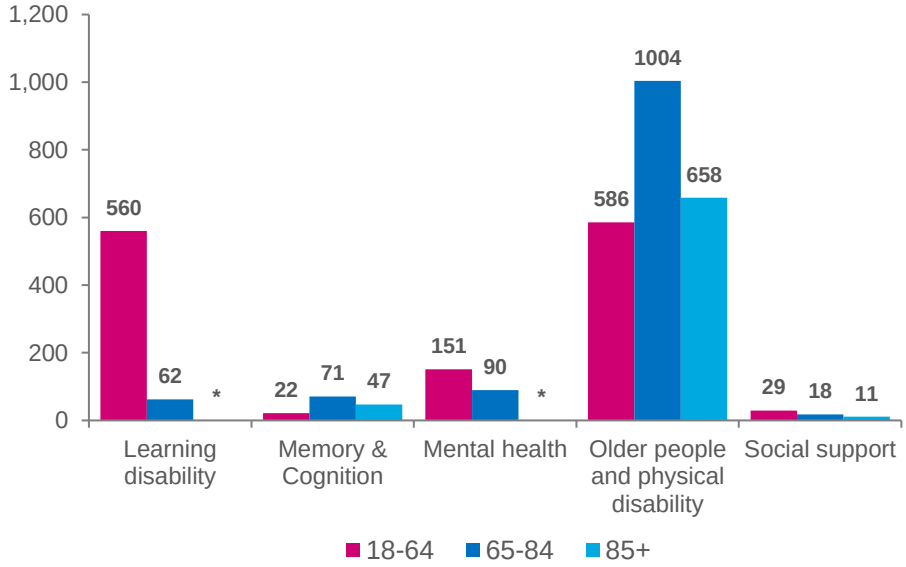


Figure 52: Primary support reason for long-term service users in 2022/23, by age group
Source: Southwark Adult Social Care Division
***denotes small numbers which have been supressed**

Adult social care also provides support to those providing unpaid care. In 2022/23 Southwark supported 167 newly identified unpaid carers.

12.2 Falls

Falls are the largest cause of emergency hospital admissions among older people and can significantly affect longer term outcomes. Those aged over 65 are at greatest risk of falling, with around a third of this group falling at least once a year, increasing to around half among those aged 80 and over.

Emergency hospital admissions for injuries due to falls in older people in Southwark are consistently above national and regional levels, despite Southwark having a relatively young population. Latest figures show there were 560 admissions in Southwark between during 2021/22, with the borough consistently having amongst the highest admission rates in South East London.

Admission rates also increase significantly with age, mirroring the national pattern. Rates among those aged 80 and over are more than four times those under 80.

In 2021/22, 135 Southwark residents aged 65+ suffered from hip fractures, similar to the rate of hip fractures seen across London and England.

Figure 53: Emergency admissions due to falls in those aged 65-79 and 80+ 2021/22.
Source: OHID, 2023. Productive & Healthy Ageing Profile.

12.3 Dementia

Dementia is a group of symptoms characterised by difficulties with one or more areas of mental function. These areas may include memory, language, ability to complete activities of daily living, behavioural changes including self-neglect and out of character behaviour and psychiatric problems. Because they are less able to perform activities of daily living, people with dementia often require additional community support and long-term care.

Figures for 2023 show over 1,800 people in Southwark have been diagnosed with dementia. Our diagnosed prevalence in 2020 was 4%, comparable to both London (4.2%) and England (4%).

Research shows a timely diagnosis of dementia can have a significantly positive impact on a person's quality of life. Latest estimates suggest that just over two thirds of those thought to be living with dementia in Southwark have received a diagnosis; comparable to regional and national levels.

In 2019/20 there were over 1,620 emergency hospital admissions by Southwark residents with a diagnosis of dementia. The borough has the highest rate of emergency hospital admission for dementia in the capital with rates significantly above both London and England.

12.4 Mortality

Deaths are considered preventable if, in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause could mainly be avoided by public health and primary prevention interventions

In 2021 there were 372 deaths among those aged under 75 in Southwark that were considered preventable. At a rate of 210 per 100,000 (age standardised); the under 75 preventable mortality rate in Southwark was significantly worse than both London and England.

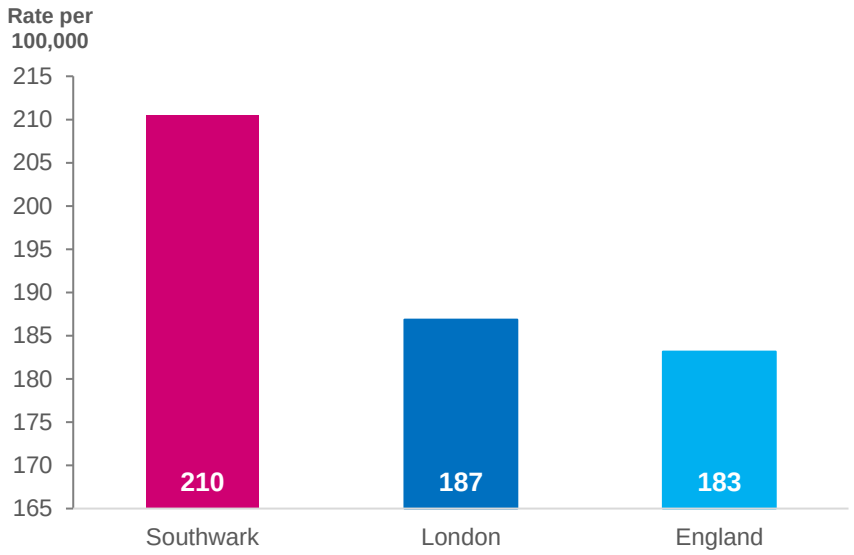


Figure 54: Preventable mortality: under 75 mortality rate from all causes considered preventable, per 100,000 population. Age standardised mortality rate.
Source: OHID, 2023. Public Health Outcomes Framework.

Preventable mortality rates are also broken down by 4 key disease groups: cardiovascular, cancer, liver and respiratory diseases. For each of these, rates of preventable mortality are higher in Southwark than London and England, with cancer being the leading cause of preventable mortality in those under 75. Despite being slightly higher, preventable mortality in Southwark is statistically similar to both London and England for all four disease groups.

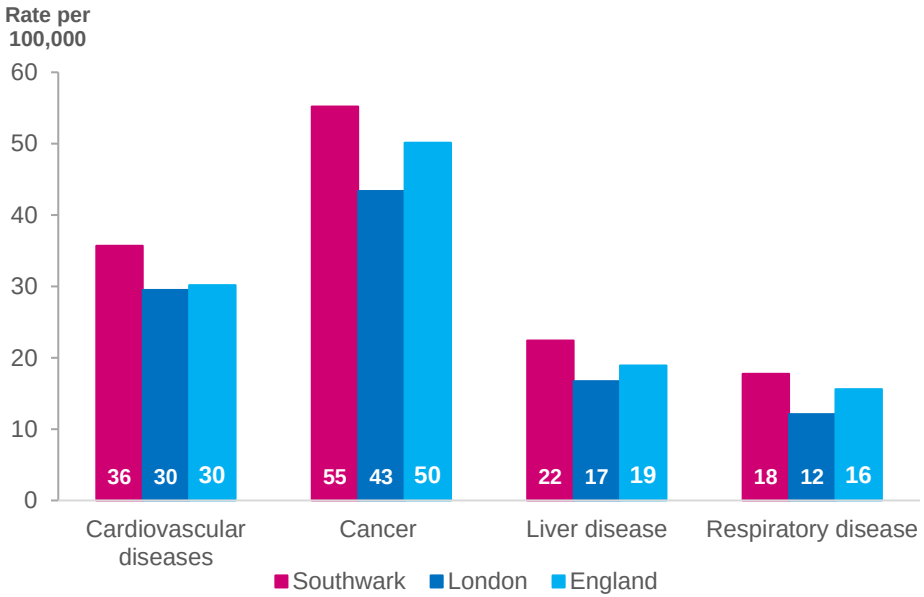


Figure 55: Preventable mortality among those aged under 75 per 100,000 residents, by condition in 2021. Age standardised mortality rate.
Source: OHID, 2023. Public Health Outcomes Framework.

Geographical inequalities in preventable mortality mirror many of the underlying health issues in the borough, with levels often highest in our more disadvantaged communities. Dulwich Village has the lowest rates of preventable mortality in the borough.

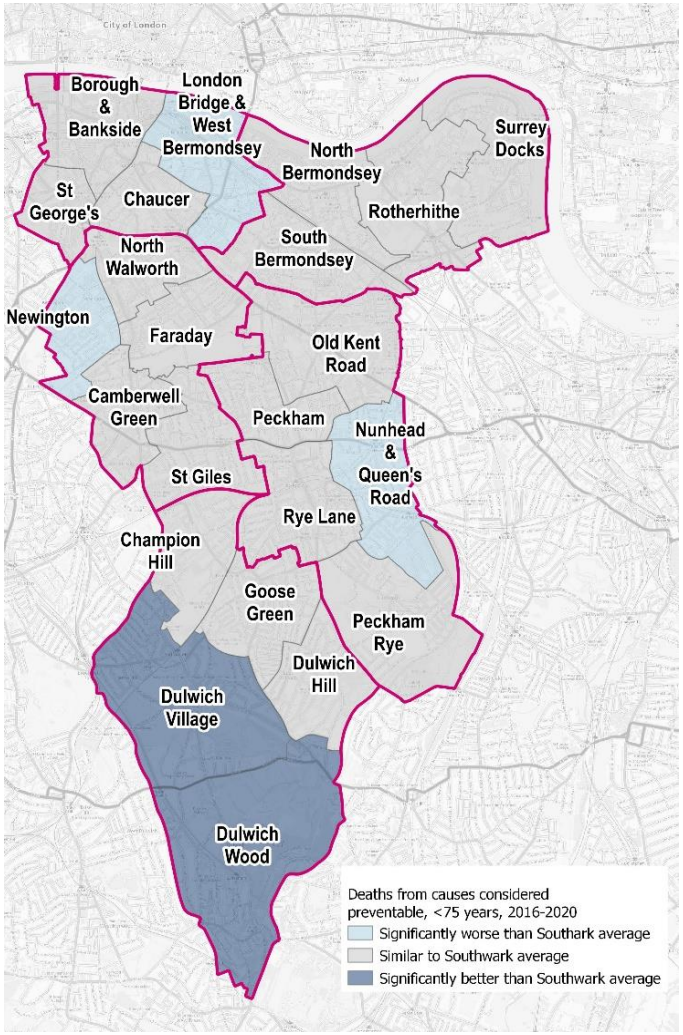


Figure 56: Significance of mortality rate from all causes considered preventable in residents under 75 years old, by ward of residence in comparison to the Southwark average (2016-2020).
Source: OHID 2023. Local Health – Small Area Public Health Data.

12.5 Mortality and COVID-19

From 2020, the preventable mortality definition includes deaths where COVID-19 is listed as an underlying cause of death. COVID-19 was the leading cause of death in England in 2020. Mortality statistics for COVID-19 are described in two sets of statistics:

- Deaths **involving** COVID-19: where COVID-19 was mentioned on the death certificate, but not necessarily an underlying cause of death.
- Deaths **due to** COVID-19: where COVID-19 was listed directly as an underlying cause of death.

Mortality rates in London were higher than those of England, both for deaths involving, and due to, COVID-19. The under 75 mortality rate was significantly lower than the overall rate, as expected, since older people are more vulnerable to COVID-19.

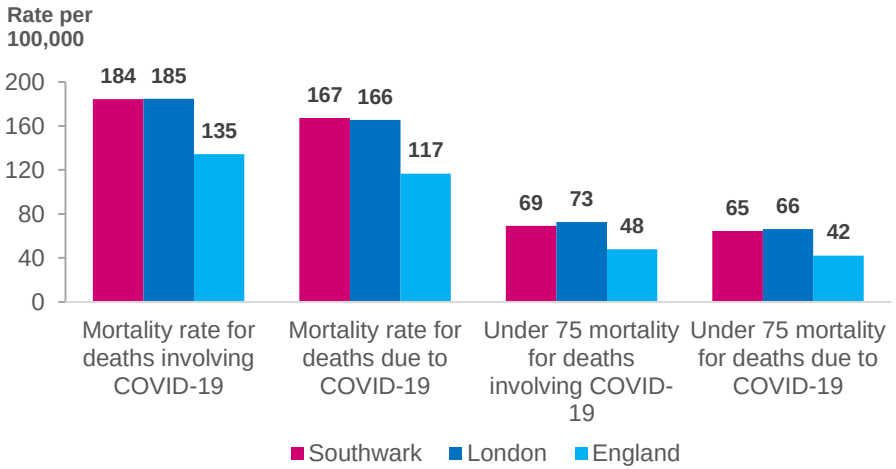


Figure 57: Mortality rates for deaths involving or due to COVID-19 for all ages and those aged under 75, 2021.
Source: OHID 2023. Mortality profile.

Mortality due to and involving COVID-19 are also skewed heavily towards men, a pattern seen across Southwark, London and England. The under 75 mortality rates due to COVID-19 in Southwark in 2021 was 81 per 100,000 for males compared to 49 for females.

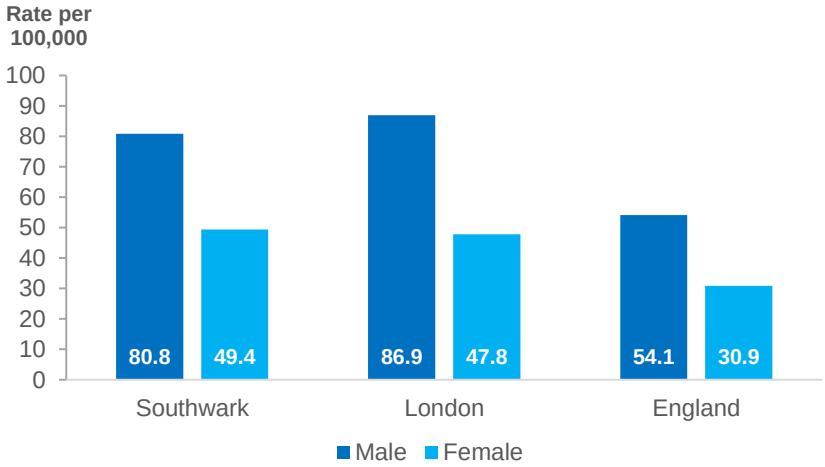


Figure 58: Under 75 mortality rate for deaths due to COVID-19 for males and females in Southwark, London and England, 2021.
Source: OHID 2023. Mortality profile.

12.6 Life expectancy

Life expectancy at birth has been increasing steadily over time. This is true across London and England, but the improvement has been more pronounced in Southwark. In 2021, life expectancy at birth was 78.2 years for men and 83.3 years for women in Southwark. These are comparable to the London and England life expectancies for both men and women.

While life expectancy in Southwark is increasing, this improvement has not been the same across the borough. Male life expectancy is highest in Dulwich Village and Chaucer wards, and lowest in London Bridge & West Bermondsey and Nunhead & Queen's road wards. Similarly for women, life expectancy is high in Dulwich Village, and neighbouring Goose Green and Champion Hill. Women's life expectancy is also lowest in London Bridge & West Bermondsey and Nunhead & Queen's Road wards as well as Peckham.

Whilst our residents are living longer, the length of the time spent living in good health is also an important factor. Healthy life expectancy is often considered a measure of whether we are adding life to years, as well as years to life.

Figures for 2017-19 show that while life expectancy among females in Southwark is higher than their male counterparts, these extra years are too often are spent in poor health.

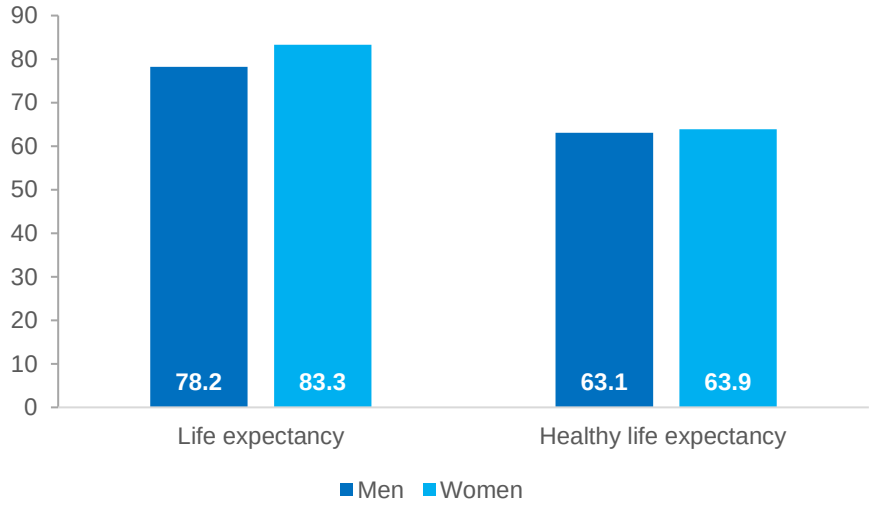


Figure 59: Life expectancy at birth (2021) vs healthy life expectancy (2018-2020) of men and women in Southwark.
Source: OHID 2023. Productive Healthy Ageing Profile.

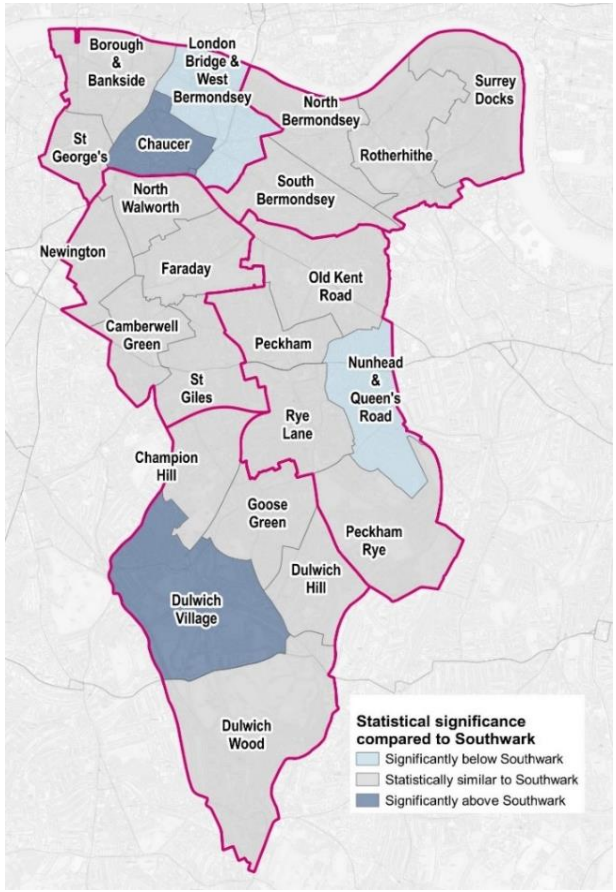


Figure 60: Significance of male life expectancy at birth, by ward, compared to the average male life expectancy in Southwark, 2016-20
Source: OHID, 2023. Local Health.

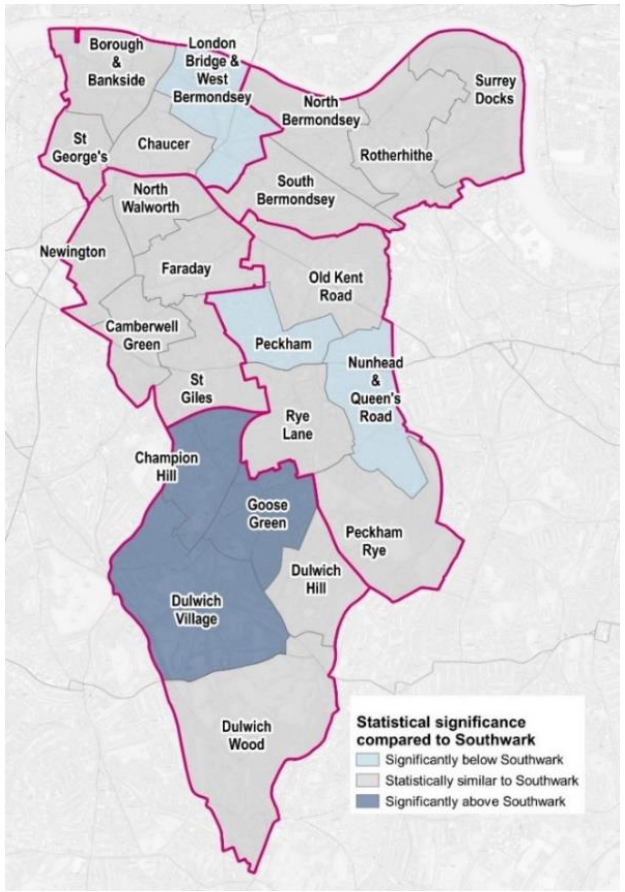


Figure 61: Significance of female life expectancy at birth, by ward, compared to the average female life expectancy for Southwark, 2016-20. Source: OHID, 2023. Local Health.

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Find out more at:

southwark.gov.uk/jsna

Agenda Item 12

Item No. 12	Classification: Open	Date: 20 July 2023	Meeting Name: Health and Wellbeing Board
Report title:		Annual Public Health Report	
Ward(s) or groups affected:		All Southwark wards and population groups	
From:		Sangeeta Leahy - Director of Public Health Southwark Council	

RECOMMENDATION(S)

1. The board note the findings of the Annual Public Health Report (APHR), and support the recommendations.

BACKGROUND INFORMATION

2. Each year, Directors of Public Health in local authorities across England fulfil a statutory requirement to write an annual report on the health of their population. The APHR is used to inform partners and residents about the health of Southwark's communities, as well as provide evidence on key health and wellbeing needs.

3. The APHR is shared with partners across the council and external partners, including the voluntary and community sector and residents. This report was published on the council website and signposted on social media and in Southwark Life.

KEY ISSUES FOR CONSIDERATION

4. The Director of Public Health chose air quality as the theme of this year's report. This includes indoor and outdoor air quality.

5. The APHR begins with an introduction from Councillor Akoto, Cabinet Member for Health and Wellbeing. Councillor Akoto highlights the significance of air quality, notes the progress we have made, and highlights that there is more we can do as individuals, businesses, organisations, and stakeholders working on air quality.

6. The report is split into the following sections:

   a) Sources and trends: an overview of sources of indoor and outdoor pollutants, as well as a summary of changes in pollutant levels over time, predictions for future levels, and geographical patterns.

b) Air quality and health: a summary of the health effects of poor air quality and associated health inequalities. This section also introduces the relationship between air quality and climate change, and highlights community views on air quality.

c) Action to improve air quality: an overview of the council's work on air quality to date, covering monitoring air quality; developments and buildings; cleaner transport; schools, health services, and communities; awareness raising; inspiring and influencing; and indoor air pollution.

d) Recommendations: a series of ten top tips for individuals, organisations, businesses, and stakeholders working on air quality to contribute to cleaner air in Southwark.

Community, equalities (including socio-economic) and health impacts

Community impact statement

7. The APHR emphasises community views on air quality and associated measures. It includes case studies focusing on specific communities as well as quotes from members of the community. The report outlines the air quality situation in specific communities, including schools, and those that are ethnicity-based and geography-based. It concludes with recommendations on collective action, using your voice, involving communities in decision-making, and ensuring action is equitable.

Equalities (including socio-economic) impact statement

8. The APHR provides a summary of air quality-related health inequalities in Southwark. It identifies population groups who are most at risk from the health effects of poor air quality, and recommends that interventions take this into account when prioritising and targeting measures.

Health impact statement

9. The APHR outlines the health effects of poor air quality in Southwark, notes the range of teams with influence over air quality, and highlights opportunities for action going forward.

Climate change implications

10. The report notes the close relationship between air quality and climate change. It recognises the opportunities provided by this, including to accelerate progress by tapping into momentum on climate action. The report also draws attention to the rare occasions where action on climate has a neutral or negative impact on air quality and careful consideration is important.

Resource implications

11. There are no direct resource implications of the APHR.

Legal implications

12. There are no legal implications.

Financial implications

13. There are no financial implications.

Consultation

14. The APHR was developed through conversations with internal and external partners to understand how Southwark is taking action on air quality, and to inform the recommendations section. There was no formal consultation.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
None		

APPENDICES

No.	Title
Appendix 1	Southwark's Annual Public Health Report 2023 - Cleaner Air, Healthier Lives

AUDIT TRAIL

Lead Officer	Sangeeta Leahy - Director of Public Health
Report Author	Kate Smith
Version	Final
Dated	6 July 2023
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Assistant Chief Executive - Governance and Assurance	No	No
Strategic Director of Finance	No	No
List other officers here		

Cabinet Member	Yes	Yes
Date final report sent to Constitutional Team		12 July 2023

Cleaner Air, Healthier Lives

Southwark's Annual Public Health Report 2023

CONTENTS

FOREWORD

This year's Annual Public Health Report highlights air quality as a significant public health concern, and suggests ways we can all contribute to cleaner air in Southwark.

The air we breathe affects us all, even before we are born. Clean air makes our lives healthier and longer. Poor air quality does the opposite, contributing to many health conditions from heart and lung diseases to cancer. Some people are more affected than others, often due to factors outside their control.

However, as individuals, businesses, organisations, and stakeholders working on air quality, there is plenty we can do to make our air cleaner. This report showcases some of the exciting work that is already happening and makes recommendations for further action.

I am thrilled to endorse this year's annual report and look forward to continuing our progress towards cleaner air in Southwark.

Cllr Evelyn Akoto

Cabinet Member for Health & Wellbeing

INTRODUCTION

Clean air helps us to live longer, healthier lives. The air we breathe, both indoors and outside, impacts our health from the moment we are conceived, and continues to affect us throughout our lives. Air pollution contributes to cardiovascular and respiratory illnesses, lung development problems in children, stroke, cancer, and numerous other health outcomes.

The impact of air quality is not felt equally, with children, older people, and those with certain long term illnesses most affected. Systemic issues like poverty and unemployment compound the harms associated with poor air quality. People in lower income neighbourhoods often experience the worst health effects despite typically contributing less to the sources of air pollution and having less ability to control their exposure to it.

The way we live, travel, move goods, and build, all influence levels of and exposure to air pollution. That means there are many levers we can pull to make improvements and there are plenty of incentives to make them. In addition to improving health and reducing health inequalities, measures to improve air quality often benefit other policy areas too. Cleaner air contributes to net zero ambitions, biodiversity improvements, and economic benefits[i].

We can all play a part in making our air cleaner. On an international and national level, air quality targets and a declaration of clean air as a human right drive and motivate the change. At the national, regional, and local level, policies, legislation, strategies, and enforcement embed the change. As individuals, we can try to improve our understanding of air quality, reduce our own emissions, and protect ourselves and others. As businesses and organisations, we can provide healthy buildings, support staff to make air quality-friendly decisions, and lead by example by reducing our own emissions. As stakeholders working on air quality, we can learn from each other, contribute our own strengths, and join forces to accelerate progress.

With a clear momentum and reason for change, there is no better time to build on our achievements and prioritise clean air and the range of benefits it can bring. As the Director of Public Health for Southwark, I encourage you to join us on our quest for cleaner air.

Sangeeta Leahy

Director of Public Health

ACKNOWLEDGEMENTS

Contributors

Kate Smith, Chris Williamson, Lisa Colledge, Paul Newman, Craig Birkett, Stefanie Buckner, Rosie Dalton-Lucas, Dale Foden, Kristin Hall, Rebecca Harkes, Laura Hills, Ginette Hogan, Kim Hooper, Keith Kiernan, Patrick Lee, Bill Legassick, Youssof Oskrochi, Vanessa Parry-O'Driscoll, Ben Pearce, Manuela Piasentin, Rachel Pidgeon, Josepha Reynolds, Sarah Robinson, Tom Robison, Tom Sharland, Paul Stokes, Mariola Viegas-Trimble, Lauren Wilkinson, Paul Wood

SOURCES & TRENDS

OUTDOOR AIR QUALITY

There are many types of outdoor air pollutants. In England, these are set out in the Air Quality Regulations and Environment Act. The focus tends to be on nitrogen oxides and particulate matter[ii]. Nitrogen dioxide and nitric oxide are the main gases of concern. They are often referred to as NO_x and considered in tandem because they frequently convert between each other.

Pollutants in the air that are not gases are referred to as particulate matter. These are classified by size, and smaller particles tend to have a greater impact on health. PM_{10} and $PM_{2.5}$ are the most commonly referenced particulates. PM_{10}, course particulate matter, refers to particles that are 10 micrometres or less in size, while $PM_{2.5}$, fine particulate matter, refers to those less than 2.5 micrometres in size. These are further classified as primary PM, which comes directly from sources, and secondary PM, which comes from chemical reactions.

The main sources of NO_x are combustion from road transport, industrial combustion, and power generation. The main sources of PM_{10} and $PM_{2.5}$ are also combustion – for example from vehicles, power stations, and domestic combustion – as well as industrial processes, and vehicle break and tyre wear. Natural sources of particulate matter include dust and sea salt.[iii] Air quality is also affected by other countries, weather patterns, and natural events.

Figure 1: Key sources of outdoor air pollution

INDOOR AIR QUALITY

Indoor air quality is also important to consider because people tend to spend the majority of their time inside. Indoor air pollution includes outdoor pollutants that move inside, as well as pollutants released inside. Indoor pollutants can also move outside. The main indoor pollutants of concern include carbon monoxide, volatile organic compounds (VOCs), and radon[iv]. These pollutants come from a range of sources such as heating and cooking appliances, cleaning products, personal care products, and building materials[v].

Figure 2: Key sources of indoor air pollution

Damp and mould is often considered to be a component of indoor air quality as spores released into the air can harm people's health. Damp and mould tend to develop due to issues around heating, insulation, condensation, and ventilation. Other bio-aerosols that affect indoor air quality include viruses, bacteria, and pollen[vi].

KEY SOURCES & TRENDS

Despite significant reductions in recent years, air pollution levels are still high across most of Southwark. As in much of London, legal air pollution limits are often exceeded.

Nitrogen oxides are the biggest contributors to local air pollution in Southwark, although local emissions fell by 33% between 2013 and 2019. This trend of falling NO_x emissions is predicted to continue into 2030. Substantial local reductions were also seen for $PM_{2.5}$ (19%) and PM_{10} (13%). The reduction in $PM_{2.5}$ is predicted to continue to 2030, while PM_{10} is projected to increase from its 2019 level.

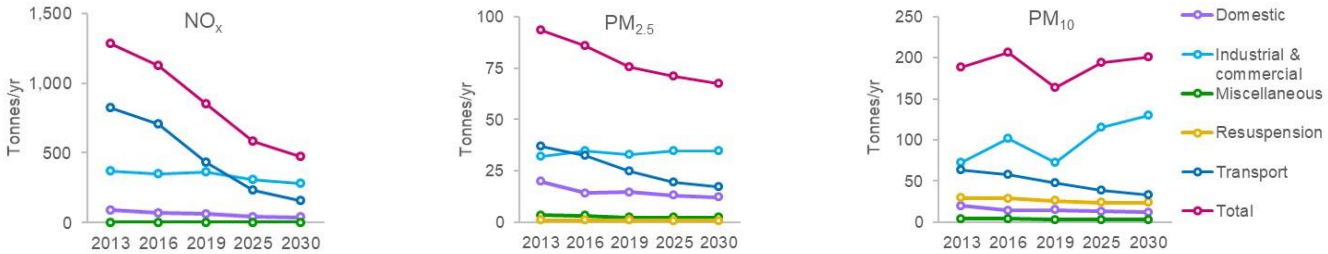


Figure 3: Predicted Southwark total annual emissions of NO_x, $PM_{2.5}$ and PM_{10} (tonnes per year), for 2013, 2016, 2019, 2025 and 2030, from modelled 2019 data, by main source
Source: GLA 2023, London Atmospheric Emissions Inventory 2019 (2023 revision)

The reduction in NO_x and particulate matter is mostly driven by reduced transport emissions. In coming years, industrial and commercial emissions are expected to be the biggest sources of NO_x, PM_{10}, and $PM_{2.5}$. Road traffic is the main source of Southwark's transport-related air pollution.

Figure 4: Predicted Southwark annual transport emissions in 2025 (tonnes), from modelled 2019 data, by source
Source: GLA 2023, London Atmospheric Emissions Inventory 2019 (2023 revision)

Southwark's industrial and commercial air pollution comes from a range of sources, especially heat and power generation, commercial cooking, and construction.

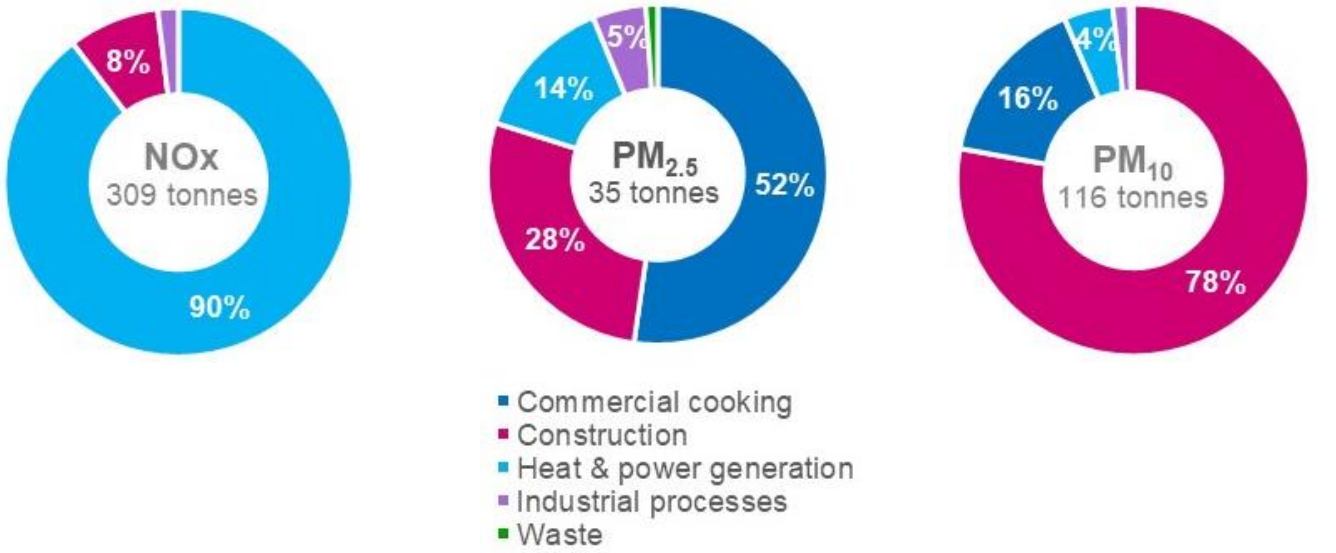


Figure 5: Predicted Southwark annual industrial and commercial emissions in 2025 (tonnes), from modelled 2019 data, by source
Source: GLA 2023, London Atmospheric Emissions Inventory 2019 (2023 revision)

GEOGRAPHICAL PATTERNS

Air pollution concentrations are highest in north-west Southwark and along major roads. In 2025, it is predicted that NO_2 concentrations that breach legal limits will cover far less of Southwark than in 2016, but pockets will occur along some main roads, especially in the north-west of the borough.

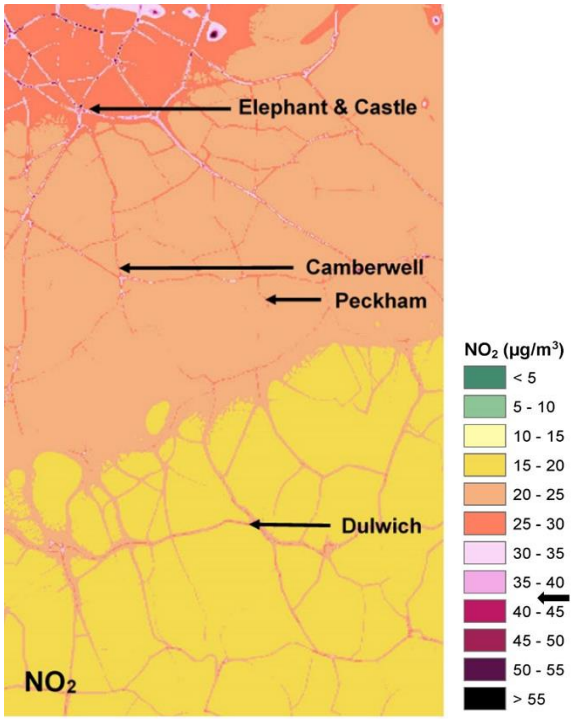


Figure 6: Predicted 2025 ground level concentrations of annual mean NO_2 (µg/m^3; 20 m grid resolution), for Southwark area, from modelled 2019 data. (UK Air Quality Standards state a legal NO_2 limit of 40 µg/m^3, indicated by map legend arrow.)
Source: GLA 2023, London Atmospheric Emissions Inventory 2019 (2023 revision)

$PM_{2.5}$ levels also fell between 2016 and 2019, but 2025 predictions indicate above-guideline levels in north-west and north-central Southwark.

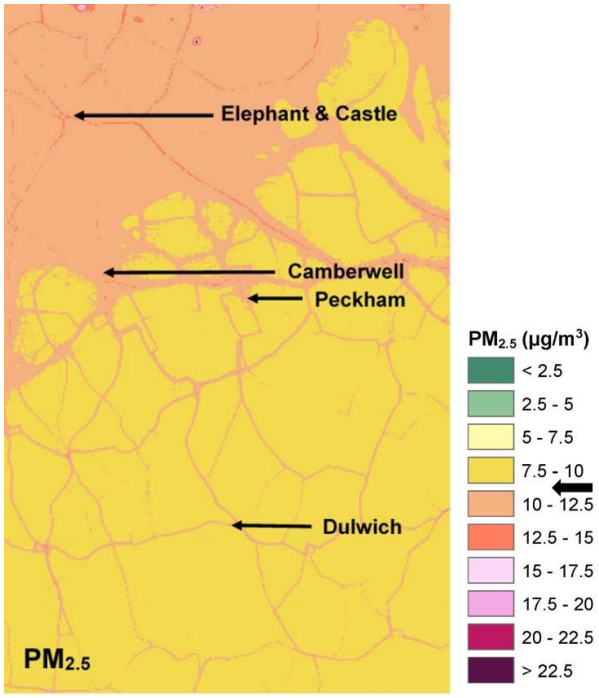


Figure 7: Predicted 2025 ground level concentrations of annual mean $PM_{2.5}$ (µg/m^3; 20 m grid resolution), for Southwark area, from modelled 2019 data. (The London Mayor's Office has committed to levels of $PM_{2.5}$ less than 10 µg/m^3 by 2030; indicated by map legend arrow.)
Source: GLA 2023, London Atmospheric Emissions Inventory 2019 (2023 revision)

Predicted 2025 PM_{10} levels are below guideline limits throughout the borough, apart from in a few isolated pockets along main roads in the north-west.

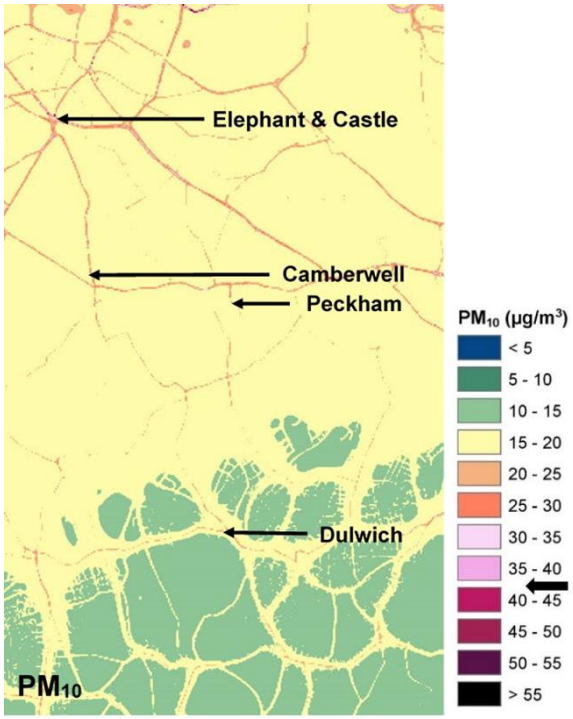


Figure 8: Predicted 2025 ground level concentrations of annual mean PM_{10} (µg/m^3; 20 m grid resolution), for Southwark area, from modelled 2019 data. (The London Mayor's Office has committed to levels of PM_{10} less than 40 µg/m^3 by 2030; indicated by map legend arrow.)
Source: GLA 2023, London Atmospheric Emissions Inventory 2019 (2023 revision)

Although there are geographic differences in air pollution levels in Southwark, the whole borough was designated an Air Quality Management Area in 2023. These are implemented in places where national air quality improvement objectives are at risk.

Southwark also has seven Air Quality Focus Areas, identified by the Greater London Authority (GLA). Each of these has specific objectives to reduce emissions or exposure to air pollution. Most of these areas are in the north-west of the borough.

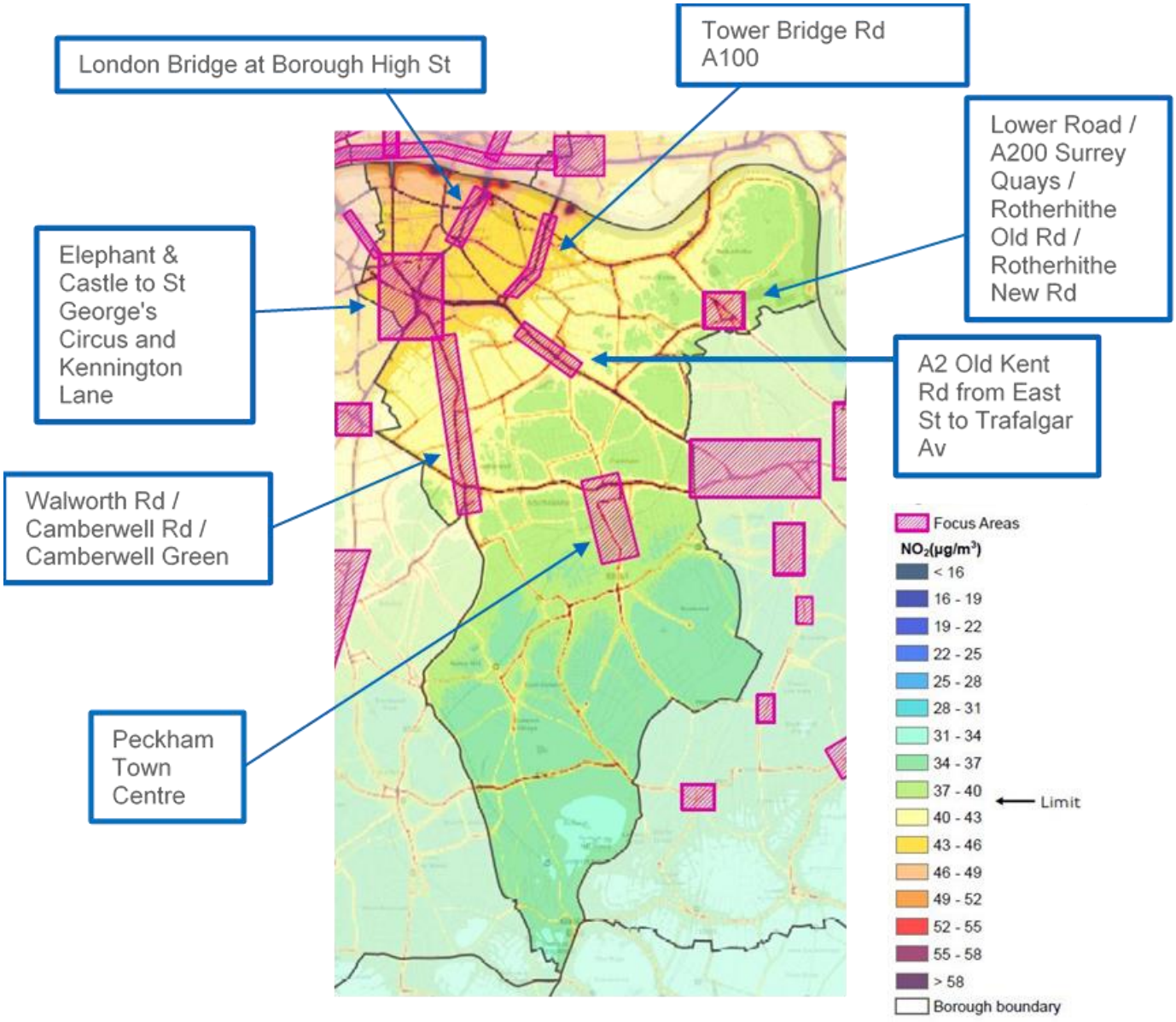


Figure 9: Southwark Air Quality Focus Areas. Map coloration indicates 2016 NO_2 levels.
Source: Southwark Council, 2021. Southwark Air Quality Annual Status Report 2020. GLA, 2022. Air Quality in Southwark: A Guide for Public Health Professionals.

AIR QUALITY & HEALTH

OVERVIEW

Poor air quality is a significant public health challenge that leads to ill health and premature death. It is thought to contribute to one in five deaths globally[vii], to be responsible for between 29,000 – 43,000 deaths annually in the UK, and to cost the NHS and social care at least £1.6 billion between 2017 and 2025 in England[viii].

Air quality affects us throughout our lives[ix], starting in the womb[x]. It can lead to low birth weight and premature birth[xi]. Children are especially vulnerable to the health effects of air pollution because they breathe faster and have organs and immune systems that are still developing[xii]. Air pollution leads to short term, acute health events like asthma attacks, as well as long term effects. Although it particularly affects children, older people, and those with certain long term conditions, it affects everyone, even at low levels[xiii].

In particular, air pollution increases the risk of cancer, respiratory and cardiovascular conditions, and stroke. There is also evidence that links air pollution with dementia, mental health conditions, and cognitive function[xiv].

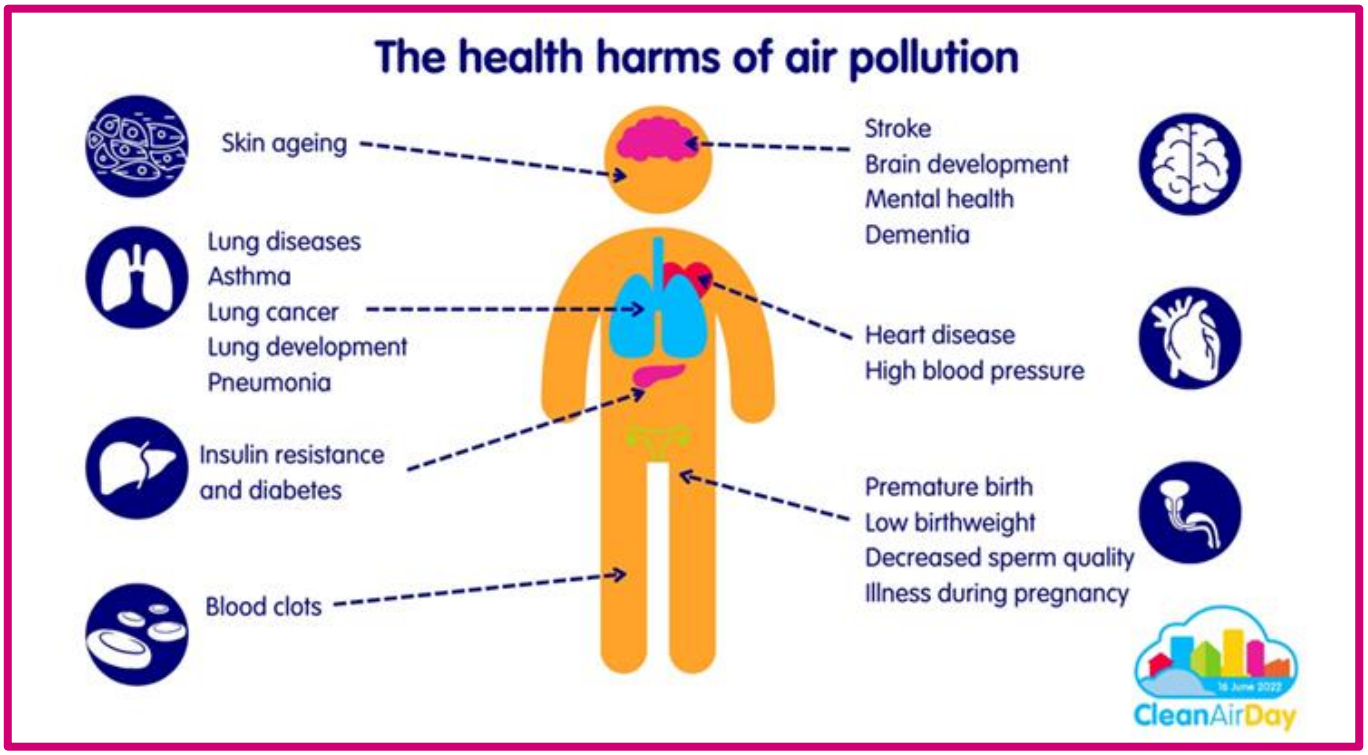


Figure 10: Health harms of air pollution
Source: Global Action Plan, 2022[xv]

Conversely, cleaner air extends lives[xvi] and the tools to clean it exist. If we tap into existing momentum from climate action, we have an opportunity to accelerate air quality progress.

AIR QUALITY & CLIMATE CHANGE

Air pollution and climate change are interlinked and interdependent. Wins for air quality are often wins for climate action too. That gives us more opportunities for effective action. Active travel is a great example of this, as is the shift away from fossil fuels. Movements away from gas boilers and polluting vehicles, and towards green streets and buildings, are all beneficial for both climate action and air quality.

On rarer occasions where action on climate has a neutral or negative impact on air quality, careful consideration is important. Now is the time to make sure current and future policy trends align both agendas. For example, as we make homes more energy efficient, ventilation is an important consideration, and as we shift towards electric vehicles, pollution from vehicle tyres and brakes is important to take into account.

Climate action provides us with an opportunity to accelerate air quality action by tapping into existing momentum. With thoughtful consideration, action on climate and air quality can go hand in hand, driving positive change in each[xvii].

AIR QUALITY & HEALTH IN SOUTHWARK

Air pollution is associated with short and long term health problems. There are significant numbers of residents in Southwark who have been diagnosed with long term conditions known to be related to poor air quality, such as diabetes and asthma. In addition, a significant number of Southwark residents experience multiple health conditions, which can increase their risk from air pollution[xviii].

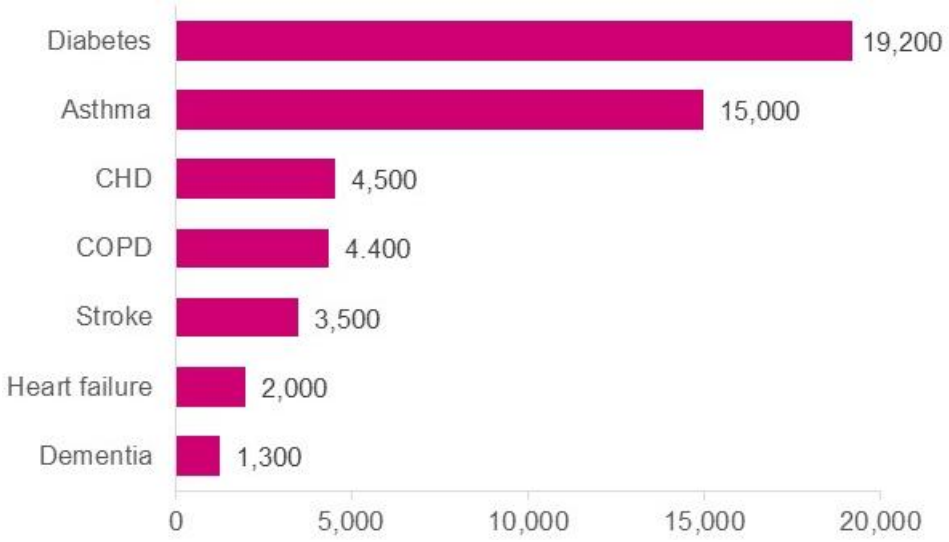


Figure 11: Number of registered Southwark GP patients with diagnosed conditions known to be affected by poor air quality, April 2023
Source: South East London Integrated Care System 2023, Comorbidities Dashboard

Modelling published in 2020 suggested that, if air pollution levels remained static, the local burden of disease would continue to grow between 2020 and 2024. There would be over 15,000 new cases of disease associated with NO_2 emissions, and more than 2,900 new cases of disease associated with $PM_{2.5}$ emissions[xix].

In 2019, almost one in ten Southwark deaths were related to air pollution[xx]. This was mostly due to $PM_{2.5}$, to which 7% of all deaths were attributed. Southwark is in the top third of London boroughs for air pollution mortality burden.

International (Global Burden of Disease) modelling estimates that 1 in 14 Southwark resident deaths in 2019 and 1 in 100 years lived with disability were attributable to air pollution. More specifically, air pollution was responsible for 12% of diabetes-related deaths and 10% of lung cancer and COPD-related deaths.

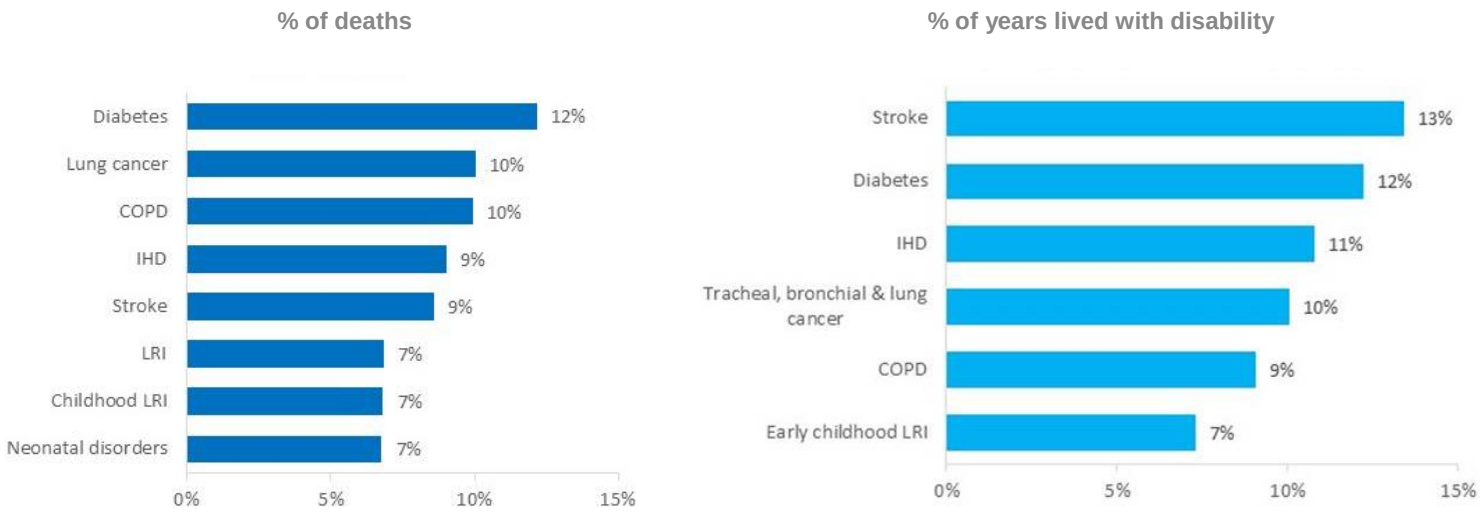


Figure 12: Percentage of 2019 Southwark residents' deaths (left) and years lived with disability (right) which were attributable to air pollution, for the most affected conditions. (Data for all ages unless otherwise specified). COPD = chronic obstructive pulmonary disease; IHD = ischaemic heart disease; LRI = lower respiratory infection; childhood = 5–14 yr; early childhood = 0–4 yr).
Source: Institute for Health Metrics and Evaluation 2023, GBD Compare data tool

HEALTH INEQUALITIES IN SOUTHWARK

The health effects of air pollution are experienced unequally[xxi]. They are influenced by: susceptibility – how likely you are to get sick; and exposure – how much polluted air you breathe in. That means children, older people, people with certain long term health conditions, and those spending more time in high pollution areas are disproportionately affected[xxii]. In turn, susceptibility and exposure are influenced by other wider determinants of health like income, employment, living conditions, and access to green space. It is crucial that interventions to improve air quality are equitable and do not exacerbate existing inequalities.

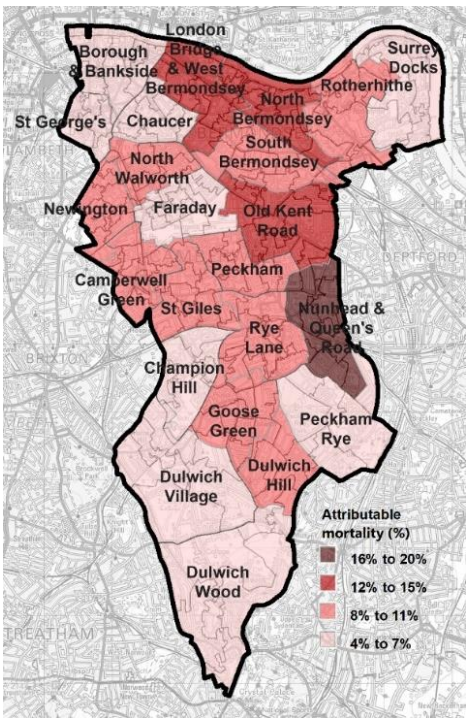
Low income groups are often at greater risk from indoor air pollution because they are more likely to live closer to outdoor pollution sources which leak indoors, live in poorer quality housing with smaller rooms and worse ventilation, and be at greater risk of underlying health conditions[xxiii]. These are the same people who typically contribute the least to air pollution, and have the least control over their own exposure to it.

Wood burning is an example of these differences between people who contribute to air pollution and those who are exposed to it. A major source of air pollution, wood burning is estimated to contribute around 17% of $PM_{2.5}$ levels in London's outdoor air[xxiv]. People who use wood burners are more likely to be wealthy, own a home, and not to rent, compared to people who do not use wood burners[xxv]. In the UK, a relatively small number of people depend on wood burning to heat their home. The most commonly cited reason for indoor burning is aesthetics.

There are racial and socioeconomic components to air quality health effects too. Exposure to air pollution is greater in communities with higher levels of deprivation or a higher proportion of people from a non-white ethnic background[xxvi]. London schools in higher deprivation areas and with a higher proportion of Black, Asian and ethnic minority pupils are exposed to higher levels of air pollution[xxvii]. Air pollution-related pregnancy outcomes are also worse for ethnic minorities and those living in areas of higher deprivation[xxviii].

Geographic differences in the health effects of air pollution are demonstrated by the mortality burden of Southwark wards. In 2019, air pollution attributable mortality was four times higher in the most affected ward compared with the least affected. About 1 in 5 (20-22%) Nunhead and Queens Road ward deaths were attributed to air pollution, which is about 50 extra deaths, versus about 1 in 20 (4-5%) deaths in St George's ward, which is two extra deaths. Although Nunhead and Queens Road residents are slightly older, more deprived, and in worse health, this is unlikely to explain the large mortality difference.

Min NO_2/$PM_{2.5}$ mortality burden (%)



Min years of life lost due to NO_2/$PM_{2.5}$

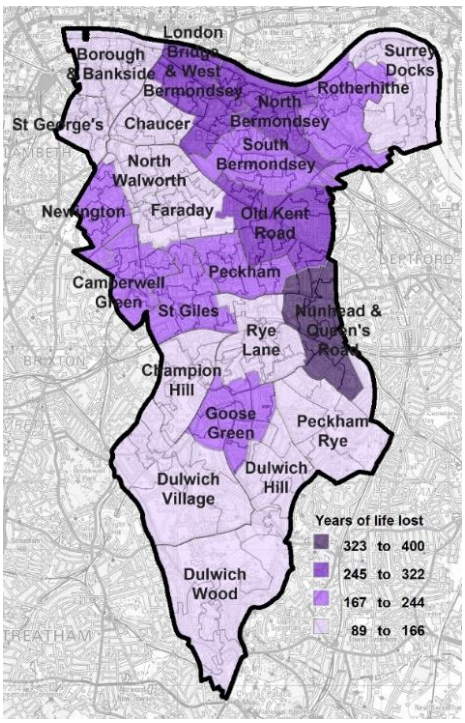


Figure 13: Air pollution mortality burden and life years lost calculated for 30+ yrs population. Min = minimum. Source: GLA, 2022. Air Quality in Southwark: A Guide for Public Health Professionals.

Furthermore, well over half (61%) of Southwark neighbourhoods fall within the most vulnerable fifth of English neighbourhoods for air pollution harm. This is based on modelled 2018 NO_2 and $PM_{2.5}$ concentrations, deprivation, and vulnerable populations and sites.

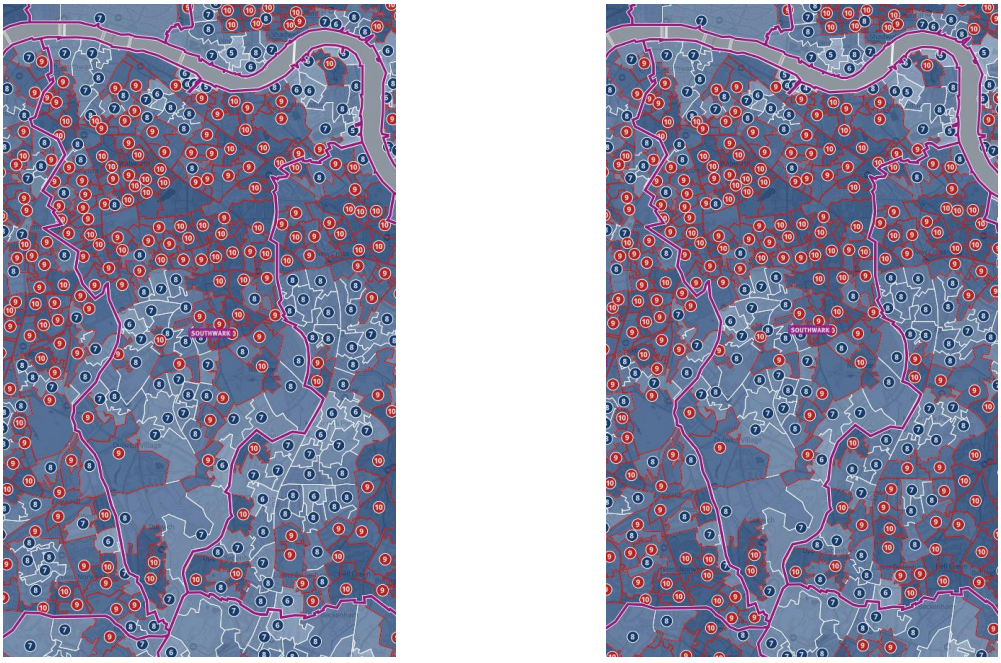


Figure 14: Vulnerability to NO_2 and $PM_{2.5}$. Neighbourhood = Lower Super Output Area. Score of 10 = most vulnerable 1/0th of England neighbourhoods; score of 9 = next most vulnerable 1/10th of England neighbourhoods.
Source: OHID, 2022. SHAPE Place Atlas.

COMMUNITY VIEWS ON AIR QUALITY

The Council recognises that people living and working in Southwark understand their needs best. We reach out to communities and local partners for feedback on strategies, help to explore certain topics further, and participation in research projects.

For example, the Council set up a Climate Change Citizens' Jury to involve residents in shaping climate action[xxix]. Air pollution was a component of this process. The jury recognised the air quality benefits of walking and sustainable travel, and asked the Council to do more. They also recognised that, often, people are not fully aware of the harm air pollution can cause.

This is a finding echoed across other forms of research. The airTEXT discovery research sought views on the airTEXT air pollution alert service. It was clear that awareness of air pollution was lacking and, even when it was present, taking action competed with other priorities such as needing a house within budget. These barriers to action are compounded by a common feeling that people cannot make a difference or have their voice heard.

Our partners' A Breath of Clean Air report[xxx] found that as people become more aware of air pollution, they are eager to engage with the issue. However, people struggle to find information and may lack confidence to take action.

ACTION TO IMPROVE AIR QUALITY

OVERVIEW

Air quality is recognised as a health concern internationally, nationally, regionally, and locally. In 2022, the United Nations (UN) declared clean air a human right[xxxi], and the World Health Organisation (WHO) has published Air Quality Guidelines, a set of evidence-based recommendations for air pollutant limit values.

The UK set its own less ambitious air quality targets in the Environment Act 2021, which are regulated by the Air Quality Standards Regulations. These include legally binding limits for concentrations of sulphur dioxide, nitrogen oxides, particulate matter, lead, benzene, carbon monoxide, and ozone in outdoor air. There is separate legislation for air pollutant emissions, which are set out in the National Emissions Ceiling Regulations 2018. This covers sulphur dioxide, oxides of nitrogen, ammonia, non-methane volatile organic compounds, and $PM_{2.5}$. In addition to this, the Government must create a national Air Quality Strategy for the UK, with a review due to be published in 2023[xxxii]. There is also a National Clean Air Strategy, published in 2019, which articulates the need for action and sets out key proposals to tackle indoor and outdoor air pollution.

There are a number of other agencies and frameworks that amplify the case for action on air pollution in the UK. The Public Health Outcomes Framework includes the number of deaths attributable to air pollution as part of its assessment of the state of public health. The UK Health Security Agency, which prevents and responds to health threats, listed air pollution in their set of priorities, while the latest annual Chief Medical Officer's report focused on the public health impacts of air pollution.

At the London level, much of the action on air pollution comes from the GLA and local authorities, alongside partners. Key documents include the Mayor's Environment Strategy (2018)[xxxiii], which sets an ambition that "London will have the best air quality of any major world city by 2050, going beyond the legal requirements to protect human health and minimise inequalities." The Mayor's Transport Strategy[xxxiv] sets out Transport for London's vision, The London Plan[xxxv] considers air quality throughout, and supplementary guidance[xxxvi] helps with the air quality of new developments.

IMPROVING AIR QUALITY IN SOUTHWARK

As set out in the Environment Act 1995, and through the Local Air Quality Management process, local authorities must review air quality in their areas. In places that are, or are likely to be, above legal air quality limits, local authorities need to declare an Air Quality Management Area and develop an Air Quality Action Plan to improve the situation. As of 2023, all of Southwark is an Air Quality Management Area[xxxvii].

Air quality features in many of Southwark's local strategies, projects, and plans, and underpins the key principles – fairer, greener, safer - set out in the Council Delivery Plan[xxxviii]. From the Climate Change Strategy[xxxix], Movement Plan[xl], and emerging Streets for People Strategy to the Nature Action Plan[xli], and Southwark Plan[xlii], the mitigation of air pollution has crossovers with, and is integrated into, many existing policies and projects. The South East London Integrated Care System, of which Southwark Council is a part, also includes a section on air quality in their Green Plan[xliii].

The bulk of the Council's work on air quality is set out in the recently published Air Quality Action Plan 2023 – 2027[xliv]. The next section of this report is based on the themes in the action plan:

- monitoring air quality;
- developments and buildings;
- cleaner transport;
- schools, health services, and communities;
- awareness raising;
- inspiring and influencing; and
- indoor air pollution.

Monitoring Air Quality

"***Until you know what's happening around, you can't make a change***."

Respondent, Southwark airTEXT Air Quality Discovery

Southwark Council monitors air quality in a number of ways. The most robust of these are six continuous Air Quality Monitoring Stations that measure NO_2, PM_{10}, $PM_{2.5}$ and, in Elephant and Castle, also ozone. Southwark also measures NO_2 with diffusion tubes located across the borough, and is part of the Breathe London network of air pollution sensors.

Expansion of air quality monitoring in Southwark

Project: Ongoing air quality monitoring

Objective: To review and assess Southwark's air quality

Overview: Before 2019, Southwark Council operated two air quality monitoring stations (AQMS) at Old Kent Road and Elephant and Castle. For a more accurate representation of air quality in Southwark, coverage was increased to six sites. The newer sites are on Tower Bridge Road, Vicarage Grove, South Circular Road, and Lower Road.

The monitoring stations all measure NO_2, PM_{10}, and $PM_{2.5}$. The Elephant and Castle AQMS also monitors ozone. The data from these stations can be found on the London Air Quality Network website. The data is also reported in the Defra statutory Air Quality Annual Summary Report, alongside a narrative on Southwark's progress on the Air Quality Action Plan.

Southwark Council also monitors air quality with 86 NO_2 diffusion tubes and a network of low-cost sensors. The data from these is only indicative, but helps to highlight air pollution hotspots where interventions could be targeted.

Paul Newman, Team Leader in Southwark Council's Environmental Protection Team said, *"Increasing the number of monitoring locations in Southwark has provided better quality data, and helped us to target air quality project resources towards parts of the borough with the greatest need to improve air quality."*

Developments & Buildings

"We don't have a garden so we go to the local park to get fresh air […] It would be nice if there were more."

Respondent, Southwark airTEXT Air Quality Discovery

The Council plays an important role in constructing, demolishing, retrofitting, and maintaining buildings. These processes can create air pollution in the form of dust and other particulate matter, as well as emissions from on-site machinery.

The Southwark Plan 2022 sets out how air quality should be tackled through the borough's planning system. The aim is for developments to meet or exceed air quality neutral standards to ensure they mitigate against poor air quality due to construction and operation of the buildings. To deliver this, Southwark is implementing the GLA Air Quality Positive and Air Quality Neutral London planning guidance, and is developing supplementary planning documents to support the implementation of these policies.

In terms of construction, when the Council delivers new build homes, contractor proposals are reviewed to consider emissions and air quality on sites, in line with Southwark's guidance and the London Plan. The main part of this involves ensuring on-site requirements are in line with building regulations and other statutory requirements like the Non-Road Mobile Machinery Low Emission Zone.

Once constructed, buildings continue to affect air quality due to emissions from heating and cooking. Southwark Council is aware of our offices' impact on greenhouse gas emissions and monitors our carbon footprint. A number of partner organisations are developing a tool to take this a step further and record not only carbon, but also air quality emissions from organisations, as outlined in the case study below.

Recording air quality emissions from buildings

Project: Air quality footprint tool development and testing

Objective: To develop a framework for company reporting of emissions relevant to air pollution, alongside existing carbon reporting, and to test the tools developed.

Overview: Organisational carbon measurement and reporting is common, but there are no systems in place to allow the same assessments of air quality, even though most combustion sources contribute to both air pollution and carbon emissions. Environment consultancy, Ricardo, reviewed the existing carbon reporting systems and developed tools consistent with these methods to enable organisations to record their air quality emissions. Southwark Council took part in a trial of the tools and is supporting Ricardo to launch them publicly.

Partners: Ricardo, Impact on Urban Health, Costain, TP Bennett, and Guys and St Thomas NHS Foundation Trust

During a business engagement survey conducted by Ricardo, 86% of businesses said that air quality is either 'very' or 'extremely' important as an environmental health concern.

Cleaner Transport

"Air quality is a big issue, especially with most of the pathways being located directly next to the road. Maybe planting more greenery between the pedestrian pathways and the road could make a difference too."

Respondent, Southwark Climate Change Citizens' Jury

Transport is the main source of air pollution in Southwark. As a result, it is an important area to address, especially given the strong co-benefits with climate action. The Council's priority is to reduce traffic, stemming from the movement of people and goods. In turn, this reduces vehicle emissions. The Council does this by encouraging active travel and public transport among those who are able to use it. Active travel also benefits residents' mental and physical health, and is an important part of climate action.

The Council has supported active travel by developing infrastructure that makes it easier, safer, and more enjoyable to choose these options. For example, we implemented various street improvements, created new cycle routes, introduced traffic reduction schemes, developed walking maps, and improved walking routes, including by widening pavements and planting along streets[xlv]. We engaged with communities on interventions like Healthy Streets[xlvi], and regularly speak to stakeholders via forums like the Walking Joint Stakeholder Group. We are also keen to make the most of different forms of transport like shared mobility services, and bicycle and e-scooter hire, alongside appropriate regulation.

Other measures Southwark has introduced include Low Traffic Neighbourhoods, emission-based vehicle parking charges, and a new fleet procurement policy that ensures diesel is a last resort. We are also exploring

novel transport options like river freight coupled with more sustainable last-mile deliveries[xlvii]. A shift to electric vehicles may also be important in the context of climate change, but it is also important to recognise that, while tailpipe emissions are reduced, these vehicles still contribute to particulate pollution.

Southwark has also benefitted from London-wide measures like the Ultra Low Emission Zone, and the trial e-scooter rental scheme. We also have free online cycle skills courses, and Quietway routes that help cyclists travel on quieter streets.

Supporting businesses to switch to clean, healthier deliveries

Project: Bikes for Business

Objective: To support businesses to switch from using traditional, more polluting delivery methods - like vans - to cargo bikes.

Overview: The movement of goods and services is a major contributor to air pollution in cities, and online parcel services are projected to exponentially increase. We, at Impact on Urban Health, have been learning how to shift cargo bikes into the mainstream by supporting businesses to make the switch. There are barriers for businesses who want to make the switch to cargo bikes so we have recommendations for how local authorities and policy makers can play a role in supporting businesses. Those insights and recommendations will be published later this year.

Partners: Team London Bridge and MP Smarter Travel

Ben Pearce, Portfolio Manager at Impact on Urban Health said "*Cargo bikes are a cleaner, healthier, more efficient, and cheaper way to transport goods and services around cities. Not only do they help improve air quality in cities, but they're good for businesses too*."

Schools, Health Services & Communities

"What we are asking vulnerable groups to do should still allow them to live their full and free life."

Rob Day, Asthma and Lung UK

Although air pollution affects everyone, it does not affect everyone equally. That is why some of the Council's work has targeted specific places and communities like schools, health services, and residents from ethnic minority backgrounds.

Following the London-based air quality audit, Southwark Council introduced its own scheme. Schools were offered a free audit and funds to implement recommendations such as school streets, green screening, and facilities for scooter and cycle parking. We also offered schools in the worst air quality areas, as well as care homes, funding to install air filter units to clean the air in classrooms or common areas. An evaluation for this air filter pilot is underway.

Separately, a small number of Southwark schools are participating in the Schools' Air quality Monitoring for Health and Education project (SAMHE). Through this project, schools are given air quality monitoring equipment which is used to create a dataset to help researchers better understand indoor air quality[xlviii].

Southwark also participates in the GLA's School Superzones initiative, which includes air quality as one of its central aims. In one of the schools, children co-designed walking maps, and attended a series of fix-a-bike workshops intended to boost pupils' cycling confidence. In the second school, students are having workshops with the Council's Highways team. Their aim is to plan potential traffic and anti-idling measures outside their school.

Neighbourhood-based air quality interventions have also been an important area of work for the Council. For example, as a high-pollution, low-income area, Walworth was chosen as a setting for a Low Emission Neighbourhood (LEN). The aim of the LEN is to reduce air pollution and encourage active travel.

Campaigning for better air quality in Southwark

Project: Live and Breathe

Objective: To campaign for better air quality in Lambeth and Southwark with musician, Love Ssega.

Overview: Young people and those from Black, Asian and ethnic minority backgrounds are among the groups most disproportionately affected by air pollution. The Live and Breathe campaign brings together young people, community artists, and cultural organisations to give people a platform to demand clean air.

During the campaign, we learned that art, sport, music, and the theme of community pride are all excellent ways to engage younger audiences on the issue of air pollution. Community workshops brought new audiences directly into the campaign and significantly shifted knowledge, beliefs, and engagement on the issue of air pollution, as well as on air pollution's disproportionate effect on people of colour.

Partners: Purpose and Love Ssega

Musician, artist and campaigner, Love Ssega, said *"It's shameful and unacceptable that young people, and specifically people from minoritised ethnicities, are disproportionately affected by air pollution in cities like London. Our LIVE + BREATHE campaign makes the links between air pollution and social justice clear. We're giving young people a chance to have their voices heard on this crucial public health issue."*

Awareness Raising

"Climate change is higher on the agenda, but air pollution is a threat here and now."

Rupert George, UK100

Despite being one of the biggest environmental threats to health, many people do not fully understand the extent of the harm posed by air pollution, or how to protect themselves from it. Southwark Council is keen to increase public awareness through communications, campaigns, and other forms of engagement. The aim is to increase people's understanding of the health risks, as well as how they can protect themselves and others, and reduce emissions. As part of this, the Council commissioned a piece of research into residents' views of air pollution in order to help us deliver tailored, effective messaging.

To raise awareness and support those at highest risk, the Council is exploring communication channels between the Council and health practitioners. We are also investigating working with Southwark's libraries to share information more widely.

Supporting people to access air quality information

Project: airTEXT

Objective: To improve the delivery and use of air quality information and associated health messages, and to reach vulnerable groups and communities who are most susceptible to the adverse effects of poor air quality.

Overview: Studies have shown that airTEXT air quality alerts have low reach and penetration among people vulnerable to the health effects of poor air quality, particularly among Black, Asian and ethnic minority

communities. A discovery phase project indicated that co-designing the service with the target communities and relaunching could help to reach more of those at greatest risk and improve health outcomes. The redevelopment phase of the project seeks to conduct community research followed by user acceptance testing on a redesigned interface of the airTEXT service.

Partners: Lambeth Council, Impact on Urban Health, Guys and St Thomas NHS Foundation Trust, Cambridge Environmental Research Consultants, Rooted by Design, dxw, and Defra

During the discovery phase of the project, research partners found that residents who seemed more isolated demonstrated a greater need for support to find and understand information, and felt there wasn't enough information getting to them.

Inspiring & Influencing

"Feel like my voice won't make a difference."

Joseph, survey respondent

As valuable as local action can be, air pollution, at its core, also needs national action. It is compounded by systemic issues like poverty and unemployment, and is transboundary in nature. For the biggest improvements, there must be action locally, nationally, and globally.

The Council sees it as part of our role to influence and inspire positive change. Sometimes this is by responding to consultations and taking part in research. Other times, it is by contributing to the evidence base by piloting projects others can learn from or adopt. For example, in 2022, the Council piloted putting smart home sensors in local estates to test their use in determining a property's risk of condensation mould. We also tested best practice in reducing pollution from demolition and construction alongside design consultants, Arup, on the Tustin Estate.

Inspiration and influence work the other way around too. We want to be inspired by the communities we work in, and by other stakeholders working on air pollution. As a result, the Council commissions extensive community research and prioritises partnership working. We also coordinate networks like the London Healthy Places Network and London Public Health and Housing Network which bring together researchers and practitioners to explore topics like air quality and sustainability.

Air pollution and construction

Project: Air quality and emissions in construction

Objective: To understand what people who work in and with the construction industry think about air pollution, and to hear their recommendations for ways to reduce air pollution from construction.

Overview: Construction is a major source of air pollution in cities. The project team surveyed people working in and with the industry – including regulators, suppliers, and developers – to better understand attitudes toward air pollution and, ultimately, develop practical recommendations to improve air quality. The next phase of this project will involve working with Southwark Council to enhance compliance with existing regulations related to air pollution from construction.

Attitudes towards air pollution within the sector reflect the scale of this public health crisis: 97% of people surveyed said that air quality is an "extremely or very important environmental health concern". We also found that the construction industry wants clear advice and regulation from policymakers to provide clarity and a level playing field.

Partners: Centre for Low Emission Construction

Daniel Marsh, Programme Manager at the Centre for Low Emission Construction said, *"The construction industry contributes significantly to air pollution, which affects the health of both on-site workers and the people living in cities. This important research highlights the need for all stakeholders to come together and tackle the impacts of construction activity and machine emissions on health and the environment."*

Indoor Air Quality

"I would also like to see the creation/introduction of more green, eco-friendly buildings. This would mean […] good indoor environmental air quality, use of materials that are non-toxic, ethical and sustainable, consideration of the environment in design, construction and operation, [and] consideration of the quality of life of occupants…"

Respondent, Southwark Climate Change Citizens' Jury

Indoor air quality is becoming a priority for the Council because people spend a large proportion of their time inside. The relationship between indoor and outdoor air pollution is fluid, with each influencing the other. That means many of the interventions mentioned previously will benefit indoor environments too. There are also pollutants released indoors - for example, from burning wood, cooking, and cleaning - which are, in turn, influenced by regulations, education, and human behaviour.

Damp and mould is one such source of poor indoor air quality. Last year, the Council revamped its approach to damp and mould, guided by the Housing Ombudsman report on the topic[xlix]. The Council created a dedicated team to inspect every report of damp in our housing stock, and to provide meaningful advice and remedies without blame, recognising the complex causes of damp and mould. Ventilation is a key way to manage damp, mould, and indoor air pollutants. As important net zero ambitions drive the Council's upcoming retrofitting projects, balancing ventilation with energy efficiency measures will be an important consideration.

Airborne pathogens can also be considered a component of indoor air quality. Well ventilated spaces and air cleaning technology can help. To test this technology in care home settings, the Council offered funding to install air filter units in common areas. An evaluation is due to take place this year.

Domestic wood burning is another source of air pollution that is of interest to the Council due to its significant impact on air quality. The Council has some ability to address wood burning, for example through smoke control areas where fines can be imposed.

Reducing air pollution from wood burning

Project: Air pollution and wood burning research

Objective: To work with data analytics and market research agencies to explore how to reduce health harms caused by wood burning. We want to understand motivations and behaviour around burning wood, as well as the most effective ways to communicate about wood burning. The intention is to reduce new take-up of wood burning and talk to current burners about burning less.

Overview: Wood burning has become the primary source of fine particulate matter – the most damaging of all air pollutants – in cities like London. Research shows that, of people who burn wood, most burn for aesthetic reasons rather than out of necessity. This has severe implications for public health so we want to know the best ways to communicate with people about the health harms of burning in cities.

The work showed that both non-burners and burners have low awareness of the polluting effect of burning wood. Both groups are keen to learn more if they are engaged in the right way. There is potential to reduce wood burning if the link between reduced domestic burning and improved air quality is clearly communicated. These insights are being finalised into a toolkit.

Partners: Kantar and Global Action Plan

Quote from someone who burns wood who was speaking at a focus group: *"The first thing I'm going to do after this group is Google 'burning' and 'pollution' and start my own research! All of these ads need something that tells you 'find out more' or 'if you're worried, go here for the facts'…"*

RECOMMENDATIONS

Action on air quality involves increasing awareness of the issue, effects, and potential action; reducing exposure to unclean air; and reducing the sources of unclean air. Some interventions should be targeted towards those most at risk.

Any intervention should be founded on three key principles. First, health and health inequalities should be at the forefront of decisions. Often those exposed to the most air pollution produce the least, and have the least ability to reduce their exposure to it. Second, we must listen to communities about their experiences and concerns around air quality. Finally, we should work in partnership, sharing skills to achieve better outcomes faster.

While tackling poor air quality requires systemic change, there are also things we can do as individuals, businesses, organisations, and stakeholders working on air pollution, as outlined below.

INDIVIDUALS

As individuals, we can play a role to address air quality concerns. We can take action to reduce our own exposure to poor quality air, reduce the amount we each contribute to it, and increase our understanding of air quality and its health effects.

Everyone's circumstances are different, which affects our capacity to take action and adjust our behaviour. Some people are less able to move away from busy streets, or reduce car use, for example. That is why individual action, while important, can only go so far. The key drivers to address air quality must be systemic, addressing underlying issues like poverty, employment, and housing. Below are some ideas of how to get started on individual action.

Ten tips for individuals

1. **Reduce your car use**. Swap to more active travel journeys if you can.
2. **Don't idle your engine**, especially around schools, care homes, and hospitals.
3. **Choose clean delivery** options, and click and collect, when shopping.
4. **Use clean fuels** to heat your home and cook. Avoid wood burning if you can.
5. **Sign up for airTEXT** alerts to know when air pollution levels are high. Adjust your behaviour to contribute less to air pollution on these days. If you are particularly vulnerable to the health effects of air pollution, you may wish to avoid high pollution areas on these days.
6. **Learn more about air quality**, improving it, and protecting yourself and others. Find out more at Clean Air Hub.
7. **Use your voice.** Speak to stakeholders in your community – like schools and employers - about air quality improvements. Respond to government consultations.
8. **Take collective action** by joining air quality movements like Clean Air Day.
9. **Consider the products you use in your home** such as air fresheners, candles, and cleaning products**.** Try to reduce use or use in well-ventilated rooms to improve indoor air quality.
10. **Consider the materials you use when renovating your home.** Try to look for low VOC paint, furniture, or flooring, and keep rooms well ventilated to reduce the health impacts of VOCs like formaldehyde.

BUSINESSES & ORGANISATIONS

Businesses and organisations also have a role to play in improving air quality. They can support staff to choose options that are good for air quality, opt for measures that improve air quality in work spaces, and make wider decisions that reduce their contribution to air pollution.

Many organisations already take climate change seriously. Given the crossover with air quality, linking these agendas can be a quick win. Below are some actions businesses and organisations may wish to consider to improve air quality in work places and practices.

Ten tips for businesses and organisations

1. **Make your organisation's transport and deliveries greener.** Consider using cargo bikes.
2. **Don't idle vehicles**, and encourage anyone visiting your organisation - especially if it is a school, health service, or care home - to do the same.
3. **Make it easier for staff to travel by foot, bike, or public transport.** Consider bike buying schemes, cycle storage facilities, and flexible work hours.
4. **Use clean fuels** to heat work spaces.
5. **Monitor your organisation's air quality emissions** alongside greenhouse gas emissions. See this air pollution reporting pilot.
6. **Support staff to learn more about air quality.** Find out more at Clean Air Hub.
7. **Make the air in work places cleaner.** Maintain ventilation and air cleaning systems. Take steps to eliminate or minimise indoor air pollution sources like damp and mould, and choose lower VOC cleaning products and building materials. Consider home working environments too.
8. **Consider the air pollution impact** of all work. Embed more clean air-friendly options where possible.
9. **Inspire others by sharing examples of your good practice.** Consider partnerships to pilot innovative ideas, for example with Impact on Urban Health.
10. **Incorporate air quality into a workplace or wellbeing job role.**

WIDER STAKEHOLDERS

Learning from each other, contributing our own strengths, and working in partnerships is a great way to accelerate progress on air quality, as demonstrated by many of the case studies in this report. Below are some actions stakeholders working to improve air pollution, like the Council and others, may wish to consider.

Ten tips for stakeholders working on air pollution

1. **Integrate action on air pollution and climate.** Focus on actions that provide a win-win scenario for both. For example, encourage active travel and prioritise green spaces.
2. **Involve communities** in project planning and decision-making. Use culturally aligned human stories to engage and represent the community in any air quality information that is produced or shared.
3. **Ensure interventions do not reinforce existing inequalities** and sources of ill health.
4. **Target interventions** towards places where people who are more vulnerable to the health effects of air pollution spend their time, for example schools, health services, and care homes.
5. **Trial innovative pilot projects.** Share learnings and invite others to take on similar work. Engage with researchers to continue to build the evidence base, especially around indoor air quality.
6. **Enforce existing regulation** to ensure that policy translates into practice.
7. **Make use of available data and evidence** on air quality, for example LAQN, Breathe London, and airTEXT.
8. **Provide information about and raise awareness** of the health effects of air pollution, how to protect ourselves from it, and how to reduce sources.
9. **Pursue partnerships** to accelerate progress and share skills. Strengthen collaboration with local health partners.
10. **Focus on particulate matter emissions**, in particular, because NO_2 is trending down. Include interventions related to construction, commercial cooking, and domestic wood burning.

SUMMARY

Indoor and outdoor air quality are important health issues in Southwark. Although there have been significant improvements in recent years, air pollution levels are still extremely high. The social justice aspect of air pollution compounds its importance, while links with climate action offer opportunities to accelerate progress.

The Council and partners are well placed to drive change in this area through our work monitoring air pollution; raising awareness of the health effects and solutions; cleaning up our buildings, transport, and processes; working alongside communities; and inspiring change through pilot projects and partnerships.

While truly addressing air pollution and its systemic causes requires national and global action, there is much we can do as individuals, businesses, organisations, and stakeholders working on air quality. Indeed, it is clear from the case studies in this report that a great deal of important, innovative work is already happening in the borough. Now, as ever, there is a need to ensure that equity, community engagement, and strong partnerships continue to be central to our approach.

Find out more

- Southwark Council's Air Quality Joint Strategic Needs Assessment
- Southwark Council's Air Quality Action Plan 2023 – 2027
- Chief Medical Officer's annual report 2022: air pollution
- Air quality and emissions in construction
- Air pollution and climate change: two sides of the same coin

PROGRESS ON LAST YEAR'S ANNUAL PUBLIC HEALTH REPORT

Last year's Annual Public Health Report focused on the value of partnership working through the COVID-19 pandemic. The report made five key recommendations. Progress against them is summarised below.

Recommendation 1: Work more closely with residents to listen to their concerns about health and wellbeing, and work together to design and implement solutions. In order to make collaboration part of residents' everyday life, we should meet our residents in community venues such as mosques, churches, local shops and youth centres.

Progress:

- A community research project was commissioned, delivered by Social Finance and Centric. It focused on developing strategic approaches to building trusting relationships between health and wellbeing partners and local communities. Recommendations from this work have been fed into the health and care system via Partnership Southwark.
- Southwark Council's public health division recruited more community health ambassadors, creating a valuable feedback loop between local communities and health services. The network members are broadly representative of the residents of Southwark (around 70% from ethnic minority backgrounds). They are well connected in their communities, with over 80% involved in a VCS (Voluntary and Community Sector) organisation, and over 50% in a faith group.
- Other examples of work involving co-production involve workshops with men over 45 from ethnic minority backgrounds to inform the design and delivery of the men's healthy weight services, and the age-friendly borough project. For the latter, community engagement events (including visits to local community groups and a shopping centre) have been used to engage older residents in conversations about how the Council can make Southwark more 'age-friendly'.
- Partnership Southwark have a number of specific programmes of work that involve closely working with residents. For example, through 1,001 Days, a series of community workshops were held in local venues in Camberwell. Through the Age Well work stream, leg ulcer clinics were visited to speak to people and understand the support they are currently accessing.

Recommendation 2: Build on the excellent work of our COVID-19 Community Health Ambassadors to broaden their work across health and wellbeing. This will support a community-led approach to health improvement.

Progress:

- Since the beginning of the Community Health Ambassador programme in October 2020, the network has grown in both size and scope. Originally the Ambassador network focussed on COVID-19. Since then, the range of topics covered has widened significantly to include mental health, cost of living and financial wellbeing, healthy eating and healthy weight, healthy lifestyle support, wider vaccination programmes, and cancer awareness and screening.
- The network now has over 140 volunteer Ambassadors, many of whom support local events and activities, such as Southwark Warm Spaces, wellbeing kiosks in libraries and other public spaces, and public events organised by VCS and statutory sector partners.
- Recent developments include developing paid Ambassador roles that will offer an opportunity to develop their own interests and projects. There is also a wider offer to the network to support events that Ambassadors would like to design and deliver.
- Funding for the network is currently in place until March 2024.

Recommendation 3: Continue to support our schools, universities and care settings with a wider focus on health and wellbeing. For example, support schools with promoting healthy eating and support care homes with seasonal vaccination programmes.

Progress:

Schools: Strengthened the relationships with schools during COVID-19, working with the education team to:

- Support school leaders to improve uptake of school aged immunisations
- Offer support and guidance to facilitate communications with parents
- Provide logistical support to the immunisation teams, including during the 2022 surge Polio vaccination campaign and the 2022/23 surge in Strep A cases.

Universities: Supported universities through student engagement and information around immunisation, and raising awareness of Monkeypox during the UK outbreak in summer 2022.

Adult Social Care: Worked with providers and system partners to improve the health and wellbeing of staff and residents by:

- Providing funding for care homes for air filter units to improve indoor air quality and reduce the spread of infectious disease.
- Providing resources and information to manage extremes of weather and keep staff and residents safe.
- Promoting annual flu vaccinations and COVID-19 boosters through in-person visits.
- Offering free support services to staff for mental health, cost of living concerns, and stop smoking advice.

Recommendation 4: Build on the existing relationships that have strengthened over the pandemic, with partners such as primary care and local hospitals, to deliver NHS services in innovative ways to maximise uptake, especially amongst Black, Asian and Minority Ethnic groups and those living in areas of social and economic disadvantage.

Progress:

- Relationships with primary care continue to strengthen. Examples include additional funding to deliver NHS Health Checks. There has been a particular focus on reducing inequalities from COVID-19, recovering from the pandemic and long-COVID, and improving uptake amongst ethnic minority communities.
- Public Health are working closely with GPs on the Digital Health Check pilot project that is currently being evaluated by Bristol University as part of a National Institutes for Health Research (NIHR) bid.

Recommendation 5: Support voluntary and community sector organisations to always have a seat at the table and to play a principal role where statutory services have in the past traditionally led.

Progress:

- Health Ambassadors support a wide range of public events organised by VCS and statutory sector partners.
- Partnership Southwark funded VCS sector representatives to be heavily involved in their work, including by representation at the Strategic Board and Partnership Executive.
- Partnership Southwark are developing a pilot grant scheme with Community Southwark and United St Saviours to tackle inequalities.

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