Open Agenda

Health and Wellbeing Board

Thursday 19 June 2025
10.00 am
Southwark Council, Ground floor meeting rooms, 160 Tooley Street, London SE1 2QH

Membership

Councillor Evelyn Akoto (Chair)	Cabinet Member for Health and Wellbeing
Dr Nancy Kuchemann (Vice-Chair)	Co-Chair Partnership Southwark and Joint Chair of the Clinical and Care Professional Leadership Group
Councillor Jasmine Ali	Deputy Leader and Cabinet Member for Children, Education and Refugees
Councillor Maria Linforth-Hall	Opposition Spokesperson for Health
Althea Loderick	Chief Executive, Southwark
Hakeem Osinaike	Strategic Director of Housing, Southwark
David Quirke-Thornton	Strategic Director of Children's and Adults' Services, Southwark
Aled Richards	Strategic Director of Environment, Neighbourhoods and Growth, Southwark
Darren Summers	Strategic Director for Integrated Care & Health (NHS South East London)
Sangeeta Leahy	Director of Public Health, Southwark
Alasdair Smith	Director of Children and Families, Southwark
Anood Al-Samerai	Chief Executive, Community Southwark
Peter Babudu	Executive Director of Impact on Urban Health, Guy's and St Thomas' Foundation
Cassie Buchanan	Southwark Headteachers Representative
Louise Dark	Chief Executive for Integrated and Specialist Medicine Clinical Group, Guy's and St Thomas' NHS Foundation Trust
Ade Odunlade	Chief Operating Officer, South London & Maudsley NHS Foundation Trust
Rhyana Ebanks-Babb	Healthwatch Southwark representative

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: 11 June 2025

PRINTED ON RECYCLED PAPER

Health and Wellbeing Board

Thursday 19 June 2025
10.00 am
Southwark Council, Ground floor meeting rooms, 160 Tooley Street, London SE1 2QH

Order of Business

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7. PUBLIC QUESTIONS (15 MINUTES)

To receive any questions from members of the public which have been submitted in advance of the meeting in accordance with the procedure rules. The deadline for the receipt of public questions is 11.59pm Friday 13 June 2025.

14. ANY OTHER BUSINESS

Date: 11 June 2025

Agenda Item 1

Southwark Health & Wellbeing Board: Plan on a page

Our vision and priorities

Our **vision** is that "people in all our communities have good health and wellbeing, living healthier as well as longer lives".

Our **priorities** are set out within the Joint Health & Wellbeing Strategy, with the Board focusing on four aims within these themed areas:

A Healthy Start in Life	Healthy Work & Lives	Support to Stay Well	Healthy Communities
Board's priority aims:			
Ensure all families in Southwark benefit from access to good quality maternity care and holistic support during the first years of life, reducing differential outcomes for Black women and families	Increase access to good quality jobs, providing support to those facing systemic inequalities and barriers to employment	Ensure that there are effective and accessible services that prevent illness and promote wellbeing, including measures to tackle "The Vital 5"	Ensure Southwark residents have access to good quality homes, streets and environments that promote good health and wellbeing

Our duties

The Health & Wellbeing Board has a number of duties required by law:

- Joint Strategic Needs Assessment
- Joint Local Health & Wellbeing Strategy
- Pharmaceutical Needs Assessment
- Oversight of Better Care Fund and Health & Care Integration

In addition, the Board will receive the following updates from members and partners:

- Local Health & Care Plan
- NHS Joint Forward Plan
- Annual Public Health Report
- Annual Health Protection Report
- Healthwatch Annual Report
- Suicide prevention strategy
- Air Quality Annual Status Report

Agenda Item 6

HEALTH AND WELLBEING BOARD

MINUTES of the Health and Wellbeing Board held on Thursday 13 March 2025 at 10.00 am at Ground Floor West - Southwark Council, 160 Tooley Street, London SE1 2QH

PRESENT:
Councillor Evelyn Akoto (Chair)
Dr Nancy Kuchemann (Vice-Chair)
Councillor Jasmine Ali
Councillor Maria Linforth-Hall
Toni Ainge
Hakeem Osinaike
Alasdair Smith (representing David Quirke-Thornton)
Rebecca Jarvis (representing Darren Summers)
Sangeeta Leahy
Anood Al-Samerai
Peter Babudu
Cassie Buchanan
Louise Dark
Ade Odunlade
Rhyana Ebanks-Babb

OFFICER SUPPORT:
Chris Williamson, Assistant Director - Place, Partnerships & Intelligence
Maria Lugangira, Principal Constitutional Officer

1. WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

2. APOLOGIES

Apologies for absence were received from;
- Althea Loderick
- David Quirke-Thornton
- Darren Summers

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 14 November 2024 were approved as a correct record of the meeting.

7. PUBLIC QUESTION TIME (15 MINUTES)

Supplementary follow up from Miles Lloyd, Southwark Community Health Ambassador and Development Manager at London Sport, Southwark Based Charity. Miles Lloyd will be meeting with Jardine Finn, Outdoor Recreation Manager (Southwark) on how to best align Southwark council and London Sport approach in order to levy funding from sport England.

ACTION: Toni Ainge Acting Strategic Director of Environment Sustainability and Leisure to follow up with Jardine Finn, Outdoor Recreation Manager (Southwark) on the outcome of the meeting with Miles Lloyd and ensure work is taken forwards.

ACTION: Anood Al-Samerai Chief Executive, Community Southwark to provide the Acting Strategic Director of Environment Sustainability and Leisure with information on the outcome of the meeting between Community Southwark, the Children Families and Young People network and Rotherhithe youth providers on funding for physical activity

8. HEALTHWATCH UPDATE AND RECOMMENDATIONS FROM BLACK MENTAL HEALTH REPORT

Rhyana Ebanks-Babb, Healthwatch Southwark (HWS) Manager presented the item. The Board were provided with some background as to why Healthwatch undertook this research project which focused on Black African and Caribbean communities and the inequalities they face in accessing mental health care. The projects main aims were to;

- Develop relationships with residents
- Provide a platform

- Find out the key issues so that it can be shared with the decision makers to drive change.

This was a 2-year project undertaken in 2 phases. Part 1 consisted of a survey of people's experiences and focus groups to address questions collectively. Part 2 focused on groups and 1:1 interviews to meet participants preferences. The summary and 8 recommendations resulting from this project can be found as an appendix to these minutes.

Healthwatch's ask of the Board

When planning the following initiatives;

- Joint Health and Wellbeing Strategy action plan 2025-27
- Partnership Southwark Health and Care Plan
- Southwark 2030 goal for "staying well"

that they are assessed through the lens of Black empowerment and Black liberation and that HWS are informed of how their work informs the above initiatives, with recommendations. How the work streams have been influenced so as to enable HWS to not only report back to the communities that have been involved but also help enable them to explore how their work has impacted communities within Southwark.

Next Steps for Healthwatch Southwark

Alongside working and promoting their work, Healthwatch Southwark not only sought formal responses from providers, but they will (i) continue sharing their findings with communities, (ii) present those finding to key decision makers such as the Health and Wellbeing Board and (iii) track the progress of providers at 6 and12 month reviews.

Based on their research HWS found that people do not know what is available in the Borough, therefore they have created a directory of services that are available on their website (Black Mental Health Service Directory | Healthwatch Southwark). They ask that this is shared with staff, service users, partners. The printed versions of this directory will be available in the coming weeks.

Ade Odunlade, Chief Operating Officer, South London & Maudsley (SLAM) NHS Foundation Trust provided a brief overview of the work currently being undertaken by SLAM to address some of the issues highlighted in Healthwatch Southwark's findings and mental health overall. Recently SLAM became 1 of 6 pilots across the country in terms of integrated health which is one of HWS recommendations. The pilot is in Lewisham and will be extended to Southwark as well. The aim is to create a neighbourhood service which includes everything ie housing, GPs and all of the services under the same roof, creating one a stop shop.

Rhyana welcomed SLAMs update and proposed that it would be useful for Healthwatch Southwark and SLAM to meet and discuss SLAMs response [**ACTION for Healthwatch Southwark and SLAM]**

Councillor Akoto ask of the Board, as a strategic body what can they do to support the issues raised? How can they ensure there are early intervention services available, and that people know about them and are able to utilise them to help alleviate pressures on GP services. What measures can be put in place to address the pressure being experienced by certain services to support residents?

Rhyana clarified that as part of the work they undertook, the GP Federation were contacted but no response back was received and their feedback would be useful in helping HWS. Rhyana requested of the Vice-Chair of the Health and Wellbeing Board, Dr Nancy Kuchemann could assist with moving this forward by raising it with the GP Federation and encourage them to work with HWS. This will in part enable HWS to understand the issues in aggregating the data or what the access barriers are and what they can do to help support get that information out [**ACTION for HWB Vice-Chair, Dr Nancy Kuchemann]**

Peter Babudu, Impact on Urban Health, proposed he would be keen to discuss how the Healthwatch report could inform joint work between Impact on Urban Health, and SEL ICS on transforming Mental Health services for Black residents **[ACTION for Impact on Urban Health]**

Rebecca Jarvis - Director of Partnership Delivery and Sustainability proposed that the Primary Care Collaborative could support with taking forward this conversation and that she would review the agenda to see if Healthwatch could present there **[ACTION for Rebecca Jarvis]**

9. ANNUAL PUBLIC HEALTH REPORT

Chris Williamson, Assistant Director Place Partnerships & Intelligence presented the item which this year highlighted work across the borough to both improve health and reduce inequalities.

The report highlighted the key principals (page 89) that partners are asked to adopt to successfully help tackle inequalities and examples of services and programmes in place to help achieve this (page 94-98). Set out below are recommendations for partners across the borough which aim to improve health of all residents and communities in Southwark.

1. Refresh the Joint Health & Wellbeing Strategy action plan alongside Southwark 2030 and other key system plans, ensuring sufficient action and resources are focused on improving the wider determinants of health, not just the health & care system.
2. Embed a culture of co-design with residents, utilising community research and opportunities such as the Southwark Insight & Intelligence Programme to spread good practice.
3. Implement policies and guidelines to ensure services across the health and care system are welcoming, inclusive, and affirming environments, such as Safe Surgeries and Pride in Practice.
4. Develop and implement cultural competency training and certification for staff across the health and care system.
5. Secure long-term, mainstream investment in targeted outreach services that focus on disadvantaged and marginalised communities in the borough
6. 6. Develop integrated service models that address the diverse needs of

residents, including physical, mental, and social well-being
7. Develop clear guides on navigating the health and care system, particularly aimed at residents born outside the UK, whilst also seeking opportunities to simplify accessibility of services.
8. Ensuring the consistent availability of reliable translation services and increasing the number of bilingual service providers.
9. Collaborate with trusted community and voluntary organisations to both engage residents and to deliver advice and support.
10. Improve and enhance data collection for marginalised communities across all health and care services, so that we can monitor improvements in access, experience and outcomes.

RESOLVED - That the Health and Wellbeing Board notes the findings of the Annual Public Health Report (APHR) 2024-25 and supports the recommendations.

10. SOUTHWARK JOINT HEALTH AND WELLBEING STRATEGY ACTION PLAN 2025-27

Rosie Dalton-Lucas - Head of Place and Partnership and Alice Fletcher-Etherington - Public Health Programme Manager presented the item which provided the Board with an update on the new action plan and outcomes framework approved in November 2024.

It was agreed that new action plan and outcomes framework should be developed with actions that:

- Are fewer in number but larger in potential impact
- Are ambitious and innovative, instead of business as usual
- Are focused on partnership working in order to address the wider detriments of health
- Align with Southwark 2030 and other borough-wide strategies

Since November 2024 work has been undertaken with teams, staff, partners from the organisations represented on Health and Wellbeing Board, plus a range of partnership Southwark forums and VCS partners in order to develop the action plan. The following were identified;

- Amendments to ensure aims to reflect need and properties
- Actions to build on progress from the previous action plan
- Actions to address gaps in work to deliver the aims of the Strategy
- Actions to address the recommendations from the Joint Strategic Needs Assessment (JSNA)

All actions in the Strategy were co-developed and agreed with staff in the organisation that own those actions with a draft report presented to Partnership Southwark and senior officers for comment prior to submission to the Health and Wellbeing Board. 4 priority areas were identified;

1. A health start in life
2. Healthy work and lives
3. Support to stay well

4. Healthy communities

The new action plan also ensures that it captures some of the recommendations from the Annual Public Health Report.

To support prioritisation of 44 actions set out in the report, the following 14 actions were identified and recommended to become *drive actions* for the Board.

A Healthy Start in Life	**Healthy work and Lives**
▪ Southwark Maternity Commission ▪ SEND Children and Family Hub ▪ Local Child Health Teams 1.	▪ Connect to work ▪ Expanding physical activity and provision in the community ▪ Addressing barriers to active trave 2.
Support to stay well	**Healthy Communities**
▪ Hubs for Health ▪ Southwark's Wellbeing Hub ▪ Women's Safety Centre ▪ Support for carers	▪ Anti-Poverty plan ▪ Air quality monitoring ▪ Integrated housing and health care support ▪ The Local Plan

These actions were selected on the basis that they could do with effective partnership working across the agencies represented in order to ensure that they are delivered effectively. The 14 actions sit across all four priorities with the aim of ensuring good representation of the different organisations that own the actions. Public health will support the prioritisation by using the 14 actions to shape the Board's forward plan so that there is specific focus on the actions. With regards to the delivery of the other 30 actions the intention is that it'd be the Board's responsibility to monitor the impact and progress of those actions and identify where progress might not be occurring.

With regards to the action on the '*Establish a new Women's Safety Centre that is integrated with wider health, employment, housing and financial support services*' there was discussion as to whether this was a feasible driver for the Health and Wellbeing Board. It was agreed to remove it from the list of *drive actions* given that the nature of its delivery and monitoring would primarily sit elsewhere within the council.

RESOLVED - That the Health and Wellbeing Board;

1. That the Health and Wellbeing Board approved the Joint Health and Wellbeing Strategy action plan for 2025-27
2. That subject to the removal of the action '*Establish a new Women's Safety Centre that is integrated with wider health, employment, housing and financial support services*' from the list of the 14 drive actions the Health and Wellbeing Board agreed the remaining 13 "drive" actions selected.

11. MATERNITY COMMISSION – VERBAL UPDATE

Rebecca Jarvis - Director of Partnership Delivery and Sustainability on behalf of the strategic Director for Integrated Care & Health provided a brief verbal update on the production of the action plan following the publication of the Maternity

Commission report.

Progress areas highlighted

- The Local Maternity and Neonatal System (LMNS) and Public Health have been working on developing a set of actions that will eventually be formalised into a single comprehensive draft action.
- A programme board has been with representation from the LMNS and Public Health, VCS, a clinical lead who is a midwife and works with Partnership Southwark. The Board is chaired by Darren Summers as the Senior Responsible Officer (SRO). Programme management support has been identified and the intention is to report back on the action plan at the June meeting of Board.
- Preconception health i.e health before pregnancy has been identified and included as priority are for ICB Women's Health team.
- National programmes: All South East London maternity services have reached compliance with the maternity incentive scheme. Saving babies' lives care bundle has been implemented.

The updated action plan will be presented to the Board at it's June meeting **[Action for Strategic Director for Integrated Care & Health]**

12. DELIVERY OF CONNECT TO WORK IN SOUTHWARK

Danny Edwards, Assistant Director of Economy provided some background context on the Connect to Work programme. This programme will provide a real opportunity for the Council to support Southwark residents into employment, many of whom have long health conditions. Key to the success of the programme will be integration, particularly with health services.

Nick Wolff, Employment and Skills Manager present the item and provided further detail on this major new employment support programme that is focused on helping people with physical and health conditions and disabilities into employment. The programme link into one of the action set out in the Southwark Joint Health and Wellbeing Strategy action plan 2025-27 (Item 10).

One of the key aspects of the programme is that it's designed to be delivered locally and cantherefore be shaped locally. The development of the delivery model in Southwark involved extensive engagement with council and NH S teams to map services, raise awareness of the offer and co-produce an approach to delivery that fits with the local landscape of provision. Key services were engaged across Public Health and Partnership Southwark, Primary Care delivery, Children's Service, Adult Social Care, Communities and Housing Solutions.

Peter Babudu, Impact on Urban Health, proposed further liaising with Danny Edwards and Nick Wolff on this item **[Action for Strategic Director for Integrated Care & Health]**

RESOLVED- That the Health and Wellbeing Board noted the plans for embedding employment support within primary care, secondary care and community health services through the Connect to Work programme, which will contribute to the delivery of the revised Health and Wellbeing Strategy action plan.

13. JOINT FORWARD PLAN – 2025/26 REFRESH

Rebecca Jarvis, Director of Partnership Delivery and Sustainability presented the item.

RESOLVED – That the Health and Wellbeing Board;

1. Noted the draft NHS South East London Integrated Care Board Joint Forward Plan refresh for 2025/26.
2. Confirmed that it considered that the refreshed Joint Forward Plan continues to take proper account of the priorities and actions outlined within the Southwark Joint Health & Wellbeing Strategy.

15. ANY OTHER BUSINESS

The Chair reminded members about the board development feedback workshop on 2nd April, 10.30-12.30.

Towards Inclusive Healthcare: Rethinking mental health services for Black African and Caribbean communities in Southwark

This report looks at how Black African and Caribbean communities in Southwark view mental health services.

The research involved **79 participants**, and had two main parts:

- **General Opinions**: Surveys and focus groups gathered broad views on mental health services.
- **Focus on Black Men**: Specific focus groups and interviews explored Black men's views on non-clinical mental health support.

What did we learn?

1. Barriers to support

Stigma, distrust of services, and a lack of awareness about available support, especially for preventive care, were major obstacles. Black men faced the greatest challenges in accessing support due to these barriers.

2. Isolation is a major factor

Isolation was a key contributor to poor mental health among Black men. Many use **informal coping methods**, such as spending time with friends or listening to music, rather than seeking help through mental health services.

3. Interest in non-clinical support

Participants showed a strong interest in **non-clinical support options** like peer groups, exercise, and creative activities. However, a lack of information about how to access these services continues to be an issue.

What can be done?

Community-based services were seen as essential for reducing stigma and providing care that feels safe and inclusive. For example, **shared experience between service providers and users** can make people feel more comfortable.

> "Offer more talking therapy and small community groups, not just medication to Black people. Work with organisations who specialise with Black people to find the right approach."
>
> -Participant

healthwatch Southwark

Recommendations

1. Provide **long-term funding** for community-based mental health services.

2. Create **projects aimed at preventing** mental health issues for Black men, e.g. through arts, exercise and wellbeing activities.
3. Offer **training and support** to community groups and local leaders, so they can help people in community spaces to access mental health support.

4. Encourage different organisations, like the NHS, Social Care and community groups, to **work together** to make sure people get the help they need.
5. Make sure all mental health services **follow the Patient and Carer Race Equality Framework** (PCREF) and let communities know how this has improved patient experience.

6. Organise a **'Taster Day' event** to showcase community services, so people can learn more about what support is available.

7. Work with community-based services to understand what support they might need, and **share knowledge** about how best to support Black communities with their mental health.

8. Launch a **mental health awareness campaign** focused on Black men, using accessible language and highlighting examples of Black men who have had good experiences using mental health services.

Agenda Item 8

Meeting Name:	Health and Wellbeing Board
Date:	19 June 2025
Report title:	A healthy start in life progress update
Ward(s) or groups affected:	All wards Key population groups (as defined by Southwark's JSNA) affected by decision/recommendation: ☐ Carers ☒ Residents with disabilities ☐ LGBTQIA+ residents ☐ Asylum seekers and refugees ☐ Rough sleepers ☒ Black and ethnic minority communities ☐ All
Classification:	Open
Reason for lateness (if applicable):	Not applicable
From:	Alice Fletcher-Etherington, Public Health Programme Manager

RECOMMENDATION(S)

1. That the Health and Wellbeing Board notes progress updates, outcome measures and requests for the board related to the "A healthy start in life" priority of the Joint Health and Wellbeing Strategy action plan 2025-27, to inform discussions at the Health and Wellbeing Board meeting on 19 June 2025 and support the activity of board members outside of meetings.
2. That the Health and Wellbeing Board comments on the usefulness of this update, and whether different content or structures should be considered for future updates, by contacting Chris Williamson.

PURPOSE OF THE ITEM

☒ Item relates to Joint Health and Wellbeing Strategy: *Priority 1 (A healthy start in life)*
☐ Statutory item
☐ Other

POINTS TO NOTE

3. An update on the actions and long-term outcome measures associated with "A healthy start in life" are provided below. Please note that differences between the values given for the long-term outcomes (between years or between Southwark and London) may not be statistically significant. The traffic light system depicted is to be used as a visual guide and should not be used to draw definite conclusions.

ACTION UPDATE

Action	Drive?	HWB lead	Operational lead	Progress update	Requests for the board	Short-term outcome update
1.1: Develop and implement an action plan to address the recommendations of the Southwark Maternity Commission	✓	Darren Summers	Claire Belgard	Action plan is being presented to the board on 19 June	To be covered in paper presented to the board.	N/A - Outcome measures to be defined within the action plan
1.2: Work with the VCS to fund and run culturally appropriate and inclusive workshops on maternity rights for pregnant people and new families		Sangeeta Leahy	Megan Velzian	A "Conversations with the Midwife" event was held in October 2024. Following the success of the event and positive feedback, work is ongoing to explore how these events can be run more regularly.	A diverse panel is essential for these events; support from Board members in influencing professionals to act as panel members would be helpful.	N/A – Extended programme has not yet started
1.3: Promote engagement with the Baby Buddy app, focusing on ensuring pregnant people are informed of the app at points of contact with the NHS and community services		Alasdair Smith	Paula Hill	The Baby Buddy app is embedded as part of our Family Hubs & Start for Life offer. The marketing materials such as pop-up banners are displayed at both Kings College and Guys and St Thomas's Hospital. There are also a number of flyers with various support groups including the breastfeeding networks and stickers have now been placed in a number of the personal child health records (red book).	None at present	Over **50 professionals** have attended awareness training. Between Oct 2023 and Jan 2025 there have been **617 app registrations.** Ethnicity break down of Baby Buddy users (as of January 2025): White: 50% Black: 12.9% Mixed: 10% Asian: 9.9% Other: 5.7%

1.4: Develop an evidence-based and integrated early intervention offer through the SEND Children and Family Hub, providing support to children with early developmental needs prior to diagnosis	✓	Alasdair Smith	Michael Crowe	A suite of evidence-based interventions have been mobilised over the past 18 months and is delivering positively for children with SEND and their families. This includes the WellComm Assessment tool, the Early Words Together and the Making it Real Programme.	Capital works to the proposed SEND Children & Family Hub are in progress, the Board are asked to continue supporting the plans to integrate and co-locate functions within the SEND Hub once fully operational.	N/A – Programme has not started yet
1.5: Deliver a consistent programme of drop-in sessions at Family Hubs, Children and Young People's Development Centres and special needs schools to provide support around common issues for children with early developmental or additional needs				We are developing a series of parent workshops for children on Community Paediatric waiting lists, relating to the areas of Sleep, Toileting, Behaviour, Feeding. We have made contact with two children's centres (Henry Fawcett in Lambeth, and Coin Street in Southwark) who are interested in supporting a pilot. We are additionally working with the SEN School Nursing team to be able to run workshops at some SEN school sites and aim to also deliver workshops at Sunshine House and Mary Sheridan Centre, to offer a variety of locations/settings for families to access. We are working through the operational running of the sessions, to ensure a sustainable and efficient process is in place. We aim to start the pilot workshops in autumn 2025.	None at present.	N/A – Programme has not started yet

1.6: Develop a joint commissioning strategy for speech and language therapy, with the aim of addressing local needs and increasing provision of evidence-based interventions		Darren Summers	Tony Parker	We are developing a transformation programme for our speech and language provision for CYP in the borough. A steering group has been established and a project plan is being developed.	Support the programme as it develops.	N/A - Outcome measures will be defined by the steering group.
1.7: Review and widen access to and uptake of existing parenting intervention services, as part of a community-based offer to prevent adverse childhood experiences (ACEs)		Alasdair Smith	Paula Hill	The Southwark parenting team have recently moved into the Community Family Help and Support service which is aiming to build on the existing community-based offer. A review of the parenting offer has been completed and action plan identified, including the need to build on existing mapping of the partnership offer to begin development of a shared Parenting Strategy for Southwark. A self-referral form was introduced in December 2024.	Board should be aware that the introduction of the self-referral has increased demand.	**58 of the 292** referrals received between Jan and March 2025 were self-referrals (20%). Self-referral has increased by 4% from previous terms. Percentage of parents showing increase in confidence in parenting or goals met – will be provided in next update.
1.8: Review the current mental health offer in schools and other educational settings to ensure quality, equity and consistency of programmes and identify gaps in coverage and provision		Alasdair Smith	Jenny Taylor/Daniel Hooper	IMHARS Evaluation Report has been finalised and shared with partners. A subgroup has been tasked with going through the recommendations and is due to meet in July. It is suggested that the SHEU survey is completed biannually (with the next being in 2025/26), but this has not been confirmed.		**1,013** pupils have conducted the Lancaster Model questionnaire since September 2024.

				The first year of implementation of the Lancaster Model has focused on 10 primary schools and 10 secondary schools, in areas of high deprivation and high levels of obesity, poor dental health and absenteeism. The top five areas of concern that have been raised by pupils are “help and support”, “safety”, “body image”, “diet” and “drug use”.		
1.9: Develop a programme of support for schools to prevent and respond to child death and self-harm, working in partnership with the aim of addressing local needs		Sangeeta Leahy	Liz Brutus	A standing operating procedure (SOP) to support schools after a sudden unexpected death of a child is in the process of being developed by Public Health in collaboration with a range of relevant partners. The developing SOP is based on national best practice and evidence however it is being tailored to the local Southwark context with a strong focus on its practical application for these difficult and emotional events.	None at present	N/A – SOP not yet developed.
1.10: Deliver a new programme to develop the role of health visitors in engaging with families around childhood vaccinations, targeting population groups with the lowest uptake		Darren Summers	Denise McLeggan	Agreement for programme to commence from 1 July 2025, contract and service specification in development. Active recruitment has commenced for dedicated health visitor to lead and deliver service,	None at present	N/A – Programme not started yet

				contingency plan in place to support roll out if delays with recruitment. Jitsuvax training provided to existing staff to support with vaccine hesitancy conversations.		
1.11: Review development and skills needs of early years workforce (across childcare, community services, healthcare and education) in relation to topics such as perinatal mental health, neglect, identification of ACEs, early response to developmental issues and maternal obesity, and embed a joined-up training offer		Alasdair Smith	Paula Hill	There is a workforce development review being undertaken as part of the implementation of the Children & Family Hub programme. The Family Hub and Start for Life steering group has agreed this will become a workstream from July 2025.	None at present.	N/A – Programme not started yet
1.12: Expand and extend the role of Local Child Health Teams to deliver interventions and signposting to tackle the wider determinants of child health, linking the teams with a broader range of children and family services	✓	Louise Dark	Eleanor Wyllie	Core local child health teams continue to operate as part of business as usual. We plan to build on local child health teams as 'integrated neighbourhood teams' are developed, to support children with complex needs.	Highlight anything the Board could support with.	N/A – Programme not started yet

LONG-TERM OUTCOMES

Aim	Long-term population health target	Baseline Indicator (year)	Measured Indicator (year)	Direction of travel	London Average (Year)	Comparison to London
Ensure all families in Southwark benefit from access to good quality maternity care and holistic support during the first years of life, reducing differential outcomes for Black women and families	Reduction of the gap in % of stillbirths to mothers born outside of the UK compared to mothers born in the UK	0.20 pp (2022)	0.34 pp (2024)		0.22 pp (2024)	
	Reduction in infant (< 1 year) mortality rate	3.8 (2022)	2.8 (2023)		3.3 (2023)	
Provide early interventions and support for children with early developmental needs and special educational needs and disabilities	Increase in % of children with free school meal status achieving a good level of development at the end of Reception in Southwark	57.8% (2021/22)	61.5% (2023/24)		58.3% (2023/24)	
	Reduction in the gap in average Key Stage 4 attainment between all pupils and pupils with SEN support	9.8 pp (2022)	8.6 pp (2023)		12.5 pp (2023)	
Promote good mental wellbeing and prevent mental illness in children, young people, and	Increase in % of Year 4 and 6 children who are very happy or happy with their life	75% (2016*)	67% (2023/24)		Data not available	Data not available

families	Reduction in rate of hospital admissions as a result of self-harm (10-24 years old)	261.2 per 100,000 (2021/22)	106.5 per 100,000 (2023/24)		125.6 per 100,000 (2023/24)	
Accelerate the reduction in childhood excess weight and obesity in Southwark	Reduction of the gap in % Year 6 children with excess weight between white and Black, Asian and ethnic minority children	4.7pp (2021/22)	2.5pp (2022/23)		Data not available	Data not available
Ensure the sustained uptake of life-saving childhood vaccinations	Reduction in the gap in MMR first dose coverage by 18 months between white and Black, Asian and ethnic minority children	Data not available	11.7 pp (June 2025)	N/A	7 .3 pp (June 2025)**	

Key

	Description
pp	Percentage Points
	Positive increase for the measure
	Negative increase for the measure
	Positive decrease for the measure
	Negative decrease for the measure
	Positive comparison to London
	Negative comparison to London
*	Most recent baseline data available
**	Data for South East London

KEY ISSUES FOR CONSIDERATION

Policy framework implications

4. There is a statutory responsibility for the Health and Wellbeing Board to produce a Joint Health and Wellbeing Strategy and provide assurance that the strategy is being delivered effectively to improve the health and wellbeing of the population.

5. The 'A healthy start in life' priority area is contributing to the Southwark 2030 goals of "A good start in life" and "Staying well".

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

6. Outcome measures have been designed to reveal the impact of these actions on health inequalities.

Climate change implications

7. None identified.

Resource, legal and financial implications

8. Resource, legal and financial decisions that relate to the delivery of individual actions will be taken separately and considered through the appropriate budget, monitoring and governance processes of the relevant organisations.

Consultation

9. The consultation process that was followed to develop the Joint Health and Wellbeing Strategy Action Plan 2025-2027 is described in the report *"Southwark Joint Health and Wellbeing Strategy action plan 2025-27"* presented to the Health and Wellbeing Board on 13 March 2025.

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS

Assistant Chief Executive, Governance and Assurance

10. None sought.

Strategic Director of Resources

11. None sought.

Other officers

12. None sought.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
Southwark Joint Health and Wellbeing Strategy action plan 2025-27	Public Health, Southwark Council	Alice Fletcher-Etherington, PublicHealth@southwark.gov.uk

AUDIT TRAIL

Lead Officer	Rosie Dalton-Lucas, Head of Programme (Place & Partnerships), Public Health
Report Author	Alice Fletcher-Etherington, Programme Manager (Place & Partnerships), Public Health
Version	Final
Dated	6 June 2025
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 Resources	No	No
List other officers here	N/A	N/A
Cabinet Member	No	No
Date final report sent to Constitutional Team		6 June 2025

Agenda Item 9

Meeting Name:	Health and Wellbeing Board
Date:	19 June 2025
Report title:	Discussion Points from Southwark Health of the Borough Event – 8th May 2025.
Ward(s) or groups affected:	All wards Key population groups (as defined by Southwark's JSNA) affected by decision/recommendation: ☐ Carers ☐ Residents with disabilities ☐ LGBTQIA+ residents ☐ Asylum seekers and refugees ☐ Rough sleepers ☐ Black and ethnic minority communities ☒ All
Classification:	Open
Reason for lateness (if applicable):	Not applicable
From:	Rosie Dalton-Lucas, Head of Place and Partnerships

RECOMMENDATION(S)

1. That the Health and Wellbeing Board notes the discussion points raised at the Southwark Health of the Borough Event.

2. That the Health and Wellbeing Board supports a review by Public Health of the discussion points against the Health and Wellbeing Strategy Action Plan so that these insights can help to shape future actions.

3. That the Health and Wellbeing Board supports further events for statutory and VCS partners to collaborate on health inequalities. The discussions to be hosted in partnership with Community Southwark / Healthwatch Southwark.

PURPOSE OF THE ITEM

☐ Item relates to Joint Health and Wellbeing Strategy:
☐ Statutory item

☒ **Other**: To update Health and Wellbeing Board members on the discussions at the Southwark Health of the Borough Event.

BACKGROUND INFORMATION

4. The Cabinet Member for Health and Wellbeing invited colleagues to attend a 'Health of the Borough' event on 8th May 2025. Over 60 participants attended from a broad range of partners including community and voluntary sector organisations, local councillors, NHS partners and Health and Wellbeing Board members. The purpose of the event was to reflect on the current state of health in the borough, and to identify opportunities for working together to tackle health inequalities more effectively.

5. Public Health presented on the current picture in relation to health inequalities, as well as outlining progress made in the last 10 years. This was followed by a panel discussion involving colleagues from Public Health, Impact on Urban Health, South East London MIND, Partnership Southwark, South London Mission, and the Community Health Ambassador Programme. The panel discussion focused on good practice that members were most proud of, as well as the continuing challenges in relation to health inequalities in the borough.

6. Workshop discussions formed the main part of the event, facilitated by Public Health and VCS partners, supporting participants to consider three questions:
   a) What health and wellbeing challenges and improvements do you see in your communities?
   b) Are there examples of good practice from your own organisations about tackling inequalities?
   c) What additional opportunities are there for us to work together?

7. The notes of this event are being shared with the Health and Wellbeing Board and will be made available to the participants as a record of the discussion.

KEY ISSUES FOR CONSIDERATION

8. The key points emerging from the discussion on each of the three themes are summarised below.

9. **Health & Wellbeing Challenges:** Discussion covered issues such as poor housing conditions, rising poverty (childhood, pensioners, food insecurity), barriers to accessing health services (navigation, digital exclusion, language), fragmented data sharing, and increasing mental health concerns, especially for youth and socially isolated individuals.

10. **Good Practice**: many local services were discussed, with high regard to community-led health outreach programs, culturally tailored services for minority groups, enhanced service accessibility through co-location. Universal services like free school meals and free swim and gym were mentioned as well as NHS social prescribing, staff peer support, and efforts to tackle discrimination and promote equality through training and advocacy.

11. **Opportunities for Collaboration & Improvement**: There was a lot of interest

in how we improve at sharing learning to strengthen our prevention work across the system and how we improve accessibility and trust in mainstream services. Greater integration was called for, as well as more flexible long-term funding for community organisations. Addressing poverty and food security as a determinant of health was seen as a key focal area for the wider system.

12. The table in Appendix 1 provides further detail of discussion points raised within each of the themes.

Policy framework implications

13. The discussions at, and recommendations from, the Southwark Health of the Borough Event represent a significant contribution to the Southwark 2030 principles of "Reducing Inequalities" and "Empowering People" and the goal of "Staying well".

14. The insights gained from the discussions at the Southwark Health of the Borough Event are of direct relevance to the Health and Wellbeing Strategy priorities of "Support to stay well" and "Healthy communities".

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

15. The aim of the event was to discuss data and action to address health inequalities with key partners and to identify opportunities for continuing this work collaboratively.

16. The event was designed to emphasise the value of partnership work in addressing health inequalities, and to highlight the actions that have been shown to have an impact on health and wellbeing.

Climate change implications

17. None identified.

Resource implications

18. Resource, legal and financial decisions that relate to the delivery of individual actions arising from the feedback at the Southwark Health of the Borough event will be taken separately and considered through the appropriate budget, monitoring and governance processes of the relevant organisations.

Consultation

19. The Southwark Health of the Borough Event invited VCS and other partners to share their insights on how statutory and VCS sectors can collaborate more effectively on tackling health inequalities. It formed a consultation exercise on these issues.

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS

Assistant Chief Executive, Governance and Assurance

20. None sought.

Strategic Director of Resources

21. None sought.

Other officers

22. None sought.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
Southwark Health and Wellbeing Strategy Action Plan 2025 - 2027	Public Health Southwark Council	Alice Fletcher-Etherington, PublicHealth@southwark.gov.uk

APPENDICES

No.	Title
Appendix 1	Southwark Health of the Borough Event – Summary of Discussion Points

AUDIT TRAIL

Lead Officer	Rosie Dalton-Lucas, Head of Place & Partnerships, Public Health
Report Author	Ginette Hogan. Public Health Policy and Programme Officer.
Version	Final
Dated	9 June 2025
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 Resources	No	No
List other officers here	NA	NA
Cabinet Member	No	No
Date final report sent to Constitutional Team		9 June 2025

Appendix 1

Southwark Health of the Borough Event – 8th May 2025

Summary of Discussion Points

Theme	Discussion points
Health and wellbeing challenges	**Housing**: • **Housing conditions** : The health impacts (children's, respiratory and mental health) of poor quality housing in the social and private sector were highlighted, particularly damp and mould. • **Access to housing support:** concern was raised regarding the equity of housing allocation process and complexity of housing needs. Significant health challenges associated with homelessness and temporary accommodation also came through the discussions. • **Affordable Housing:** attendees highlighted that it is increasingly hard for families to afford to stay in the borough, meaning many pupils travel to school from out of borough. **Poverty and disadvantage:** • **Childhood poverty:** Many families do not have the resources to meet their basic needs which results in poorer childhood experiences. • **Pensioner poverty:** There was particular mention of older people, with a third of pensioners living in poverty. • **Food poverty:** Particularly in areas of deprivation, with concerns around ease of access to poor quality food and lack of affordable nutritious food **Understanding the health and wellbeing offer:** • **Navigation:** Difficult to locate and compare health and wellbeing service information across the sector, and confusion about roles of different organisations and Council departments.

	• **'Digital by default':** scepticism about this approach and concern that the 'digital divide' could widen health inequalities. • **Language barriers:** present some residents with difficulty accessing information about services. **Research and data:** • **Risk of duplication**: because organisations/ departments collect data differently and sharing data can be difficult. • **Resident involvement:** should be embedded in designing/delivering community research. Research insights/ impact should be fed back to the community. • **Public sector equality duty:** relies on understanding service access so really important we have the data. **Mental health support:** • **Young people:** feeling unsafe, hopeless, and lacking input from parents (due to time and capacity). • **Connectedness:** many people feel isolated / lonely / disconnected from community. • **Resilience:** complexity of needs makes it hard to build and sustain resilience. **Funding cuts/ reduced service capacity across providers:** • **Staff wellbeing:** Poor wellbeing and stress levels of frontline workers especially. • **Meaningful interactions:** Lack of time for deeper conversations to address complex issues. • **Smaller organisations:** Smaller VCS organisations often struggle to access funding.

Improvements seen in our communities	**The health outreach programme**: • **Community Health Ambassadors:** have improved the Vital 5 health check service engagement with residents. • **Improved reach**: to faith and Latin American communities.

	• **Health kiosks:** have improved access to health checks across libraries, leisure and workplaces. **Tailored offers to support inequalities**: • **Black residents:** culturally tailored support for diabetes has been beneficial. • **Faith groups**: are being more engaged as trusted organisations to cascade support to their community members. • **Service users co-producing services:** with organisations such as South East London MIND, Black River Counselling, The Nook, and Queer Finds research project. **Improving navigation and service access:** • **GSTT:** mentioned as good practice for supporting navigation across their service offer. • **Primary care**: Extended access in primary care has been important for improved accessibility. • **Co-location of services**: has benefited access to the Citizen's Advice offer (via roadshows) and Rose Vouchers (food support) which are offered in Children's Centres. **Other developments of note:** • **New alms-houses:** for older residents with more holistic support e.g. Appleby Blue. • **Employment and mental health:** greater acknowledgement of the link between these issues including the mental health benefits of being employed.

Examples of good practice	**Mainstream services:** • **Council services:** Free healthy school meals and the free swim and gym offer, as well as our leisure centres and libraries were all highlighted as examples of good practice. • **Healthwatch Southwark (VCS):** highlighted in relation to its signposting and advice services. • **NHS Social prescribing:** built connections across the system, and working in partnership. There has been a

	doubling of referrals each year demonstrating expansion and success. **Supporting our staff:** • **Peer support services** for frontline workers. • The **South London Early Years Stronger Practice Hub** supporting over 1,000 childminders (nurseries, schools, and childminders) to network and share good practice. **Tackling discrimination and advocating for equality:** • **Training** for statutory services around discrimination and cultural sensitivity. • **Black Thrive** provides projects on employment support, poverty, projects for black women and people going through the prison system. **Mental health:** • **The NEST** helps identify gaps in services for young people and improve access. Focus on multi-agency working in partnership with the Council, CAMHS & schools, ensuring targeted service provision.

Additional opportunities to collaborate / address challenges	**Learning and developing our prevention work together** • **More in-person events to share information,** network and explore how services can be more effective (e.g. learning from Alms-house model) • **More focus needed on evaluation** of interventions across the system to determine what interventions are working best. **Collaborate across sectors, with service users, and at place level:** • **Engaging young people:** understand what children and young people need / access by involving them more. • **Schools and wider partners:** to teach children about wider determinants of health e.g. access to nature, managing money etc.

	• **Call for closer working with faith organisations and VCS** organisations • **Co-locating services in local neighbourhoods:** for community-focused, locally tailored services. Can facilitate better communications and sharing of assets (knowledge / buildings / specialist skills e.g. language/cultural competence skills etc). **Mainstream services**: • **Staff training**: staff need a clear map of health and wellbeing services to signpost people more effectively. Also need to help frontline staff create welcoming environments; use more accessible, inclusive language; and put empathy skills into practice. • **Accessibility of online resources:** use familiar 'icons' to help navigate; support Google Translate for non-English speakers. • **Understand reasons for poor service uptake:** e.g. not meeting needs of community; or not culturally appropriate; or lack of trust. • **Service to service communications**: need to improve between the Council and CAMHS. **Funding:** • **Open conversations about funding cuts:** and how greater collaboration might address some of the gaps • **Consortia arrangements** could be better used to deliver services together. Council could help convene these and put more value on collaborations between organisations. • **Longer-term and flexible funding.** Small organisations need a flexible approach proportionate to value of the grant. Longer-term funding of voluntary and community sector services is less wasteful. **Community engagement / co-production / leadership:** • **Communities need more support to use their lived experience** to develop / co-produce services. • **Involve Community Health Ambassadors** more to engage residents and encourage uptake of services/ support in their area.

	• **More funding and support needed for community spaces**, that are accessible to all residents, and support community led projects. **Holistic and practical support:** • **Intergenerational projects** via family hubs or in older adults' residential care for cross learning and addressing isolation / happiness, food / cooking skills etc. • **Family support**: A more holistic approach to address the causes of challenges like food security /domestic abuse. • **Practical skills development for families:** e.g. more cook and eat workshops to encourage varied diets. **Food security / healthy food:** • **More food growing:** community gardening on estates and in schools. • **More awareness raising**: on the health impacts of commercial baby food and drink. • **Improved access to cooking facilities:** for asylum seekers and refugees and more investment in community kitchens. **Wider health and wellbeing services:** • **Similar services should work together** so that they can refer clients to each other when maximum numbers are met. • **Recognition that health is not just about GPs and hospitals**. There is a need to understand what it is within communities that can support / help people to thrive. • **More emphasis needed on social value** approaches / work with corporates to benefit the community.

Agenda Item 10

Meeting Name:	Health and Wellbeing Board
Date:	19 June 2025
Report title:	Southwark Maternity Commission Action Plan
Ward(s) or groups affected:	Residents who are planning pregnancies, families, children and young people
Classification:	Open
Reason for lateness (if applicable):	Not applicable
From:	Darren Summers, Strategic Director Integrated Health and Care

RECOMMENDATION(S)

1. That the Health and Wellbeing Board note the progress on the development of the Maternity Commission Action Plan
2. The board are asked to consider whether the actions underway and proposed will achieve the proposed outcomes and to make suggestions on any further actions that may be required

BACKGROUND INFORMATION

3. The Southwark Maternity Commission (SMC) was set up to assess and address inequalities in maternity care, particularly for families from a minority ethnic and/or socially disadvantaged background.

4. Over the course of nine months, from Jan to Sep 2024, SMC engaged with over 750 local residents, voluntary and community sector representatives, local maternity care service providers and local workforce.

5. It did so through engagement including six public meetings, extensive community engagement and stakeholder workshops.

6. The Health and Wellbeing Board approved the Maternity Commission report at its meeting of 14 November and received a verbal update that work was underway to develop an action plan at its meeting on 13 March 2025.

7. This report presents the current action plan in Appendix One.

8. The board is due to receive its first annual review by November 2025, a fuller three-year review in September 2027 and a final five-year evaluation in September 2029.

9. The SMC identified five overarching themes:

- Tackling discrimination and better supporting women with specific needs.
- Making sure women are listened to and supported to speak up, whatever their language or background.
- Providing women with the right information at the right time in the right way.
- Joining up council and NHS services better around women's needs, and making sure care is consistent across borough borders.
- Supporting the workforce to remain in their roles and be able to give compassionate and kind care for all mothers.

10. These themes and the findings of the SMC were used to develop ten recommendations. The first three are asks of central government, while the remaining seven are targeted towards the local maternity system, VCS organisations and Southwark Council. The ten recommendations are:

1. Leadership in addressing racism that leads to unequal maternal health
2. Develop a new national way of reporting maternal health
3. Review the maternity workforce
4. Evaluate the fairness of maternity services
5. Listen to and empower families
6. Preparation and support before pregnancy
7. Give parents the right information, at the right time, in the right way
8. Create a joined-up approach to families' needs between the NHS, southeast London boroughs, and voluntary and community sector
9. Southwark Council to review their role in maternity care
10. Review how feedback is dealt with.

11. Outcomes

As the action plan is further developed and implemented it is intended to track how the actions in aggregate achieve impact on the outcomes described in the maternity commission report, these are:

- Outcome 1: Reduced infant mortality
- Outcome 2: Reduced maternal morbidity
- Outcome 3: Increased positive experience of maternity care
- Outcome 4: Increased staff satisfaction
- Outcome 5: Closing the health inequality gaps

12. Progress over the past six months

The following actions have progressed or been completed over the last six months:

- Public health has completed a brief needs analysis using council data, which has highlighted disproportionalities in perinatal mental health needs, maternal obesity, hypertension, and gestational and Type 2 diabetes
- Development of the action plan has identified that there is a good training and development offer available across a range of partners including psychological support to build resilience
- A range of community-based initiatives and targeted campaigns are in place.
- There has been a very successful start to the pre-conception campaign being promoted through a number of Southwark locations and on-line

13. Maternity incentive scheme and progress of our trusts

The Maternity Incentive Scheme is an NHS England programme aimed at improving safety standards within maternity units. Under this scheme, NHS trusts that demonstrate compliance with ten safety actions are eligible to receive a rebate of 10% from their original contribution to the Clinical Negligence Scheme for Trusts (CNST).

These ten safety actions cover key areas such as perinatal death reviews, data collection and submission, clinical workforce planning, adherence to best practice clinical standards, and meaningful engagement with women, birthing people, and families.

Across South East London each maternity and neonatal service has worked diligently – supported at the system level – to meet these safety criteria, and all are now compliant. Among the Trusts, Kings College Hospital has shown the most significant improvement.

KEY ISSUES FOR CONSIDERATION

Although the action plan describes several actions underway that are relevant to recommendations one to three, the main ‘agent of change’ to deliver these actions is central government. Lobbying of central government will be led by the relevant political leads.

Policy framework implications

14. The SMC findings should be considered within the context of other local plans and policies designed to reduce inequalities and improve health and wellbeing in the borough.

15. The SMC should also inform and build upon existing plans of the South East London Integrated Care System’s Local Maternity and Neonatal System.

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

Community impact statement

16. The report involved extensive engagement with residents, trust partners, and local voluntary and community sector organisations in its development. These community members will continue to be involved as the action plan is developed and implemented.

Equalities (including socio-economic) impact statement

17. A primary aim of the SMC was to assess inequalities in maternity care. Based on national data, this took a particular focus on women from a minority ethnic and/or socially disadvantaged background. The report takes into account how different communities are affected by poor maternal and infant outcomes.

18. This includes the protected characteristics outlined in the Equality Act 2010, along with considerations of how multiple characteristics may intersect to exacerbate inequalities.

19. The report recommendations and the subsequent action plan will aim to reduce the inequalities identified.

Health impact statement

20. The SMC was initiated to assess the inequalities in maternity health outcomes in the borough. Implementation of the report's recommendations should have a positive impact on maternal health and consequently infant health.

Climate change implications

21. There are no direct implications on climate change arising from this work.

Resource implications

22. The SMC to this point has been led by the Public Health Division on behalf of the Cabinet Member for Health and Wellbeing. It has required cross-council collaboration with other departments such as Communications and Community Engagement, Public Affairs, and the Constitutional team.

23. It is likely that full implementation of the recommendations will have resource implications, particularly for NHS partners who bear a large proportion of the responsibility for the recommended actions over the five years. Early response from the SEL LMNS (presented on 17 Oct 2024) welcomed the SMC report and acknowledged the alignment with various existing or planned SEL LMNS activities with SMC recommendations. Furthermore, Southwark Stands Together welcomed the report and offered support of partnership working from various teams across Southwark Council.

Consultation

24. The SMC action plan will be co-produced and overseen by key partners across Southwark Council, NHS, VCS and residents. It is envisaged that each recommendation area will have its own sub- working group, which will receive oversight from a strategic steering group overseen by the Southwark Health & wellbeing Board.

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS

Assistant Chief Executive, Governance and Assurance

25. None sought.

Strategic Director of Resources

26. None sought.

Other officers

27. None sought.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
The Southwark Maternity Commission: Recommendations to tackle the inequalities in pregnancy and childbirth experienced by families in Southwark (2024)	Public Health Division, Children & Adults Department	Megan Velzian Megan.velzian@southwark.gov.uk

APPENDICES

No.	Title
Appendix 1	The Southwark Maternity Commission Action Plan

AUDIT TRAIL

This section must be included in all reports.

Lead Officer	Darren Summers - Strategic Director Integrated Health and Care
Report Author	Claire Belgard - Acting Director of Integrated Commissioning, Zenette Abrahams – Project Manager
Version	Final
Dated	June 2025
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 Resources	No	No
List other officers here	N/A	N/A
Cabinet Member	Yes	Yes
Date final report sent to Constitutional Team		09 June 2025

Maternity Commission Action Plan – June 2025

Recommendation (heading)	Recommendation (detail)	Lead agents of change	Actions in progress	Additional actions proposed
Recommendation 1: Leadership in addressing racism that leads to unequal maternal health:	Introduce clear, evidence-based policies that address racism and inequalities in maternity care and the wider healthcare system. Include review and improvement in existing frameworks and systems, such as the NHS Workforce Race Equality Standard and ending charging migrants for maternity services	Central Government The Local Neo-Natal and Maternity System (LMNS) Guys and St Thomas (GSTT) Kings College Hospital (KCH) South London and Maudsley (SLaM)	Public health has conducted a brief needs analysis using council data, which has highlighted disproportionalities in perinatal mental health needs, maternal obesity, hypertension, and gestational and Type 2 diabetes The LMNS has a dashboard that identifies the outcomes against ethnicity and deprivation at NHS provider level	Bring different local government and NHS data sets together at a borough level where possible. Identify a lead partner to work with our NHS Trusts to develop a compassionate charging policy for refugees and migrants, learning from the work undertaken by Lewisham Refugee and Migrant Network published in 2021 The LMNS is developing a 'Talking about difference' resource and cultural sensitivity training package for maternity and neo-natal staff, and has led parent education in different languages Work with Impact for Urban Health and the Integrated Care Board (ICB) project lead to reflect the Black Maternal Health Project findings into this action plan

Recommendation 1: (cont)				
Recommendation 2: Develop a new national way of reporting maternal health	Work with local authorities to introduce a way to record and respond to perinatal health data. Make sure all maternal health data is collected and reported in a standard way across all healthcare settings and focuses on ethnicity to highlight and address if people are getting unfair and different treatment.	Central Government	The LMNS is building a dashboard for oversight of peri-natal data for maternity and neonatal services at a NHS trust and borough level – the final version is being tested, though mortality data is challenging as numbers are relatively small.	
Recommendation 3: Review the maternity workforce	Review the wider maternity healthcare system's capacity to support its workforce, with a focus on improving pay, conditions, and resilience. Provide healthcare professionals with training, resources, and a supportive work environment to improve compassion in care, particularly for Black and Asian mothers.	Central Government, LMNS, GSTT, KCH, SLaM	Each maternity service offers development to their staff including mandatory training and updating. There is a psychological support service on offer at each trust for staff and they can also access professional Midwifery Advocates (PMASs) who are midwives trained to provide support to staff and women. In addition to trust level development the LMNS has several training offers in place including Birthrights, Civility Saves Lives, Trauma Informed Care and training by Make Birth better to support those that are running birth reflection sessions or debriefs with women.	A significant labour ward coordinator programme is being planned with the first cohort starting in September, this also includes 360-degree assessments and bespoke development plans. The LMNS is about to commence a career clinic offer. The maternity providers are implementing the Safe Environment Learning Charter (SELC) for student midwives.

Recommendation 3: (cont)			Each LMNS unit tends to have a rolling recruitment offer, and through significant work vacancy rates have been improved significantly and a focus continues on retention.	
Recommendation 4: Evaluate the fairness of maternity services	Review current services for Southwark residents with the highest levels of need. Develop and improve new and existing services to make sure they work for people with complex, overlapping needs.	LMNS, GSTT, KCH, SLaM, GPs, Southwark Council, VCFSE	A range of local actions are underway including: Community based interventions such as targeted campaigns to increase uptake of maternity vaccinations, the offering of 'baby boxes' to vulnerable residents, and a Vitamin D campaign Maternity and neonatal services providing infant feeding and health weight policy are being implemented, and both GSST and KCL are prioritising continuity of carers through continuity midwifery teams/enhanced continuity service	Pathways for women with female genital mutilation are being mapped at KCH and GSTT NHS trusts have signed up to regional NHS postnatal guidance, and are reviewing gaps in current provision Evaluation and monitoring of Bright Beginnings pathway is in progress

Recommendation 4: (cont)			All three trusts have signed off the regional postnatal guidance to provide needs-based, equitable and comparable care	
Recommendation 5: Listen to and empower families	Create an inclusive environment where all family members are heard and have the information to make sure their needs are met. Improve communication by creating and promoting accessible resources so that families are fully informed and can navigate the healthcare system.	LMNS, GSTT, KCH, SLaM, Southwark Council, VCFSE organisations	A staff training video created by a VCFSE organisation and migrant service users has been released LMNS are working through the Maternity and Neonatal Voices Partnership (MNVP) guidance to ensure that leads are representative of the communities and collaboration with local community groups/organisations	Embed the VCFSE training video as part of mandatory training Implement the findings of the review of MNVP Sharing the findings of the 10-month evaluation report on Parent Education Work through the net iteration of the Personalised Care and Support Plans (PCPs) with the MNVP and service users
Recommendation 6: Preparation and support before pregnancy	Southwark partners (Local Maternity and Neonatal System, local authorities, voluntary and community sector and maternity care providers) raise awareness together of the importance of getting ready for pregnancy. Use all services and contacts so that women arrive at maternity services in the best possible health (in particular those at risk of poorer maternal health outcomes).	LMNS, GSTT, KCH, SLaM, GPs, Southwark Council, VCFSE organisations	Data shows that over 1600 people have used the national Tommys [planning tool since the promotion campaign started in April 2025 This is supported on the council website and through posters and promotions in libraries, leisure centres and Southwark Life magazine	LMNS to carry out further preconception campaign based on the outcomes of the Tommys campaign later in 2025 A Public Health working is identifying additional access points for promotion of preconception advice

Recommendation 7: Give parents the right information, at the right time, in the right way	Southwark partners (Local Maternity and Neonatal System, local authority, voluntary and community sector and maternity care providers) work together on their communications across each stage of the perinatal period. Make sure women and their partners get the right, inclusive and culturally appropriate information	LMNS, GSTT, KCH, SLaM, GPs, Southwark Council, VCFSE	Information on services and advice has been included to the Start for Life brochure. Information about the Baby Buddy app added to GSTT self-referral auto-reply.	Further development of a suite of information for parents for each stage of the perinatal period Learning from the Tommys campaign to maximise the promotion of materials to achieve the maximum reach to parents
Recommendation 8: Create a joined-up approach to families' needs between the NHS, SEL boroughs, and voluntary	Strengthen partnerships by creating a network for staff delivering care to Southwark residents. Share learning, facilitate integration across services and improve knowledge and resource sharing. Look for opportunities for co-commissioning with neighbouring boroughs to enhance and provide consistent services across borough borders.	LMNS, GSTT, KCH, SLaM, GPs, Southwark Council, VCFSE	MNVP '15 steps' and 'Walk the Patch' take place twice a year, there provide trusts with feedback from service users on the unit environment. This feedback is included in trust improvement plans The LMNS lead on oversight for national and regional programmes to support improvements in care and implementation of care pathways such as the Saving Babies Lives Care Bundle The Maternal Medicine Network ensures that women have access to specialist clinical services regardless of postcode	Gain a clearer understanding of local barriers to collecting and sharing data Work with the LMNS to implement newly agreed regional postnatal guidance across the borough Work with commissioners and neighbouring boroughs to identify any opportunities for co-commissioning

Recommendation 9: Southwark Council to review their role in maternity care	Look at their role in assurance and scrutiny of the maternity care system and empower system leaders to hold people to account. Together with local trusts review, identify and close gaps in maternity services. Consider their role in housing and cost of living services, and in collaborating with local voluntary, community, faith and social enterprise sector organisations.	Southwark Council	Public Health have established a multiagency delivery group including Council housing and cost of living services which has started to progress Commission actions together	Work with the Council's Constitutional team due to start shortly
Recommendation 10: Review how feedback is dealt with	Work with NHS trusts to review how they identify, share and respond to patient and staff complaints, particularly ones about racial discrimination. Embedding a culture where staff are encouraged and supported to speak up. Make sure that the context of reviews is appropriate and develop an integrated, borough-wide response to review findings.	LMNS, GSTT, KCH, SLaM, GPs, Southwark Council, VCFSE	Several Actions are underway to address recommendation 10 including: Working through existing NHS Trusts mechanisms to improve how we use feedback that supports inclusive approaches to improvement programmes. These include Complaints, Concerns, Issues raised through PALs services, established patient forums Working through the Quality Surveillance Group of the Local Maternity & Neonatal System improvement work underway to better triangulate complaints, concerns, safety incidents that informs areas for focus as a system to incorporate into programmes of improvement work	Work to embed VCSE insights into our engagement work and our understanding of patient and service user feedback Work with Primary Care in developing processes of how we include complaints, concerns raised into improvement programmes, and additionally how this feed back into NHS Trusts and into the Quality Surveillance Group Need to facilitate residents to provide more non identifiable demographic data when making complaints raising concerns Develop evaluation/audit programme specifically aimed at

Recommendation 10 (cont)			Working with Maternal Voices partners to ensure that patient experience informs and triangulates with feedback. Working through NHS Trusts established Freedom to Speak Up mechanisms to increase inclusion and better align and triangulate feedback and input into programme plans Civility safes lives training being rolled out across acute NHS Trusts, and trauma informed care and birth rights training currently being rolled out To support the development of key personnel, and promote an inclusive safety culture, each maternity service within SEL is implementing the *Labour Ward Coordinator Education and Development framework*. This supports women in real time to speak up and identity concerns in care	identifying impact of change projects

Agenda Item 11

Meeting Name:	Health and Wellbeing Board
Date:	19 June 2025
Report title:	Joint Strategic Needs Assessment (JSNA) Annual Report 2025
Ward(s) or groups affected:	Name the wards the decision effects or 'All' if all Key population groups (as defined by Southwark's JSNA) affected by decision/recommendation: ☐ Carers ☐ Residents with disabilities ☐ LGBTQIA+ residents ☐ Asylum seekers and refugees ☐ Rough sleepers ☐ Black and ethnic minority communities ☒ All
Classification:	Open
Reason for lateness (if applicable):	Not applicable
From:	Sangeeta Leahy, Director of Public Health Tom Seery, Senior Public Health Programme Manager – Knowledge & Intelligence

RECOMMENDATION(S)

1. That the Health and Wellbeing Board note the findings of the Joint Strategic Needs Assessment (JSNA) Annual Report 2025 and agree to an annual update.

2. That the Health and Wellbeing Board note the achievements and challenges for health and wellbeing in the borough.

3. That the Health and Wellbeing Board note and reflect on actions from recently completed needs assessments.

4. That the Health and Wellbeing Board agree the JSNA projects recommended for the coming year.

PURPOSE OF THE ITEM

☐ Item relates to Joint Health and Wellbeing Strategy: *[Describe priority, aim or action item relates to e.g. Action 2.1]*
☒ Statutory item
☐ Other: *[Please explain justification for item]*

BACKGROUND INFORMATION

5. This report has two main objectives:

   - To update the board on changing patterns of health and inequalities in the borough, as outlined in the JSNA Annual Report 2025.

   - To outline next steps for the JSNA programme and proposed projects for the year ahead.

6. Joint Strategic Needs Assessment is a process designed to inform and underpin the Joint Health and Wellbeing Strategy 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).

7. 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. The report forms part of the borough's Joint Strategic Needs Assessment work programme and informs local action to improve health and wellbeing in Southwark.

8. All JSNA reports are published and accessible via: www.southwark.gov.uk/insight-hub

KEY ISSUES FOR CONSIDERATION

2024 JSNA Programme update

9. Seven needs assessments were completed in the past year:

   - Latin American Health
   - LGBTQIA+ Health and Wellbeing
   - Hot Weather
   - Carers
   - Gypsy, Roma, and Traveller Populations (factsheet)
   - Poverty (factsheet)
   - Child & Adult Obesity (factsheet)

10. Each needs assessment undergoes an annual review to evaluate implementation and progress against each of the recommendations. Although none of the completed needs assessment from 2024 have reached the 1-year review period, we have been able to identify progress against many of the recommendations, including:

    - Cultural competency training is being commissioned for Community Health Ambassadors, clinicians and frontline staff supporting the health outreach programme, with the first round of training beginning in summer 2025.

- A Pride in Practice programme is in the process of being implemented in primary care to improve the experience of health services among LGBTQIA+ residents.
- Monthly health outreach sessions have been set up at a local LGBTQIA+ community shelter, the Outside Project, with clinicians from the Bridge Clinic offering support and guidance.
- A monthly health outreach hub site focusing on Latin American residents has been established at Castle Square.
- Multiple language options are in the process of being rolled out across our digital health kiosks in the borough, including Spanish and Portuguese
- Cared-for person support plans are linked across social services and NHS systems.
- A hospital discharge pathway for carers has been developed as part of the wider South East London Accelerated Reform Fund project.

2025 JSNA Annual Report

11. Southwark's Annual JSNA Report is structured to provide an overview of the population and communities that reside in the borough and the social and economic environment. The report also breaks down our understanding of health and wellbeing through the life course.

12. The report provides an overview of our changing population:

- Latest population projections (2022) suggest that our population will grow 14% by 2040 and is set to take place across almost all parts of the borough.

- The largest population increases are expected in redevelopment areas around Old Kent Road, Canada Water, and Elephant and Castle, as well as among those aged 71-80.

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

- Southwark has the fourth largest LGB+ population and the fifth largest trans population of any English local authority: 8.1% residents aged 16+ (nearly 21,000 people) identify as non-heterosexual, and 1.2% (over 3,000 people) report a gender identity different to their birth sex registration.

- Almost a quarter of households (33,000) had at least one resident with a disability.

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

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

- We continue to see improvements towards infant and child health, with infant deaths down by two thirds since 2002.
- Key risk factors to ill-health such as smoking continue to improve, changing from 1 in 7 adults to 1 in 5 adults between 2011 to 2024.
- Levels of air pollution have fell by 30% since 2018, leading to a 29% reduction in deaths attributed to air pollution.

14. Although there have been improvements in health outcomes in Southwark, many challenges remain:

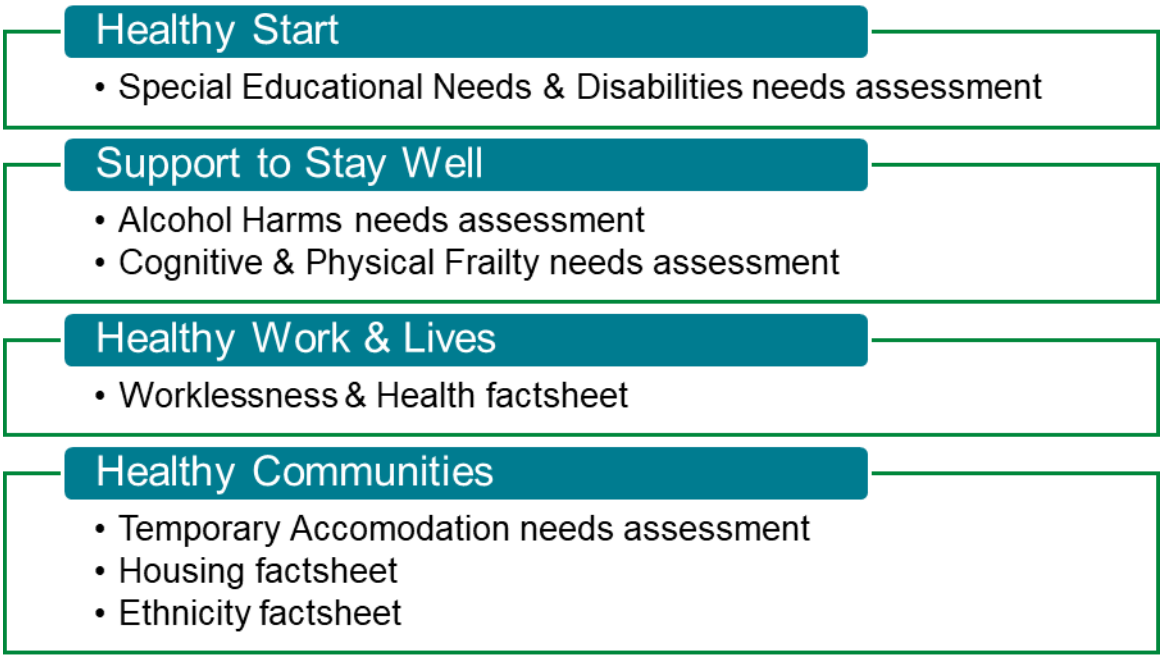
- The population is expected to increase by 14% up to 2040, highest for those above the age of 60, who are the group that face the greatest burden of ill-health.
- Improvements in overall life expectancy have stalled. At the same time there has been a fall in healthy life expectancy.
- People residing in areas of highest socioeconomic disadvantage live for fewer years and spend more of those years in poorer health.
- There are a rising number of people living with long-term conditions, particularly impacting those residents of highest socioeconomic disadvantage.
- Children and families residing in areas of higher socioeconomic disadvantage face greater hardship and often require support to meet basic needs, such as access to healthy and affordable food.

2025 JSNA Programme

15. Over the coming year several in-depth projects are recommended for the JSNA programme and will aim to align with the four Health & Wellbeing Board (HWBB) priority areas, these projects include:

- Special Educational Needs & Disabilities needs assessment
- Oral Health needs assessment
- Temporary Accommodation needs assessment
- Alcohol Harms needs assessment
- Cognitive & Physical Frailty needs assessment
- Worklessness & Health factsheet
- Housing factsheet
- Ethnicity factsheets

16. The figure below outlines where specific projects align with the 4 HWBB priority areas.



17. Maternal Health is not directly covered by 2025 projects, however work to address inequalities in maternity care in the borough is ongoing as a result of Southwark's Maternity Commission (developed in 2024).

Policy framework implications

18. The JSNA process underpins 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.

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

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

Community impact statement

20. 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

21. 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

22. 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

23. The JSNA programme includes work assessing the wider determinants of health, including issues relating to housing and employment.

Resource implications

24. 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.

25. We are also improving our cross-council collaboration for JSNA projects, working with teams across the council to identify core areas of work. 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.

Note: Legal/Financial implications (and when to seek supplementary advice)

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.

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.

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS

Assistant Chief Executive, Governance and Assurance

29. None sought.

Strategic Director of Resources

30. None sought.

Other officers

31. None sought.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
JSNA Annual Report 2025	Public Health Division, Children & Adults Department	Tom Seery Tom.seery@southwark.gov.uk

Appendices

No.	Title
Appendix 1	Joint Strategic Needs Assessment (JSNA) Annual Report 2025

AUDIT TRAIL

Lead Officer	Sangeeta Leahy, Director of Public Health
Report Author	Tom Seery, Senior Public Health Programme Manager – Knowledge & Intelligence
Version	Final
Dated	June 2025
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 Resources	No	No
List other officers here	N/A	N/A
Cabinet Member	No	No
Date final report sent to Constitutional Team		6 June 2025

JSNA Annual Report 2025

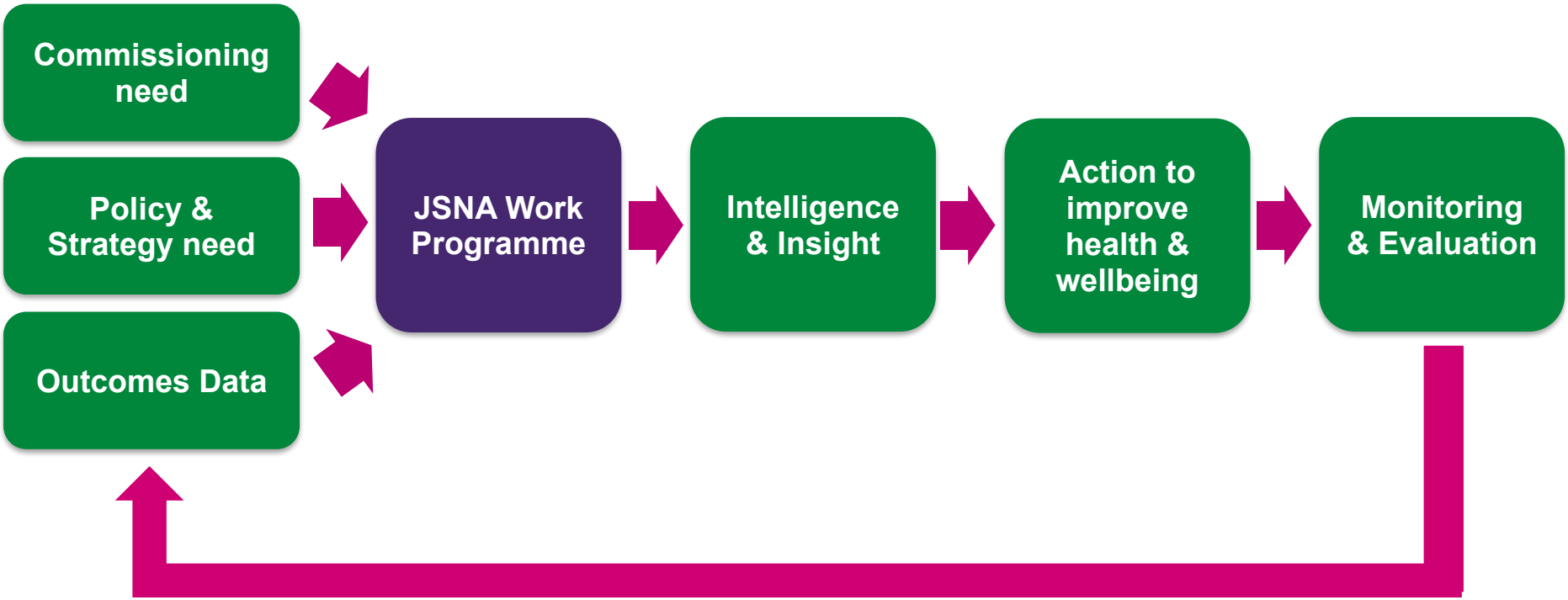
Southwark's Joint Strategic Needs Assessment

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

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.

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 population

Ethnicity:

The largest proportion (51%) of residents have a White, followed by Black/Black British (25%) ethnic background; ~40% of residents were born outside the UK. Greater diversity is observed among children and young people (under 30 years).

Religion:

Over 40 distinct religions are reported by Southwark residents; 43% reported their religion to be Christian, a 10% decline since 2011.

Unpaid care:

Nearly 6% of Southwark's population provide unpaid care. Increased demand for care is observed to disproportionately affect women, people from Black African ethnic backgrounds, and those living with disability and complex care needs.

Population:

Home to some 315,520 people, Southwark has a comparatively young population (median age: 33.4; London: 35.9; England: 40.7 years).

Language:

Over 80 languages are spoken in the borough. Of the 53,700 residents whose main language is not English, 19% cannot speak English well or have no English proficiency.

Sexual orientation & gender identity:

Southwark has the 4th largest LGB+ and the 5th largest trans population in England; 8.1% of residents aged 16+ identify as non-heterosexual, and 1.2% report a gender identity different to their birth sex registration.

Housing:

Socially rented households (from the Council and housing associations) account for 40% of households in the borough.

3.2 Achievements

We continue to see improvements in infant and child health, through better access to early years services, in addition to school-based interventions such as educational care plans and free school meals.

Southwark is making strives to improve its physical, structural and social environment, helping to improve health and wellbeing for residents and limit the exposure to risk factors that have a negative impact on life quality.

We are prioritising services which help detect the early signs of disease, whilst implementing programmes to increase the adoption of healthy behaviours.

Starting well

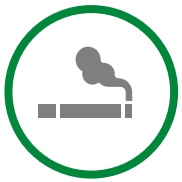
Infant deaths are down by two thirds since 2002

Emergency admissions for children under 5 have fallen by 35% since 2013

There were 85 less asthma-related hospital admissions in 203/24 for children under the age of 19

Living well

Levels of air pollution have fallen by 30% since 2018, leading to a 29% reduction in deaths attributed to air pollution



Levels of smoking are down by over a quarter since 2011, changing from 1 in 7 to 1 in 5 adult smokers

New cases of HIV have reduced by almost 65% since 2013, whilst the engagement in HIV testing is 40% higher than in 2018

Ageing well

Hospital admissions for falls among the elderly have reduced by a quarter since 2010

Over three-quarters of those thought to be living with dementia in Southwark have received a diagnosis; higher than regional and national levels

There has been a 40% reduction in preventable mortality in Southwark between 2001 and 2023

3.3 Challenges

Despite the improvements in many health outcomes, challenges persist. Life expectancy has stalled, quality of life years is decreasing, and there are a rising number of people living long-term conditions. These issues are exacerbated within and between population groups, as inequalities are widening.

People residing in areas of highest socioeconomic disadvantage live shorter lives and spend more of those years in poorer health. Children and families residing in areas of higher socioeconomic disadvantage face greater hardship and often require support to meet basic needs, such as access to healthy and affordable food. Residents from a black ethnic background are more likely to experience excess weight and are disproportionately impacted by long term conditions such as Hypertension and Diabetes.

Starting well

An increasing number of children are living in poverty with free school meal eligibility rising by 68% since 2018

Over 2 in 5 Year 6 children and 1 in 5 Reception children have excess weight levels

Coverage for essential childhood vaccinations have dropped or stalled compared to 10 years ago

Living well

There are 2,000 more residents living with 3+ long term conditions such as mental health and hypertension since last year

The number of newly identified rough sleepers continues to increase, 800 identified in 2024/25, up 22% from the previous year

Inequalities of health & wellbeing outcomes by ethnicity and socioeconomic disadvantage remain and are worsening

Ageing well

Trends indicate there has been a longer-term pattern of stalling in life expectancy, with no discernible improvement over the last decade

Residents are spending only 60 years in good health, which is lower than a decade ago

Preventable mortality in Southwark remains significantly higher than in London

3.4 JSNA Programme work

The Southwark Insight Hub has been redeveloped in the last year and can be accessed here: www.southwark.gov.uk/insight-hub. The hub brings together a range of information on the demographics of Southwark and our neighbourhoods, a new interactive data-tool, and in-depth analysis from the Joint Strategic Needs Assessment.

Several in-depth needs assessments have been completed in the last year, focusing on communities or topic areas where there are specific needs or inequalities in the borough, and align with the priorities set out in our Joint Health and Wellbeing Strategy.

In the past year, needs assessments completed as part of Southwark's JSNA programme included:

- Latin American Health
- LGBTQIA+ Health and Wellbeing
- Hot Weather
- Carers
- Gypsy, Roma, and Traveller Populations (factsheet)
- Poverty (factsheet)
- Child & Adult Obesity (factsheet)

Needs assessments provide the opportunity to conduct in-depth reviews and establish system-wide recommendations to improve health and wellbeing for our residents. Each needs assessment undergoes an annual review to evaluate progress against their recommendations. Although completed needs assessment from 2024 have not reached the 1-year annual review timepoint, we have already been able to identify progress against many of the recommendations, including:

- Cultural competency training is being commissioned for Community Health Ambassadors, clinicians and frontline staff supporting the health outreach programme, with the first round of training beginning in summer 2025.
- A Pride in Practice programme is in the process of being implemented in primary care to improve the experience of health services among LGBTQIA+ residents.
- Monthly health outreach sessions have been set up at a local LGBTQIA+ community shelter, the Outside Project, with clinicians from the Bridge Clinic offering support and guidance.
- A monthly health outreach hub site focusing on Latin American residents has been established at Castle Square.
- Multiple language options are in the process of being rolled out across our digital health kiosks in the borough, including Spanish and Portuguese.
- Cared-for person support plans are linked across social services and NHS systems.
- A hospital discharge pathway for carers has been developed as part of the wider South East London Accelerated Reform Fund project.

Many of our needs assessments have cross-cutting implications across the 9 protected equality characteristics. It is essential that we identify and provide recommendations to promote equality and prevent discrimination for communities in various aspects of life. We are in the process of conducting a review of these recommendations to identify common themes and assess implementation.

4. SOUTHWARK'S JOINT HEALTH & WELLBEING STRATEGY (2022-2027)

Southwark's Joint Health and Wellbeing Strategy (JHWS) sets out how the Health and Wellbeing Board will work together to prevent ill-health, promote wellbeing and reduce health inequalities.

The strategy runs from 2022 to 2027, and the underpinning action plan sets out how partners will ensure progress against the aims of the strategy. Priorities covered in the action plan include:

Many outcome measures set out across these four priorities areas are highlighted in this report through the life course approach. This JSNA Annual Report focuses on longer-term outcome measures as indicators of the long-term success of the Joint Health and Wellbeing Strategy.

Life expectancy and healthy life expectancy are the overall measures of the health of our population. Furthermore, the gap in life expectancy between those living in neighbourhoods with the lowest and highest levels of socio-economic disadvantage are our overall measures of health inequalities.

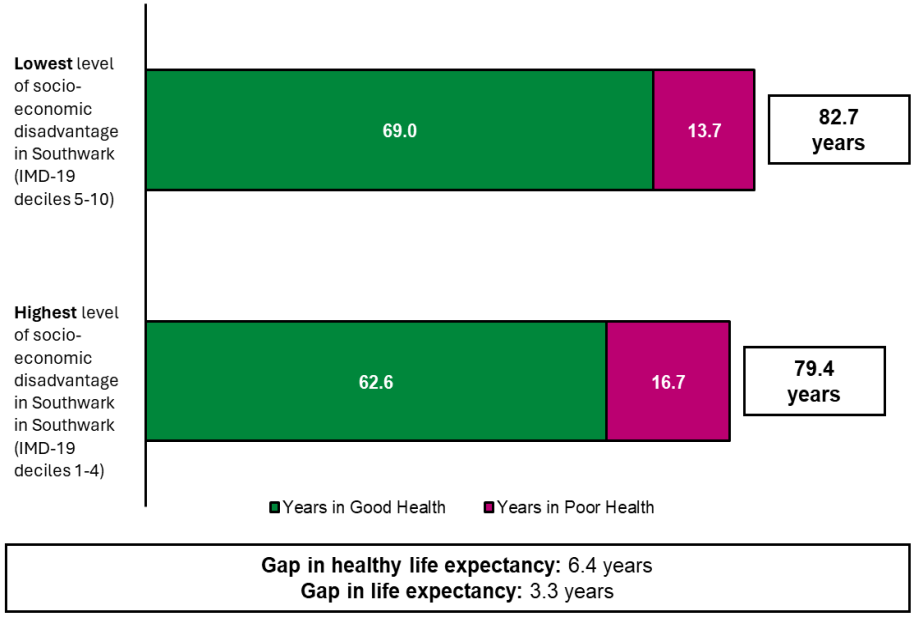
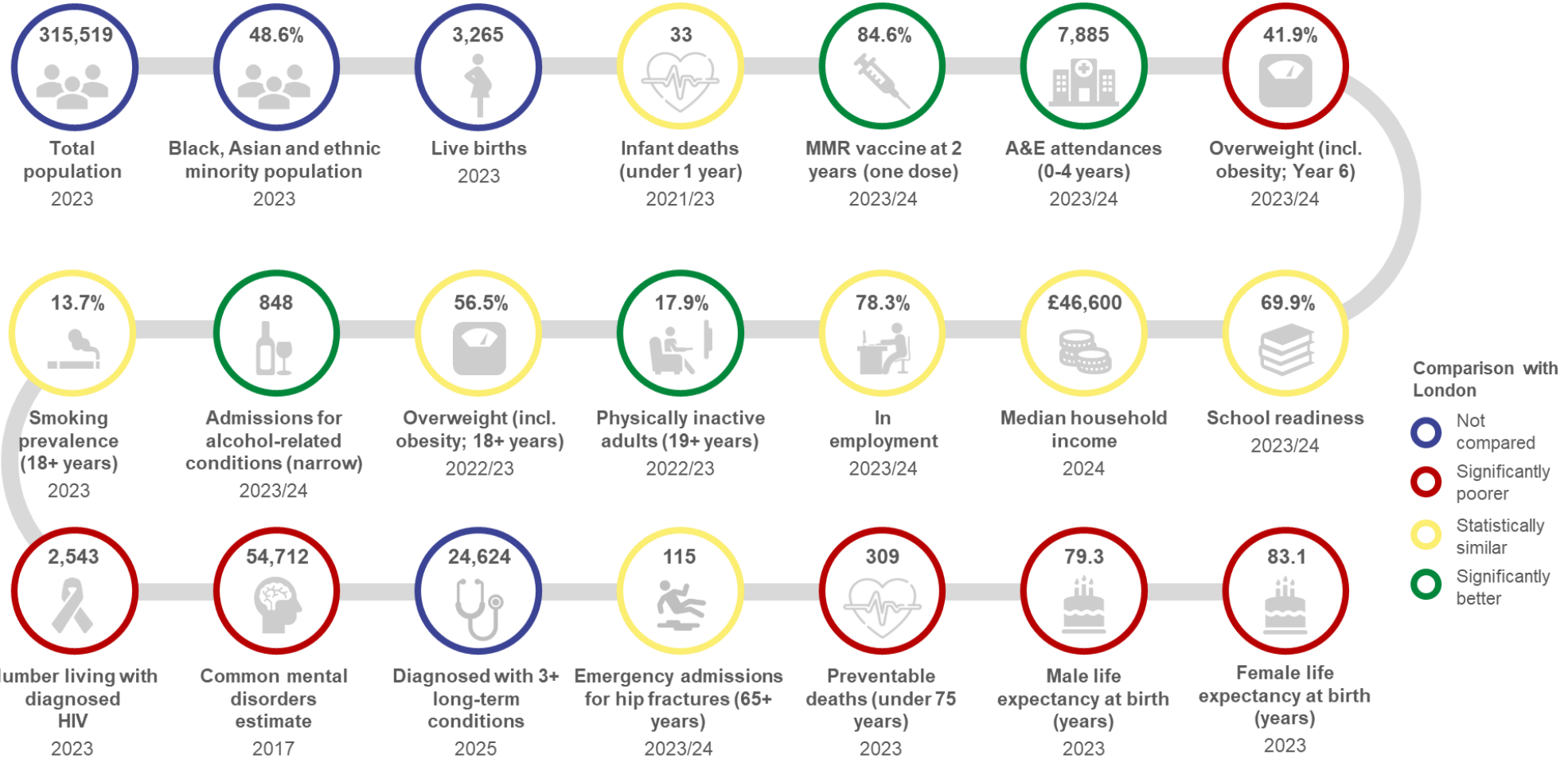


Fig 1. Life expectancy and number of years spent in good health (healthy life expectancy) at birth, in Southwark, regardless of sex by level of deprivation (IMD-19 decile 1-4 vs 5-10) of area of residence, 2024. Source: Southwark Public Health Division, 2025.

5. SOUTHWARK HEALTH & WELLBEING INFOGRAPHIC

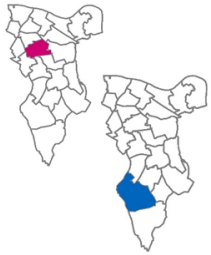


6. HEALTH & WELLBEING GEOGRAPHIC INEQUALITY INFOGRAPHIC

There is a wide and growing range of data that highlights the geographical inequality in health and wellbeing outcomes in the borough, often linked to socio-economic disadvantage. Further detail on the health of wards and neighbourhoods in Southwark is available via the Southwark Insight Hub.

Our poorest outcomes are concentrated in our most deprived neighbourhoods:

Faraday
has the highest level of socio-economic deprivation (2019)



60.1% are from a Black and minority ethnic background (2021)

30.2% of children under 16 years old live in relative poverty (2024)

7.9% claiming out-of-work benefits (March 2025)

10.7% above the Southwark average crime rate (2024/25)

48.3% Of year 6 pupils are overweight or obese (2021/22-2023/24)

14.7% above the Southwark average for emergency hospital admissions (2016/17-2020/21)

78.8 male life expectancy
84.5 female life expectancy (2016-20)

Dulwich Village
has the lowest level of socio-economic deprivation (2019)

19.2% are from a Black and minority ethnic background (2021)

3.5% of children under 16 years old live in relative poverty (2024)

2.2% claiming out-of-work benefits (March 2025)

46.9% below the Southwark average crime rate (2024/25)

19.3% Of year 6 pupils are overweight or obese (2021/22-2023/24)

39.6% below the Southwark average for emergency hospital admissions (2016/17-2020/21)

87.1 male life expectancy
89.5 female life expectancy (2016-20)

7. HEALTH & WELLBEING ETHNICITY INEQUALITY INFOGRAPHIC

Local data on inequalities between demographic groups highlights 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.

Residents from Black African and Black Caribbean backgrounds have amongst the poorest outcomes in the borough

Black African & Black Caribbean residents have amongst the poorest health & wellbeing outcomes

29% of Black residents live in the most deprived neighbourhoods (2019)

43% Black children in Year 6 are overweight or obese (2023/24)

50% Black students achieve a Grade 5 or above in English & Maths (2023/24)

46% Black adults experience food insecurity (2019)

31% Flu vaccine coverage in residents of a Black ethnicity (2023/24)

57% Estimated bowel cancer screening uptake in Black population (2025)

White residents have amongst the best health & wellbeing outcomes

17% of White adults live in the most deprived neighbourhoods (2019)

30% White children in Year 6 are overweight or obese (2023/24)

65% White students achieve a Grade 5 or above in English & Maths (2023/24)

9% White adults experience food insecurity (2019)

48% Flu vaccine coverage in residents of a White ethnicity (2023/24)

65% Estimated bowel cancer screening uptake in White population (2025)

8. COMMUNITIES

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. Southwark is a rapidly growing borough with large numbers of young adults and residents from a wide range of ethnic and demographic backgrounds. **Significant inequalities remain** between different population groups mirroring trends seen at a national level. This inequality holds our whole community back; the desired harmony and prosperity we all look for in Southwark relies on a more equal society. **Reducing inequality is a core principle of the Joint Health & Wellbeing Strategy and Southwark 2030**.

Home to some **315,520** people, Southwark has a comparatively young population, with a large number (41%) of the population of young working age (aged 20 to 39 years).

Southwark is the **fifth highest** ranking local authority in England for residents identifying as **trans or non-binary**. Within the borough **3,200** residents reporting a gender identity different from their sex registered at birth

Southwark is a diverse borough with residents from a wide range of ethnicities and backgrounds. Of people living in Southwark, **51% are of a White ethnicity, compared to 81% nationally**.

In 2021, **Southwark ranked highest** of all local authorities in England for the proportion of households which rent accommodation from the Council, at **27%**.

Southwark is ranked fourth in England for proportion of residents identifying with a **non-heterosexual orientation, most frequently lesbian, gay or bisexual**. This equates to roughly **21,000** residents.

Almost a **quarter of households** (33,000) had at least one resident with a **disability**. Over the last decade, there has been an **increase** in the number of hours of **unpaid care** residents provide.

8.1 Current population

Home to some 315,520 people, Southwark has a comparatively young population. The median age (33.4 years) is more than two years younger than London, and almost seven years younger than England.

Figure 1 shows the age structure of Southwark compared to England (black outline). The chart demonstrates that the low average age in the borough arises not from large numbers of children, but from a large number of young working-age residents: 41% of the Southwark population is aged 20 to 39.

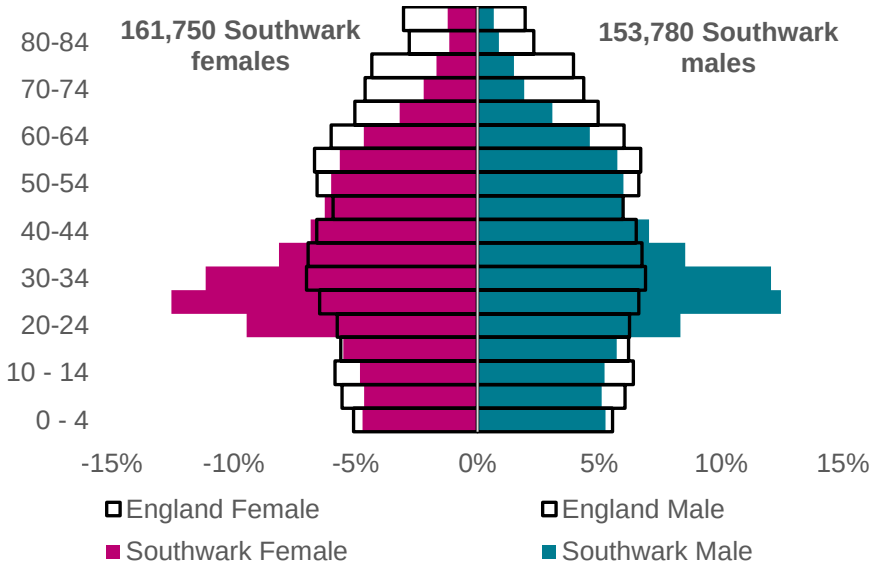


Fig 2. Age structure of Southwark compared to England, 2023
Source: ONS 2025. Mid-year population estimates, mid-2023.

8.2 Population change

The population of Southwark grew by 6% between 2013 and 2023, in line with 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 Southwark age profile have been among adults aged 55 to 69 years old, and children under 5 years old.

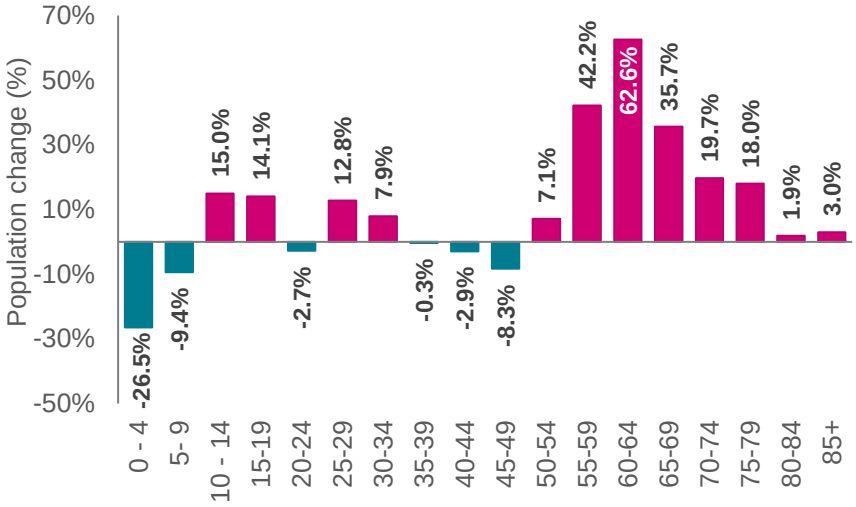


Fig 3. Percentage change in Southwark population by age, 2013 to 2023
Source: ONS 2025. Mid-year population estimates, 2013 and 2023.

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. BY 2040, the population of Southwark is projected to have increased by 14%

(2022-based projection). This is 1.6 times greater than the projected increase for London (+9% increase). By age, the largest increase is projected among those aged 71 to 80 years old (+92%, 2022 to 2040). However, during this period the number of young people aged 11 to 20, and 5 to 10 year olds is projected to decrease by 11% and 9%, respectively.

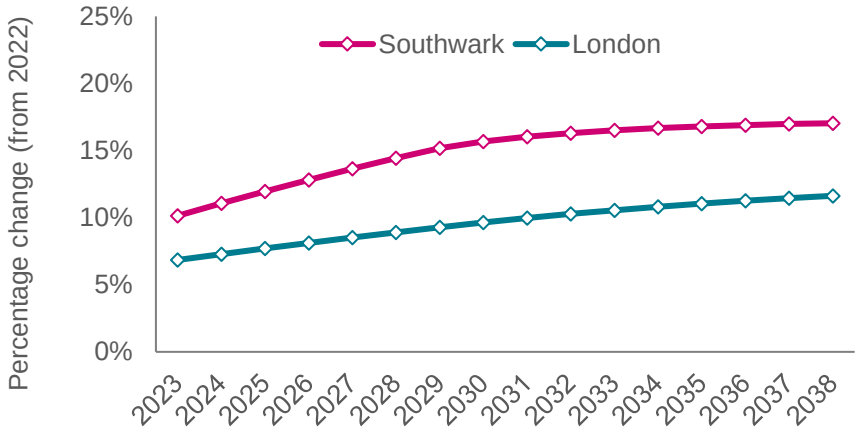


Fig 4. Projected population change in Southwark from 2022 baseline.
Source: GLA 2025. Population projections (2022-based).

8.3 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, approximately 9,200 people in Southwark recorded this 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.

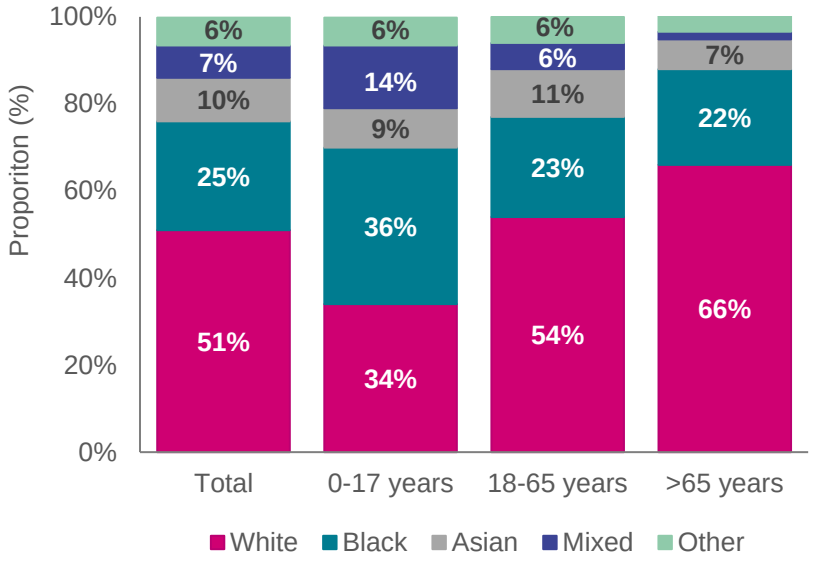


Fig 5. Southwark population by broad ethnic group and age, 2021
Source: ONS 2023. Census 2021 – Age and ethnic group.

Equality, Diversity and Inclusion: Southwark celebrates the richness of our diverse communities and partners are committed to addressing the needs of all residents with particular focus on the most vulnerable**.** We recognise that we may not have always got this right in the past, but we are dedicated to **intensifying our commitments** to strengthen engagement with staff, residents, businesses and the wider community to shape and deliver on the promise of a fairer future for all.

Over 80 languages are spoken in Southwark, with 79% of the population speaking English as their main language. The most common main 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 residents were born overseas: 40% were 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.

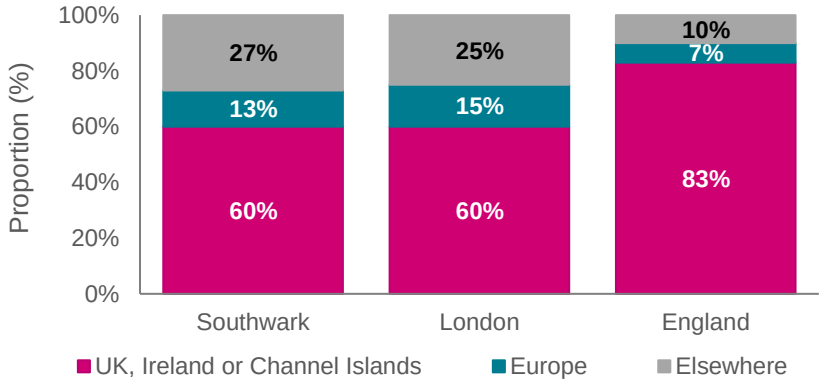


Fig 6. Residents' country of birth as a proportion of total population, 2021. Source: ONS 2022, Census 2021, International migration, England and Wales.

In March 2025, 914 asylum seekers were resident in Southwark (receiving support under Section 98, 95 or 4). Compared to London, Southwark has seen a significant decrease in the number of asylum seekers supported over the last year (March 2024 to March 2025); down by 26% compared to a decrease of 1% across the capital. Of the South-East London boroughs, Southwark hosts the highest number of asylum seekers (second highest: Lewisham).

8.4 Religion and 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 comparable 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.

8.5 Sexual orientation

Southwark is ranked fourth in England for proportion of residents identifying with a non-heterosexual orientation, most 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.

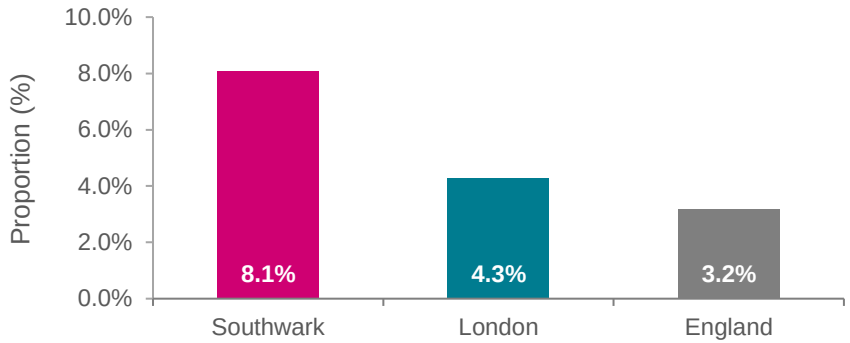


Fig 7. Residents identifying with a non-heterosexual sexual identity Source: ONS 2023. Census 2021 - Sexual orientation, England and Wales.

Intersectionality: It is important to acknowledge that neighbourhoods and population groups experiencing inequality are not homogenous. Within-group differences shaped by factors such as ethnicity, gender identity, sexual orientation, disability, and socioeconomic status can significantly influence individuals' experiences and outcomes.

When designing interventions, services, and strategies aimed at improving outcomes and reducing inequality, it is critical to adopt an intersectional approach. This involves understanding how overlapping social and demographic characteristics can interact to compound disadvantage and marginalisation.

8.6 Gender identity

Southwark is the fifth highest ranking local authority in England for residents identifying as trans or non-binary. 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.

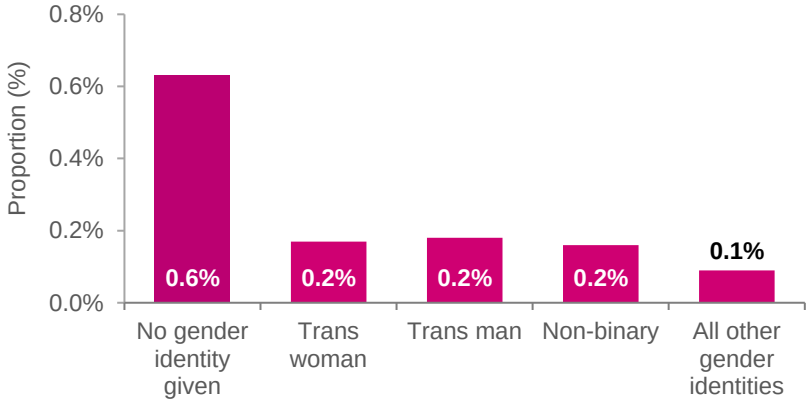


Fig 8. Proportion of Southwark residents who reported a gender identity different to their sex assigned at birth. Source: ONS 2023. Census 2021 – Gender identity, England and Wales.

8.7 Disability and 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.

In 2021 over 42,000 Southwark residents (14%) recorded 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.

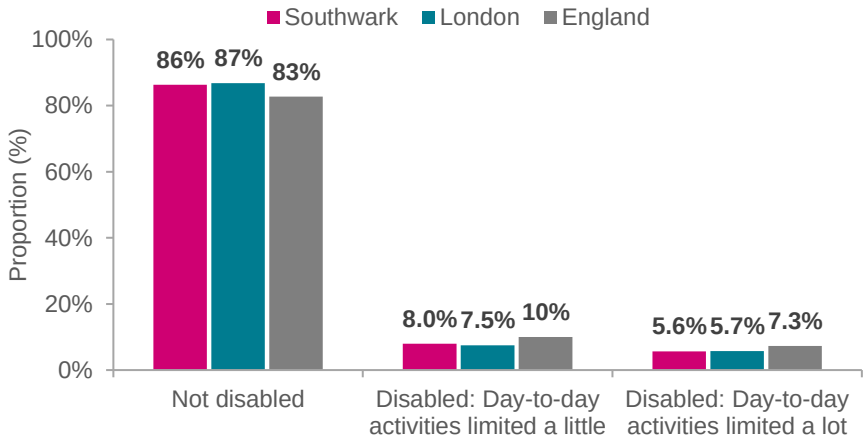


Fig 9. Proportion of Southwark, London and England residents who were disabled at the time of the census. Source: ONS, 2023. Census 2021 – Health, disability and unpaid care, England and Wales.

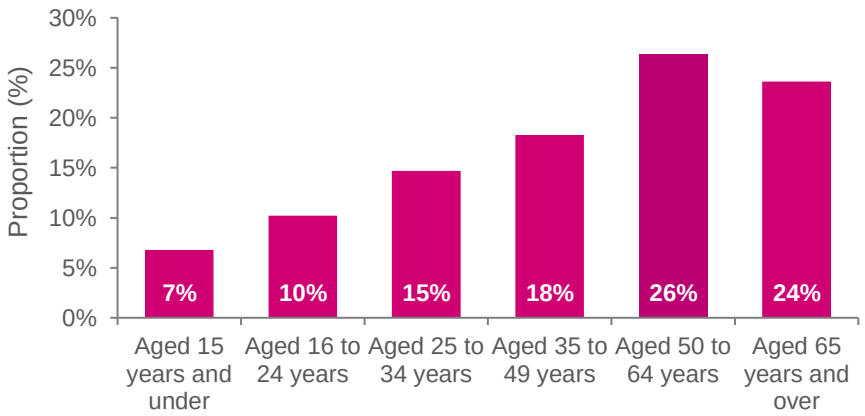


Fig 10. Disabled residents of Southwark by age group. Source: ONS 2023. Census 2021 – Age and disability.

Of those in Southwark who were disabled in 2021, half were aged 50 or over. Levels of disability among residents of different ethnicities broadly mirror that of the general population in the borough.

The Family Resource Survey by the Department of Work and Pensions, collects data on what disability/disabilities people have. The latest national survey was conducted in 2023/24.

For disabled working-age adults, 48% reported a mental health impairment, the most prevalent category among this age group. This was closely followed by a mobility impairment, at 42%. The third most likely impairment type related to stamina, breathing or fatigue, at 35%. Local patterns of disability are likely to broadly reflect these categories.

During 2023/24, 0.4% of individuals attending a Southwark GP practice were recorded to be people living with a learning disability; this is significantly lower than in London (0.5%) and England (0.6%).

Similarly, during 2024/25, 1.3% of Southwark residents were living with autism spectrum condition; the largest proportion were observed among those aged 6-12 years old (31%).

8.8 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.

The increased demand for care disproportionately affects women, people from Black African ethnic backgrounds, and those who themselves live with disability and complex care needs.

Joint Health & Wellbeing Strategy Long Term Population Health Measure

Priority Area 3: Support to stay well

Measure: Reduction in the % of unpaid carers reporting a mental health condition or long-standing illness

8.9 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 in 2021, there were about 130,800 households, an increase of over 10,000 since 2011. In 2021, Southwark ranked highest of all local authorities in England for the proportion of households which rent accommodation 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%, equating to 52,000 socially rented households in the borough.

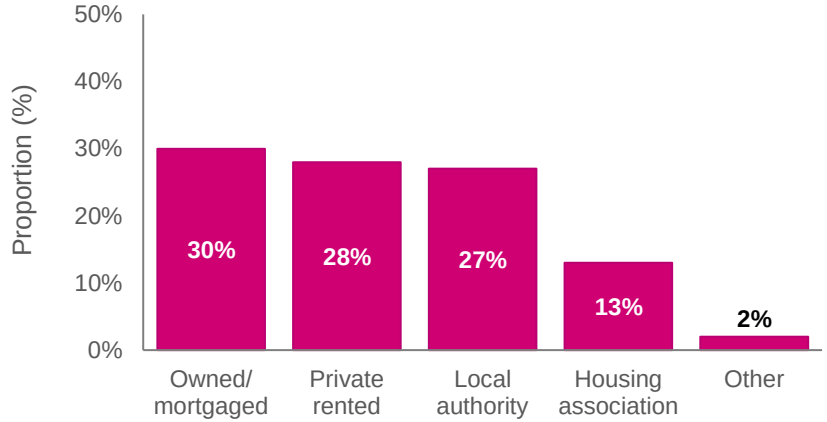


Fig 11. Housing tenure profile in Southwark in 2021
Source: ONS 2023. Census 2021 – Housing, England and Wales.

There has been an increase of 9,000 privately rented households since 2011, making up 28% of households in the borough. An estimated 11% of social housing and 18% of privately rented housing in Southwark is non-decent.

Most recent figures (January 2025) show over 4,000 households to be living in temporary accommodation provided by Southwark Council, 66% higher than in 2018. This includes over 5,000 dependent children, with specific needs related to health and education. Overall, younger women aged 18 to 44 years and people from Black ethnic groups are disproportionately represented among main applicants to temporary accommodation.

Household disadvantage is measured by taking a number of factors into account, including employment, education, health and disability and housing quality. In 2021, 51% of Southwark households were classed as disadvantaged, comparable to the London and England. In Southwark, 12% of households (approximately 16,000) are classed as overcrowded, higher than the London and England average.

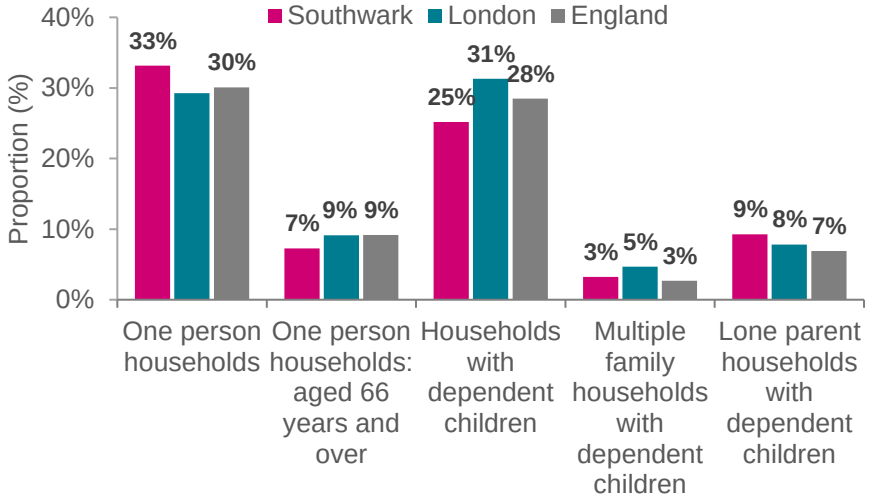


Fig 12. Proportion of households with selected household compositions, in Southwark, London and England. Source: ONS 2022. Census 2021 – Household and resident characteristics, England and Wales

9. PLACE

Where **people live** has a significant impact on their health outcomes. The **social determinants of health**, broadly defined as the conditions in which people are born, live and work, have a powerful influence on health inequalities. Improving where we live and the social environment around us is a key strategic approach of **Southwark 2030** and **encompasses several of the six goals: Goal 3 – A Safer Southwark; Goal 4 – A Strong and Fair Economy; Goal 6 – A Healthy Environment.**

Higher levels of social and economic disadvantage often go hand in hand with poorer access to resources like healthy and affordable food, green spaces, and quality healthcare, leading to poorer health outcomes. Child poverty, poor housing conditions, unemployment, and poor air quality can directly impact physical health throughout the life course.

There are variations in levels of socioeconomic disadvantage between **Southwark's 23 wards**, with higher levels of disadvantage located in the north of the borough compared to the south.

In 2024/25, over **800 individuals** were identified by as **rough sleepers in the borough, a 22% increase on the year before.** Many of those identified required support for their **mental health & substance misuse**.

While economic activity in Southwark is comparable to the region, Southwark has a higher **unemployment rate (5.5%)** than the national average (**3.8%**), highlighting challenges to gaining employment.

Levels of air pollution in Southwark remain an issue to the environment and to health. Despite experiencing a **30% decrease in PM2.5 concentrations** since 2018, levels remain almost **twice** above recommended levels.

Southwark experiences higher levels of **child poverty**. In 2024, **over 10,000 children** aged below 16 were living in poverty in Southwark, mostly residing in the wards of **Faraday, North Walworth, and Old Kent Road**.

Incidences **of theft and violence** against a person in Southwark are higher than those in London. However, the number of hospital admissions related to violence among residents has **fallen by almost 60%** since monitoring began in 2009/10.

9.1 Southwark's geographical boundaries

The geography of Southwark can be divided into 3 broad groups for which health needs and service delivery can be assessed:

- 23 Electoral wards
- 10 Council Neighbourhoods
- 5 Integrated Neighbourhood Teams

The significance of these geographies when assessing the health and wellbeing of the borough are many. It allows for a better visual understanding of the health needs of residents within specific geographical areas, offering an opportunity to target interventions to specific parts of the borough. This level of granularity also offers a better accuracy and targeting of funding to reduce existing health inequalities. More information on each of Southwark's communities can be found at: Southwark Insights Hub | Southwark's population and demographics.

Fig 13. Southwark's ten integrated neighbourhood areas and their respective wards.

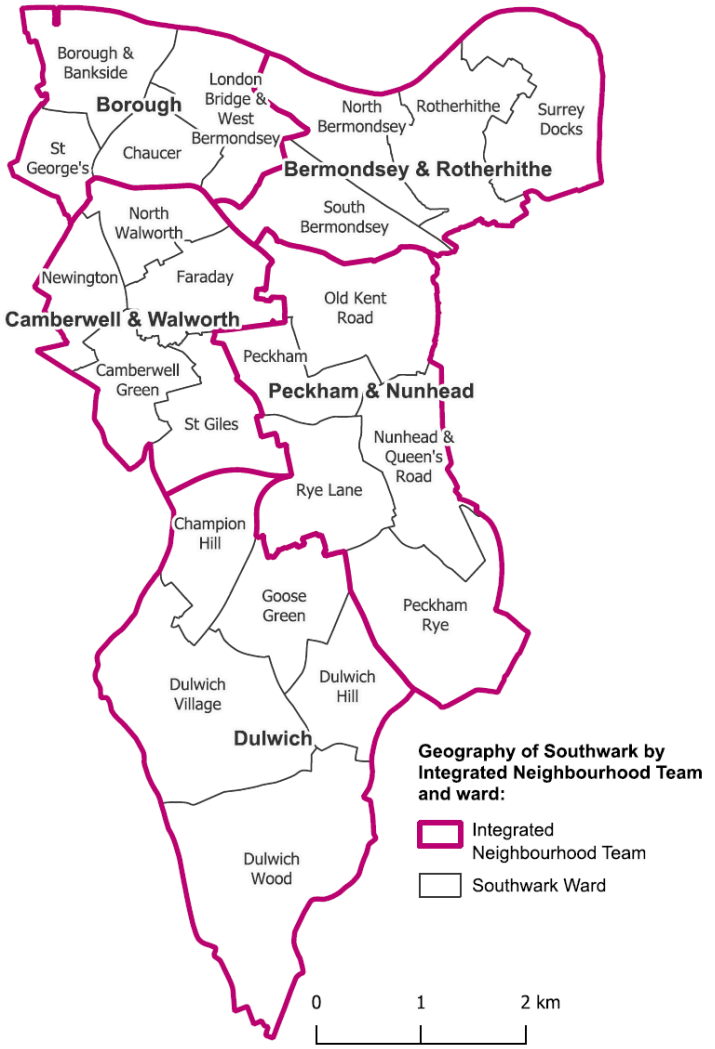


Fig 14. Southwark's five Integrated Neighbourhood Teams and their respective wards.

9.2 Areas by socioeconomic disadvantage

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

Southwark's relative deprivation levels have improved since 2015, but it remains one of the most deprived areas in England.

IoD 2015	IoD 2019
Rank of Averages Rank: 23rd	Rank of Averages Rank: 43rd
Rank of Average Score: 40	Rank of Average Score: 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 fifth nationally. These are concentrated across the central and northern parts of Southwark, such as Faraday and Peckham. It is important to acknowledge that pockets of disadvantage also exist within areas of affluence, such as the Kingswood estate in Dulwich Wood.

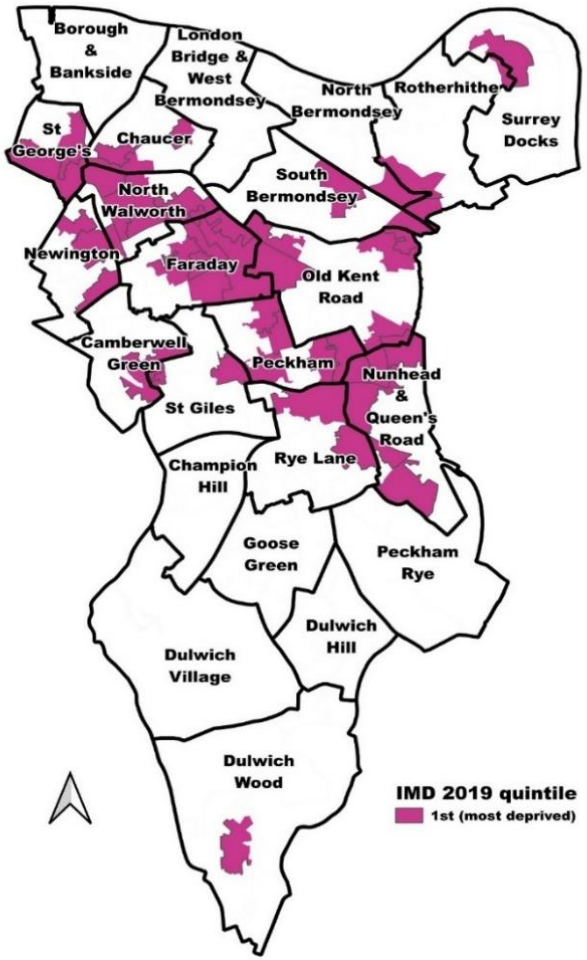


Fig 15. Southwark LSOAs in the 2019 Index of Deprivation first quintile (among the 20% most deprived LSOAs England-wide). Source: Ministry of Housing, Communities and Local Government 2019.

Access to parks, GPs, pharmacies and transportation

Almost all of Southwark's 315,520 population is within 15-minute walking distance of a GP. Approximately a third of GPs in Southwark are located within the most disadvantaged neighbourhoods. There are 57 community pharmacies in Southwark, with over 90% of residents being within a 10-minute walk from a pharmacy. Of all pharmacies, 23% are located within the 10% most disadvantaged communities within the borough.

There are noticeable variations in access to public transport across the borough. There are excellent or very good levels of public transport in disadvantaged areas in the centre and north-east of the borough who are served by major transport links including London Bridge, Elephant and Castle and other overground trains in the Peckham area. However, there are gaps in transportation access in the less disadvantaged areas in the south of the borough.

Access to parks and green spaces across the borough are not evenly distributed, with a 50% difference in green space coverage between the least and most green wards.

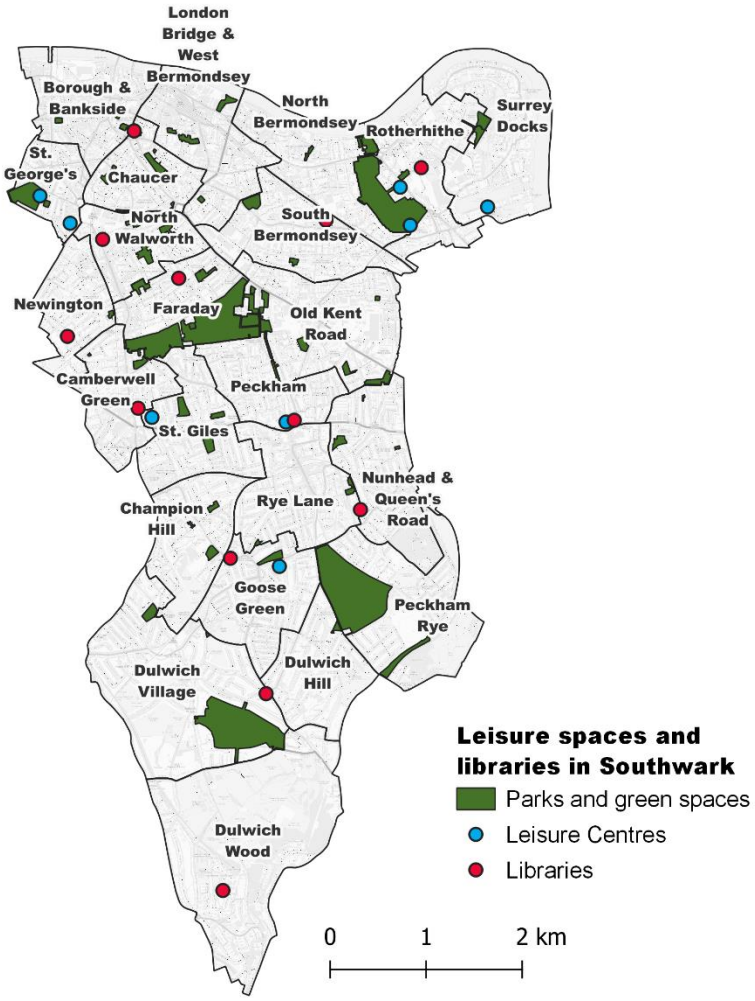


Fig 16. A map of green spaces, parks and libraries in Southwark.

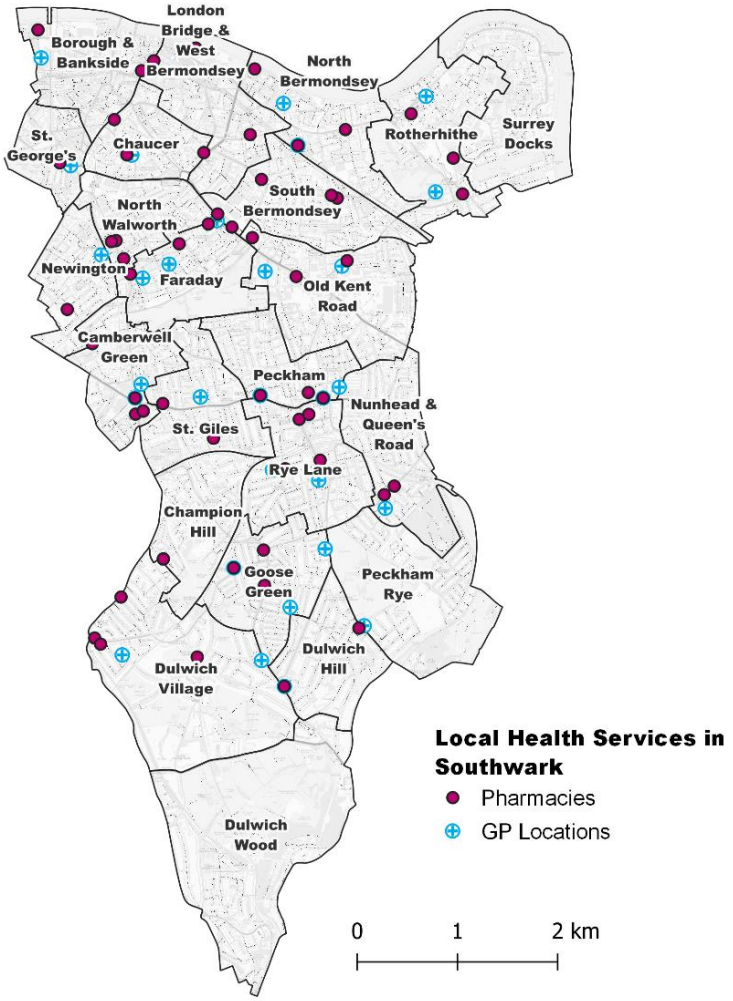


Fig 17. Local health services (pharmacies and GPs) in Southwark.

9.3 Employment and income

Figures for 2024 show that levels of economic activity in Southwark are comparable to London and England. For the year up to 31st December 2024, 81% of the population aged 16+ were economically active, 74% of whom were in employment, a 3% point decrease compared to 2023. Economic inactivity disproportionately impacts certain groups, such as those with a long-term health condition.

Joint Health & Wellbeing Strategy Long Term Population Health Measure

Priority Area 2: Health work and lives

Measure 1: Reduce gap in the employment rate between those with a long-term health condition and the overall employment rate

Measure 2: Reduce gap in employment rate between those who are in receipt of long-term support for a learning disability (aged 18 to 64) and the overall employment rate

Despite economic activity levels in Southwark reflecting similar levels to the region, levels of economic activity remain well below the levels of 2020 (86.7%) and are currently the same as 2015 levels.

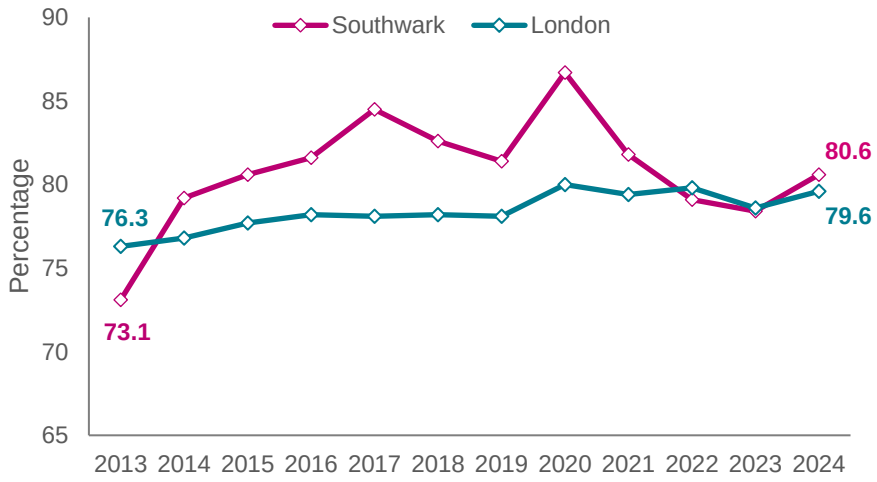


Fig 18. Economically active residents aged 16+ in Southwark and London: December 2014 – December 2024.
Source: ONS annual population survey 2024.

The median (average) household income in Southwark in 2024 was £46,634, higher the UK average of £37,861. However, there was a wide range of incomes across the borough, with around 1 in 30 (3%) households having a total income of less than £15,000 per year.

While average income in Southwark is higher than UK levels, there are significant geographical inequalities, with median income highest in Dulwich Village (£61,229) and lowest in Peckham (£36,405).

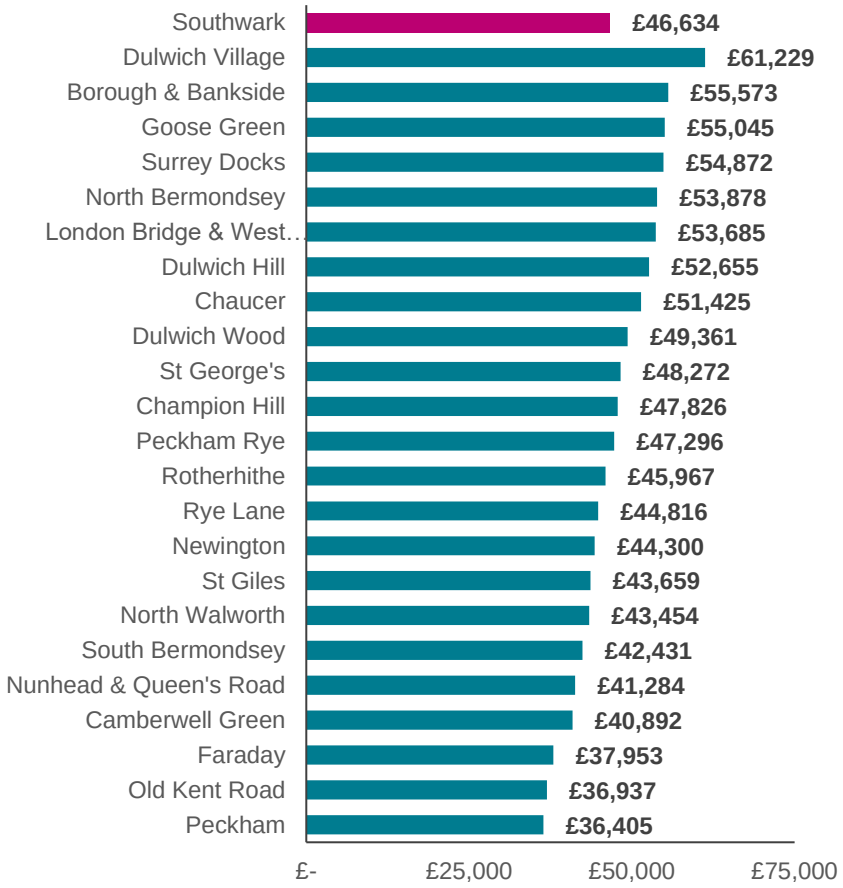


Fig 19. Median gross household income by ward, 2024.
Source: CACI Paycheck Directory, 2024.

9.4 Child poverty

Children are classed as growing up in relative poverty if their family income is below the poverty line: earning 60% below the median income in the reference year, before housing costs such as rent, heating, electricity and water. They must also be in receipt of Child Benefit and at least one other household benefit (Universal Credit, tax credits, or Housing Benefit) at any point in the year to be classed as low income.

In 2023/24, approximately 10,300 children aged 0-15 in Southwark were living in poverty, before housing costs were factored in, equating to 20.5% of children in the borough, less than the England average (21.8%). After factoring in housing costs including rent and water rates, the proportion of children in poverty doubled to 41% (25,000). This ranked Southwark the 8th highest amongst London boroughs for child poverty After Housing Costs (AHC), with the London average for this metric standing at 35%.

Joint Health & Wellbeing Strategy Long Term Population Health Measure

Priority Area 4: Healthy and connected communities

Measure: Reduction in the % of children living in relative poverty

There is a greater impact of child poverty in north and central areas of the borough, such as Borough & bankside, Faraday, & Old Kent Road. This aligns with our understanding of areas which face greater socioeconomic disadvantage.

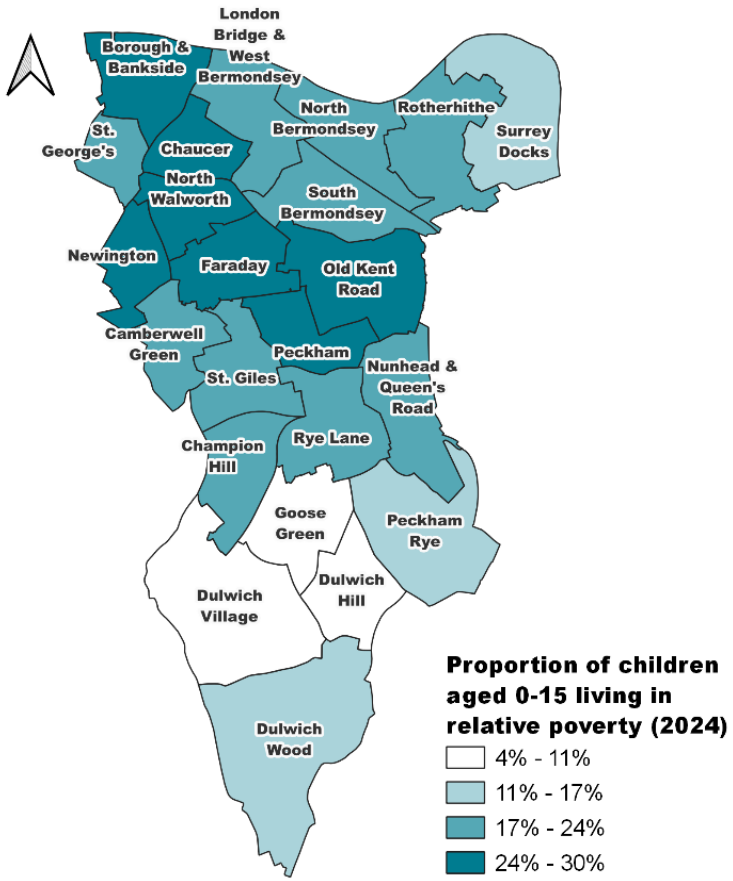


Fig 20. Percentage of children aged 0-15 yr living in poverty (relative low income families) by ward, before housing costs 2023/24.Source: Department for Work and Pensions 2025. Children in low income families: Relative low income 2023/24. Accessed via StatXplore.

9.5 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 also had a knock-on effect, increasing prices of goods and services across multiple industries.

Who is most affected?

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.

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.

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 January 2022 and January 2024. While there has been a steady decrease in food inflation in the last year, from 4% in January 2024 to 3% in January 2025, prices continue to increase impacting low-income households the most.

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.

Data from Impact on Urban Health in 2023 highlighted that 82% of those surveyed in Southwark reported not eating for a whole day because they couldn't afford or access food, conveying the financial challenges experienced by residents.

Joint Health & Wellbeing Strategy Long Term Population Health Measure

Priority Area 2: Healthy work and lives

Measure: Reduction in the % of residents experiencing food poverty

9.6 Homelessness

Southwark has one of the largest number of rough sleepers in London. In 2024/25 over 800 individuals were identified by outreach teams as rough sleepers in the borough, a 22% increase on the year before. Of the rough sleepers identified, 42% were new rough sleepers and 19% were classed as living on the streets (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 Borough & Bankside, London Bridge & West Bermondsey and St George's, with pockets in Faraday, Old Kent Road, Rye Lane and Champion Hill. The geographical spread is closely linked to transport hubs within the borough and areas of high footfall.

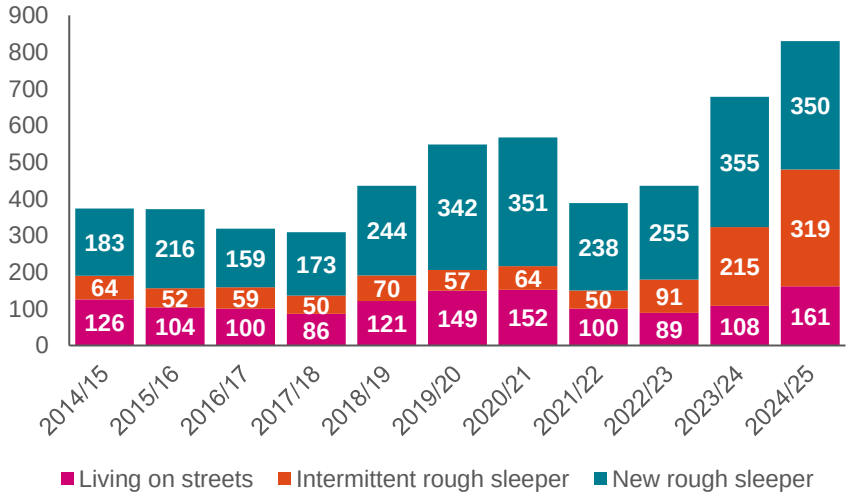


Fig 21. Numbers of rough sleepers identified by outreach teams in Southwark, 2014/15 to 2024/25.
Source: GLA, 2024. Rough sleeping in London (CHAIN reports).

In 2024/25, most rough sleepers identified in Southwark were male (83%). A third (33%) were 36-45 years old, followed by those aged 26-35 years old (25%). The main ethnic groups were White (46%, including 26% White-British) and Black (25%).

The most common support need for those rough sleepers receiving an assessment was mental health (44%). However almost a third (31%) had more than one support need related to mental health, drugs or alcohol, reflecting the complexity of the health needs for this population group.

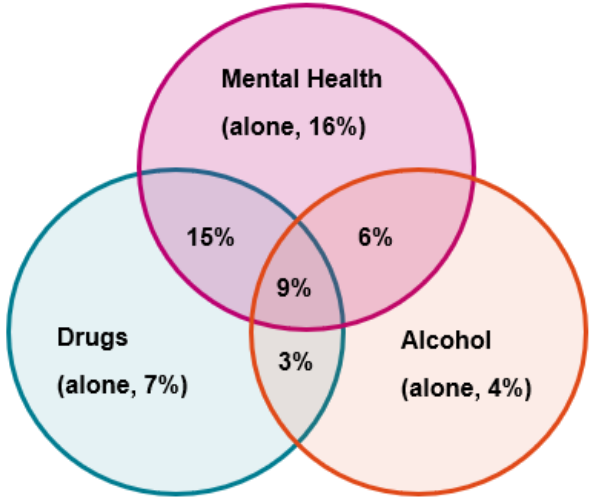


Fig 22. Recorded support needs of Southwark rough sleepers with needs assessed, 2024/25.
Source: GLA, 2025. Rough sleeping in London (CHAIN reports).

9.7 Crime

Crime can have a significant impact on the health and wellbeing of residents and communities. Between 2024 and 2025, there were over 43,100 offences recorded in Southwark. This was equivalent to 140 offences per 1,000 population, a rate significantly higher rate than the London average of 114 offences per 1,000 population.

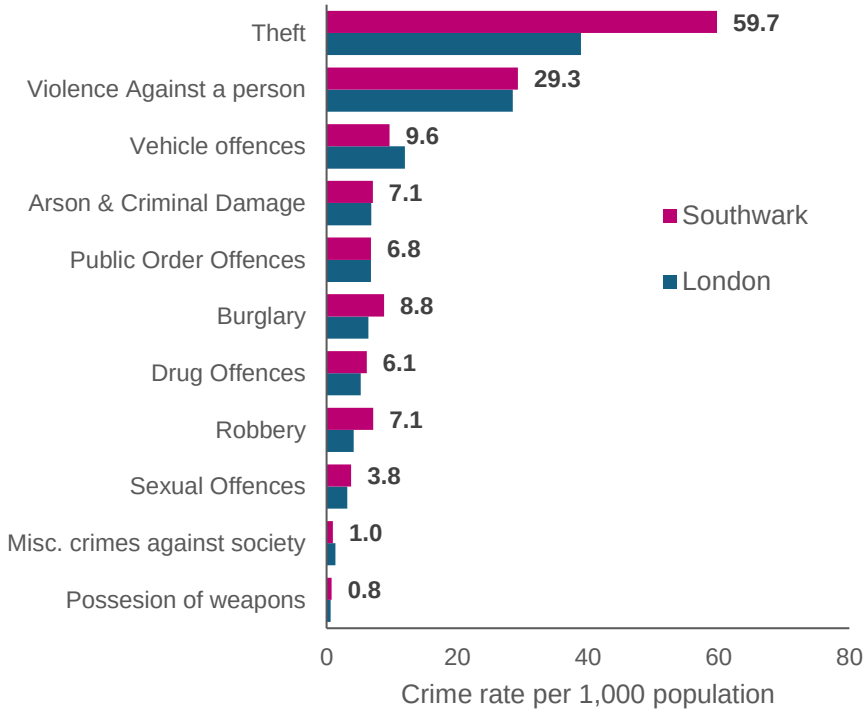


Fig 23. Crime rate for Southwark and London, 2024/25.
Source: GLA, London Datastore, 2025. Crime Dashboard.

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

In 2024/25, there were almost 18,400 recorded cases of theft in Southwark and about 9,000 cases of violence against the person. Across the borough, the highest crime rates were in Borough & Bankside, St George's and London Bridge & West Bermondsey.

Emergency hospital admissions for violence (including sexual violence) are comparable to London and England averages. Over the three-year period 2021/22–2023/24, there were 360 such admissions of Southwark residents. The number of hospital admissions related to violence among residents has fallen by almost 60% since monitoring began in 2009/10.

9.8 Air quality

There is strong evidence showing the harmful effects of air pollution on health. These include exacerbation of respiratory conditions (such as asthma and chronic respiratory disease) and increased emergency hospital admission rates.

London-wide, levels of the pollutants nitrogen dioxide (NO_2) and particulate matter of diameter 10 μm or less (PM_{10}) exceed national air quality standards. Southwark's largest single source of air pollution is road transport, contributing one-third of $PM_{2.5}$ emissions. Domestic and commercial fuels, used mostly in cooking and heating, as well as power stations and industry also contribute substantially to levels of NO_2, PM_{10} and $PM_{2.5}$.

Southwark is a busy inner London borough with high levels of nitrogen dioxide (NO_2) and particulate matter 2.5 ($PM_{2.5}$), mainly from road transport. In 2023, Southwark's annual average $PM_{2.5}$ concentration was 8.9 µg/m³, higher than London and England levels and almost twice the WHO guidance value of 5.0 µg/m³, despite a

30% decrease on 2018 levels. Southwark's one primary air quality monitoring station is located on the Old Kent Road.

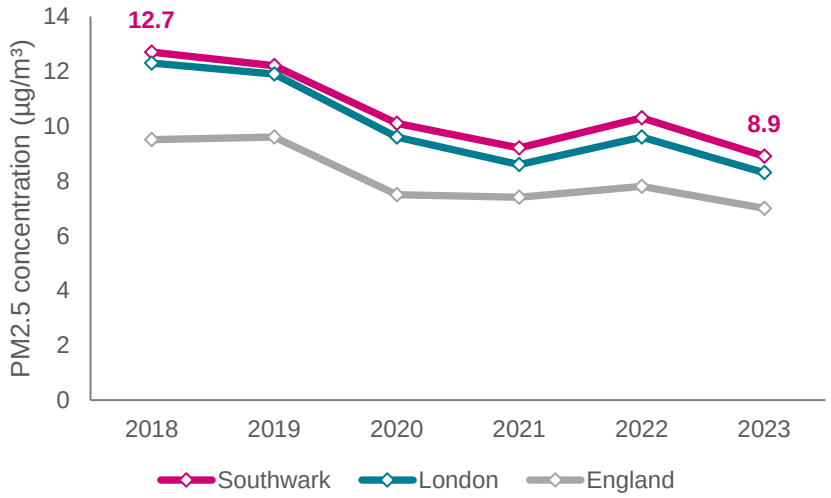


Fig 24. Average annual concentration of $PM_{2.5}$ for Southwark, London and England, 2018 to 2023.
Source: OHID, 2025. Respiratory Disease Profile.

While short-term exposure to air pollution is known to harm health, the relative risk of long-term exposure is much greater, contributing to the initiation, progression and exacerbation of disease. Nitrogen dioxide is linked to lung damage, while $PM_{2.5}$ and PM_{10} are associated with respiratory disease, lung damage and cancer. Long-term exposure to air pollution also increases the risk of premature death. Air pollution exposure is estimated to reduce average UK life expectancy by 6 months. The impact of $PM_{2.5}$ on mortality is greater in Southwark than across London and England (see figure below), but the impact has reduced since 2010 due to falling emission rates.

Fig 25. Percentage of adult deaths attributable to $PM_{2.5}$ air pollution in Southwark, London and England, 2023.
Source: OHID, 2024. Public Health Outcomes Framework.

Southwark has seven Air Quality Focus Areas which have specific targets set for air pollution levels. More information on the health impact of air quality is available in the 2023 Annual Public Health Report, available at: www.southwark.gov.uk/aphr.

Joint Health & Wellbeing Strategy Long Term Population Health Measure

Priority Area 4: Healthy and connected communities

Measure: Reduction in fraction of mortality attributable to particulate air pollution in Southwark

9.9 Heat exposure

Excessive heat exposure is a significant public health concern, leading to increased morbidity and mortality, especially among vulnerable populations. A third of local GPs were either located in or on the border of an area with high levels of heat risk. For other key services in Southwark, analysis indicates that 1 hospital, 3 care homes, and 4 supported living facilities are in areas with the highest heat risk scores.

While excessive heat is a major threat to population health, cold weather also presents a challenge to public health. Both cold temperatures experienced in indoor and outdoor spaces present an increased risk of cardio-respiratory morbidity and mortality in vulnerable groups compared to non-winter times (April – November). In 2021, there were 57% (230) more winter deaths compared to non-winter periods in Southwark. The highest burden of winter deaths was observed amongst those aged over 85+, with COVID-19 playing a significant role in these trends during this period.

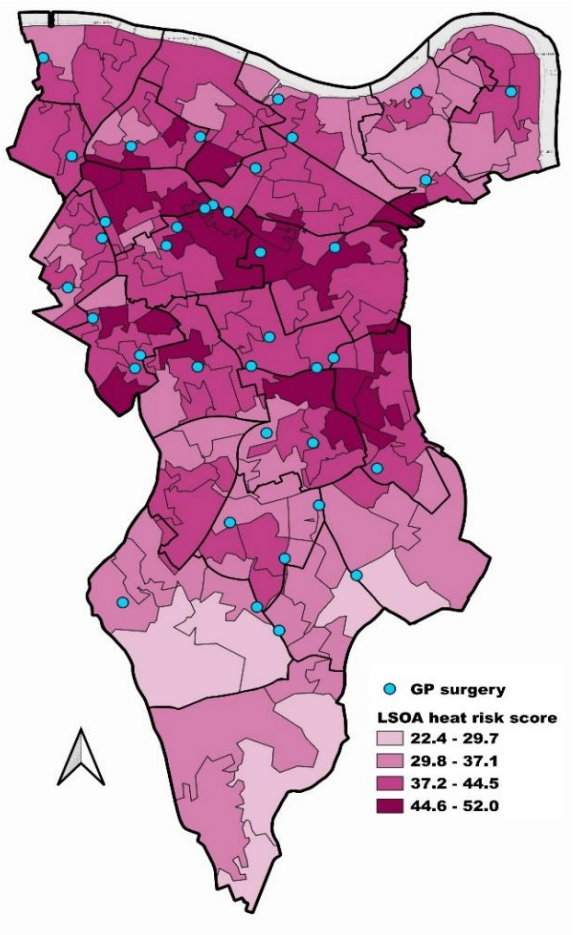


Fig 26. Southwark lower super output areas (LSOAs) by Greater London Authority heat risk score, plus GP surgeries.
Sources: GLA 2024, SELICS 2024, CCG 2024, Southwark Council 2024, Guy's & St Thomas' and South London & Maudsley NHS Foundation Trusts 2024, ONS 2024.

10. RESIDENTS' VOICE

Health & Wellbeing Board partners must ensure that **local services and programmes** address residents' concerns and priorities. Partners need to **work together with communities** to **address the inequalities in access, experience and outcomes.**

There has been a wide range of community engagement over the last year, highlighting residents' views on local health and wellbeing. **Local resident surveys, community engagement and stakeholder workshops** have highlighted common themes. Residents have also been trained as **Community Researchers**, directly involved communities in **co-producing evidence and action** on health inequalities.

Themes from recent resident feedback include:

- Listening to and empowering families.
- Access to good, healthy, affordable food.
- Good quality, safe, affordable housing.
- Safer, cleaner, more walkable local streets.
- Embedding a culture of co-design with residents into the creation and delivery of local services.
- Leadership in addressing the racism that drives maternal health inequalities.
- More variety of fitness activities to help people stay physically and mentally well.
- Concerns about good mental health (at all ages), and better access to mental health support.
- More co-ordinated services, including co-production with residents and those with lived experience, plus better feedback on how participants' voices shape local service development.

10.1 Rebuilding trust through community engagement and empowerment

Over the past year, local community engagement has included consultation on women's and girls' safety, young people's support, and an older Black residents' centre.

Women's and Girls' Safety

Southwark Council's Women's and Girls' Safety Survey 2024/25 aimed to understand participants' experiences of living, working and travelling in the borough.

The main survey was accompanied by five sub-surveys assessing experiences in five locations disproportionately affected by violence against women and girls (VAWG).

More than 700 responses were received:

- Over half of respondents (54%) did not feel safe travelling in Southwark
- Two-fifths (41%) felt less safe than a year ago
- Almost two-thirds (64%) had experienced gender-based violence
- Almost half (47%) did not trust police to deal appropriately with gender-based violence

These results have informed local work focused on: street cleaning and walkway clearance; street lighting maintenance; CCTV monitoring; and ongoing partnership working with police, businesses and other stakeholders.

Positive Futures for Young People

The Southwark Council Positive Futures for Young People Fund empowers young people in the borough through enhancing education, career and personal development opportunities. Funding supports local youth services organisations, youth centres, an adventure playground and the Southwark Youth Parliament.

The Fund's 2025 Positive Futures for Young People Survey had 470 responses from across the borough, many from less advantaged areas, and with a wide range of ethnic groups and gender and sexual identities represented.

Four-fifths (39%) of respondents used some kind of youth club or facility. Common reasons for not doing so included:

- Lack of information (almost one-quarter; 23%)
- Lack of appeal (one-sixth; 14%)
- Lack of time (one-eighth; 13%)

Participants wanted youth clubs to offer skills training, sport and physical activity, creative activities, trips, volunteering opportunities, mentoring and career planning, mental health and wellbeing support, and opportunities to socialise in a safe place.

Southwark Black Seniors

Following the Council's 2023 commitment to develop a Centre for Black African and Caribbean Elders, the Southwark Black Seniors consultation was undertaken to better understand Black seniors' health and wellbeing needs and how a centre could address these.

The consultation engaged both Black seniors and service providers,

with over 180 respondents. Participants wanted the Centre to deliver culturally sensitive health care, intergenerational activities, learning and volunteering opportunities, and help with transport access, while being aware of Black elders' community diversity and welcoming to members of all ethnic backgrounds.

Following survey completion, a steering group of residents, public sector, and voluntary and community sector (VCS) workers has been formed to shape development of the Centre for Black African & Caribbean Elders.

10.2 Resident Insight Survey

The first Resident Insight Survey took place between July – August 2024. The first wave results highlighted that crime and perceptions of safety, housing, and resident involvement in local decision making are priority areas for our residents.

The survey results are representative at a ward level by age, ethnicity, economic status, disability and tenure, and will take place every six months. Further analysis is planned as future waves of the survey are completed.

10.3 Southwark Maternity Commission

The Southwark Maternity Commission was established in early 2024 to understand the health inequalities in maternity care in the borough, especially amongst Black and Brown women and people who give birth. The commission heard from over 600 residents and frontline professionals through a series of public meetings in the community, targeted surveys and specially commissioned insights research, and is now publicly available here: Report of Southwark Maternity Commission.

Work with stakeholders led to the development of 5 key themes:

- Tackling discrimination
- Ensuring women are listened to and supported to speak up
- Providing women with the right information at the right time
- Joining up Council and NHS services better
- Supporting the workforce to provide compassionate, kind and high quality care

These themes were used to develop ten recommendations, including:

- Leadership in addressing racism that leads to unequal maternal health
- Develop a new national way of reporting maternal health
- Review the maternity workforce
- Evaluate the fairness of maternity services
- Listen to and empower families
- Preparation and support before pregnancy
- Give parents the right information, at the right time, in the right way
- Create a joined-up approach to families' needs between the NHS, South East London boroughs, and voluntary and community sector
- Southwark Council to review their role in maternity care
- Review how feedback is dealt with

10.4 Health and Wellbeing in Lambeth and Southwark Survey

In 2024, Southwark-based charitable organisation Impact on Urban Health conducted a health and wellbeing study in Southwark and Lambeth. To optimise findings that were relevant and reflective of the local population, the study was developed with community researchers to help amplify the voices residents.

Areas of focus for the study were on overall health & wellbeing, discrimination & trust, access to healthcare, and living environment. Key findings from the study include:

- An estimated 65% of residents responded to be in 'very good' or 'good' health.
- Having one or more long-term conditions influenced whether people reported being in good health or not.
- Residents from a black ethnic background, not speaking English as a first language, living with disabilities or mental health issues faced experiences of discrimination within healthcare.
- Housing was identified as common issues for residents, these included issues such as poor maintenance management, lack of heating or hot water, noise and pollution, and short-term renting.

10.5 Southwark School Health Related Behaviour Survey

In 2024 a survey of pupils in primary and secondary schools across Southwark was undertaken. Over 2,500 pupils aged 9 to 12 and over 880 pupils aged 11 to 15 were included in the survey. The survey provides an important snapshot of the health and wellbeing of local children. Headline results from the survey are shown opposite.

Primary School Survey:

- 5% had nothing to eat or drink for breakfast on the day of the survey; another 2% only had snacks for breakfast that morning
- 35% of pupils said they had used a foodbank or similar source of free or subsidised food in the last 12 months
- 29% of pupils said that they worry 'quite a lot' or 'a lot' about money/family finances
- 48% of pupils said they did active play on at least 3 days in the last 7 days
- 23% of Year 6 pupils said they were never supervised while using the Internet at home. In the past year 92% of Year 6 pupils said that they have been told how to stay safe online
- 7% of pupils had a score of 12 – 30 on the Stirling Children's Wellbeing Scale, indicating poor mental health

Secondary School Survey:

- 34% had nothing to eat or drink for breakfast on the day of the survey; another 6% only had a drink that morning.
- 20% of pupils said their household has used 'food banks' or similar sources of free or subsidised food in the last 12 months
- 24% of pupils said that they worry 'quite a lot' or 'a lot' about money/family finances
- 8% of pupils responded that they have smoked in the past or smoke now. 18% of Year 8 pupils and 31% of Year 10 pupils said they have at least tried vaping
- 87% of pupils responded that they have been told how to stay safe while online in the last year
- 19% of pupils responded that they have been bullied at or near school in the last 12 months
- 27% of pupils had a medium-low self-esteem score

11. STARTING WELL

The first priority of the Joint Health & Wellbeing Strategy is to ensure every child in Southwark has a "**healthy start in life"** and aligns with the Southwark 2030 goal of a **"good start in life".** Both aim to ensure that our children and young people have a great childhood that builds on a very solid foundation for adult life.

Despite Southwark experiencing a **10-year decline in the total number of live births**, the need to support good **maternal health and provide positive early experiences for children** remains a priority due to the inequality in outcomes that are present throughout maternal, childhood, and adolescent health within the borough.

Live births in Southwark have dropped by almost **one-third** from **2013 (4,706) to 2023 (3,265).**

The **Fertility rate** in **Dulwich Hill** (54.3/1k) was **double** that in **Borough & Bankside** (22.6/1k).

There were **305 less** emergency hospital admissions for Southwark children **under 5** in 2023/24.

There were **126 (per 100k) less** hospital admissions for **asthma** in Southwark under 19s in 2023/24.

Excess weight remains a noticeable issue within the borough as more than **2 in 5** Southwark **Year 6 children** have excess weight levels. Levels of excess weight have remained high for the **past 10 years**.

Inequalities for **vaccination coverage** and **excess weight** are present within the borough. **Black children** have a lower coverage of the MMR vaccination, as well as experiencing higher levels of excess weight.

Child coverage for the **6-in-1, MMR, and Flu** vaccines are above or similar to the **London average,** however uptake is well below recommended levels. Vaccination coverage for the **6-in-1** vaccine has dropped by **7%** over the **past 10 years**.

For children identified as having an Education, Health and Care plan, there was a **97% increase** in the number of children with **autism spectrum disorder** as their primary need between the years 2016 and 2024.

11.1 Births

The total number of babies born in Southwark has decreased substantially over the past 10 years. There were 3,259 live births in 2024, down from 4,746 in 2014, a drop of almost one-third (31%). Note that Southwark's local birth information comes from NHS data, which excludes births at home and in private facilities; Office for National Statistics birth figures are somewhat higher.

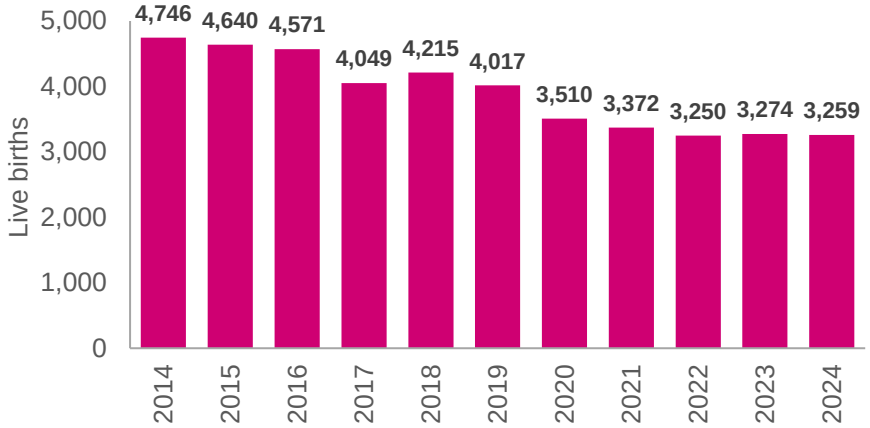


Fig 27. NHS-recorded live births to Southwark residents, 2014 to 2024. Source: NHS Digital, 2025. Local births data.

The decline in the birth rate in Southwark is seen across all age groups, but particularly among younger women. The average age of mothers giving birth in Southwark is now around 33 years.

Across the borough, there is substantial variation in birth rate. The 2021–23 estimated general fertility rate in Dulwich Hill (54.3 births per 1,000) was over double that in Borough & Bankside (22.6 births per 1,000).

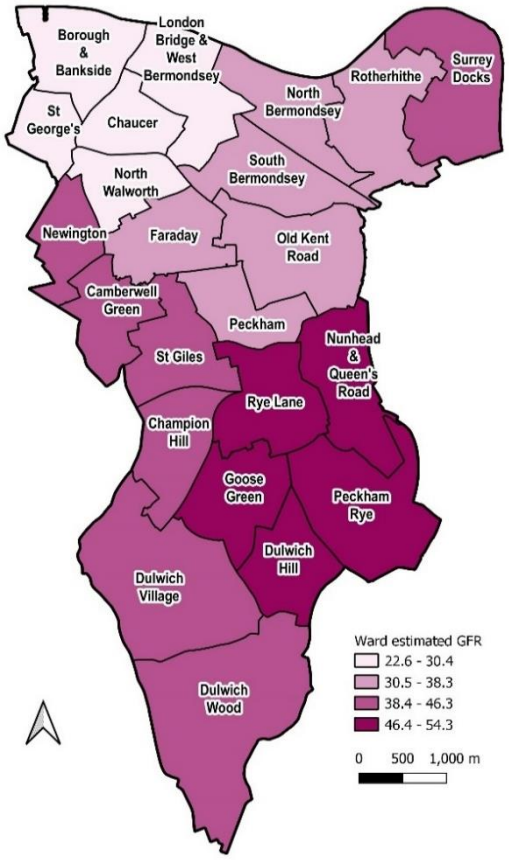


Fig 28. 3-yr average estimated general fertility rate by Southwark ward, 2021–2023.Sources: NHS Digital, 2025, Local birth files; ONS, 2024, small area population estimates.

Mothers and birthing parents in Southwark come from a diverse range of backgrounds. In 2023, three-fifths (61%) were born in Europe – most (72%) of these were born in England. The most common non-UK countries of birth were Nigeria, Ghana, Sierra Leone and India.

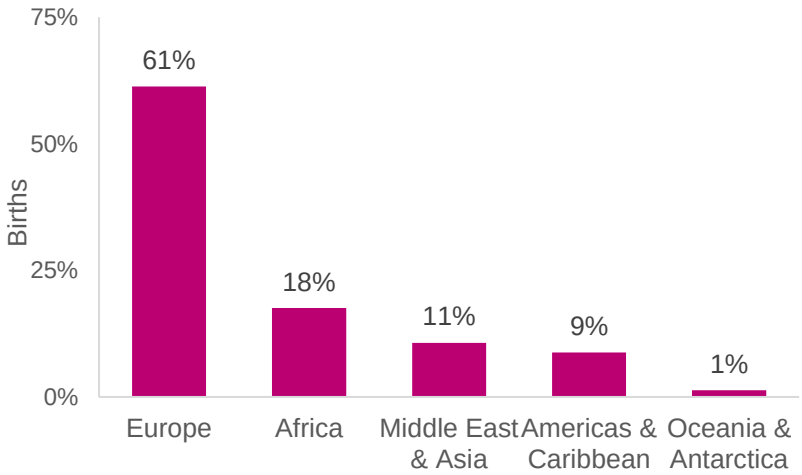


Fig 29. Southwark 2023 births by mother's continent of birth.
Source: NHS Digital, 2025. Local birth data.

Stillbirths remain rare, with 42 cases over 2021–2023: rates are comparable to London and England. However, there are significant inequalities: almost two-thirds (63%) of stillbirths were to women and birthing parents not born in the UK; and of these people, over one-third (35%) were born elsewhere in Europe, over one-quarter (27%) in Africa, and one-fifth (19%) in South America or the Caribbean.

11.2 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 2002, with rates falling by almost two-thirds; though improvements have slowed in recent years. Between 2021 and 2023 there were 33 infant deaths locally, with half of these deaths occurring within the first 7 days of life.

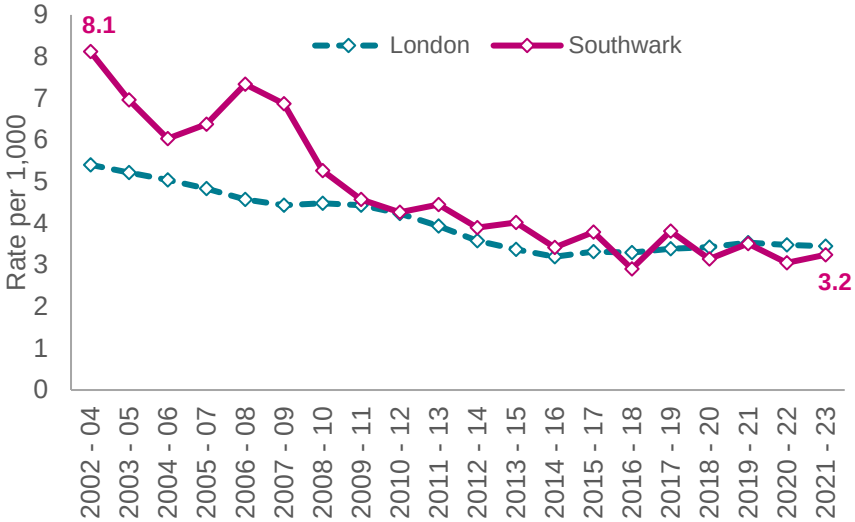


Fig 30. Infant deaths under 1 year of age, per 1,000 live births: 2002-2023.
Source: OHID, 2025. Public Health Outcomes Framework

Joint Health & Wellbeing Strategy Long Term Population Health Measure

Priority Area 1: A healthy start in life

Measure: Reduction in infant (< 1 year) mortality rate

11.3 Childhood vaccinations

Vaccination is the safest and most effective way of protecting individuals and communities from vaccine-preventable diseases.

Uptake of childhood vaccinations in Southwark is generally comparable to London averages but below England averages and target levels (95%). Levels of childhood 6-in-1 vaccination (covering diphtheria, tetanus, pertussis, polio and Haemophilus influenza type B) have generally fallen in recent years, with the most recent year showing a 1.3 percentage point reduction.

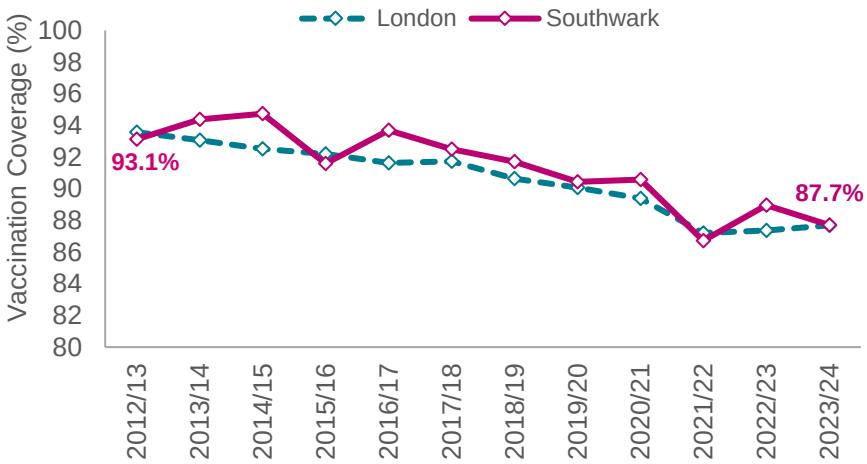


Fig 31. Childhood 6-in-1 vaccination coverage at 2 years of age, for Southwark & London: 2013/14 to 2022/23. Source: NHS England, 2024. Child Vaccination Coverage Statistics, 2012-13 to 2023-24.

Coverage of the measles, mumps and rubella (MMR) vaccine has been falling steadily in recent years, down from over 90% in 2014/15, to just under 85% in 2023/24. Coverage in Southwark is far below the threshold needed for herd immunity (95%). In 2024, a measles outbreak incident was declared in London, driven by low vaccination uptake.

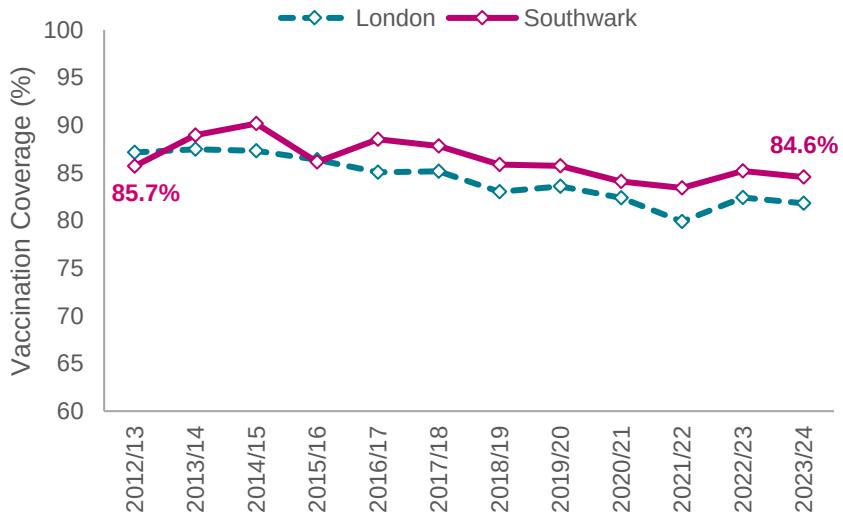


Fig 32. Childhood MMR vaccination coverage at 2 years of age, for Southwark & London: 2012/13 to 2023/24.
Source: NHS England, 2024. Child Vaccination Coverage Statistics.

Nationally, evidence shows that people living in more disadvantaged communities, along with some ethnic community groups have lower uptake of vaccinations levels. In Southwark, 1–5 yr olds' MMR non-vaccination levels are six times higher in some North Walworth and Chaucer ward neighbourhoods (72%) than in some Dulwich Village neighbourhoods (12%), and are particularly high in the north west of the borough and among residents with a Black Caribbean background (44%).

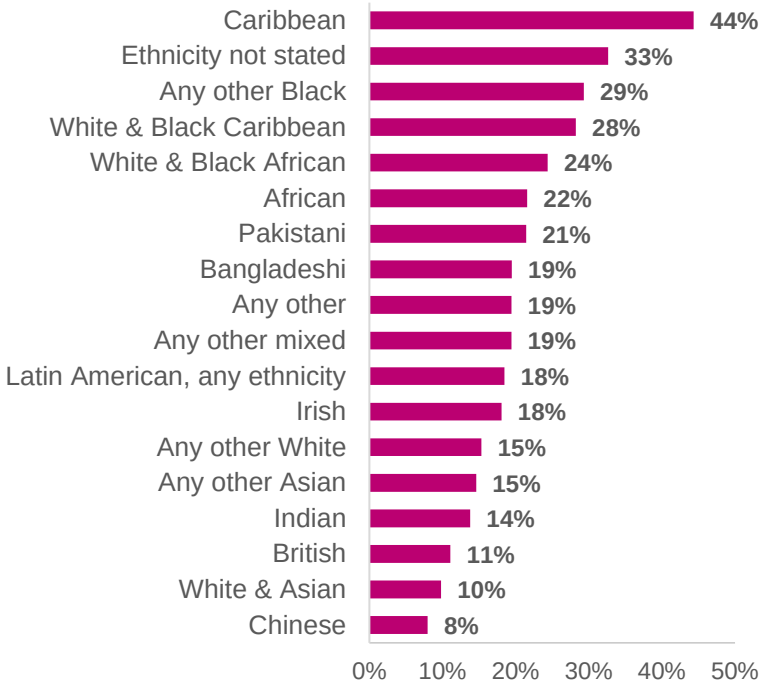


Fig 33. MMR non-vaccination rates for 1–5 yr old Southwark GP patients by ethnic group and for Latin American identity (any ethnic group), June 2025. Source: SEL ICS, 2025. Primary Care Childhood Immunisations Dashboard.

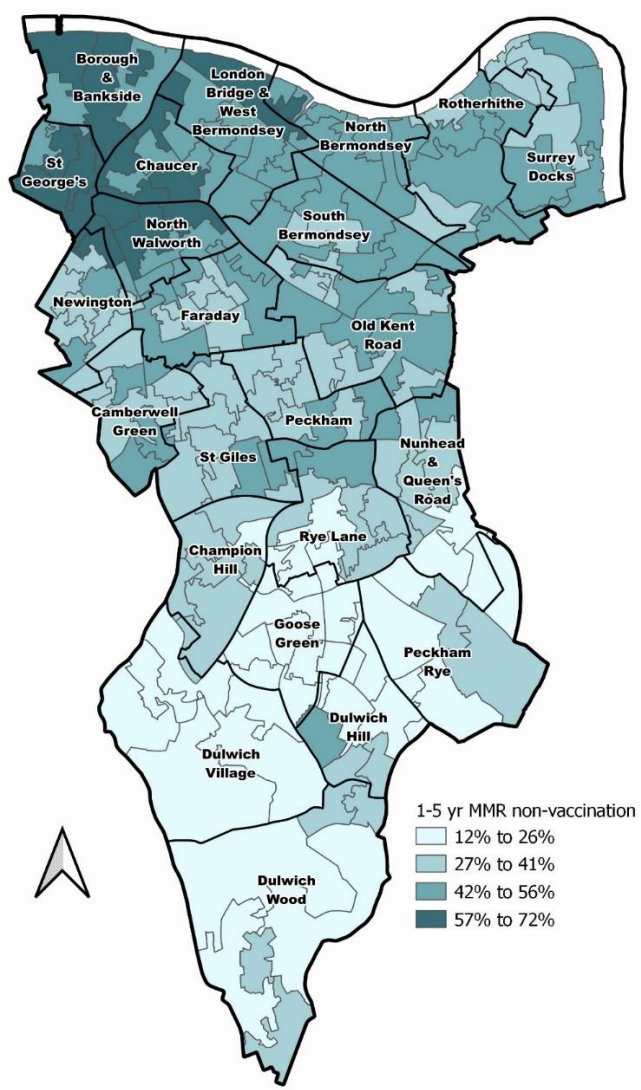


Fig 34. Southwark Lower Super Output Areas (LSOAs) by MMR non-vaccination rate in 1–5 yr old resident Southwark GP patients, June 2025. Source: SEL ICS, 2025. Primary Care Childhood Immunisations Dashboard.

Joint Health & Wellbeing Strategy Long Term Population Health Measure

Priority Area 1: A healthy start in life

Measure: Reduction in the gap in 6 in 1 vaccine coverage at 12 months between white and Black, Asian and ethnic minority children

11.4 Healthy weight

Excess weight in childhood typically persists into adulthood and is associated with increased risk of a range of health consequences, including type 2 diabetes, hypertension and heart disease. In Southwark, levels of excess weight among Year 6 pupils are consistently above London and national levels, and this has continued into the most recent year of data (2023/24).

In 2023/24, roughly 1 in 5 (23.4%) Reception pupils were overweight or obese, with levels increasing to over 2 in 5 (41.9%) among Year 6 pupils. Over the last 15 years, levels of excess weight levels have remained generally stable for Reception and Year 6 pupils, fluctuating between 22-29% and 39-43%. Despite efforts to reduce the prevalence of excess weight within school age children, this has not translated into less children with excess weight, particularly amongst Year 6 pupils who are almost twice as likely to have excess weight when compared to Reception pupils.

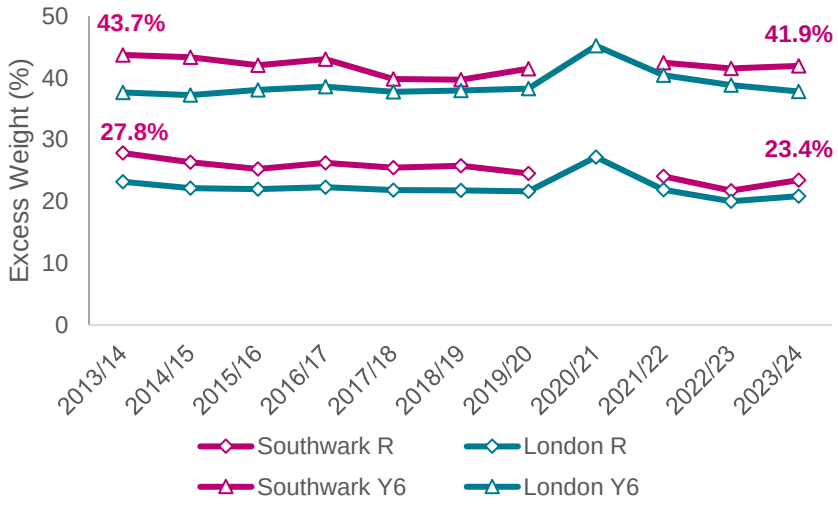


Fig 35. Prevalence of excess weight (overweight or obesity) in Reception and Year 6 pupils in Southwark, London and England, 2013/14 to 2023/24. Source: OHID, 2024. Child health profiles.

There are significant inequalities in levels of excess weight within the borough, 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. Over the 3 years 2021/22–2023/24, over two-fifths of Year 6 pupils in Camberwell Green (45%), Faraday (42%) and Peckham (41%) wards were overweight or obese, more than twice the level in Goose Green and Dulwich Village (both 15%).

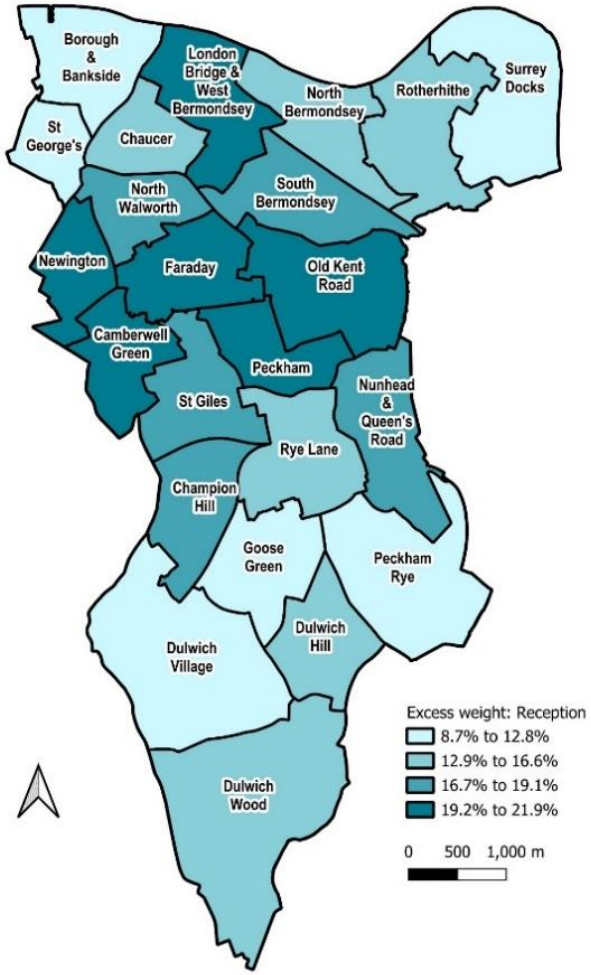


Fig 36. Excess weight (overweight or obese) prevalence among Southwark Reception pupils, 2021/22 to 2023/24.
Source: National Child Measurement Programme, 2023 to 2025.

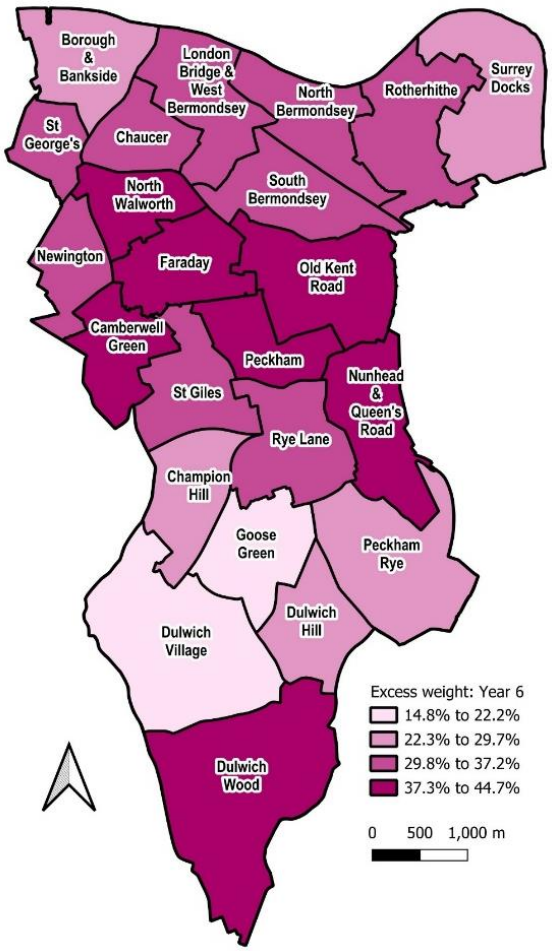


Fig 37. Excess weight (overweight or obese) prevalence among Southwark Year 6 pupils, 2021/22 to 2023/24.
Source: National Child Measurement Programme, 2023 to 2025.

Joint Health & Wellbeing Strategy Long Term Population Health Measure

Priority Area 1: A healthy start in life

Measure: Reduction of the gap in % Year 6 children with excess weight between white and Black, Asian and ethnic minority children

11.5 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."*

On 31st March 2024, there were 2,557 children in need in Southwark. This translates to the rate of 453 per 10,000 children, which is higher than London and England with rates of 370 and 333 per 10,000 children respectively. This is down 6.7% from the 2,741 children assessed as being in need on 31st March 2023. For Southwark children in need, the most common primary need was abuse or neglect, reflecting the national picture. The figure opposite shows Southwark children's primary needs at assessment, for 2024.

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 contributory factors identified for Southwark children in need in 2024 were:

- Domestic abuse (1,428 cases, down 114 cases from 2023)
- Parental mental health (710 cases, up 17 cases from 2023)
- Emotional abuse (623 cases, down 12 cases from 2023)
- Physical abuse (555 cases, up 5 cases from 2023)
- Child's mental health (469 cases, down 79 cases from 2023)

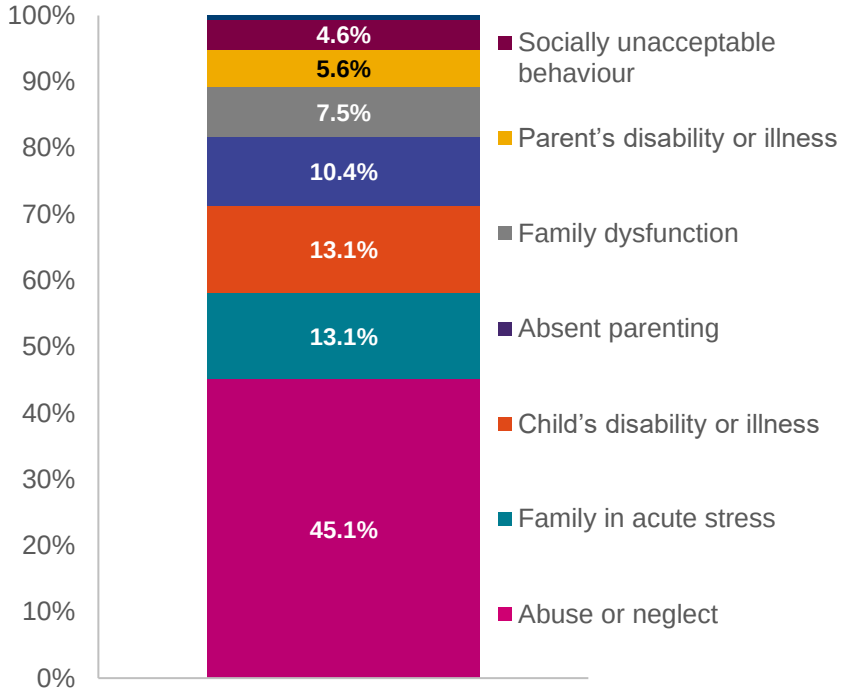


Fig 38. Southwark 2024 child in need assessment episodes, by primary need identified. Sources: Department for Education, 2024; Children in Need, 31st March 2023 to 31st March 2024.

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 2024, there were 269 children in Southwark with a child protection plan. This was an increase from the previous year. The most common underlying cause was emotional abuse, followed by neglect. However, the number of child protection plans at any point in Southwark during the year ending 31st March 2024 reduced from the previous year. The rate was 112 child protection plans per 10,000 children, compared to 116 in the previous year.

11.6 Special Educational Needs and Disabilities

Between 2022/23 and 2023/24, the number of children in Southwark schools with an Education, Health and Care (EHC) plan or SEN support increased by 10.8% (2022/23: 2,095; 2023/24: 2,321). Over the same period, the number of children with SEN support/SEN without an EHC plan increased by 4.1% (2022/23: 7,123; 2023/24: 7,412). During 2023/24, a statistically similar proportion of children in Southwark schools (4.8%) had an EHC plan compared to London (4.9%) and England (4.8%) values.

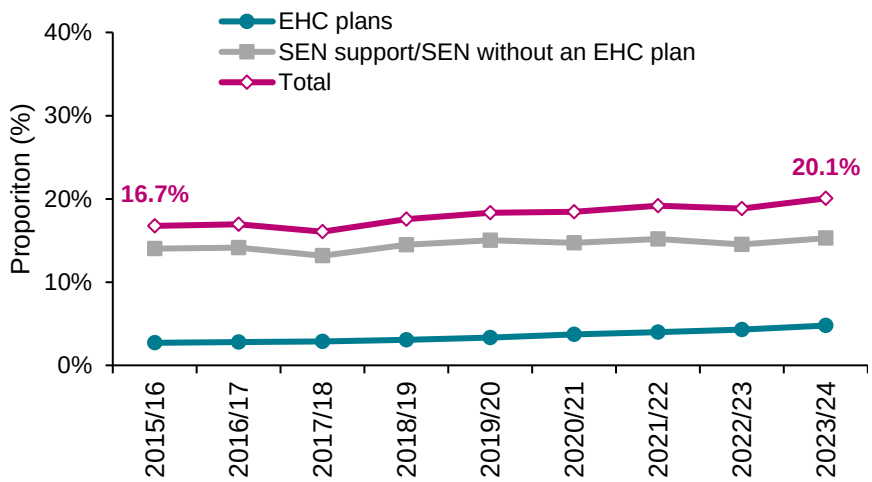


Fig 39. Proportion of children in Southwark schools with an EHC plan, SEN support or either: 2015/16-2023/24.

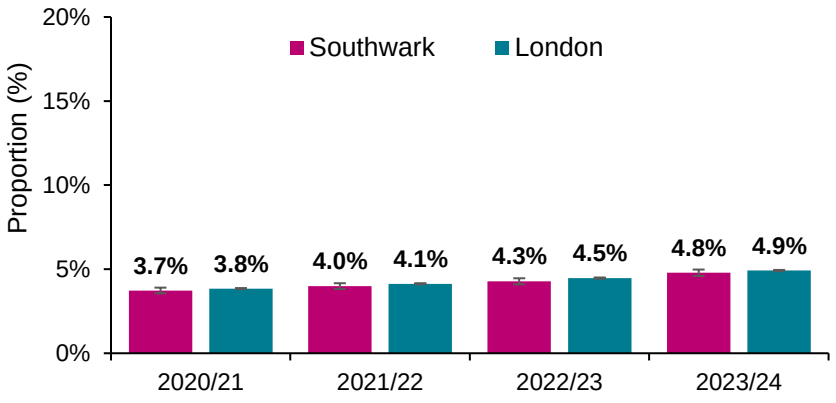


Fig 40. Proportion of children in Southwark and London schools with a EHC plan over time.

Joint Health & Wellbeing Strategy Long Term Population Health Measure

Priority Area 1: A healthy start in life

Measure 1: % of children with free school meal status achieving a good level of development at the end of Reception in Southwark

Measure 2: Gap in average Key Stage 4 attainment between all pupils and pupils with SEN support

When analysing trends in the number of children in Southwark with an EHC plan, there was a 97% increase in the number of children with Autism Spectrum Disorder (ASD) as their primary need between the years 2016 and 2024, increasing from 569 to 1,121.

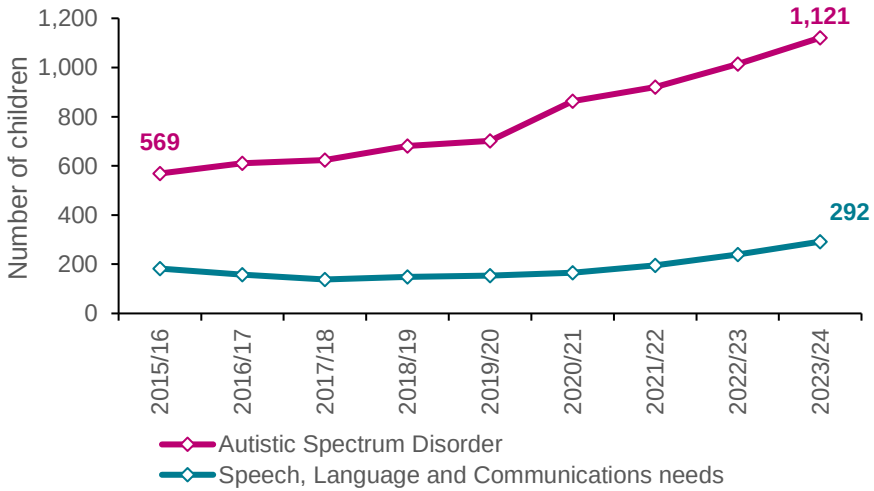


Fig 41. The number of SEND children with an EHC plan, by their primary need: 2015/16 to 2023/24.

11.7 Healthcare use

A&E attendances in young children are often preventable, being commonly caused by accidental injury or by minor illnesses which could have been treated in primary care. In 2023/24, there were almost 7,900 A&E attendances by Southwark children aged 0-4 yr, with rates significantly lower than both London and England levels.

In 2023/24, there were 1,110 emergency hospital admissions of Southwark children under the age of 5, a reduction of 305 admissions when compared to the previous year. Borough admission rates are significantly lower than London and England. However, there are substantial inequalities, with significantly higher levels seen in the north of the borough.

Some instances of hospital admissions are due to managed conditions such as asthma. The rate of hospital admissions for asthma (under 19 years) in Southwark have fallen noticeably over the past 10 years, from 259 per 100,000 residents in 2013/14 to 133 per 100,000 residents in 2023/24, which equates to a reduction of 85 hospital admissions.

12. LIVING WELL

Priority 3 of the Joint Health & Wellbeing Strategy is "**Support to Stay Well**" which closely aligns with the "**Staying Well**" goal of the Southwark 2030 strategy. Both focus on ensuring that everyone in the borough can lead **healthy, fulfilling lives**. They emphasise **early intervention and prevention**, aiming to reduce health inequalities and support both physical and mental wellbeing.

Living well is often influenced by modifiable risk factors that can lead to the development of long-term conditions such as cancer, diabetes, heart disease and poor mental health. These **long-term conditions are not evenly distributed throughout the population**, with those from disadvantaged backgrounds, **Black, Asian, or those of Mixed Ethnicity, and those from the LGBTQI+ communities bearing the highest burden of disease**. These groups often intersect, increasing negative outcomes.

Southwark is comparable to the national picture, with **tobacco, overweight/obesity, risky alcohol consumption, high blood sugar and poor diet** being the top five risk factors affecting healthy living.

In 2023/24, about **9,200** Southwark GP patients had a **cancer diagnosis, 1,800** more cases than the previous year. The most prevalent forms of cancer were **prostate (20%) and breast (18%).**

Since 2018, Southwark has **increased testing rates by 36%**, experiencing increases in the number of cases of **Chlamydia, HIV and Genital Warts**. These cases are concentrated to the North and West of the borough.

Bowel Cancer screening has **increased** by more than half since the programme began. In 2024 over 23,000 Southwark residents were screened. However, there is a declining in breast and cervical cancer screening.

Over **115,000** Southwark GP patients are living with **1+ long-term condition**, **4,000** more than the previous year. Patients from a **Black ethnic background are over-represented** among those with long-term health conditions.

We estimate around **1 in 5 adults** have a common **mental health disorder** in Southwark. Diagnosed depression (aged 10-29) is more than **twice as common in females** when compared to males.

12.1 Risk factors

Global Burden of Disease study data shows the top risk factors for poor health. Southwark is comparable to the national picture, with tobacco, overweight/obesity, risky alcohol consumption, high blood sugar and poor diet being the top five health risk factors.

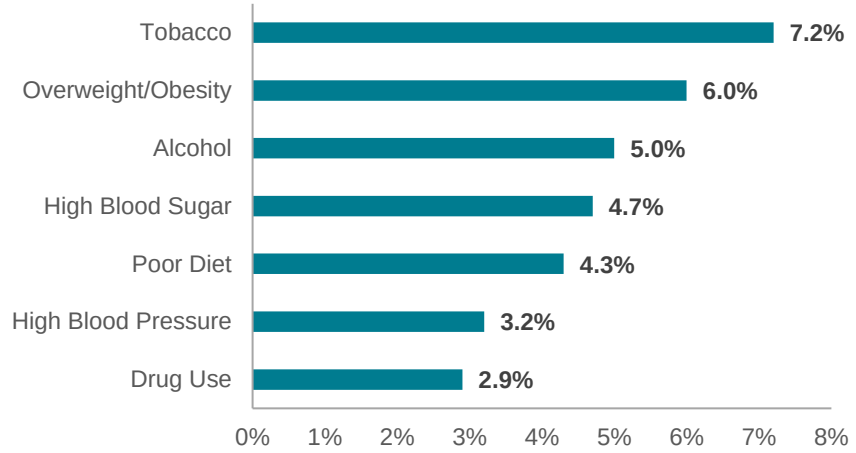


Fig 42. Risk factors causing greatest loss of years of life due to disability or premature death (Disability-Adjusted Life Years) in Southwark, 2021. Source: IHME 2025. Global Burden of Disease Compare tool

Joint Health & Wellbeing Strategy Long Term Population Health Measure

Priority Area 3: Support to stay well

Measure 1: Reduction of smoking prevalence in adults

Measure 2: Reduction in the gap in obesity prevalence in adults by ethnicity

The figure below shows the prevalence of key behavioural risk factors in Southwark adults, compared with London and England levels.

14% Southwark adults smoke, almost doubling to 27% among routine & manual workers, similar to London and England levels.

Over half (57%) of Southwark adults are overweight or obese, lower than London and England levels.

There were 1,425 alcohol-specific hospital admissions in Southwark in 2023/24, comparable to the England and London rates.

1 in 3 (34%) Southwark 16+ yr olds eat their recommended '5-a-day', similar to London and England.

Over 1 in 6 (18%) Southwark adults are inactive, lower than London and England levels.

49 Southwark residents died of drug misuse over 2021–23; levels were similar to London and England.

Fig 43. Behavioural health risk factor levels in Southwark. Source: OHID 2024. Public Health Profiles.

12.2 Sexual health

Poor sexual and reproductive health has a significant impact on Southwark residents' wellbeing. The borough has the second highest level of sexually transmitted infections (STIs) in England, after Lambeth. Levels of diagnosed infections in Southwark are over twice the London average and more than five times the national average.

STI testing in Southwark has been increasing since 2020. Between 2022 and 2023, there was a 9% increase in STI testing in the borough (excluding chlamydia testing in under-25s). A total of over 57,000 tests were conducted in 2024, a 21% increase compared to pre-pandemic levels (47,210) and the second highest number of tests in England.

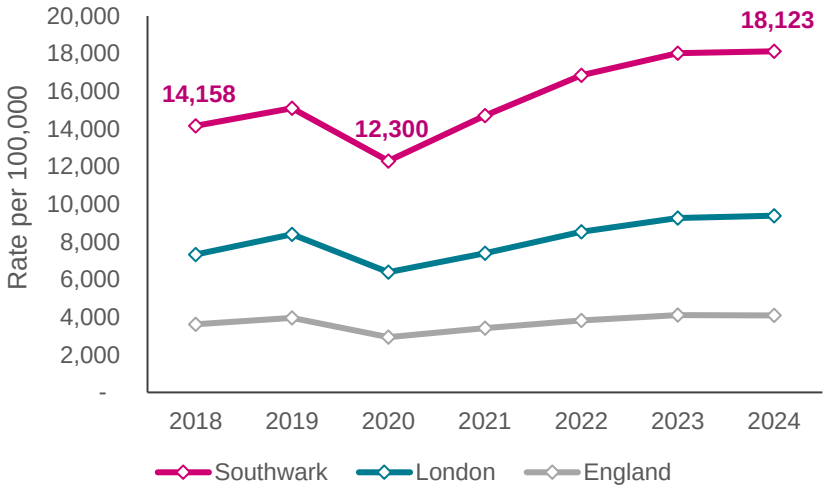


Fig 44. STI testing rate (excluding chlamydia aged 24 and under) per 100,000 population in Southwark, London and England, 2018–2024. Source: OHID, 2025. Sexual and Reproductive Health Profiles.

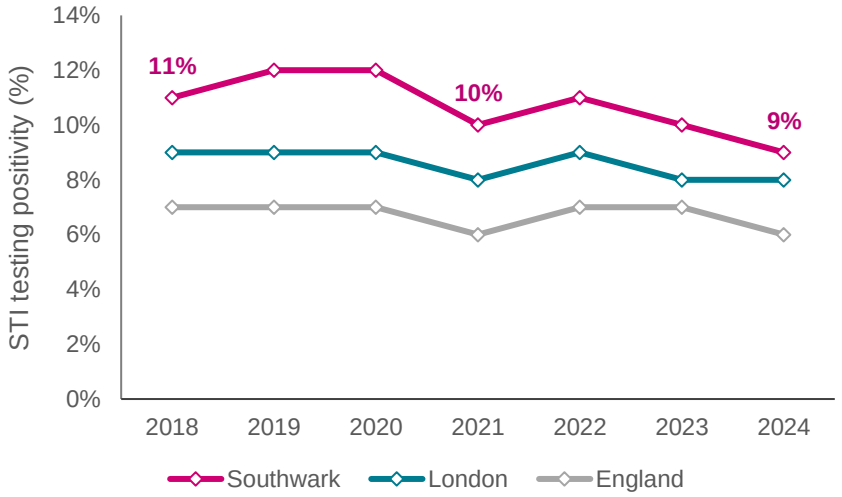


Fig 45. Annual STI positivity rate in Southwark, London and England residents, 2018–2024. Source: OHID, 2025. Sexual and Reproductive Health Profiles.

In 2024, there were 8,800 new STI diagnoses among residents, a 1% decrease compared with 2023. Last year, Southwark had a:

- 9.1% decrease in gonorrhoea diagnoses (- 273)
- 10.5% decrease in chlamydia diagnoses (- 373)
- 10.1% decrease in genital warts diagnoses (- 39)

Local STI infections are highest among:

- Men: account for over three-quarters (77%) of cases
- 25–34 year olds: over two-fifths (42%) of cases
- Gay and bisexual men: over half (55%) of cases

2023 data showed that new STI diagnosis rates were not equal across Southwark: the highest levels were seen in north-west and west-central areas of the borough.

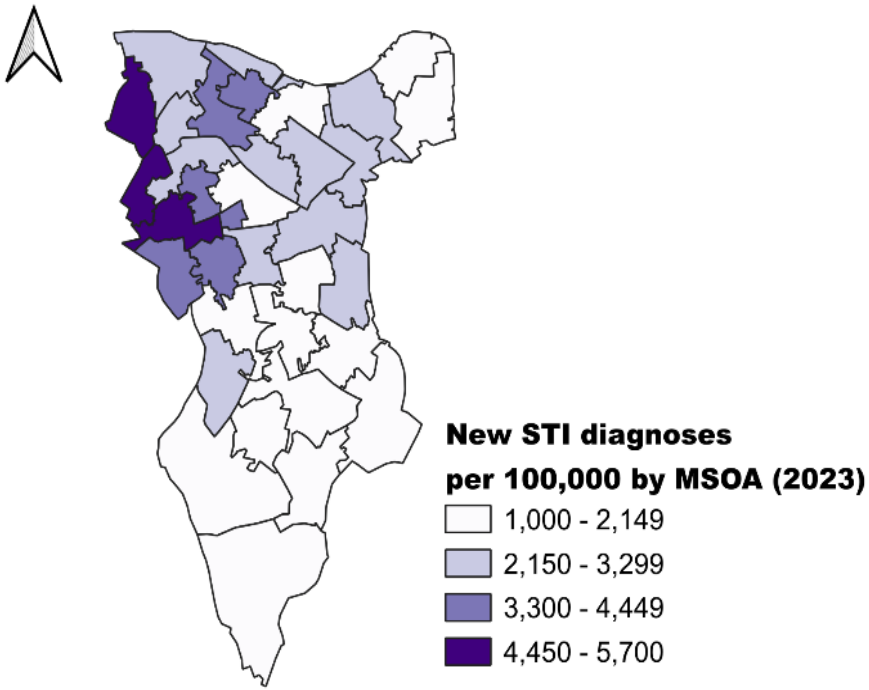


Fig 46. Prevalence of new STI diagnoses in all-age Southwark residents, per 100,000 population, by Middle Super Output Area, 2023.
Source: UKHSA 2023.

HIV

In addition to high levels of sexually transmitted infections, Southwark also has high levels of HIV. The borough has the second highest prevalence rate in England, after Lambeth. Southwark rates of diagnosed HIV are over double London levels and over five times higher than the England average. In 2023, there were 3,100 residents with diagnosed HIV living in Southwark. There were 85 new cases identified in that year, the fifth highest in London. Figures indicate highest prevalence of HIV is in the north-west and centre-west of the borough.

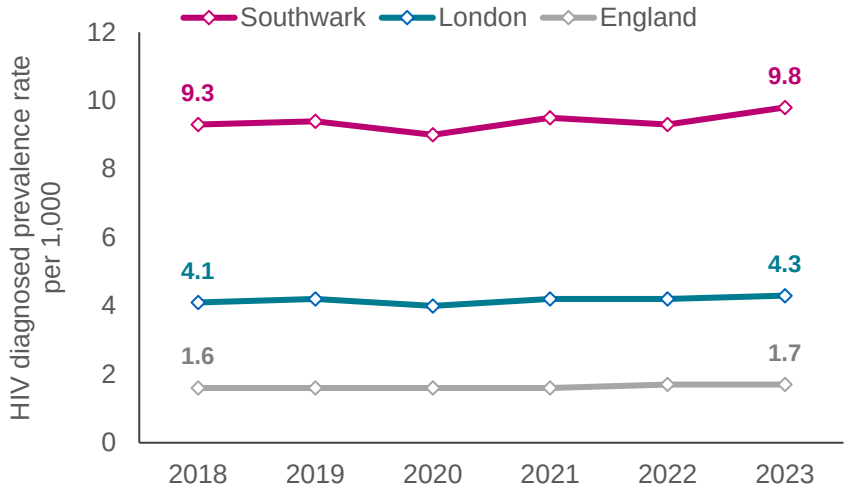


Fig 47. HIV diagnosed prevalence rate per 1,000 residents in Southwark, London and England, 2018 to 2023.Source: OHID, 2024. Sexual and Reproductive Health Profiles

Levels of HIV testing in the borough are significantly higher than London and England averages, with 65% of eligible specialist sexual health service attendees accepting an HIV test. Testing levels in 2023 were 25% higher than pre-pandemic levels seen in 2019 and were almost double the rate observed across the London region.

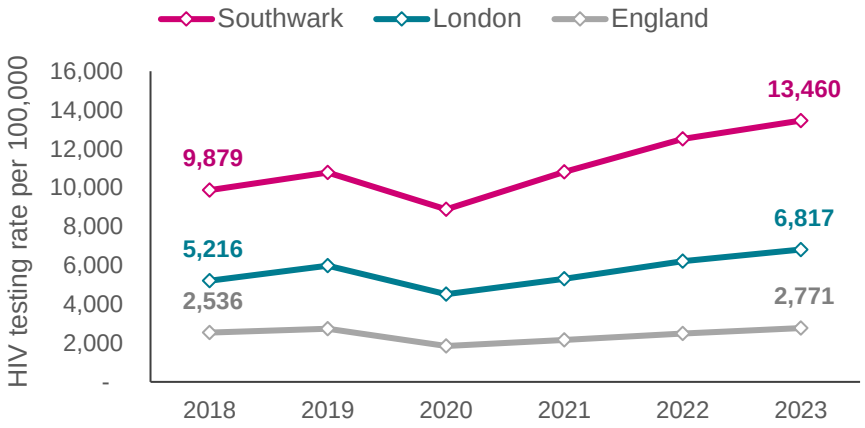


Fig 48. HIV testing rate per 100,000 residents in Southwark, London and England, 2018 to 2023.Source: OHID, 2024. Sexual and Reproductive Health Profiles.

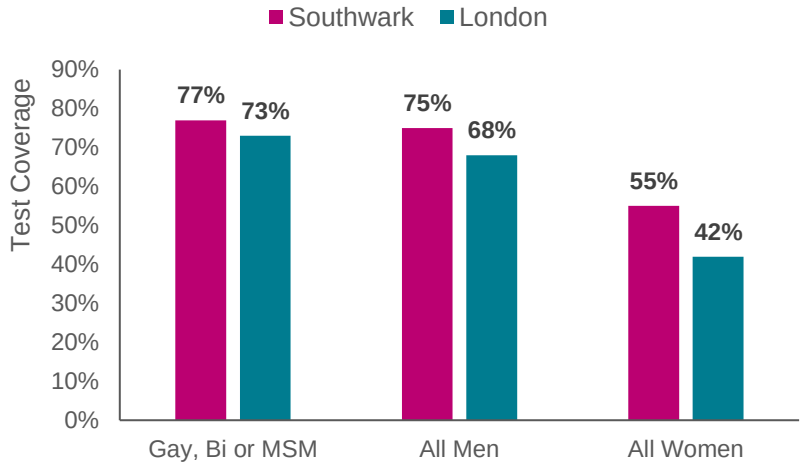


Fig 49. HIV testing coverage among those eligible for an HIV test in specialist sexual health services, by sexual identity group, for Southwark and London, 2023.
Gay, bi or MSM = gay, bisexual and other men who have sex with men.
Source: OHID 2025. Sexual and Reproductive Health Profiles.

Late diagnosis of HIV is an important predictor of poor health and premature death. In 2021–23, 42% of Southwark adults diagnosed with HIV received a late diagnosis, comparable to London (41%) and England (44%).

Almost one-third (32%) of gay, bisexual and other men who have sex with men (MSM) received a late diagnosis in 2021-23, lower than levels for heterosexual or bisexual women (46%) and heterosexual men (79%). This large difference between late diagnosis in heterosexual males compared to their gay, bisexual or MSM peers can partly be explained by less stigma, higher testing rates and therefore greater reach of testing amongst the latter groups, reducing the number of people identified with a late HIV diagnosis.

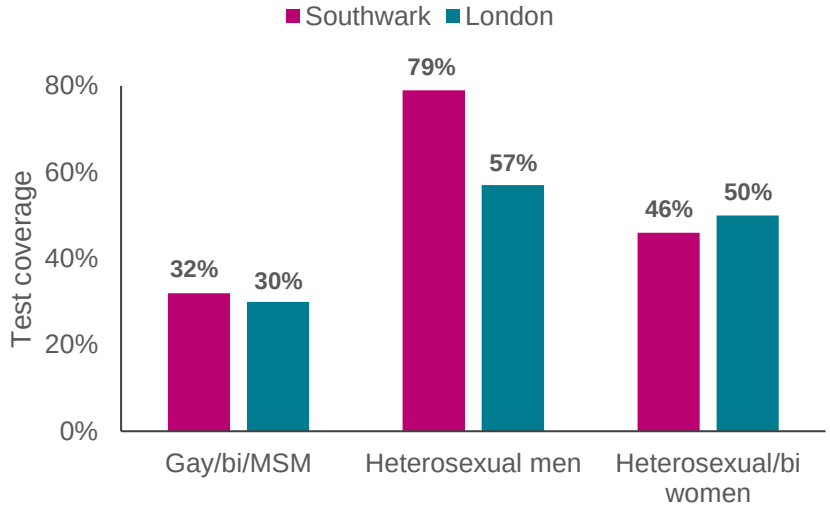


Fig 50. Percentage of HIV cases (15+ yr, first diagnosed in UK) with a late diagnosis, by sexual identity group, in Southwark and London, 2021–23.Bi = bisexual; MSM = men who have sex with men; het = heterosexual. Source: OHID 2025. Sexual and Reproductive Health Profiles.

12.3 Drug and Alcohol usage

Drug and alcohol usage is a significant health concern within Southwark, contributing to negative health outcomes such as mental health issues, liver disease, and early mortality.

Alcohol Misuse

Alcohol dependency is a complex medical condition characterised by an impaired ability to stop or control alcohol use despite adverse social, occupational, or health consequences. Alcohol dependency rates in Southwark (16%) are broadly comparable to levels seen across England (14%).

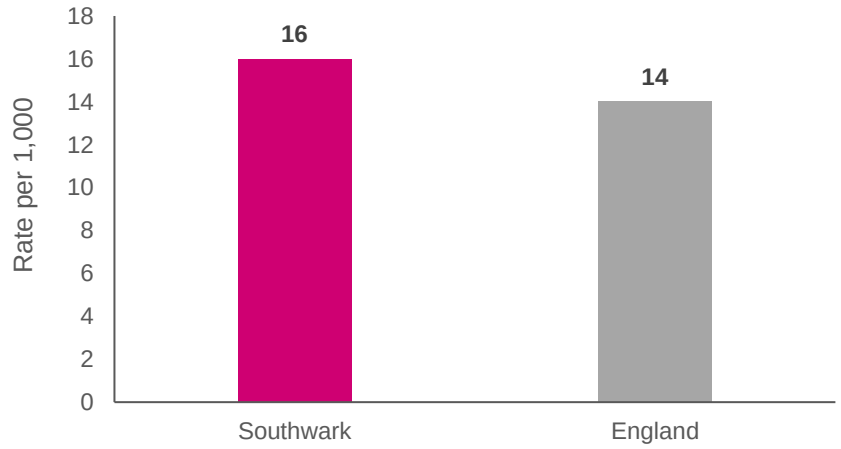


Figure 51. Estimated alcohol dependency rate per 1,000 in Southwark and England 2019/20.

The consequences of problematic alcohol usage are a major contributory factor to premature mortality both locally and nationally. Deaths which have been wholly caused by alcohol consumption have fluctuated in recent years in Southwark, decreasing from its peak in 2021 of 18 deaths per 100,000 to 14 deaths per 100,000. These levels are comparable to the national rate but higher than the London average. It is important to note that alcohol-specific deaths exclude deaths whereby alcohol was a contributing factor, potentially masking the true scale of alcohol harm.

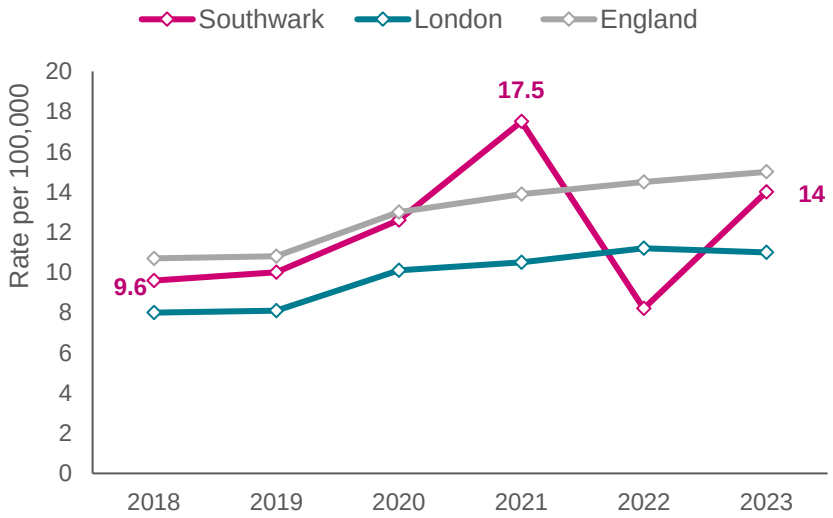


Figure 52. Alcohol-specific mortality rate per 100,000 in Southwark, London and England 2023.

Drug Misuse

In 2019/20, the rates of opiate and crack cocaine use in the local population were estimated based on models using a range of data. An estimated 2,605 people in Southwark regularly used opiate and/or crack cocaine in 2019/20, or 11.1 per 1,000 adult population. This was slightly higher than both London (10.9 per 1,000) and England (9.5 per 1,000). These drugs have direct health consequences on health including overdosing, cardiovascular complications and dental issues.

Figure 53. Estimated opiate and/or crack cocaine usage rate per 1,000 in Southwark, London and England 2019/20.

In the year concluding 2023/24, there were just over 1,000 Southwark residents receiving treatment for opiate or non-opiate substance misuse. Almost three quarters of those in treatment for these substances were male (73%), with the largest ethnic group in treatment being those from a White background (71%). The ethnic trends in treatment show that since 2018, the number of service users from a White background has been decreasing, while the number of service users from a Black ethnic background has been increasing. While there are multiple explanations for this increase, this presents an opportunity to address the disproportionate health and social consequences of drug misuse experienced in this community such as poor mental health and sectioning under the mental health act.

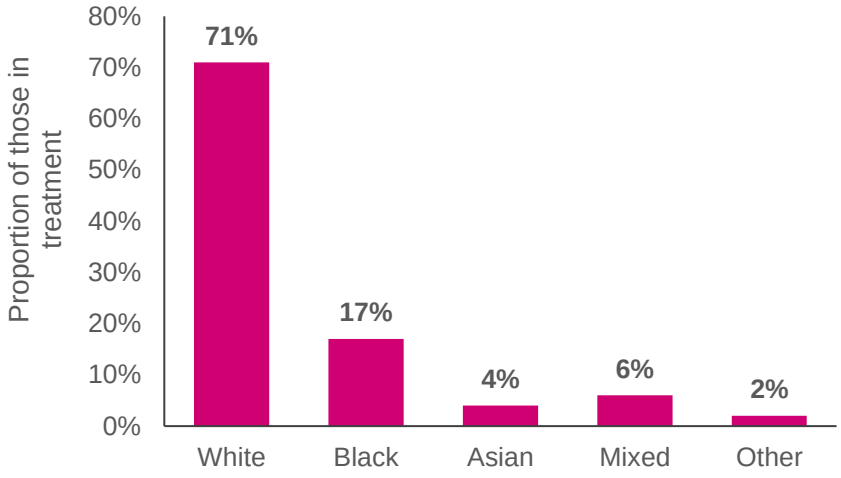


Figure 54. The proportion of adults in treatment for opiate and/or crack cocaine in 2023/24, by broad ethnic group.

12.4 Long-term conditions

The Department of Health & Social Care defines a long-term condition (LTC) 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, have a significant impact on people's health and wellbeing.

Over 115,000 Southwark GP patients are living with one or more long-term condition; over 34,700 are living with three or more. The most diagnosed long-term conditions among Southwark GP patients are hypertension, depression and obesity. They are the most prevalent conditions in both the North and South Southwark Primary Care Networks, as well the most diagnosed conditions England-wide.

Hypertension

Hypertension (high blood pressure) is the most prevalent long-term condition in the borough, and a key risk factor for life-threatening conditions such as heart attacks, kidney disease and strokes. Hypertension disproportionately affects those from a Black ethnic background, making up 45% of diagnosed patients, but only 37% o the registered patient list. Additionally, prevalence is skewed towards those aged over 50 living in the most disadvantage neighbourhoods in the borough.

Depression

People from Black, Asian and other minoritised ethnic groups are known to be at greater risk of poor mental health due to greater exposure to risk factors (especially poverty, trauma, discrimination and unpaid care work) and poorer access to support services (often due to stigma and cultural barriers). However, depression diagnosis levels are disproportionately low among those from non-White groups. These patients make up over half (51%) of all Southwark GP patients, but only around one-third (37%) of patients with diagnosed depression.

Obesity

Obesity reduces life expectancy and increases the risk of cancer, chronic diseases and poor mental health. In Southwark, recorded obesity rates are more than twice as high in GP patients from Black groups (14%) compared with White groups (7%). Levels are lower among those from Asian (6%), mixed (5%) and other (5%) ethnic groups. It is worth noting that these figures are thought to substantially underestimate the level of obesity within the population, with estimates indicating 57% of adults in Southwark are obese.

Diabetes

Diabetes mellitus is the fourth most common long-term condition in Southwark. Type 2 diabetes is most common type of diabetes, with over 20,200 local people diagnosed with this condition. A further 29,140 local GP patients have known raised blood sugar (i.e. non-diabetic hyperglycaemia), putting them at risk of developing diabetes. Diabetes causes cardiovascular, kidney, foot, eye diseases, and raises the risk of infections. Type 2 diabetes onset can be prevented or delayed by lifestyle changes. Across Southwark GPs, the majority of diabetic patients were aged between 40-79, living in the most disadvantaged areas, and almost half (47%) were from a Black ethnic background.

Hypertension 39,821	**Depression** 39,375	**Obesity** 30,804
Non-diabetic hyperglycaemia 26,837	**Diabetes mellitus** 20,795	**Asthma** 15,584
Chronic kidney disease 10,049	**Cancer** 9,074	**Coronary heart disease** 4,820
Severe mental illness 4,473	**COPD** 5,135	**Stroke** 3,890

Fig 55. Patient numbers for most prevalent long-term conditions diagnosed by Southwark GPs, May 2025.
Source: South East London Integrated Care System, 2025. Comorbidities dashboard.

The diagnosed prevalence of many long-term conditions has increased over time, with the three leading causes of long-term conditions seeing notable increases. Cases of diagnosed hypertension, depression and obesity have all each increased on average by at least 1,000 people over the last three years.

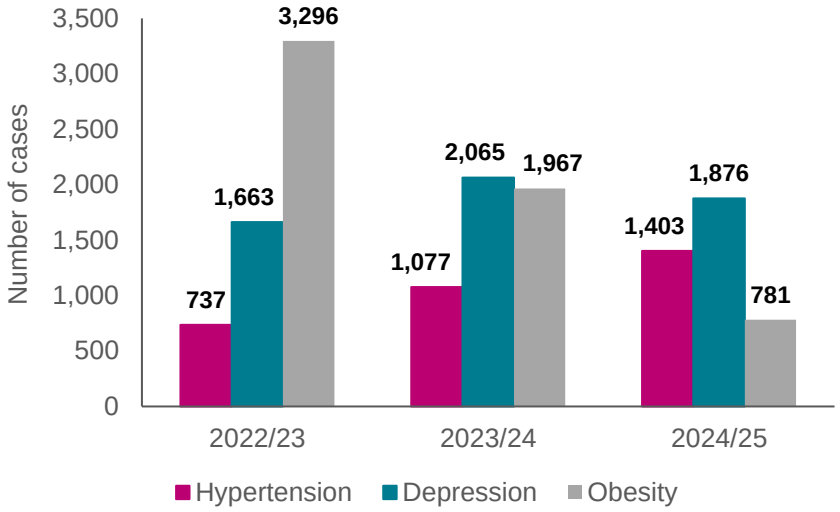


Fig 56. Yearly increase of diagnosed hypertension, depression and obesity for Southwark GP patients: 2022/23-2024/25.
Source: South East London Integrated Care System, 2025. Comorbidities dashboard.

Multi-morbidity

Multi-morbidity refers to living with multiple long-term health conditions. Research on the development of multiple long-term conditions continues to expand; key findings from national and local data indicate that:

- People in the UK are developing multiple long-term conditions at an increasingly younger age.
- Nationally, people from Black, Asian and minoritised ethnic groups are more likely to develop multiple long-term conditions, and to develop them at a younger age, than those from White groups.
- Multiple long-term conditions are more common in communities experiencing higher levels of socio-economic disadvantage. Progression to two (or more) long-term conditions happens up to 10 years earlier among people living in the most disadvantaged areas of the country, compared to those in the most affluent areas.
- Certain long-term conditions are linked: having one increases the likelihood of developing other, associated conditions.

In Southwark, around 115,400 people have been diagnosed with one or more long-term conditions; about 34,700 people have three or more.

Locally, more than half (56%) of local GP patients with one or more long-term conditions are female; under half (44%) are male. Levels are similar among patients with three or more long-term conditions (53% are female; 47% are male).

Southwark GP patients from a Black ethnic background are over-represented among those with long-term health conditions. They account for over one-third (34%) of those with one or more long-term conditions, and over two-fifths (41%) of those with three or more long-term conditions, despite making up only one-quarter (27%) of the GP patient population.

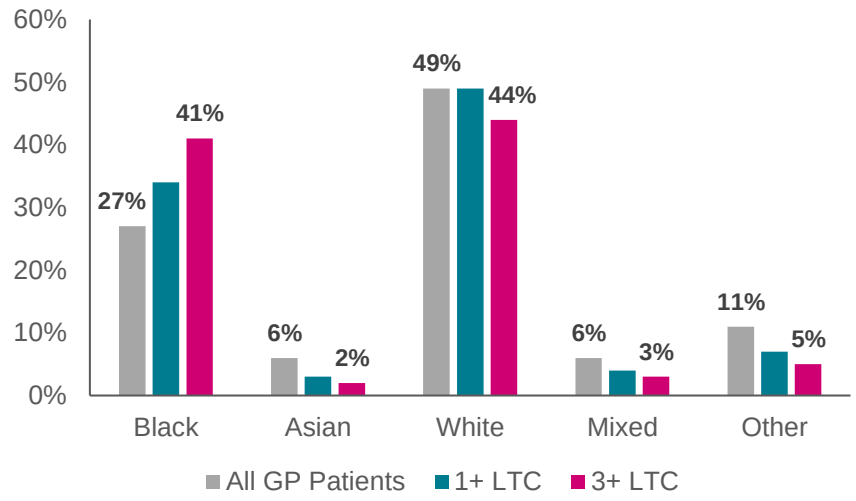


Fig 57. Percentage of Southwark GP patients by ethnic group, for all registered patients, those with 1 or more long-term conditions (LTC), and those with 3 or more LTC.
Source: South East London Integrated Care System, 2025.

As populations age, so too does the number of people with multiple long-term conditions. This change requires a shift towards better co-ordinated and more integrated care, rather than just higher numbers of disconnected care episodes. Research increasingly emphasises the importance of addressing patients' social and economic context, in order to prevent, and slow progression of, multiple long-term conditions.

12.5 Cancer

In 2023/24, just over 9,200 Southwark GP patients had a cancer diagnosis (3%), higher than the London (2.5%) rate but lower than England (4%). Among all Southwark GP patients in May 2024, the most prevalent forms of cancer were prostate (19%) and breast (18%).

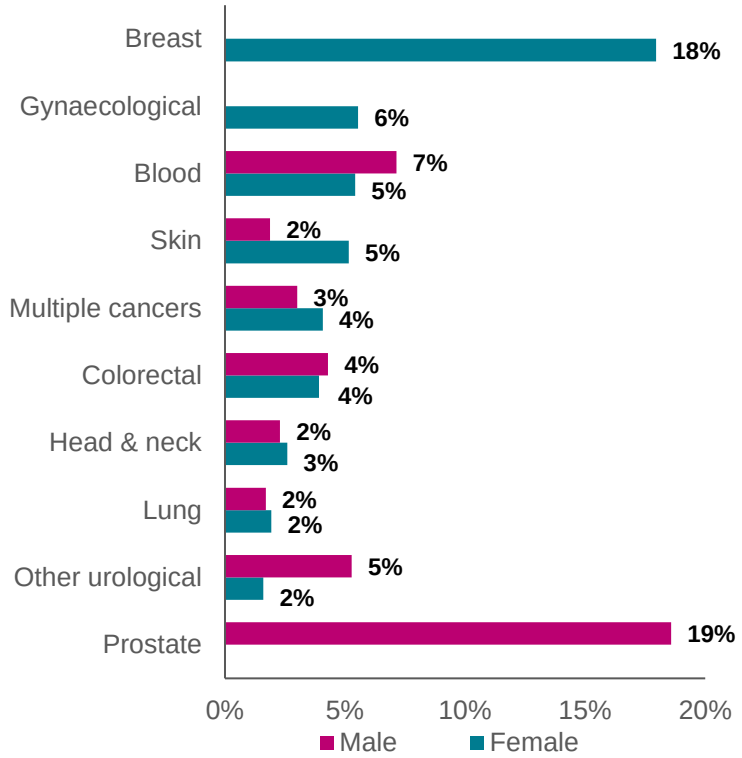


Fig 58. Percentage prevalence of cancers by site and gender, for all Southwark GP patients, Jan 2025.
Source: South East London Integrated Care System, 2025. Cancer Population Insights Dashboard.

In 2022/23, the overall incidence of new cancer cases in Southwark (254 per 100,000) was lower than levels in South East London (329 per 100,000) and England (456 per 100,000).

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. In 2023 evidence from Cancer Research UK cited an estimated 33,000 extra cancer cases UK-wide each year due to socio-economic deprivation – nearly 1 in 10 of all cases.

Cancer prevalence rates vary between different ethnic groups with those from a White ethnic background having a higher cancer prevalence (3%) than those from non-White ethnic background (1%). Differences in age structure and healthcare access should be considered when interpreting these between-group differences.

Cancer screening is a vital tool that enables cancer diagnosis at an early and more treatable stage. Screening is currently available for bowel, breast and cervical cancers. In 2024, Southwark bowel and breast cancer screening rates were significantly lower than the England levels but comparable to the London average; cervical cancer screening rates were similar to London but significantly lower than England.

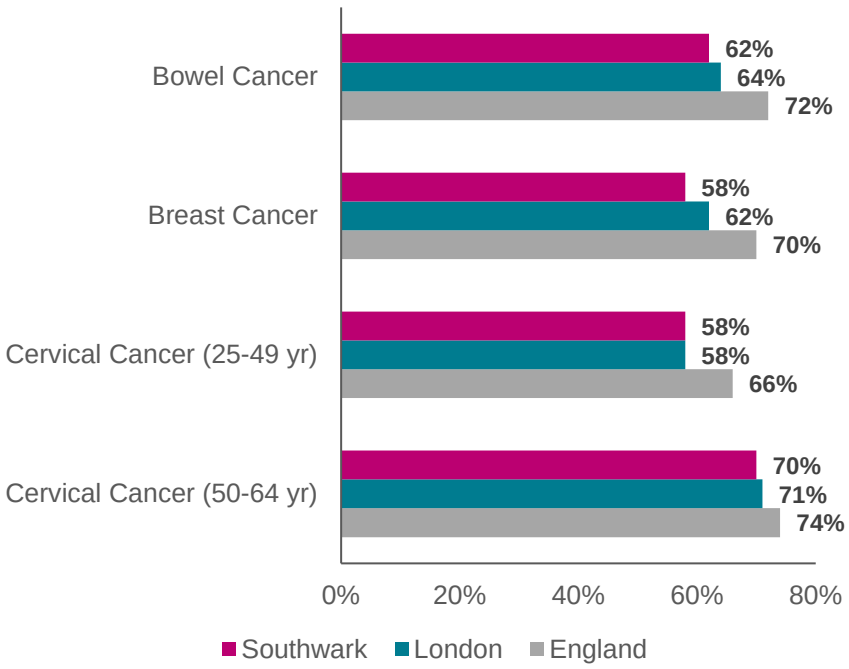


Fig 59. Proportion of eligible residents receiving screening for bowel, breast and cervical cancer, for Southwark, London and England, in 2024. Source: OHID, 2025. Public Health Outcomes Framework.

South East London provides data on cancer screening coverage for local GP patients from different ethnic groups. Although the figures provided are estimates, the large gap between cervical cancer screening coverage in Black patients (74%) versus patients from Asian and other ethnic groups (55%) is notable.

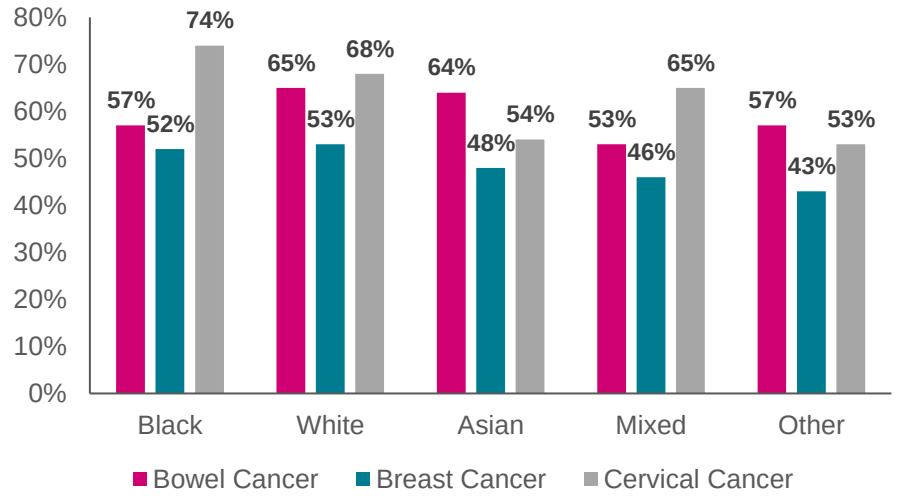


Fig 60. Estimated proportion of eligible Southwark GP patients receiving screening for bowel cancer, breast cancer and cervical cancer, May 2024. Source: South East London Integrated Care System 2024. Cancer Population Insights Dashboard.

Early cancer diagnosis improves the chances of a good health outcome. The NHS Faster Diagnosis Framework aims for 75% of cancers to be diagnosed early (i.e. at stage 1 or 2) by 2028. Early diagnosis levels vary by cancer type and gender. In 2021, the percentage of common cancers in South East London diagnosed early were:

- Breast cancer: 60% (female)
- Uterine cancer: 60% (female)
- Cervical cancer: 37% (female)
- Prostate cancer: 38% (male)
- Other urological cancer: 18% (female); 20% (male)
- Bowel cancer: 29% (female); 32% (male)
- Lung cancer: 32% (female); 24% (male)

12.6 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 estimated that 1 in 4 people will experience a mental health problem in any given year.

In 2017, approximately 54,700 people in Southwark aged 16+ had a Common Mental Disorder (CMD), equating to an estimated prevalence of 21% within the population. This was significantly higher than the estimated prevalence for London (19%) and England (17%). The prevalence of common mental disorders in Southwark residents aged 65 or more was estimated at 13%, significantly higher than London (11%) and England (10%).

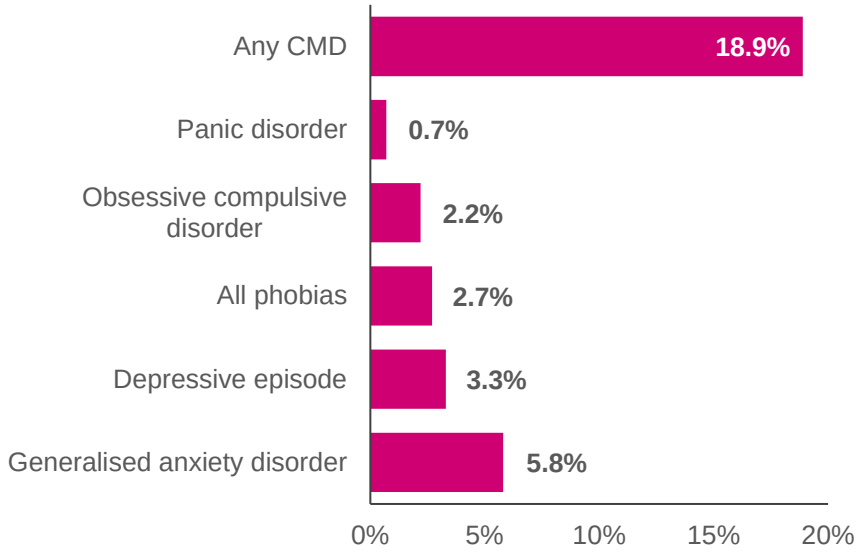


Fig 61. Common mental disorder (CMD) prevalence in London adults. Source: NHS Digital, 2016. Adult Psychiatric Morbidity Survey, 2014.

The 2014 English Adult Psychiatric Morbidity Survey (APMS) found that 1 in 6 adults had a common mental disorder in the week prior to the survey, rising to almost in 1 in 5 adults in London. The prevalence of different disorders is shown in the figure above; generalised anxiety disorder was the most common. All types of common mental disorders are more common in women: 1 in 5 women report experiencing them, compared to 1 in 8 men. The gender gap is particularly pronounced among those aged 16–24. In this age group, more than three times as many young women experience common mental disorders compared with young men.

The same survey also found that almost a quarter (23%) of adults from Black community groups reported experiencing a common mental disorder in the past week, substantially higher than levels among White British (17%) and White Other (14%) groups; levels among those from Mixed and Other (20%) ethnic groups were also higher, while reported levels among Asian groups (18%) were comparable. Results for the 2022 Adult Psychiatric Morbidity Survey are expected in mid-2025.

Among Southwark GP patients aged 10–29, diagnosed depression is more than twice as common in females (13%) compared to males (6%).

Local survey results suggested that, in 2023, about 1 in 6 (16%) Southwark adult residents had a mental health condition lasting longer than 12 months. Of Southwark survey respondents reporting a long-term mental health condition, 40% also had a long-term physical health condition, 26% also had a physical or mobility condition, and 22% also had a learning disability. Close to half (45%) of Southwark respondents reported using mental health services

over the last 2 years. Of those who did, over half (53%) reported that accessing the service was not easy. Mental health service use was more likely among Southwark and Lambeth respondents who were:

- Younger than 35 years
- Disabled
- Living with learning disabilities
- Unpaid carers
- LGBTQ+
- Religious
- from White or Mixed Ethnic backgrounds
- Struggling financially
- Feels lonely
- And at the lowest and highest ends of the income scale

Joint Health & Wellbeing Strategy Long Term Population Health Measure

Priority Area 4: Healthy and connected communities

Measure 1: Reduction in the percentage of adults who feel lonely often or always

Measure 2: Reduction in gap in prevalence of depression between White and Black residents

Severe mental illness

Severe mental illness (SMI) refers to a range of conditions including schizophrenia, bipolar affective disorder and depression with psychosis. In 2024/25, just over 4,000 Southwark GP patients had a diagnosed severe mental illness.

There are strong ethnic inequalities in the prevalence of severe mental illness. Almost 4 in 10 (40%) severe mental illness patients are from Black ethnic backgrounds, compared with 1 in 4 (26%) of all Southwark GP patients. Southwark also has a notably higher percentage of SMI patients from Black ethnic backgrounds when compared to South East London. Patients from Asian, White and Other ethnic groups are under-represented based on general GP patient population levels.

Fig 62. Proportion of Southwark & South East London SMI patients by broad ethnic group: 2024/25
Source: South East London Integrated Care System, 2025. SMI dashboard.

In terms of age, severe mental illness is most prevalent among those aged 41–60. This group make up over 4 in 10 (44%) of all severe mental illness patients compared with 1 in 4 (26%) of GP patients generally.

Residents diagnosed with SMI should be offered an annual health check, covering 6 core components:

- Lipid profile
- Smoking Status
- Blood Pressure
- Body Mass Index
- Blood Glucose
- Alcohol Consumption

In 2024/25, approximately half (48%) of Southwark SMI patients received an annual health check. This was the 3rd highest when compared to all other South East London boroughs, behind Bexley and Lambeth but below the national average (55%). There was little difference in receiving all 6 health checks between ethnic groups.

In 2021-23, there were 570 premature deaths in Southwark among residents who had been referred to mental health services in the 5years prior to death. Rates in Southwark (126 per 100,000) are significantly higher than London (107 per 100,000) and England (111 per 100,000).

South London and Maudsley NHS Foundation Trust

The main provider for acute mental health care in Southwark is South London and Maudsley NHS Foundation Trust (SLaM). Up to December 2024, there were 24,300 people were in contact with mental health services provided by SLaM.

Self-harm

Self-harm is one of the top 5 causes of acute medical admission in England. Research suggests that people attending Accident & Emergency due to self-harm have a 66-fold higher risk of suicide in the following year, compared with general population risk.

In 2023/24, there were 180 emergency hospital admissions for intentional self-harm in Southwark, with a rate of 51 emergency admissions per 100,000 population. Southwark's rate was comparable to London levels and significantly lower than England.

Half (50%; 90) of these admissions were female residents. In this category, Southwark's self-harm emergency admissions rate for women (49.9 per 100,000) is similar to London levels and significantly lower than England.

Suicide

The three-year suicide rate in Southwark has remained similar over the past 20 years, and in 2021–23 was comparable to London levels and significantly lower than England. In 2023, there were 24 reported deaths of Southwark residents by suspected suicide, nearly double the number reported in 2022 (13). Actual numbers of suicide deaths will vary due to absent or delayed reporting.

Often no single cause explains why someone has taken their own life. Several risk factors often combine to increase an individual's risk. At the same time, the presence of risk factors does not necessarily lead to suicidal behaviour. For example, it is estimated that 80-90% of people who die by suicide are experiencing a mental health condition. However, only a small proportion of those with depression will attempt suicide.

13. AGEING WELL

Being able to stay **healthy in later life** is a crucial issue for us as individuals but also for the sustainability of society. This is particularly pertinent given the **projected increase of older adults** in Southwark.

Ageing well supports the wider strategic landscape in Southwark, including Southwark 2030, **Goal 5: Staying Well** which aims to ensure residents across the whole community can have good health and wellbeing.

Ageing well enables residents to understand their potential for **physical, social and mental health and wellbeing** throughout their life course. Supporting older people to look after their own health, particularly those with multiple conditions, including frailty is essential to optimise quality of life and health outcomes.

Healthy life expectancy in Southwark has observed a near consistent decline among both female and male residents. Most recent figures indicate **Southwark males to live 0.3 years** more in good health compared to Southwark females.

Since 2010 (to 2023/24), the rate of **emergency admissions due to falls** in the borough has **fallen by 16%** among those aged 65-79 and by **27%** among those 80+.

In 2023 there were **309 deaths considered preventable** in Southwark, with rates significantly higher than London. Preventable mortality among men is more than double the level among women.

Despite being the leading cause of preventable mortality for residents aged 75 and under, **causes of preventable mortality by cancer have dropped by 37%** for the 11 years up to 2023.

Despite the significant adverse impact of COVID-19 on mortality rates, local and national trends shows that there has been a longer-term pattern of **stalling in life expectancy**, with no discernible improvement over the last decade.

National analysis suggests there is no single cause driving **these slow-downs in life and healthy life expectancy**, with factors including austerity-driven constraints on public spending, growing complexity of medical conditions and **widening health inequalities**.

13.1 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.

During 2023/24, 490 admissions due to falls were observed among those aged 65 years old and over in Southwark. Admission rates increased significantly with age, mirroring the national pattern. Rates among those aged 80 and over were nearly four times those under 80. Nonetheless, rates for Southwark residents aged 80+ were significantly below regional and national levels.

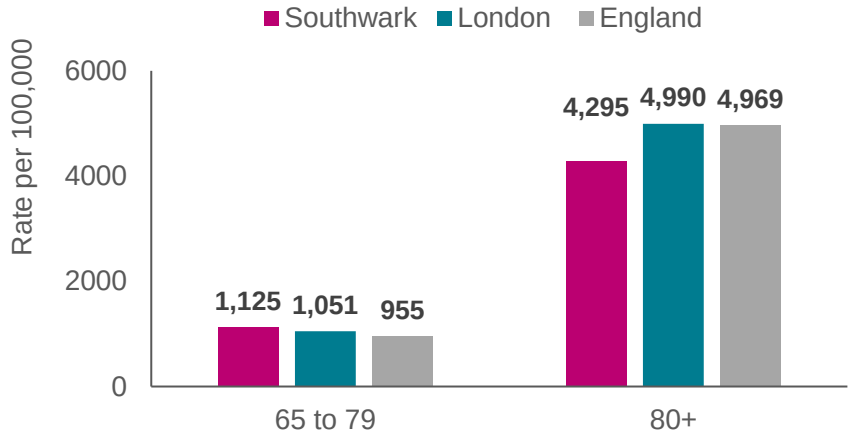


Fig 63. Emergency admissions due to falls in those aged 65-79 and 80+ 2023/24.Source: OHID, 2025. Productive & Healthy Ageing Profile.

Since 2010, the rate of emergency admissions due to falls in the borough has fallen by 16% among those aged 65-79 and by 27% among those 80+. Over the same period, the rate of hip fracture in residents aged 65 and over has decreased by 22%.

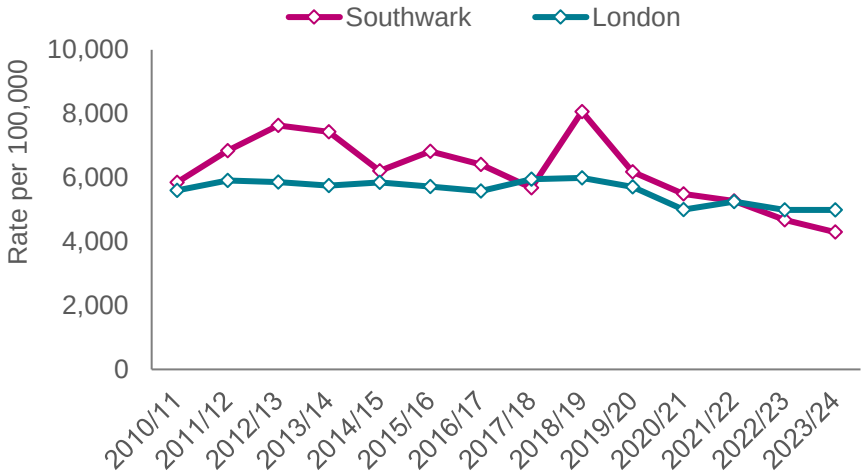


Fig 64. Emergency admissions due to falls in those aged 80+: 2023/24. Source: OHID, 2025. Productive Healthy Ageing Profile.

Joint Health & Wellbeing Strategy Long Term Population Health Measure

Priority Area 3: Support to stay well

Measure: Reduction in rate (per 100,000) of emergency hospital admissions due to falls in people aged 65 and over in Southwark

13.2 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. As they are less able to perform activities of daily living, people with dementia often require additional community support and long-term care.

Figures for 2025 show over 1,500 people in Southwark are estimated to have a dementia diagnosis. Research shows a timely diagnosis of dementia can have a significantly positive impact on a person's quality of life. Estimates for 2024 suggest that around three-quarters (71%) of those thought to be living with dementia in Southwark have received a diagnosis; higher than regional (67%) and national levels (65%).

During 2024/25, there were over 23,430 primary care appointments among Southwark residents with a diagnosis of dementia. The rate of primary care appointments among Southwark residents with a diagnosis of dementia was comparable to neighbouring South-East London boroughs.

13.3 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.

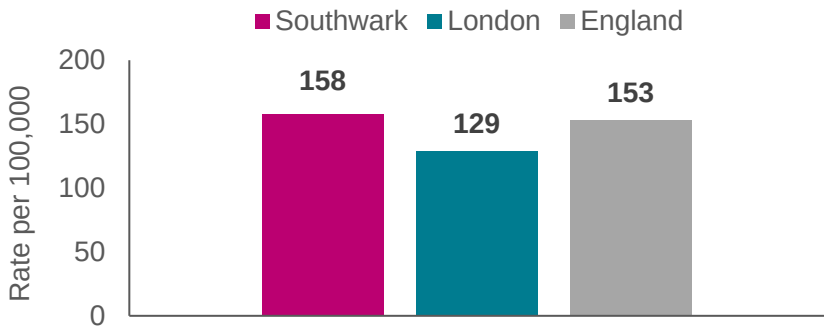


Fig 65. Preventable mortality: under 75 yr age-standardised mortality rate from all causes considered preventable, per 100,000 population, Southwark, London and England, 2023. Source: OHID, 2025. Public Health Outcomes Framework.

In 2023 there were 309 deaths among those aged under 75 in Southwark that were considered preventable; 14% more than the previous year. The preventable mortality rate in Southwark is significantly higher than London but comparable England. Preventable mortality is significantly higher among male (215 per 100,000) compared to female (105 per 100,000) residents.

Preventable mortality is broken down by four key disease groups: cardiovascular disease, cancer, liver disease and respiratory diseases. Between 2021-23, preventable deaths from cancer and respiratory diseases in Southwark were significantly higher than London. Unlike national and regional trends, under 75 deaths from respiratory disease considered preventable were statistically similar between male and female residents.

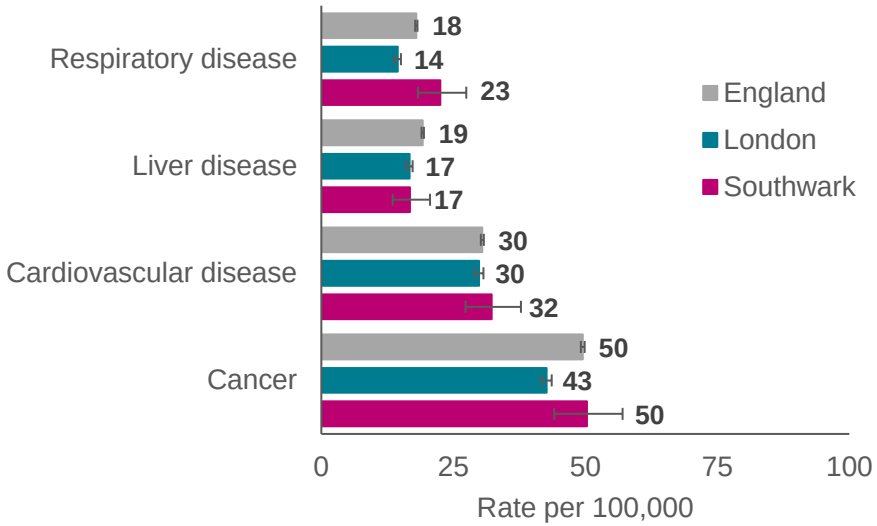


Fig 66. Age-standardised preventable mortality rate among under 75 yr olds per 100,000 residents, by condition: 3-year average, 2021-23.
Source: OHID, 2025. Public Health Outcomes Framework.

Cancer remains the leading cause of preventable mortality in those under 75 locally, regionally and nationally. Among Southwark residents, a noticeable reduction has been observed over the last decade.

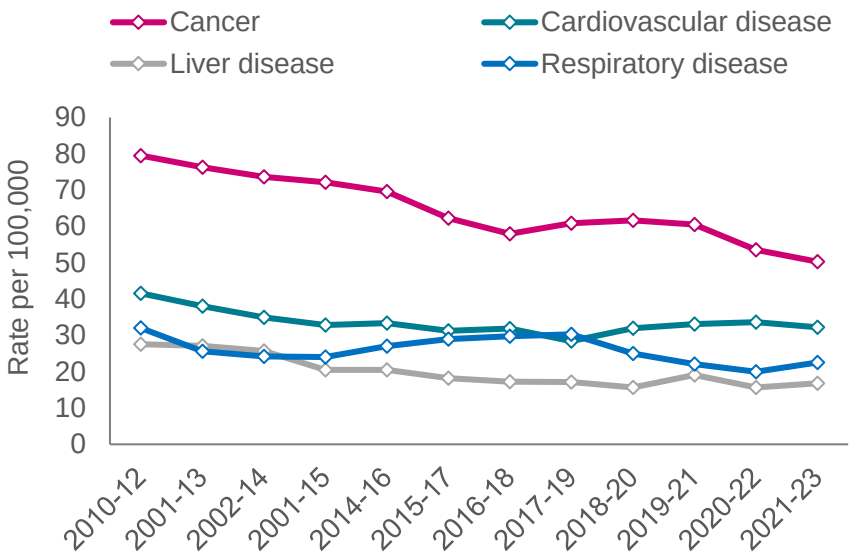


Fig 67. Age-standardised preventable mortality among under 75 yr olds per 100,000 residents, by condition: 3-year average, 2010-12 to 2021-23.
Source: OHID, 2025. Public Health Outcomes Framework.

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 Ward has the lowest rate of preventable mortality whilst Nunhead & Queen's Road has the highest rate.

13.4 Life expectancy

Life expectancy is the overarching measure of the health of the population. In 2021-23, life expectancy at birth was 78.9 years for men and 83.6 years for women in Southwark. Female life expectancy was significantly higher than England but significantly lower than London. Male life expectancy was comparable to England but lower than London.

Up to 2011 there was a consistent pattern of increasing life expectancy in both Southwark and England, along with a closing of the inequality gap. While the COVID-19 pandemic has impacted recent life expectancy figures, trends shows that there has been a longer-term pattern of stalling in life expectancy locally and nationally, with no discernible improvement over the last decade.

National analysis suggests there is no single cause driving this slow down, with factors including:

- Slowing down in improvements in premature mortality from heart disease and stroke
- Slowing down of improvements in mortality among younger adults under the age of 60
- Increases in winter deaths in 2014-15 through to 2017-18

The analysis also showed impact of this slowing down in improvements has been greatest amongst the most disadvantaged communities, exacerbating inequalities.

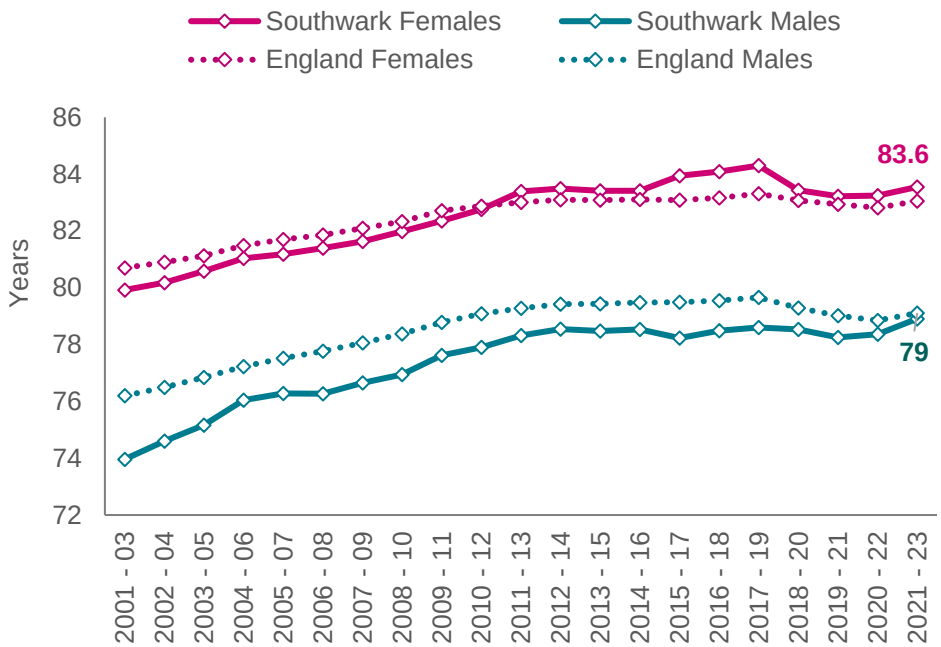


Fig 68. Southwark female and male life expectancy at birth
Source: OHID 2025. Productive Healthy Ageing Profile.

Life expectancy is not uniform across the borough. Based on 2016–20 data, male life expectancy is highest in Dulwich Village ward (87.1 years) with men in Nunhead & Queen's Road living more than 10 years less (75.3 years). Female life expectancy is highest in Champion Hill (89.8 years), almost 10 years higher than London Bridge & West Bermondsey (80.0 years).

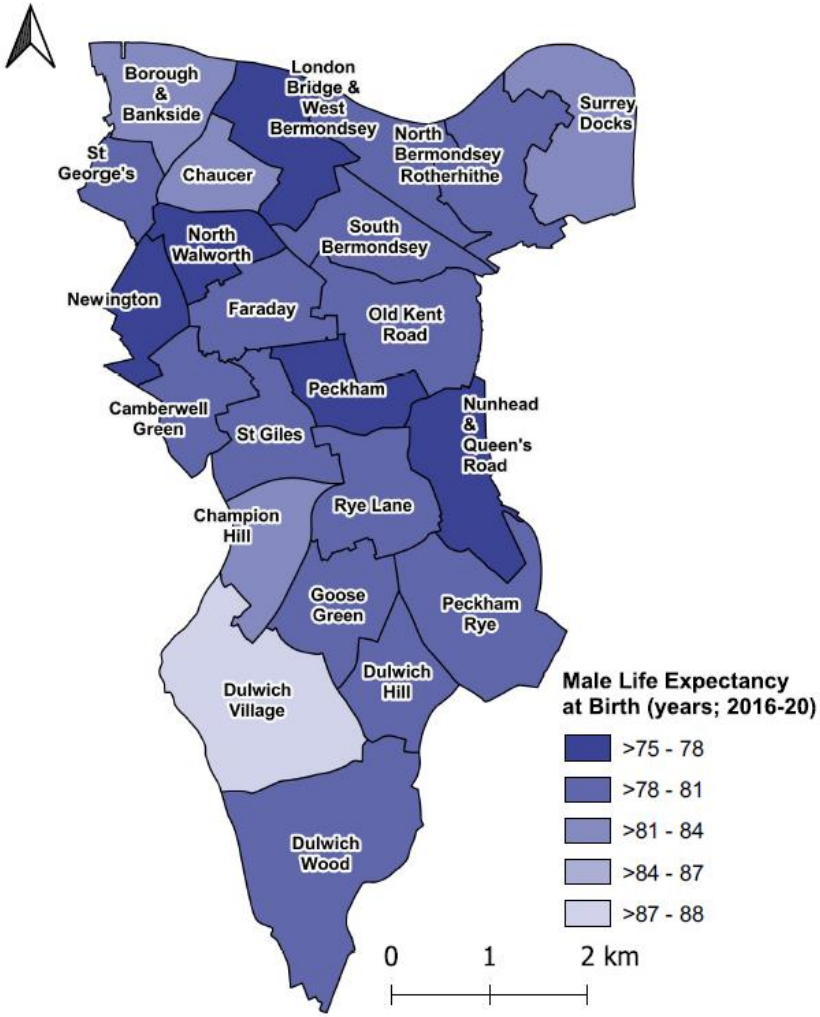


Fig 69. Male life expectancy at birth by ward, 2016–20.
Source: OHID, 2025. Local Health.

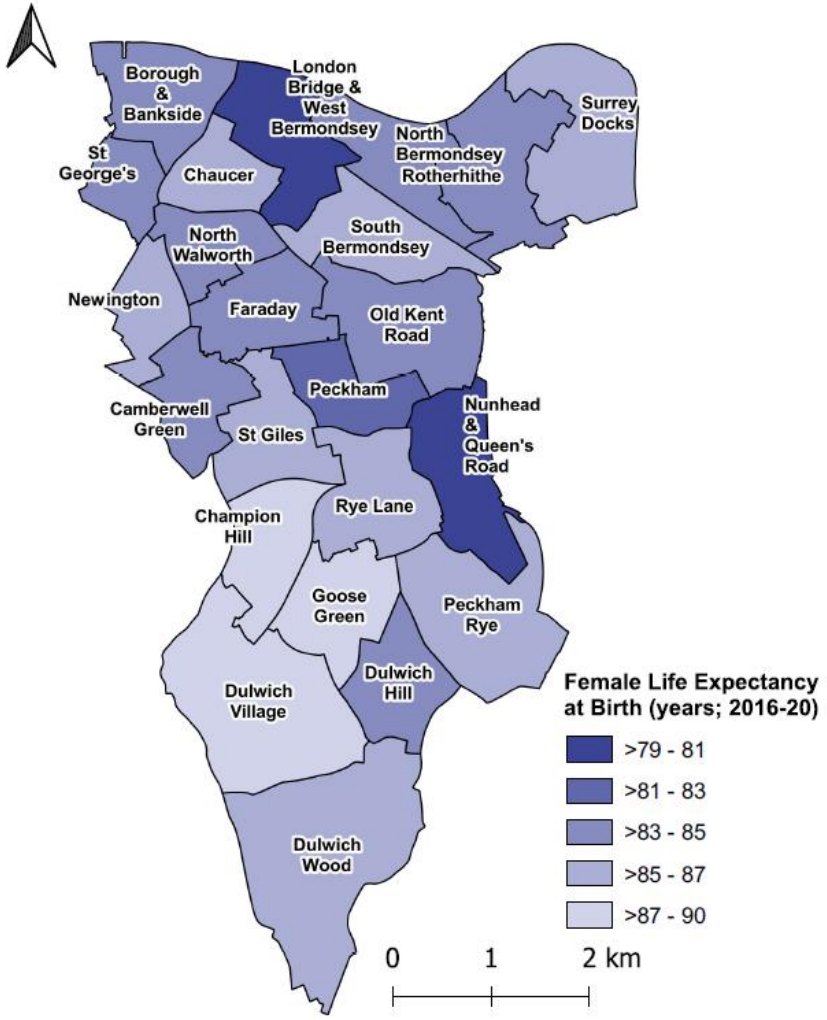


Fig 70. Female life expectancy at birth by ward, 2016–20.
Source: OHID, 2025. Local Health.

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. Despite Southwark females living more years than males, these extra years are spent in poorer health.

Healthy life expectancy in Southwark among males and females is just over 60years, with residents spending a further 20years living in poor health.

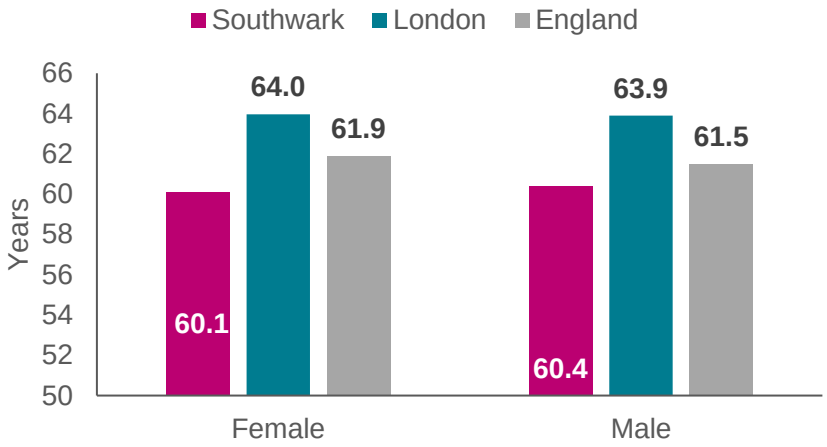


Fig 71. Female and male healthy life expectancy at birth in Southwark, London and England: 2021-2023.
Source: OHID 2025. Productive Healthy Ageing Profile.

Healthy life expectancy in Southwark has observed a near consistent decline among both female and male residents. Since 2015-16, a greater decline has been observed among female Southwark residents (drop: 4.6 years) compared to male Southwark residents (drop: 2.9 years).

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Find out more at:

www.southwark.gov.uk/insight-hub

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

Agenda Item 12

Meeting Name:	Health and Wellbeing Board
Date:	19 June 2025
Report title:	Better Care Fund 2025/26
Ward(s) or groups affected:	All
Classification:	Open
Reason for lateness (if applicable):	Not applicable
From:	Darren Summers, Strategic Director for Integrated Health and Care/Southwark Place Executive Lead

RECOMMENDATION(S)

1. That the Health and Wellbeing Board approves the use of the 2025/26 Better Care Fund (BCF) as detailed in the planning templates (appendices 1,2 and 3).

PURPOSE OF THE ITEM

☐ Item relates to Joint Health and Wellbeing Strategy
☒ Statutory item
☐ Other

2. It is a national condition that the Better Care Fund plan is agreed by the Health and Wellbeing Board.

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 service delivery. 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. The 2025/26 BCF Policy Framework and planning guidance was issued on 30th January, requiring submission of a BCF plan meeting the requirements by 31st March. The completed planning templates (appendices 1, 2 and 3) have been agreed through the Joint Commissioning Oversight Group and the respective governance processes of the council and the ICB, including the sign off by the Chief Executive and Director of Finance of each organisation. They have been submitted on a provisional basis to NHSE, subject to agreement by this Health and Wellbeing Board meeting. This governance route was previously agreed with the chair as preferable to the alternative of holding an extraordinary board meeting immediately before submission and is permitted in the guidance.

KEY ISSUES FOR CONSIDERATION

5. The Better Care Fund submission consists of 3 templates submitted for the national assurance process as follows:

   - **Narrative Template** (appendix 1)**:** this provides a description of the plan and what it is trying to achieve**.**
   - **Finance and data template** (appendix 2): this provides a breakdown of the financial details of the plan including brief descriptions of the 41 schemes within the plan. It also provides details of the performance metrics and targets for 2025/26.
   - **Intermediate Care Capacity and Demand** (appendix 3)**:** this provides forecasts of the likely numbers of discharges from hospital requiring different sorts of intermediate care, and the capacity required to meet this.

6. A summary "plan on a page" of the BCF is shown in Table 1 overleaf, highlighting key features of the plan.

Key changes

7. Key changes in the 2025/26 BCF Plan compared to the 2024/25 plan approved by the Health and Wellbeing Board in July 2024 are summarised below:

   a) The 2 key objectives have been reworded to align with the new government priorities of supporting the shift from sickness to prevention, and from hospital to home. This does not impact on the type of services funded through the BCF in 2025/26.
   b) Most services funded through the BCF in 2024/25, which are core services requiring recurrent funding, are rolled forward into 2025/26 with relatively minor amendments.
   c) The element of the BCF that was previously the ringfenced hospital discharge fund (£7.1m) has been de-ringfenced and merged into the main fund. It was agreed to continue using that funding to support discharge in 2025/26.
   d) New key targets have been set relating to hospital admissions of over 65's and delayed discharge from hospital.
   e) There was 1.7% growth in the national NHS minimum contribution to the BCF, translating to £0.8m locally. This was applied exclusively to social care schemes to help address cost pressures, equating to a 3.9% increase in the related social care budget to £21.7m. Unlike previous years, there was no growth in the amount of the NHS contribution earmarked for community health services (£11.7m).
   f) There was no growth in the national Better Care Grant of £22m provided to the Council for the BCF.
   g) The plan addresses the need for capacity to expand to enable the Disabled Facilities Grant to be fully spent in 2025/26. The grant was expanded from £1.84m to £2.09m late in 2024/25 and was underspent, with £1m carrying forward into 2025/26. This will enable an expansion in the numbers receiving home adaptations to enable them to live independently at home.
   h) "Additional contributions" through which the council and NHS previously

included budgets above the minimum BCF funding requirements are no longer a feature of the Southwark BCF.

8. Further details on these and other aspects of the BCF are available in the plan on a page overleaf and the full templates in the appendices.

Table 1: Better Care Fund 2025/26 – Summary on a page

Objective 1: To support the shift from sickness to prevention – including timely, proactive and joined-up support for people with more complex health and care needs; use of home adaptations and technology; and support for unpaid carers.

Objective 2: To support people living independently and the shift from hospital to home – including help prevent avoidable hospital admissions; achieve more timely and effective discharge from acute, community and mental health hospital settings; support people to recover in their own homes (or other usual place of residence); and reduce the proportion of people who need long-term residential or nursing home care.

Pooled Budget of £57.6m – minimum requirement with the funding from:

- **NHS minimum contribution: £33.5m**
- **Council Better Care grant: £22.0m**
- **Disabled Facilities Grant: £2.1m**

Note this incorporates the previous hospital discharge fund (£7.1m) which is no longer ringfenced. Local additional contributions to the budget are no longer made.

National Conditions

- A jointly agreed plan between health and social care, signed off by the chief executives of the council and ICB and the Health and Wellbeing Board.
- Plan implements the 2 key objectives.
- Provides the NHS's minimum funding contribution to adult social care.
- Compliance with detailed planning guidance confirmed through NHSE assurance process.
- Pooled budgets reflected in an agreement known as a section 75.

How it is spent:

Social Care £43.75m including:

- Home care, reablement and intermediate care, care homes, hospital discharge and transfers of care teams, equipment and telecare, flexi care and step-down flats, discharge to assess, mental health, carers and voluntary sector services.

Community health £11.75m including:

- GSTT community health including @home, urgent community response, falls service, palliative care, equipment, mental health discharge, step down flats, complex health discharge placements, homeless discharge support, King's outreach therapy services.

Housing adaptations: £2.1m including**:**

- Disabled Facilities Grants (for non-council housing) to enable people with disabilities to live at home, and handyperson service.

Expenditure is further categorised as follows: Proactive care to those with complex needs (£20.6m); Home adaptations and tech (£4.9m); VCS Carers (£0.4m); preventing hospital admissions (£9.5m); timely hospital discharge (£17.8m), care home admission avoidance (£4.4m)

Local BCF priorities

- Alignment with the Southwark Health and Wellbeing strategy and with Partnership Southwark's health and care plan priorities, in particular the development of Integrated Neighbourhood Teams and the roll out of the frailty pilot model.
- Contribute to system sustainability through improved admissions avoidance and supporting discharge.
- Ensuring a good quality and sustainable care sector, particularly for care homes.

Key targets and metrics (new for 25/26)

- **Emergency hospital admissions by Southwark residents aged over 65 yrs (new):** contain growth at 2.5%
- **Hospital discharge delays:** maintain performance of 90%+ patients discharged on discharge ready date, and improve performance on average days delayed
- **Care home admissions:** contain growth at 2.5%

There are subsidiary measures on admissions due to falls, avoidable admissions and discharge to usual place of residence monitored locally.

Next steps and 2026/27 BCF planning

9. Following agreement from this board and the national BCF assurance process a letter of approval should be issued in June and the pooled budget can be formally agreed and the Section 75 agreement underpinning the joint commitment will be signed.

10. Given the lateness of national planning guidance it is planned to undertake a review of services mid-year against the revised BCF policy framework objectives and new key metrics, providing sufficient time to implement any commissioning changes from the start of 2026/27.

11. It is anticipated that the 2026/27 BCF plan will return to a multi-year format which will improve the planning process.

Policy framework implications

12. The Department of Health and Social Care and the Ministry of Housing, Communities and Local Government published a Policy Framework for the implementation of the Better Care Fund (BCF) in 2025/26 on 30th January 2025. NHS England also issued the document "BCF Planning Requirements 2025/26" to local systems requiring the development of plans at Health and Wellbeing Board level. The BCF plan submitted is consistent with the national framework and reflects local policy on integration as set out in the Partnership Southwark Health and Care Plan and the Health and Wellbeing Strategy. It is also consistent with the aims of the Council Delivery Plan "Staying Well" objective.

Community impact statement

13. 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.

14. 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 global majority 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

15. The way that BCF contributes to the equalities and health inequalities objectives of the draft Health and Care Plan and the Health and Wellbeing Strategy is set out in the full BCF plan.

Health impact statement

16. 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 for all Southwark residents in need of health or

care services. The full BCF plan sets out how the BCF aligns to the delivery of the Health and Wellbeing Strategy.

Climate change implications

17. The BCF plan will be delivered in line with the Partnership Southwark policy statement on environmental sustainability which incorporates the environmental policies of partnership organisations.

Resource implications

18. The finance template in the template in appendix 2 sets out the breakdown of the funding sources and the planned expenditure against each for 2025/26.

Consultation

19. The BCF plan sets out consultation undertaken through local partnership arrangements.

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS

Strategic Director of Resources (09EN2025-26)

20. The Strategic Director of Resources notes the recommendations of this report for the Health and Wellbeing Board to agree the submitted provisional 2025-26 BCF Planning templates. In addition also notes the breakdown of how funds will be allocated as detailed in Appendix 2. It is important that officers ensure expenditure is in line with the allocated plan and monitored and reported through the respective governance pathways.

21. The pooled budget income streams now represent a significant proportion of the funding and the Better Care Fund and Local Authority Better Care Grant contributes in excess of £44m to the council's Adults Social Care budget. Therefore a longer term commitments and multi-year agreements for these funds would be welcome to ensure additional clarity and confidence into the budget setting process. Given the current economic climate which affects both organisations a longer term view on budget planning is encouraged in future years.

Assistant Chief Executive, Governance and Assurance

22. None sought.

Background Papers	Held At	Contact
Better Care Fund	160 Tooley St	Adrian Ward Adrian.ward@selondonics.nhs.uk

APPENDICES

No.	Title
Appendix 1	Narrative Template
Appendix 2	Finance and data template
Appendix 3	Intermediate Care Capacity and Demand

AUDIT TRAIL

Lead Officer	Darren Summers, Strategic Director for Integrated Health and Care/Southwark Place Executive Lead
Report Author	Adrian Ward, Head of Planning, Performance and Business Support, NHS South East London Integrated Care Board
Version	Final
Dated	06/06/2025
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 Resources	Yes	Yes
List other officers here	N/A	N/A
Cabinet Member	No	No
Date final report sent to Constitutional Team		6 June 2025

Appendix 1

Integration and Better Care Fund

Better Care Fund 2025-26 HWB submission

Narrative plan template

Submission 31st March 2025

HWB	Southwark
ICB	South East London ICB

Introduction

The Southwark Better Care Fund (BCF) narrative plan has been developed jointly by Southwark Council and South East London Integrated Care Board (ICB) and approved by lead officers of both organisations. It is subject to formal approval by the Southwark Health and Wellbeing Board at its next scheduled meeting on June 19th 2025.

The narrative plan is to be read in conjunction with the planning template containing details of planned expenditure and performance metrics, and the intermediate care capacity and demand template.

Collectively the documents describe local plans to establish a pooled budget between the Council and the ICB for 2025/26 for the provision of integrated community based health and care services that meet the national objectives and other requirements of the BCF as set out in the national BCF policy framework and planning guidance.

This draft of the plan is to be submitted on 31st March for assessment under the national BCF assurance process. The final draft of the plan may reflect amendments agreed following the assurance process.

Section 1: Overview of BCF Plan

This should include:

- *Priorities for 2025-26*
- *Key changes since previous BCF plan*
- *A brief description of approach to development of plan and of joint system governance to support delivery of the plan and where required engage with BCF oversight and support process*
- *Specifically, alignment with plans for improving flow in urgent and emergency care services*
- *A brief description of the priorities for developing for intermediate care (and other short-term care).*

Where this plan is developed across more than one HWB please also confirm how this plan has been developed in collaboration across HWB areas and aligned ICBs and the governance processes completed to ensure sign off in line with national condition 1.

Priorities for 2025/26

The local priorities for the 2025/26 BCF fully align with the delivery of the re-framed national objectives for the BCF and the wider system which are:

- **To support the shift from sickness to prevention –** including timely, proactive and joined-up support for people with more complex health and care needs; use of home adaptations and technology; and support for unpaid carers.
- **To support people living independently and the shift from hospital to home** – including help prevent avoidable hospital admissions; achieve more timely and effective discharge from acute, community and mental health hospital settings; support people to recover in their own homes (or other usual place of residence); and reduce the proportion of people who need long-term residential or nursing home care.

Additional specific local priorities to which the BCF plan aligns include:

- The recently refreshed Partnership Southwark Health and Care Plan focus on Frailty, Integrated Neighbourhood Teams, Prevention and Health Inequalities and Mental Health have a strong link to BCF objectives. These are also reflected in the refreshed ICB Joint Forward Plan.
- Contributing to system sustainability objectives in the context of major budget pressures and rising demographic demand pressures through improved admissions avoidance and timely discharge from hospital.

- Mitigating the impact of real terms reductions in resources via improved effectiveness and integrated working, including earlier intervention to prevent deterioration and the need for more costly services.
- Ensuring optimal delivery of the Disabled Facilities Grant budget plan impacted by recent capacity issues.
- Developing the Nursing Care market to better meet demand for high needs people with dementia and reduce associated hospital discharge delays.
- Seek continued recovery and improvement in the Integrated Community Equipment service.
- Re-commissioning of reablement and home care services.
- Continue to develop bed-based step down intermediate care options.
- Improved data sharing and data quality supporting multi-disciplinary working, monitoring and evaluation of outcomes and further development of demand and capacity modelling.
- Undertake a mid-year review of the BCF in order to provide sufficient time to plan for agreed changes to be made at the start of 2026/27.

The BCF plan is aligned to the priorities of the Southwark Health and Wellbeing Strategy, in particular the key goals associated with the following high level priorities:

- Support to stay well
- Healthy and connected communities
- Integration of health and social care

The Urgent and Emergency Care Plan and the BCF are aligned through consideration of the totality of acute based and community-based initiatives to support hospital discharge and admissions avoidance. The Urgent and Emergency Care lead reports to the Director of Integrated Commissioning overseeing the BCF, helping to ensure a whole system approach. For example, the UEC plan makes specific reference to the Urgent Community Response and discharge to assess priorities of the BCF as key to overall demand management approach.

There is also strategic alignment with the delivery of the objectives in the Southwark 2030 place strategy, in particular the “staying well” focus on the wellbeing of people with long term conditions and disabilities, and their carers.

Key changes since the previous BCF plan

Schemes funded by BCF

The majority of schemes funded under the 2024/25 plan are continuing into the 2025/26 plan. These are deemed by partners to be providing a range of vital core services that help people live independently and safely at homes, avoid unnecessary admissions to hospital and care homes and support timely and effective discharge from hospital. The areas where there have been changes include:

- **Decommissioning:** The overnight homecare service has been de-commissioned as monitoring showed the service model was no longer delivering value for money and service user needs can be met with alternative services. The £241,000 budget will be re-invested in other BCF schemes with major inflationary cost pressures.
- **Hospital Discharge Fund:** Following the de-ringfencing of the hospital discharge fund existing usage has been reviewed and it has been agreed the funding will continue to be applied to discharge schemes. Existing 2024/25 schemes will continue to be funded with a small number of changes to better target the resource at the services with highest demand in the context of no growth in funding.
- **Growth and real terms reductions:** There has been agreement between partners that all the 2025/26 growth in the NHS contribution to the BCF (£804,000) will be invested in social care in line with national requirements. This will be used to offset inflationary pressures in social care. As there is no growth for community health services, in order to fund the contractual uplift there has been a reduction in planned BCF funding for complex ICB funded pathway 2 and 3 discharges. It should be noted that there is also no growth in the de-ringfenced Hospital Discharge element of the BCF and the Local Authority Better Care Grant.
- **Additional contributions**: it has been agreed by partners to change the approach to additional contributions above minimum requirements to the BCF. These amounted to £2.5m in 20245, evenly split between partners. Following review of the pilot it was considered that there is no longer any benefit in the current approach and it is proposed that these budgets are returned and managed outside the BCF alongside other mainstream resources, with the BCF budget being set at the mandated amount only. This will simplify and streamline the administration of budgets. It is important to note that this does not reflect a reduction in services overall, and is in line with BCF requirements and common practice in other boroughs.
- **Consolidation of budget lines**: For 2025/26 several schemes that were funding similar or identical services have been merged. This rationalisation is mainly presentational, making the plan more focussed, and does not relate to any of the previous lines being de-funded. For example, separate tranches of home care funding reflecting growth allocations over a number of years no longer need to be shown as separate budget lines. There has also been a regrouping of schemes under the revised primary objective headings which improves the presentation of the budget information.
- **New metrics and stretch targets:** as set out in section 2.

BCF Governance Arrangements

The BCF plan 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 Joint Commissioning Oversight Group it is formally agreed through each organisation's respective governance requirements, including Chief Executive sign off this year as required by the guidance.

The Southwark Health and Wellbeing Board does not allow for delegated approval of the BCF submission, and has elected not to hold extraordinary meetings for sign off arrangements. It will therefore be approved at the next Health and Wellbeing Board after submission. The date for this has not been set but is expected to be in June 2025.

Following submission to NHSE the plan is subject to the national assurance process and any comments received to improve the plan are addressed.

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.

The Joint Commissioning Oversight Group meets bi-monthly and reviews the development and delivery of the BCF Plan, including oversight of the quarterly monitoring process. The group includes the Director of Adult Social Care, the Director of Integrated Commissioning (joint post) the Strategic Director for Integrated Health and Care/Southwark Place Executive lead (joint post), the ICB Director of Partnership Delivery and Sustainability and the Finance leads from the council and ICB. The group reports to the Health and Wellbeing Board on BCF related issues.

Priorities for developing intermediate care (and other short-term care).

A key priority is to consolidate and develop the good performance of the current intermediate care services provided to people in their own, and the Avon Unit providing bedded intermediate care. The reablement service is being recommissioned providing an opportunity to align services with emerging neighbourhood teams.

A major source of delayed discharge bed days relates to the availability of suitable nursing care home discharge to assess placements for people with dementia, hence this is a key commissioning priority. The care home liaison service is also developing an in-reach approach into care homes which has potential to reduce admissions to hospital and facilitate timely transfers from hospital.

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Section 2: National Condition 2: Implementing the objectives of the BCF

Please set out how your plan will implement the objectives of the BCF: to support the shift from sickness to prevention; and to support people living independently and the shift from hospital to home. This should include:

- *A joint system approach for meeting BCF objectives which reflects local learning and national best practice and delivers value for money*
- *Goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans*
- *Demonstrating a "home first" approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care*
- *Following the consolidation of the Discharge Fund, explain why any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other* services are expected to enhance UEC flow and improve outcomes.

Objective 1: To support the shift from sickness to prevention – including timely, proactive and joined-up support for people with more complex health and care needs; use of home adaptations and technology; and support for unpaid carers.

The Southwark BCF supports the shift from sickness to prevention by providing co-ordinated support in the community that supports the health and wellbeing of people with health and care needs and avoid or delay the need for more intensive health services. A range of BCF services are vital for maintaining the health and wellbeing of older people in particular.

Timely, proactive and joined-up support for people with more complex health and care needs

A key priority for Partnership Southwark for 2025/26 is to further develop our multi-disciplinary team approach in the community through the development of Integrated Neighbourhood Teams. A specific pilot relating to Frailty is well advanced and will be rolled out across the borough.

A range of BCF funded services help provide integrated support for people with complex health and care needs. Examples include the Enhanced Intervention Service (Intensive Support Team) which is an integrated mental health team providing additional

psychological support to enable people with learning disabilities to maintain stable placements in local care homes rather than needing transfer to a more restrictive setting.

The Transfers of Care Service is funded through the BCF and continues to provide a strong responsive service for out of hospital pathways, including 7 day working as part of the discharge hub model.

The BCF continues to provide funding for Intermediate Care Southwark which is an integrated reablement and intermediate care service focusing on providing proactive joined up support for people at risk of admission and in need of urgent support, or support to be safely discharged home. The service combines community health and social care services in one team. This includes the @home service which provides the urgent community response and is fundamental to the shift from hospital to home treatment.

A further example of joined up support is the recently established BCF funded Care Home Support Team (OT and Physio) that provide multi-disciplinary team support to care homes. Their input not only ensures residents get their needs met timely but also helps to improve the timely discharge for pathway 3 residents. This team has been pivotal in enabling the move to a trusted assessor model for pathway 3 discharges from hospital.

Home adaptations: **Disabled Facilities Grant (DFG) and wider services**

The DFG service supports the delivery of BCF objectives by providing funding for non-council housing adaptations that enable residents to continue living independently and safely in their own home, avoiding the need to move to a care home, reducing the risk of hospital admission and supporting discharge from hospital. Adaptations provided include stairlifts, level access showers and bathroom alterations and building alterations to enable access.

Key features of the plan for 2025/26 are as follows:

- The DFG budget increased to £2.092m in 2025/26, incorporating a £0.253m increase on the opening 2024/25 budget (this uplift was also provided in Q4 of 2024/25).
- Issues that impacted on capacity and resulted in an underspend in 2024/25 will be addressed in 2025/26 through plans underway for improved staffing cover arrangements, ensuring DFG application processes are effectively supported.
- To make best use of the additional resources active consideration is being given to a range of wider uses of DFG such as expanded handyperson service funding, staffing resources (OT, surveyor and financial counsellor) and increasing the numbers of minor adaptations funded by uplifting the cost threshold. These will be incorporated into the DFG subject to agreement.
- There are plans to increase awareness of the DFG offer amongst the public and referring agencies, following a slight reduction in referrals noted in 2024/25.
- Workflow analysis shows there will be a healthy number of adaptations in the pipeline at the start of 2025/26 and capacity in place to clear backlogs.

- The service will continue to work closely social services to ensure clients' needs are met.

As a result, there is a high level of confidence that the DFG budget will be fully spent in 2025/26 and impact maximised, and plans for investing the carried forward underspend will be developed.

Telecare

The telecare service provides a pendant alarm service as well as a range of more specialised safety equipment such as digital wellbeing monitoring devices and services enabling falls to be responded to, including specialist staff and equipment for lifting people after a fall avoiding unnecessary ambulance call outs. This is a key preventative service enabling people to live safely and independently in their own home.

At the start of 2025/26 the Telecare team will be concluding the analogue to digital switchover and all the service provision in the borough will then be completely digital; this is well ahead of the national switchover deadline. Along with the digital switchover, the Telecare Team is trialling new, predictive technology. The hope is that the predictive technology will assist with proactive care and assessments of needs.

Equipment

The Integrated Community Equipment Service is commissioned jointly by the council and ICB has been an area of significant expenditure growth as well as an area of concern in performance terms. The plan for 2025/26 is to work closely with the provider and operational colleagues to ensure the service continues to improve on areas such as delivery times, stock recycling, and offers value for money, including in the way that items are prescribed. A fixed term project manager is in post to explore options for the future ICES service, to ensure a sustainable and high-quality service can be commissioned in the future. An options appraisal will be completed in 2025 and will include information and ideas from other services and feedback from key stakeholders about what an improved ICES service model could look like.

Home First Approach

The home first discharge to assess approach to hospital discharge provided through Intermediate Care Southwark is very well established in Southwark, and compared to other comparable boroughs relatively low volumes of pathway 2 bedded intermediate care are commissioned. This reflected by the metric on discharge to normal place of residence for which latest data at 96% is the third highest in London. More recently a number of bedded step down and discharge to assess options have been commissioned in a local care home for patients who can not be discharged directly home but the vast majority still receive a home first approach.

Carers

Support for unpaid carers is a key priority across the partnership and the key importance of properly involving and supporting carers in hospital discharge decisions as well as avoiding admissions to hospital and care homes is recognised.

BCF resources are allocated to the local VCS (Southwark Carers) for the provision of a range of services including information and advice regarding carers' rights; support accessing grants; support navigating statutory services; peer support; delivery of a range of activities and events in the community; and delivery of outreach work to identify new carers. In addition, the funding allocated to VCS dementia services includes delivery of support to the unpaid carers of residents recently diagnosed with dementia. This includes information, advice, support with practical matters such as power of attorney, and emotional support.

There is also an online service (Mobilise) that is free for carers to access, providing practical and emotional support to carers via an AI-powered assistant, connection with other carers via a hub, and free one-to-one advice via a 30-minute call.

There is also 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. Carers advocacy is also funded to help ensure the right support is obtained.

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

Objective 2: To support people living independently and the shift from hospital to home – including help prevent avoidable hospital admissions; achieve more timely and effective discharge from acute, community and mental health hospital settings; support people to recover in their own homes (or other usual place of residence); and reduce the proportion of people who need long-term residential or nursing home care.

The Southwark BCF will support the shift from hospital to home by helping ensure that avoidable hospital and care home admissions are prevented and that patients who are admitted to hospital are supported to be safely and effectively discharged as soon as they are ready for discharge. Relevant BCF funded schemes include:

- Home care
- Residential Care and Nursing Care, including permanent admissions and discharge to assess temporary placements
- Step up step up and step down reablement and intermediate care at home through the integrated Intermediate Care Southwark team
- Step and step down beds and in the Avon Unit, including discharge to assess

- Step down flats
- Urgent Community Response
- Transfers of Care Team
- Telecare and community equipment
- VCS funding – e.g. older people's hub, social prescribing
- Community health services
- Falls service
- Mental health and learning disability personal budgets
- Mental health reablement
- Disabled Facilities Grant

Fundamental to the Integrated Neighbourhood Team model, which is a Partnership Southwark priority for 2025/26, is preventing avoidable admissions by improving the co-ordination of support for people with long term conditions at risk of admission.

The continuous improvement approach to hospital discharge will include consideration of national best practice including consideration of the high impact changes model for discharging people with dementia, building on previous work on the wider high impact change model.

The section below sets out the arrangements in place for driving improvement in discharge.

Discharge Solutions Improvement Group

South East London ICS has an established multi-agency group including representatives from acute and mental health trusts, and borough social services and commissioning leads that focuses on delivering agreed improvements as set out in the SEL Discharge Plan. Southwark and local trusts are active members of this group, which meets regularly discussing issues such as the delivery of discharge standards, performance data, examples of good practice from across the system, discharge related funding including from the BCF and sharing learning from MADE processes (multi-agency discharge events).

A mission statement for the plan was agreed following a discharge summit:

"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".

Key objectives include:

- developing a common framework to deliver transfers of care standards, including Transfers of Care Hubs and the Home First discharge to assess approach

- ensuring discharge pathways are safe, personalised and promote independence and recovery
- focussing on meeting complex needs
- maximising admissions avoidance

Discharge Operational Delivery Group (Southwark and Lambeth)

This group meets regularly with to drive specific local operational improvements and undertake problem solving with local trust leads. The group focusses on specific issues including weekend discharge, discharge pathway improvements, and transfers to care homes.

Southwark Transfers of Care Improvement plan

Southwark has developed an action plan bringing together a range of activities promoting good discharge improvements, focussing on specific local issues including:

- Developing the Transfer of Care Passport, including resolving technical issues with the EPIC system
- Expanding and embedding the trusted assessor model for use in care homes
- Develop the care home liaison services funded by the BCF to facilitate improved communications around discharge to care homes, including a focus on admissions from care homes and subsequent return to the care home.
- Improved communications materials for patients and family/carers on the discharge process.
- Building on the learning from the innovative Partnership Southwark returning home from hospital project which employed VCSE community researchers to explore the patient experience of the discharge process with a sample of people during and shortly after the process.
- Increasing community capacity to support discharge, in particular for care homes suitable for patients with high levels of dementia which is the key area with a shortfall of capacity causing delays
- Further develop joint work with housing including input into the discharge team.

The plan is overseen by the Southwark Integrated Health and Social Care Board.

Metrics and stretch targets for 2025/26

As set out in the revised national planning framework we are required to set out high level targets for 3 key measures. The metrics template has been completed for this draft of the plan, setting out the rationale for our proposed targets and why they are considered stretching in the context of anticipated demand pressures. In summary these are:

- **Emergency admissions by Southwark residents aged over 65 yrs (new):** contain growth at 2.5%
- **Discharge delays:** maintain performance of 90%+ patients discharged on discharge ready date, and improve performance on average days delayed to 8 days in line with benchmarks.
- **Care home admissions:** contain growth at 2.5%

In setting these targets careful consideration was given to underlying demand growth trends, including acuity of needs and total population growth, the potential impact of service developments and ICB Operational Plan assumptions. For example, Hospital Episode Statistics (HES) data suggests a potential growth rate of 9.7% in 2024/25 based on data to December and population projections forecast 4.3% growth in over 65's in 2025/26.

The emergency admissions and discharges targets will be reviewed during the year as the new data sets develop and there is a greater system-wide understanding, including data quality, and potential for improvement.

Locally monitored metrics: will include the previous BCF metrics of effectiveness of reablement and admissions for falls and ambulatory care conditions and discharges to usual place of residence.

Changes to the use of the hospital discharge funding element of the BCF

Following the de-ringfencing of the previous hospital discharge funding within the BCF it has been agreed that for 2025/26 the funding will remain focussed on hospital discharge services rather than shifting to prevention or admissions avoidance. There have been a small number of changes on the ICB side to redirect funding to areas with highest cost pressures. Over the course of 2025/26 consideration will be given to a measured shift towards admissions avoidance in advance of 2026/27 planning decisions, ensuring that patient flow is not negatively impacted.

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Please describe how figures for intermediate care (and other short-term care) capacity and demand for 2025-26 have been derived, including:

- *how 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26)*
- *how capacity plans take into account therapy capacity for rehabilitation and reablement interventions*

The capacity and demand figures for intermediate care have been derived from detailed work on actuals data to the end of Q3 and extrapolated for a full year, providing the baseline for 2025/26. The source of this data is primarily from social care systems as there remain issues with the ability to use acute and community health data accurately for the national model, which will remain a challenge until the EPIC system is fully optimised. Also taken into account is the projected seasonal variation in non-elective admissions reflected in the ICB Operational Plan assumptions, and the estimates of the Trust split for Southwark patients.

There remain weaknesses in the model which result in difficulties in accurately identifying the difference between historic demand and capacity. Developing a system wide demand and capacity model will be a priority for 2025/26, taking advantage of improving EPIC data and the flexibility now being offered under the BCF requirements to develop a model that works best locally.

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, especially dementia
- 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.

Hospital discharge funding and other BCF funding has been targeted at these areas.

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Section 3: Local priorities and duties

Local public bodies will also need to ensure that in developing and delivering their plans they comply with their wider legal duties. These include duties:

- *to have due regard to promoting equality and reducing inequalities, in accordance with the Equality Act 2010 public sector equality duty.*
- *to engage or consult with people affected by the proposals. For ICBs, trusts and foundation trusts this includes their involvement duties under the NHS Act 2006.*
- *for ICBs, to have regard to the need to reduce inequalities in access to NHS services and the outcomes achieved by NHS services.*
- *for ICBs, to have regard to the duty to support and involve unpaid carers in line with the Health and Care Act 2022*

Please provide a short narrative commentary on how you have fulfilled these duties

All services funded through the BCF are managed in line with the governance arrangements of the lead commissioner for each scheme. This includes the organisational policies, procedures and controls that ensure that the ICB and Council comply with their wider legal duties.

BCF services are focussed on promoting the health and wellbeing of people with support needs who frequently have to have protected characteristic under the Equality Act, for example older people, people with disabilities and serious mental health problems. This contributes significantly to the drive to reduce health inequalities.

The BCF has a specific focus on supporting carers in line with the Health and Care Act as set out in the previous section.

Click or tap here to enter text.

Appendix 2. Southwark BCF Planning Template submitted 31.03.25

Better Care Fund 2025-26 Update Template

Data Sharing Statement

Data sharing Statement
Please see below important information regarding Data Sharing and how the data provided during this collection will be used. This statement covers how NHS England will use the information provided. Advice on local information governance which may be of interest to ICSs can be seen at: https://data.england.nhs.uk/sudgt/ Please provide your submission using the relevant platform as advised in submission and supporting technical guidance. **Purpose of Data Collection** NHS England is collecting data on behalf of Better Care Fund (BCF) partners to fulfil statutory duties, including improving healthcare quality, efficiency, and transparency. The data supports operational and strategic planning, financial management, workforce planning, and system feedback, as mandated by the NHS Act 2006 and relevant regulations. **Type and Scope of Data** Patient-level data, including identifiable information like NHS numbers, is not required. Data includes finance, activity, workforce, and planning information as specified in the national guidance documents. The BCF planning template is categorized as "Management Information," and aggregated data, including narrative sections, will be published on the NHS England website and gov.uk. **Access, Sharing, and Publication** The BCF planning template is categorised as 'Management Information' and data submitted will be published in an aggregated form on the NHS England website and gov.uk. This will include a narrative section. Please also note that all BCF information collected here is subject to Freedom of Information requests. Internal Access: Data will be accessed by NHS England national and regional teams on a "need-to-know" basis and may be shared internally to support statutory responsibilities. External Sharing: Data will be shared with partner organisations and Arms' Length Bodies (ALBs) including BCF partners (i.e. Ministry of Housing, Communities and Local Government (MHCLG), Department of Health and Social Care (DHSC) and NHS England) for joint working and policy development. Publication: Local Health and Wellbeing Boards (HWBs) are encouraged to publish local plans. Until publication, recipients of BCF reporting data (including those accessing the Better Care Exchange) cannot share it publicly or use it for journalism or research without prior consent from the HWB (for single HWB data) or BCF national partners (for aggregated data). All information is subject to Freedom of Information requests. **Storage and Security** Data will be securely stored on NHS England servers. Shared data will be minimised and handled per confidentiality and security requirements. The BCF template is password-protected to ensure data integrity and accurate aggregation. Breaches may require resubmission. **Data Analysis and Use** NHS England will analyse data submissions for feedback, reporting, benchmarking, and system improvement. Triangulation with other data may be conducted to support deeper analysis and insights and inform decision-making. **Concerns** For any questions about data sharing, please contact your regional Better Care Managers or the national Better Care Fund team england.bettercarefundteam@nhs.net

Better Care Fund 2025-26 Update Template

1. Guidance

HM Government

NHS England

Overview

HWBs will need to submit a narrative plan and a planning template which articulates their goals against the BCF objectives and how they will meet the national conditions in line with the requirements and guidance set out in the table on BCF Planning Requirements (published).

Submissions of plans are due on the 31 March 2025 (noon). Submissions should be made to the national Better Care Fund england.bettercarefundteam@nhs.net and regional Better Care Managers.

This guidance provides a summary of the approach for completing the planning template, further guidance is available on the Better Care Exchange.

Functional use of the template

We are using the latest version of Excel in Office 365, an older version may cause an issue.

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

This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Within the BCF submission guidance there will be guidance to support collaborating across HWB on the completion of templates.

Data Sharing Statement

This section outlines important information regarding Data Sharing and how the data provided during this collection will be used. This statement covers how NHS England will use the information provided. Advice on local information governance which may be of interest to ICSs can be seen at https://data.england.nhs.uk/sudgt/ - Please provide your submission using the relevant platform as advised in submission and supporting technical guidance.

2. Cover

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. To view pre-populated data for your area and begin completing your template, you should select your HWB from the top of the sheet.

Governance and sign-off
National condition one outlines the expectation for the local sign off of plans. Plans must be jointly agreed and be signed off in accordance with organisational governance processes across the relevant ICB and local authorities. Plans must be accompanied by signed confirmation from local authority and ICB chief executives that they have agreed to their BCF plans, including the goals for performance against headline metrics. This accountability must not be delegated.

Data completeness and data quality:
- 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 in this table 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).
- 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'.
- The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
- Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'. Please ensure that all boxes on the checklist are green before submission.

3. Summary

The summary sheet brings together the income and expenditure information, pulling through data from the Income and Expenditure tabs and also the headline metrics into a summary sheet. This sheet is automated and does not require any inputting of data.

4. Income

This sheet should be used to specify all funding contributions to the Health and Wellbeing Boards (HWB) Better Care Fund (BCF) plan and pooled budget for 2025-26. The final planning template will be pre-populated with the NHS minimum contributions, Disabled Facilities Grant and Local Authority Better Care Grant. Please note the Local Authority Better Care Grant was previously referred to as the iBCF. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

Additional Contributions
This sheet also allows local areas to add in additional contributions from both the NHS and LA. You will be able to update the value of any Additional Contributions (LA and NHS) income types locally. If you need to make an update to any of the funding streams, select ‘yes’ in the boxes where this is asked and cells for the income stream below will turn yellow and become editable. Please use the comments boxes to outline reasons for any changes and any other relevant information.

Unallocated funds
Plans should account for full allocations meaning no unallocated funds should remain once the template is complete.

5. Expenditure

For more information please see tab 5a Expenditure guidance.

6. Metrics

Some changes have been made to the BCF metrics for 2025-26; further detail about this is available in the Metrics Handbook on the Better Care Exchange. The avoidable admissions, discharge to usual place of residence and falls metrics/indicators remain the same. Due to the standing down of the SALT data collection, changes have been made to the effectiveness of reablement and permanent admissions metrics/indicators.

For 2025-26 the planning requirements will consist of 3 headline metrics and for the planning template only the 3 headline metrics will be required to have plans entered. HWB areas may wish to also draw on supplementary indicators and there is scope to identify whether HWB areas are using these indiciators in the Metrics tab. The narrative should elaborate on these headline metrics [and may] also take note of the supplementary indicators. The data for headline metrics will be published on a DHSC hosted metrics dashboard but the sources for each are also listed below:

1. Emergency admissions to hospital for people aged 65+ per 100,000 population. (monthly)
- This is a count of non-elective inpatient spells at English hospitals with a length of stay of at least 1 day, for specific acute treatment functions and patients aged 65+
- This requires inputting of both the planned count of emergency admissions as well as the projection 65+ population figure on monthly basis
- This will then auto populate the rate per 100,000 population for each month
https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65
Supplementary indicators:
Unplanned hospital admissions for chronic ambulatory care sensitive conditions.
Emergency hospital admissions due to falls in people aged 65+.

2. Average number of days from Discharge Ready Date to discharge (all adult acute patients). (monthly)
- This requires inputting the % of total spells where the discharge was on the discharge ready date and also the average length of delay in days for spells where there was a delay.
- A composite measure will then auto calculate for each month described as 'Average length of discharge delay for all acute adult patients'
- This is a new SUS-based measure where data for this only started being published at an LA level since September hence the large number of missing months but early thinking about this metric is encouraged despite the lack of available data.
https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/
Supplementary indicators:
Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more.
Local data on average length of delay by discharge pathway.

3. Admissions to long term residential and nursing care for people aged 65+ per 100,000 population. (quarterly)
- This section requires inputting the expected numerator (admissions) 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 2024-25. Data for this metric is not yet published, but local authorities will collect and submit this data as part of their SALT returns. You should use this data to populate the estimated data in column H.
- The pre-populated cells use the 23-24 SALT data, but you have an option of using this or local data to use as reference to set your goals.
- The pre-populated 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) mid-year population estimates. This is changed from last year to standardize the population figure used.
- The annual rate is then calculated and populated based on the entered information.
https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-outcomes-framework-ascof/england-2023-24
Supplementary indicators:
Hospital discharges to usual place of residence.
Proportion of people receiving short-term reablement following hospital discharge and outcomes following short term reablement.

7. National conditions
This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund Policy Framework for 2025-26 (link below) will be met through the delivery of your plan. (Post testing phase: add in link of Policy Framework and Planning requirements) This sheet sets out the four conditions, where they should be completed and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that the HWB meets expectation. Should 'No' be selected, please note the actions in place towards meeting the requirement and outline the timeframe for resolution. In summary, the four National conditions are as below: - National condition 1: Plans to be jointly agreed - National condition 2: Implementing the objectives of the BCF - National condition 3: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) - National condition 4: Complying with oversight and support processes - How HWB areas should demonstrate this are set out in Planning Requirements

Better Care Fund 2025-26 Planning Template

2. Cover

Version 1.5

Please Note:
- The BCF planning template is categorised as 'Management Information' and data from them will be published in an aggregated form on the NHS England website and gov.uk. This will include any narrative section. Some data may also be published in non-aggregated form on gov.uk. 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 Better Care Exchange) 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 (MHCLG, DHSC, NHS England) 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.

Governance and Sign off

			Complete:
Health and Wellbeing Board:	Southwark		Yes
Confirmation that the plan has been signed off by Health and Wellbeing Board ahead of submission - Plans should be signed off ahead of submission.	No		Yes
If no indicate the reasons for the delay.	The next HWB meeting available for agreement of the plan is in Ju		Yes
If no please indicate when the HWB is expected to sign off the plan:	Thu 19/06/2025	<< Please enter using the format, DD/MM/YYYY	Yes

Submitted by:	Adrian Ward		Yes
Role and organisation:	Head of Planning, Performance and Business Support, SELICB		Yes
E-mail:	adrian.ward@selondonics.nhs.uk		Yes
Contact number:	0208 176 5349		Yes
Documents Submitted (please select from drop down) **In addition to this template the HWB are submitting the following:**	Narrative		Yes
	C&D National Template		Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	Organisation	
Health and wellbeing board chair(s) sign off	Health and Wellbeing Board Chair	Cllr	Evelyn	Akoto	cllrevelyn.akoto@southwark.gov.uk		Yes
Named Accountable person	Local Authority Chief Executive	n/a	Althea	Loderick	althea.loderick@southwark.gov.uk		Yes
	ICB Chief Executive 1	n/a	Andrew	Bland	andrew.bland@selondonics.nhs.uk	NHS SEL ICB	Yes
Finance sign off	LA Section 151 Officer	n/a	Clive	Palfreyman	clive.palfreyman@southwark.gov.uk		Yes
	ICB Finance Director 1	n/a	Mike	Fox	mike.fox@selondonics.nhs.uk	NHS SEL ICB	Yes

Area assurance contacts	Local Authority Director of Adult Social Services	n/a	David	Quirke-Thornton	David.Quirke-Thornton@southwark.gov.uk		Yes
	DFG Lead	n/a	Keith	Kiernan	Keith.Kiernan@southwark.gov.uk		Yes
	ICB Place Director 1	n/a	Darren	Summers	darren.summers@selondonics.nhs.uk	NHS SEL ICB	Yes
Please add any additional key contacts who have been responsible for completing the plan	Head of Planning, Performance and Business Support, SELICB	n/a	Adrian	Ward	adrian.ward@selondonics.nhs.uk	NHS SEL ICB	
	Director of Joint Commissioning	n/a	Claire	Belgarde	Belgard, Claire <claire.belgard@southwark.gov.uk>	Joint post	

Assurance Statements

National Condition	Assurance Statement	Yes/No	If no please use this section to explain your response	
National Condition One: Plans to be jointly agreed	The HWB is fully assured, ahead of signing off that the BCF plan, that local goals for headline metrics and supporting documentation have been robustly created, with input from all system partners, that the ambitions indicated are based upon realistic assumptions and that plans have been signed off by local authority and ICB chief executives as the named accountable people.	Yes		Yes
National Condition Two: Implementing the objectives of the BCF	The HWB is fully assured that the BCF plan sets out a joint system approach to support improved outcomes against the two BCF policy objectives, with locally agreed goals against the three headline metrics, which align with NHS operational plans and local authority adult social care plans, including intermediate care capacity and demand plans and, following the consolidation of the Discharge Fund, that any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.	Yes		Yes
National Condition Three: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)	The HWB is fully assured that the planned use of BCF funding is in line with grant and funding conditions and that funding will be placed into one or more pooled funds under section 75 of the NHS Act 2006 once the plan is approved	Yes		Yes
	The ICB has committed to maintaining the NHS minimum contribution to adult social care in line with the BCF planning requirements.	Yes		Yes
National Condition Four: Complying with oversight and support processes	The HWB is fully assured that there are appropriate mechanisms in place to monitor performance against the local goals for the 3 headline metrics and delivery of the BCF plan and that there is a robust governance to address any variances in a timely and appropriate manner	Yes		Yes

Data Quality Issues - Please outline any data quality issues that have impacted on planning and on the completion of the plan	
The discharge delays metric is based on a new data set and there are concerns about underlying data quality which may impact on future trends and projections when corrected.	Yes

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.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5. Expenditure	Yes
6. Metrics	Yes
7. National Conditions	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2025-26 Planning Template

3. Summary

Selected Health and Wellbeing Board: Southwark

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,092,231	£2,092,231	£0
NHS Minimum Contribution	£33,458,946	£33,458,946	£0
Local Authority Better Care Grant	£22,017,633	£22,017,633	£0
Additional LA Contribution	£0	£0	£0
Additional ICB Contribution	£0	£0	£0
Total	**£57,568,810**	**£57,568,810**	**£0**

Expenditure >>

Adult Social Care services spend from the NHS minimum contribution

	2025-26
Minimum required spend	£21,421,434
Planned spend	£21,713,694

Metrics >>

Emergency admissions

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Emergency admissions to hospital for people aged 65+ per 100,000 population	1,981	1,891	1,815	2,039	1,909	1,963	2,112	1,855	2,151	2,039	2,039	2,039

Delayed Discharge

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Average length of discharge delay for all acute adult patients	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80

Residential Admissions

		2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	607.5	169.9	133.8	144.6	159.1

Better Care Fund 2025-26 Planning Template

4. Income

Selected Health and Wellbeing Board: Southwark

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Southwark	£2,092,231
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc Local Authority BCF Grant)	**£2,092,231**

Complete:

Local Authority Better Care Grant	Contribution
Southwark	£22,017,633
Total Local Authority Better Care Grant	**£22,017,633**

Are any additional LA Contributions being made in 2025-26? If yes, please detail below	No

Yes

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

Yes

NHS Minimum Contribution	Contribution
NHS South East London ICB	£33,458,946
Total NHS Minimum Contribution	**£33,458,946**

Are any additional NHS Contributions being made in 2025-26? If yes, please detail below	No

Yes

Additional NHS Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	
Total NHS Contribution	**£33,458,946**	

Yes

	2025-26
Total BCF Pooled Budget	**£57,568,810**

Funding Contributions Comments Optional for any useful detail
It has been agreed between partners to change the approach to additional contributions in 2025/26. The BCF is scaled back to minimum contributions only whereas previously approx £2m was included as additional contributions. This does not mean that services have been reduced, just that these budgets have been transferred to mainstream budgets and are no longer accounted for as part of the BCF. It should also be noted that it is intended that 2024/25 underspend on Disabled Facilities Grant will be carried forward for 2025/26.

Yes

Better Care Fund 2025-26 Planning Template

5. Expenditure

Selected Health and Wellbeing Board: Southwark

<< Link to summary sheet

Running Balances	2025-26 Income	Expenditure	Balance
DFG	£2,092,231	£2,092,231	£0
NHS Minimum Contribution	£33,458,946	£33,458,946	£0
Local Authority Better Care Grant	£22,017,633	£22,017,633	£0
Additional LA contribution	£0	£0	£0
Additional NHS contribution	£0	£0	£0
Total	**£57,568,810**	**£57,568,810**	**£0**

Required Spend

This is in relation to National Conditions 3 only. It does NOT make up the total NHS Minimum Contribution (on row 10 above).

	2025-26 Minimum Required Spend	Planned Spend	Unallocated
Adult Social Care services spend from the NHS minimum allocations	£21,421,434	£21,713,694	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes

Scheme ID	Activity	Description of Scheme	Primary Objective	Area of Spend	Provider	Source of Funding	Expenditure for 2025-26 (£)	Comments (optional)
1	Long-term home-based social care services	Pathway 1 Discharges - Care at Home	5. Timely discharge from hospital	Social Care	Private Sector	NHS Minimum Contribution	£ 3,631,063	
2	Long-term residential/nursing home care	Pathway 3 Discharge Support - Nursing Care	5. Timely discharge from hospital	Social Care	Private Sector	NHS Minimum Contribution	£ 3,346,697	
3	Long-term residential/nursing home care	Pathway 3 Discharge Support - Residential Care	5. Timely discharge from hospital	Social Care	Private Sector	NHS Minimum Contribution	£ 2,897,255	
4	Long-term residential/nursing home care	CHC Discharge to Assess - Council Costs	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 540,600	
5	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Intermediate Care Southwark - Rehab and Reablement	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 1,059,346	
6	Discharge support and infrastructure	Transfer of Care Service	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 2,307,195	
7	Urgent community response	Intermediate Care Southwark - Urgent Community Response	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	NHS Minimum Contribution	£ 615,422	

8	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Reablement Care	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 2,052,752	
9	Long-term home-based social care services	Community Mental Health Services	1. Proactive care to those with complex needs	Social Care	Local Authority	NHS Minimum Contribution	£ 694,300	
10	Wider local support to promote prevention and independence	Enhanced Psychological Support for those with LD	1. Proactive care to those with complex needs	Social Care	Local Authority	NHS Minimum Contribution	£ 29,000	
11	Personalised budgeting and commissioning	Learning Disability - Personal Budgets	6. Reducing the need for long term residential care	Social Care	Local Authority	NHS Minimum Contribution	£ 223,660	
12	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Mental Health Reablement	1. Proactive care to those with complex needs	Social Care	Local Authority	NHS Minimum Contribution	£ 357,698	
13	Personalised budgeting and commissioning	Mental Health - Personal Budgets	6. Reducing the need for long term residential care	Social Care	Local Authority	NHS Minimum Contribution	£ 965,175	
14	Assistive technologies and equipment	Integrated Community Equipment Services (ICES)	2. Home adaptations and tech	Social Care	Private Sector	NHS Minimum Contribution	£ 1,017,150	
15	Assistive technologies and equipment	Telecare	2. Home adaptations and tech	Social Care	Private Sector	NHS Minimum Contribution	£ 623,995	
16	Wider local support to promote prevention and independence	Voluntary Sector Prevention Services	4. Preventing unnecessary hospital admissions	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 952,386	
17	Support to carers, including unpaid carers	Voluntary Sector Carers Services	3. Supporting unpaid carers	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 400,000	
18	Long-term home-based social care services	Ethical Care Charter or Home Care	1. Proactive care to those with complex needs	Social Care	Private Sector	Local Authority Better Care Grant	£ 10,783,338	
19	Long-term residential/nursing home care	Nursing Care Placements	1. Proactive care to those with complex needs	Social Care	Private Sector	Local Authority Better Care Grant	£ 6,401,349	
20	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Reablement care	6. Reducing the need for long term residential care	Social Care	Private Sector	Local Authority Better Care Grant	£ 1,990,227	
21	Long-term residential/nursing home care	Residential Care Placements	1. Proactive care to those with complex needs	Social Care	Private Sector	Local Authority Better Care Grant	£ 1,480,951	
22	Housing related schemes	Flexicare and Stepdown accommodation	6. Reducing the need for long term residential care	Social Care	Private Sector	Local Authority Better Care Grant	£ 861,768	
23	Long-term residential/nursing home care	Residential Care Charter	1. Proactive care to those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 500,000	
24	Disabled Facilities Grant related schemes	Disabilities Facilities Grant	2. Home adaptations and tech	Other	Local Authority	DFG	£ 2,092,231	

25	Wider local support to promote prevention and independence	Enhanced Intervention Services - ICB element	1. Proactive care to those with complex needs	Mental Health	NHS Mental Health Provider	NHS Minimum Contribution	£ 235,181	
26	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Admissions avoidance - ERR and @home	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 6,133,788	
27	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Falls Service	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 662,458	
28	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Palliative Care at Home	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 595,968	
29	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Therapy Services - Occupational Health, Foot Health, Speech & Language	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 338,841	
30	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Neuro - Rehabilitation Team	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 211,794	
31	Assistive technologies and equipment	Community Equipment Service	2. Home adaptations and tech	Community Health	Private Sector	NHS Minimum Contribution	£ 1,157,758	
32	Wider local support to promote prevention and independence	Behavioural Support - LD and autism	1. Proactive care to those with complex needs	Community Health	Local Authority	NHS Minimum Contribution	£ 100,000	
33	Discharge support and infrastructure	Mental Health Discharge Housing Workers	5. Timely discharge from hospital	Mental Health	NHS Mental Health Provider	NHS Minimum Contribution	£ 60,000	
34	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Expand step down housing	5. Timely discharge from hospital	Mental Health	NHS Mental Health Provider	NHS Minimum Contribution	£ 269,000	
35	Discharge support and infrastructure	Home Treatment Team	5. Timely discharge from hospital	Mental Health	NHS Mental Health Provider	NHS Minimum Contribution	£ 60,000	
36	Discharge support and infrastructure	Outreach Service	5. Timely discharge from hospital	Community Health	NHS Acute Provider	NHS Minimum Contribution	£ 176,000	
37	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Pathway 2 & 3 Discharges	5. Timely discharge from hospital	Community Health	Private Sector	NHS Minimum Contribution	£ 1,073,716	
38	Discharge support and infrastructure	Homeless discharge service	5. Timely discharge from hospital	Community Health	Charity / Voluntary Sector	NHS Minimum Contribution	£ 120,000	
39	Discharge support and infrastructure	Discharge to Assess	5. Timely discharge from hospital	Community Health	Local Authority	NHS Minimum Contribution	£ 120,000	
40	Discharge support and infrastructure	Care Home Liaison Service	5. Timely discharge from hospital	Community Health	Local Authority	NHS Minimum Contribution	£ 60,000	
41	Wider local support to promote prevention and independence	Voluntary Sector Prevention Services	6. Reducing the need for long term residential care	Community Health	Charity / Voluntary Sector	NHS Minimum Contribution	£ 370,748	

5a. Expenditure Guidance

Guidance for completing Expenditure sheet

How do we calcute the ASC spend figure from the NHS minimum contribution total?

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

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

The requirement to identify which primary objective scheme types are supporting is intended to provide richer information about the services that the BCF supports. Please select [from the drop-down list] the primary policy objective which the scheme supports. If more than one policy objective is supported, please select the most relevant. Please note The Local Authority Better Care Grant was previously referred to as the iBCF.

On the expenditure sheet, please enter the following information:

1. Scheme ID:
- Please enter an ID 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. Activity:
- Please select the Activity from the drop-down list that best represents the type of scheme being planned. These have been revised from last year to try and simplify the number of categories. Please see the table below for more details.
3. 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. Primary Objective:
- Sets out what the main objective of the scheme type will be. These reflect the six sub objectives of the two overall BCF objectives for 2025-26. We recognise that scheme may have more than one objective. If so, please choose one which you consider if likely to be most important.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
6. 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.
7. 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 NHS 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.
8. Expenditure (£)2025-26:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
9. Comments:

Any further information that may help the reader of the plan. 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.

2025-26 Revised Scheme Types

Number	Activity (2025-26)	Previous scheme types (2023-25)	Description

1	Assistive technologies and equipment	Assistive technologies and equipment Prevention/early intervention	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	Housing related schemes	Housing related schemes Prevention/early intervention	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
3	DFG related schemes	DFG related schemes	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.
4	Wider support to promote prevention and independence	Prevention/early intervention	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 wellbeing
5	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Home-based intermediate care services Home care or domiciliary care Personalised care at home Community based schemes	Includes schemes which provide support in your own home to improve your confidence and ability to live as independently as possible Also includes 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
6	Short-term home-based social care (excluding rehabilitation, reablement and recovery services)	Personalised care at home	Short-term 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.
7	Long-term home-based social care services	Personalised care at home	Long-term 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 or to deliver support over the longer term to maintain independence.
8	Long-term home-based community health services	Community based schemes	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'
9	Bed-based intermediate care (short-term bed-based rehabilitation, reablement or recovery)	Bed-based intermediate care services (reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	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.
10	Long-term residential or nursing home care	Residential placements	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.
11	Discharge support and infrastructure	High Impact Change Model for Managing Transfer of Care	Services and activity to enable discharge. Examples include multi-disciplinary/multi-agency discharge functions or Home First/ Discharge to Assess process support/ core costs.
12	End of life care	Personalised care at home	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home for end of life care.
13	Support to carers, including unpaid carers	Carers services	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.

14	Evaluation and enabling integration	Care Act implementation and related duties Enablers for integration High Impact Change Model for Managing Transfer of Care Integrated care planning and navigation Workforce recruitment and retention	Schemes that evaluate, 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. Schemes may include: - Care Act implementation and related duties - High Impact Change Model for Managing Transfer of Care - where services are not described as "discharge support and infrastructure" - Enablers for integration, including schemes that build and develop the enabling foundations of health, social care and housing integration, and joint commissioning infrastructure. - Integrated care planning and navigation, including supporting people to find their way to appropriate services and to navigate through the complex health and social care systems; may be online or face-to-face. Includes approaches such as Anticipatory Care. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated plans, typically carried out by professionals as part of an MDT. - Workforce recruitment and retention, where funding is used for incentives or activity to recruit and retain staff or incentivise staff to increase the number of hours they work.
15	Urgent Community Response	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.
16	Personalised budgeting and commissioning	Personalised budgeting and commissioning	Various person centred approaches to commissioning and budgeting, including direct payments.
17	Other	Other	This should only be selected where the scheme is not adequately represented by the above scheme types.

Better Care Fund 2025-26 Planning Template

6. Metrics for 2025-26

Selected Health and Wellbeing Board: Southwark

8.1 Emergency admissions

		Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Complete:
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,953	1,844	1,790	1,971	1,880	1,934	2,061	1,790	n/a	n/a	n/a	n/a	The target reflects an aspiration to contain the growth in emergency admissions to 2.5% compared to 2024/25 levels. This is considered a stretching target given that: a) projected increase of 4.3% in population of over 65's in Southwark between 2024/25 and 2025/26 (note: the pre-populated data in this template does not reflect projected annual growth). b) SELICB in their Operational Planning are assuming an overall growth pressure of 2.5% in non-elective admissions after the net impact of admissions avoidance initiatives and underlying demand growth. c) projected 2024/25 growth in admissions is projected to be 9.7% up on 2023/24 (assuming Q4 2024/25 is the same as Q3). To contain growth at 2.5% in this context will require a significant impact from the BCF funded and wider system admissions avoidance initiatives set out in the narrative template despite a lack of real terms growth in the BCF.	Yes
	Number of Admissions 65+	540	510	495	545	520	535	570	495	n/a	n/a	n/a	n/a		
	Population of 65+*	27,656	27,656	27,656	27,656	27,656	27,656	27,656	27,656	n/a	n/a	n/a	n/a		
		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan		
	Rate	1,981	1,891	1,815	2,039	1,909	1,963	2,112	1,855	2,151	2,039	2,039	2,039		
	Number of Admissions 65+	548	523	502	564	528	543	584	513	595	564	564	564		Yes
	Population of 65+	27,656	27,656	27,656	27,656	27,656	27,656	27,656	27,656	27,656	27,656	27,656	27,656		

Source: https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65

Supporting Indicators		Have you used this supporting indicator to inform your goal?	
Unplanned hospital admissions for chronic ambulatory care sensitive conditions. Per 100,000 population.	Rate	Yes	Yes
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Rate	Yes	Yes

8.2 Discharge Delays

*Dec Actual onwards are not available at time of publication

	Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	n/a	n/a	n/a	n/a	n/a	0.46	0.85	0.95	n/a	n/a	n/a	n/a	The target is to maintain the level of performance broadly at current 90% levels for patients discharged by discharge ready date, and improve to the SEL average of 8 days delayed where not. This is based on published data from September to December 2024, as reliable earlier data is not available. This is considered to be stretching given the impact of demographic changes on acuity of need presenting for all P1, P2 and P3 discharges. In addition, if the number of admissions does increase in line with SELICB planning projections in 8.1 (2.5%) there will be further pressures on the discharge system.	Yes
Proportion of adult patients discharged from acute hospitals on their discharge ready date	n/a	n/a	n/a	n/a	n/a	93.4%	92.1%	88.8%	n/a	n/a	n/a	n/a		
For those adult patients not discharged on DRD, average number of days from DRD to discharge	n/a	n/a	n/a	n/a	n/a	7.0	10.7	8.5	n/a	n/a	n/a	n/a		
	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan		
Average length of discharge delay for all acute adult patients	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	It should be noted that there has not been a detailed analysis of this new data set. There have been concerns expressed about data quality in terms of recording the discharge ready data and the actual discharge date. It is possible recorded performance will decrease as data quality increases. The target will kept under review and will need to be rebased during the year. It should also be noted that the trusts have not yet devised trajectories for these targets, which may impact on final targets. The 90% target exceeds national average performance (86.5% in December 2024). This will require a significant impact from the BCF funded and wider system discharge initiatives as set out in the narrative template despite a lack of real terms growth in the BCF.	
Proportion of adult patients discharged from acute hospitals on their discharge ready date	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%		Yes
For those adult patients not discharged on DRD, average number of days from DRD to discharge	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00		Yes

Source: https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/

Supporting Indicators		Have you used this supporting indicator to inform your goal?	
Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more.	Number of patients	Yes	Yes
Local data on average length of delay by discharge pathway.	Number of days	No	Yes

8.3 Residential Admissions

		2023-24 Actual	2024-25 Plan	2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4	Rationale for how the local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	665.3	556.8	607.5	169.9	133.8	144.6	159.1	The target is to contain the growth in permanent admission to 2.5% above current levels, projected to be 164 admissions for 2024/25. This is similar to the growth in 2024/25. and aligns with the rationale for the predicted growth in non-elective admissions in 8.1. This is considered stretching in the context of the projected increase in older people with increased needs, particularly for Pathway 3 discharges for whom care at home is not a viable option. In the previous year a lower stretch target was agreed that was not delivered due to demand growth.	Yes
	Number of admissions	184	154	168	47	37	40	44		Yes
	Population of 65+*	27,656	27,656	27,656	27,656	27,656	27,656	27,656		

Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population are based on a calendar year using the latest available mid-year estimates.

Supporting Indicators		Have you used this supporting indicator to inform your goal?	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Percentage	No	Yes
The proportion of people who received reablement during the year, where no further request was made for ongoing support	Rate	Yes	Yes

Better Care Fund 2025-26 Update Template

7: National Condition Planning Requirements

Health and wellbeing board: Southwark

National Condition	Planning expectation that BCF plan should:	Where should this be completed	HWB submission meets expectation	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Timeframe for resolution	Complete:
1. Plans to be jointly agreed	Reflect local priorities and service developments that have been developed in partnership across health and care, including local NHS trusts, social care providers, voluntary and community service partners and local housing authorities	Planning Template - Cover sheet Narrative Plan - Overview of Plan	Yes			Yes
	Be signed off in accordance with organisational governance processes across the relevant ICB and local authorities	Planning Template - Cover sheet	Yes			Yes
	Must be signed by the HWB chair, alongside the local authority and ICB chief executives – this accountability must not be delegated	Planning Template - Cover sheet	No	HWB meeting to sign off on 19th June	19-Jun	Yes
2. Implementing the objectives of the BCF	Set out a joint system approach for meeting the objectives of the BCF which reflects local learning and national best practice and delivers value for money	Narrative Plan - Section 2	Yes			Yes
	Set goals for performance against the 3-headline metrics which align with NHS operational plans and local authority adult social care plans, including intermediate care capacity and demand plans	Planning Template - Metrics	Yes			Yes
	Demonstrate a 'home first' approach and a shift away from avoidable use of long-term residential and nursing home care	Narrative Plan - Section 2	Yes			Yes
	Following the consolidation of the previously ring-fenced Discharge Fund, specifically explain why any changes to the use of the funds compared to 2024-25 are expected to enhance urgent and emergency care flow (combined impact of admission avoidance and reducing length of stay and improving discharge)	Narrative Plan - Section 2	Yes			Yes
3. Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)	Set out expenditure against key categories of service provision and the sources of this expenditure from different components of the BCF	Planning Template - Expenditure	Yes			Yes
	Set out how expenditure is in line with funding requirements, including the NHS minimum contribution to adult social care		Yes			
4. Complying with oversight and support processes	Confirm that HWBs will engage with the BCF oversight and support process if necessary, including senior officers attending meetings convened by BCF national partners.	Planning Template - Cover	Yes			Yes
	Demonstrate effective joint system governance is in place to: submit required quarterly reporting, review performance against plan objectives and performance, and change focus and resourcing if necessary to bring delivery back on track	Narrative Plan - Executive Summary	Yes			Yes

BCF Capacity & Demand Template 2025-26

1. Guidance

Overview

This template has been unlocked to allow editing as required. It is optional to submit capacity & demand figures as per this template format and a customised format of this will be accepted.

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 can be input into 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. You should select your HWB from the top of the sheet which will also reveal pre-populated trusts for your area.

2. Once you are satisfied with the information entered the template should be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

3. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority. If your plan has been signed off by the full HWB, or has been signed off through a formal delegation route, select YES. If your plan has not yet been signed off by the HWB, select NO.

3. Capacity and Demand

A full capacity and demand planning document has been shared on the Better Care Exchange, please check this document before submitting any questions on capacity and demand planning to your BCM. Below is the basic guidance for completing this section of the template.

This template follows the same format as last year and so contains all the previously asked for data points including demand (referrals), block and spot capacity, average duration of treatment and time from referral to treat all split by pathway. It is however only required that some form of data points are submitted to show projected demand (disaggregated by step-up and step-down) and capacity for intermediate care and other short term care. The additional data points on average treatment time, time to treat and spot/block capacity split are optional but have remained in case you may find these data points useful.

As with the last capacity and demand update, summary tables have been included at the top of both capacity and demand sheets that will auto-fill as you complete the template, providing and at-a-glance summary of the detail below.

List of data points in template:

3.1 C&D Step-down

Estimates of available capacity for each month of the year for each pathway.
Estimated average time between referral and commencement of service.
Expected discharges per pathway for each month, broken down by referral source.
Estimates of the average length of stay/number of contact hours for individuals on each of the discharge pathways.

3.2 C&D Step-up

Estimated capacity and demand per month for each service type.
Estimated average length of stay/number of contact hours for individuals in each service type for the whole year.

Better Care Fund 2025-26 Capacity & Demand Template

2. Cover

HM Government

NHS England

Version 1.1

Health and Wellbeing Board:	Southwark
Completed by:	Adrian Ward
E-mail:	adrian.ward@selondonics.nhs.uk
Contact number:	0208 176 5349
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No
	Thu 19/06/2025 << Please enter using the format, DD/MM/YYYY

Once complete please send this template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'C&D - Name HWB' for example 'C&D - County Durham HWB'. Please also copy in your Better Care Manager.

<< Link to the Guidance sheet

Better Care Fund 2025-26 Capacity & Demand Template

3.1. C&D Step-down

Selected Health and Wellbeing Board: Southwark

Step-down	Capacity surplus (not including spot purchasing)												Capacity surplus (including spot puchasing)											
Capacity - Demand (positive is Surplus)	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Reablement & Rehabilitation at home (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other short term bedded care (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	-7	-7	-8	-7	-8	-7	-7	-8	-7	-8	-7	-7	0	0	0	0	0	0	0	0	0	0	0	1

Average LoS/Contact Hours per episode of care	
Full Year	Units
	Contact Hours per package
	Contact Hours per package
41	Average LoS (days)
	Average LoS (days)
43	Average LoS (days)

Capacity - Step-down		Refreshed planned capacity (not including spot purchased capacity)												Capacity that you expect to secure through spot purchasing											
Service Area	**Metric**	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new packages commenced.	125	133	130	134	131	129	136	130	134	131	124	130	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home (pathway 1)	Estimated average time from referral to commencement of service (days). All packages (planned and spot purchased)	2	2	2	2	2	2	2	2	2	2	2	2												
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0	0	0	0	0	0	0												
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new packages commenced.	8	10	10	10	10	10	9	11	10	11	8	9	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	10	10	10	10	10	10	10	10	10	10	10	10												
Other short term bedded care (pathway 2)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other short term bedded care (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0	0	0	0	0	0	0												
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new packages commenced.	7	8	7	8	7	7	8	7	8	7	7	8	7	7	8	7	8	7	7	8	7	8	7	8
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	10	10	10	10	10	10	10	10	10	10	10	10												

Demand - Step-down

Please enter refreshed expected no. of referrals:

Pathway	Trust Referral Source	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total Expected Step-down:	Total Step-down	**143**	**153**	**150**	**154**	**151**	**148**	**156**	**150**	**154**	**151**	**142**	**150**
Reablement & Rehabilitation at home (pathway 1)	Total	**125**	**133**	**130**	**134**	**131**	**129**	**136**	**130**	**134**	**131**	**124**	**130**
	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	55	58	57	59	57	57	60	57	59	57	54	57
	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	51	55	53	55	54	53	56	53	55	54	51	53
	OTHER	19	20	20	20	20	19	20	20	20	20	19	20
Short term domiciliary care (pathway 1)	Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	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
Reablement & Rehabilitation in a bedded setting (pathway 2)	Total	**8**	**10**	**10**	**10**	**10**	**10**	**9**	**11**	**10**	**11**	**8**	**9**
	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	3	4	4	4	4	4	4	5	4	5	3	4
	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	4	5	5	5	5	5	4	5	5	5	4	4
	OTHER	1	1	1	1	1	1	1	1	1	1	1	1
Other short term bedded care (pathway 2)	Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	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
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Total	**14**	**15**	**15**	**15**	**15**	**14**	**15**	**15**	**15**	**15**	**14**	**15**
	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	6	7	7	7	7	6	7	7	7	7	6	7
	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	6	6	6	6	6	6	6	6	6	6	6	6
	OTHER	2	2	2	2	2	2	2	2	2	2	2	2

Better Care Fund 2025-26 Capacity & Demand Template

3.2. C&D Step-up

Selected Health and Wellbeing Board: Southwark

Step-up

Refreshed capacity surplus:

Capacity - Demand (positive is Surplus)	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & 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

Average LoS/Contact Hours

Full Year	Units
	Contact Hours
	Contact Hours
41	Average LoS
	Contact Hours

Capacity - Step-up

Please enter refreshed expected capacity:

Service Area	Metric	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	36	38	37	38	38	37	39	37	38	38	35	37
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	2	2	2	2	2	2	2	2	2	2	2	2
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0

Demand - Step-up

Please enter refreshed expected no. of referrals:

Service Type	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	36	38	37	38	38	37	39	37	38	38	35	37
Reablement & Rehabilitation in a bedded setting	2	2	2	2	2	2	2	2	2	2	2	2
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

Health & Wellbeing Board Action Log

ID	Board item	Details	Action	Board member	Lead officer	Date raised	Target date	Progress/Update	Update date	Status Open/Closed
25.3/1	Public Question	Question on physical activity and working with London Sport	Follow up with Jardine Finn on the outcome of the meeting with Miles Lloyd (London Sport) and ensure work is taken forwards	Toni Ainge	N/A	13/03/2025	19/06/2025	Jardine Finn has met with Miles and a meeting was held with Public Health Officers about Place working in Southwark and potential funding. Miles will update Southwark in due course as to potential Sport England Place opportunities (June/July).	02/06/2025	Closed
25.3/2	Public Question	Question on physical activity and working with London Sport	Provide the Acting Strategic Director of Environment Sustainability and Leisure with information on the outcome of the meeting between Community Southwark, the Children Families and Young People network and Rotherhithe youth providers on funding for physical activity.	Anood Al-Samerai	N/A	13/03/2025	19/06/2025	Meeting took place in March with VCS groups, council officers from Youth and Play and Children's, and three trusts and foundations. Agreed we would share information about existing services and start to flesh out clearer vision for youth services in Rotherhithe. Next meeting 2nd July.	12/05/2025	Closed
25.3/3	Healthwatch update	Black Mental Health Report	Meet to discuss the Healthwatch Black Mental Health report recommendations and SLaM's response	Rhyana Ebanks-Babb; Ade Odunlade	N/A	13/03/2025	19/06/2025			Open
25.3/4	Healthwatch update	Black Mental Health Report	Meet to discuss how the Healthwatch Black Mental Health report recommendations can inform partnership working between Impact on Urban Health and SEL ICS on transforming mental health services for Black residents	Peter Babudu; Rhyana Ebanks-Babb	N/A	13/03/2025	19/06/2025	Brief follow-up conversation has been had but still to meet substantively	16/05/2025	Open
25.3/5	Healthwatch update	Black Mental Health Report	Facilitate introduction between Healthwatch Southwark and the GP federations to enable collaborative working to address the Healthwatch Black Mental Health report recommendations	Nancy Küchemann	N/A	13/03/2025	19/06/2025			Open
25.3/6	Healthwatch update	Black Mental Health Report	Discuss with Healthwatch about how best to engage with primary care around the Black Mental Health report	Darren Summers	Rebecca Jarvis	13/03/2025	19/06/2025	Rebecca and Rhyana met, and Rhyana is now a member of the Primary Care Committee (a formal subcommittee of the PSSB).	12/05/2025	Closed
25.3/7	Healthwatch update	Black Mental Health Report	Disseminate the Healthwatch report to teams/organisations and identify ways of working collaboratively to improve services and implement the Healthwatch Black Mental Health report	All members; Rhyana Ebanks-Babb	N/A	13/03/2025	19/06/2025	Report was disseminated via the Board. Healthwatch happy to close this action.	14/05/2025	Closed
25.3/8	Joint Health and Wellbeing Strategy	Action plan report	Removed Women's Health Centre action from list of drive actions	Chris Williamson	Alice Fletcher-Etherington	13/03/2025	31/03/2025	Final version of the action plan has been uploaded to Council website	02/05/2025	Closed
25.3/9	Joint Health and Wellbeing Strategy action plan	Action 1.1: Develop and implement an action plan to address the recommendations of the Southwark Maternity Commission	Present action plan to Board at June meeting	Darren Summers	N/A	13/03/2025	19/06/2025	Action plan is being presented at June Board meeting		Open
25.3/10	Joint Health and Wellbeing Strategy action plan	Action 2.1: Embed employment support within primary care, secondary care and community health services through the Connect to Work programme	Share research relevant to Connect to Work with Danny Edwards	Peter Babudu	N/A	13/03/2025	19/06/2025	Complete	16/05/2025	Closed
25.5/1	Board priorities		Update priorities based on discussion at informal Board prioritisation session	Chris Williamson	Alice Fletcher-Etherington	08/05/2025	19/06/2025	Paper summarising priorities was sent to board on 27/5/25	27/05/2025	Closed
25.5/2	Board priorities		Develop guidance for Board sponsors	Chris Williamson	Alice Fletcher-Etherington	08/05/2025	19/06/2025	Guidance for Board sponsors was included within priorities paper sent on 27/5/25	27/05/2025	Closed
25.5/3	Board priorities	Priority aim 4: Ensure Southwark residents have access to good quality homes, streets and environments that promote good health and wellbeing	Meet to discuss how to refine priority aim 4	Cllr Evelyn Akoto; Hakeem Osinaike; Sangeeta Leahy; Ade Odunlade; Nancy Küchemann	N/A	08/05/2025	19/06/2025	Meeting arranged for 31/7/25	05/06/2025	Open
25.5/4	Board priorities	Insight visits	Meet to discuss approach to insight visits	Chris Williamson; Rhyana Ebanks-Babb; Anood Al-Samerai	Alice Fletcher-Etherington	08/05/2025	19/06/2025	Meeting arranged for 23/6/25	03/06/2025	Open

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MUNICIPAL YEAR 2025-26

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