Lambeth together

Lambeth INT delivery plan

July – December 2025

Working in partnership for a healthier borough

Executive summary

Lambeth Together is committed to working in partnership, working together to improve health and care outcomes by building on our already strong relationships, developing programmes of work to address all health and care activity in Lambeth, and prioritising fairness and equity in all we do. Lambeth has a strong history of delivering integrated work, including CHILDS and Thriving Communities. The move from a 'national health service' to a 'neighbourhood health service' will build on this existing work to develop sustainable integrated neighbourhood teams which better support our residents.

This pack sets out Lambeth's integrated neighbourhood team delivery plan for July to December 2025. This builds on the national and SEL guidance around developing a neighbourhood health service, the London Target Operating Model for neighbourhoods, as well as the significant work that has been undertaken at place to develop our local model of support. Our Health, Our Lambeth lays out our delivery priorities as a partnership up to 2028, and the principles within here form the basis of our work around integrated neighbourhood teams – including tackling inequalities in experience and access.

Our integrated neighbourhood team delivery will be led by our partnership integrator between Guy's and St Thomas' Trust (GSTT) and the Lambeth General Practice Provider Alliance (LGPPA) working on behalf of all of our Lambeth partners. An Memorandum of Understanding (MOU) capturing the role of the integrator is due to be endorsed and signed in July 2025 and will be inserted into this document once it is completed. As the integrator, they will lead on the development work outlined within this document.

Our INTs will be delivered in our five neighbourhoods: North Lambeth & Stockwell, Brixton & Herne Hill, Clapham, Streatham and Norwood. Lambeth will have four integrated neighbourhood teams by April 2026: frailty; multiple long term conditions; children & young people; and mental health. This will be supported by existing work on prevention and community engagement. To date, we have agreed outline areas of focus for the integrated neighbourhood teams which will be developed over the next six months for review in January 2026. All of the programmes will take a population health management approach to ensure that we are delivering the right care, in the right place, at the right time. The proposed programmes are laid out in slides 16-22.

Underpinning all of this work will be a comms and engagement strategy which works with residents, staff and stakeholders across the borough to bring them on the journey and help with the design, delivery and review of our integrated neighbourhoods teams. Slide 24 lays out how we are going to undertake this approach across Lambeth.

Overview

Contents

To be shared with:

Lambeth INT Working Group

NWDA Leadership Board

CYP Leadership Board

LWNA Leadership Team

LT EDI Sub Group

Lambeth Clinical Cabinet

GSTT INT Delivery Committee

Lambeth Council Mgmt. Board

Lambeth Together Care Partnership Board

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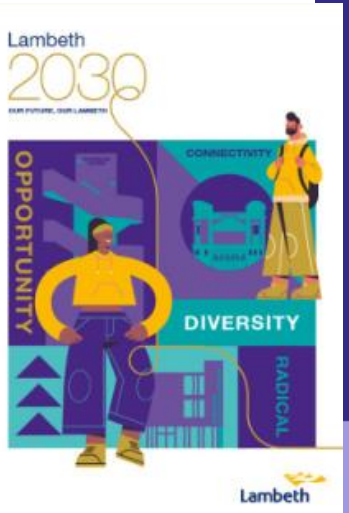
Introduction

Working in partnership for a healthier borough

Introduction

- The aim of neighbourhood working is to bring together services and local communities through a population health management approach. Neighbourhood working is part of our national policy direction (Fuller Report (2022), Darzi Review (2024), the developing reform of NHS England and ICBs and the London Target Operating Model for Neighbourhoods (2025)) and our regional approach in South East London.
- In Lambeth Together we have a history of developing more integrated local health and care delivery models across children, adults and mental health services, and we have committed to partnership working through Our Health, Our Lambeth, as well as in borough documents like Lambeth 2030. Examples of our established work include CHILDS, PCAN and Thriving Communities.
- We want working in this way to better support residents to ensure they get the right help, at the right time, in the right place. We know that our existing challenges across the NHS and local government cannot be solved by continuing to work in the way we do today – instead, this is about putting communities at the heart of our work and taking a holistic, coordinated and proactive approach to support people with complex needs.
- Our data shows us that there are significant inequalities in terms of how people access and experience the support they need. We think neighbourhood working will help to address these inequalities to better support our residents by increasing join up across our services and with VCFSE and community groups.



Our Health, Our Lambeth
Lambeth Together health and care plan 2023-28

Working in partnership for a healthier borough

What are neighbourhoods?

A neighbourhood is a specific geographical area or community that resonates with residents and that local services, organisations and communities can coalesce around to address needs and improve outcomes. We have agreed 5 neighbourhoods in Lambeth (slide X).

Neighbourhood working includes developing, local place-based partnerships across statutory partners, community groups, residents, and other local stakeholders to address the wider determinants of health and wellbeing, tackle inequalities and better coordinate support. We recognise that neighbourhood working will require significant reorganising of existing services, including community services and mental health, and will be a key enabler to delivering our neighbourhood ambitions.

Integrated Neighbourhood Teams (INTs) will further advance multi-disciplinary working by integrating staff from health, social care, and the voluntary sector into a single, place-based team to deliver coordinated care for identified cohorts within a neighbourhood. Developing INTs will be part of how we deliver some of our care at a neighbourhood level more broadly. This is the focus of the high level delivery plan, while noting the importance of the broader neighbourhood agenda.

Broader neighbourhood working

In Lambeth we recognise that a neighbourhood health service is broader than integrated neighbourhood teams. The Neighbourhood Health guidance sets out the 6 Core Components of Neighbourhood Health. The Integrated Neighbourhood Teams (INT) Delivery Plan focused on two of these areas: Population Health Management and Neighbourhood multidisciplinary teams (MDTs – in Lambeth referred to as INTs). Work to deliver the remaining four components will be led elsewhere within the system, with alignment to the INT development.

Alongside this we are also developing a wider neighbourhood working approach through local place-based partnerships with the council, statutory partners, community groups, residents and other local stakeholders to better coordinate support, tackle inequalities and address the wider determinants of physical and mental ill-health, such as poverty, poor housing, social isolation and the physical environment. This work will also be co-ordinated and delivered beyond the scope of INTs but is aligned to the development of our neighbourhoods.

The NHS Confederation has made the case that a ‘neighbourhood health service’ and ‘shifting care into the community’ should not solely mean shifting a medical model into communities. It requires a new proactive model of care that works more effectively with communities and wider partners. Therefore, the focus on developing INTs should complement the existing work already being delivered within communities themselves.

Lambeth's Thriving Communities provide a model for statutory partners to work more effectively with community-led initiatives and tackle issues at the grassroots, hyper local level within neighbourhoods. Each of our neighbourhoods has at least one Thriving Community network, although at this stage some are more developed. Through the Ecology Group and our wider neighbourhood working approach, we will share learning and best practice to further embed this model across all 5 neighbourhoods.

Adopting a One Public Estate approach across all partners can facilitate greater integration and co-location of services where meaningful to do so. This also provides an opportunity to address gaps in local community infrastructure and assets to better enable communities to support and enhance their own health and wellbeing.

A key opportunity will be improving the 'economic health' of residents who are restricted in their employment opportunities due to long-term physical and mental health conditions. The Connect to Work programme will support residents who are classed as 'economically inactive' back into employment.

Restructuring our community services to align with the new neighbourhoods in Lambeth and provide a consistent approach to support within the ‘neighbourhood health service’ model.

INT development timeline

We are here

Next review

Short term: April-June

Developing high level delivery plan

- Developed insights for each care pathway
- Identified named neighbourhood leads from each partner
- Agreed which INT will be tested in each neighbourhood, along with a high level approach
- Overarching programme plan with resources identified (aligned to integrator conversations)

Medium term: July-Dec

Detailed design and initial delivery of INT model

- Our integrator will be set up and structured against requirements within the delivery plan
- Each neighbourhood to undertake detailed design work before starting to deliver frontline change, using initial insights and learning to develop the model
- Alongside this work, there will be ongoing work around data and insights to help develop the future model

Long term: January 2026 onwards

Embedding and iterating our INT model

- All neighbourhoods have an INT model in place and are starting to embed this new way of working
- Using a test and learn model to measure impact for our INT models and adapt as needed
- Consideration of when models are able to be scaled to other neighbourhoods or new interventions are able / ready to be implemented

2026 onwards – start next phase of work to scale INTs!

Governance

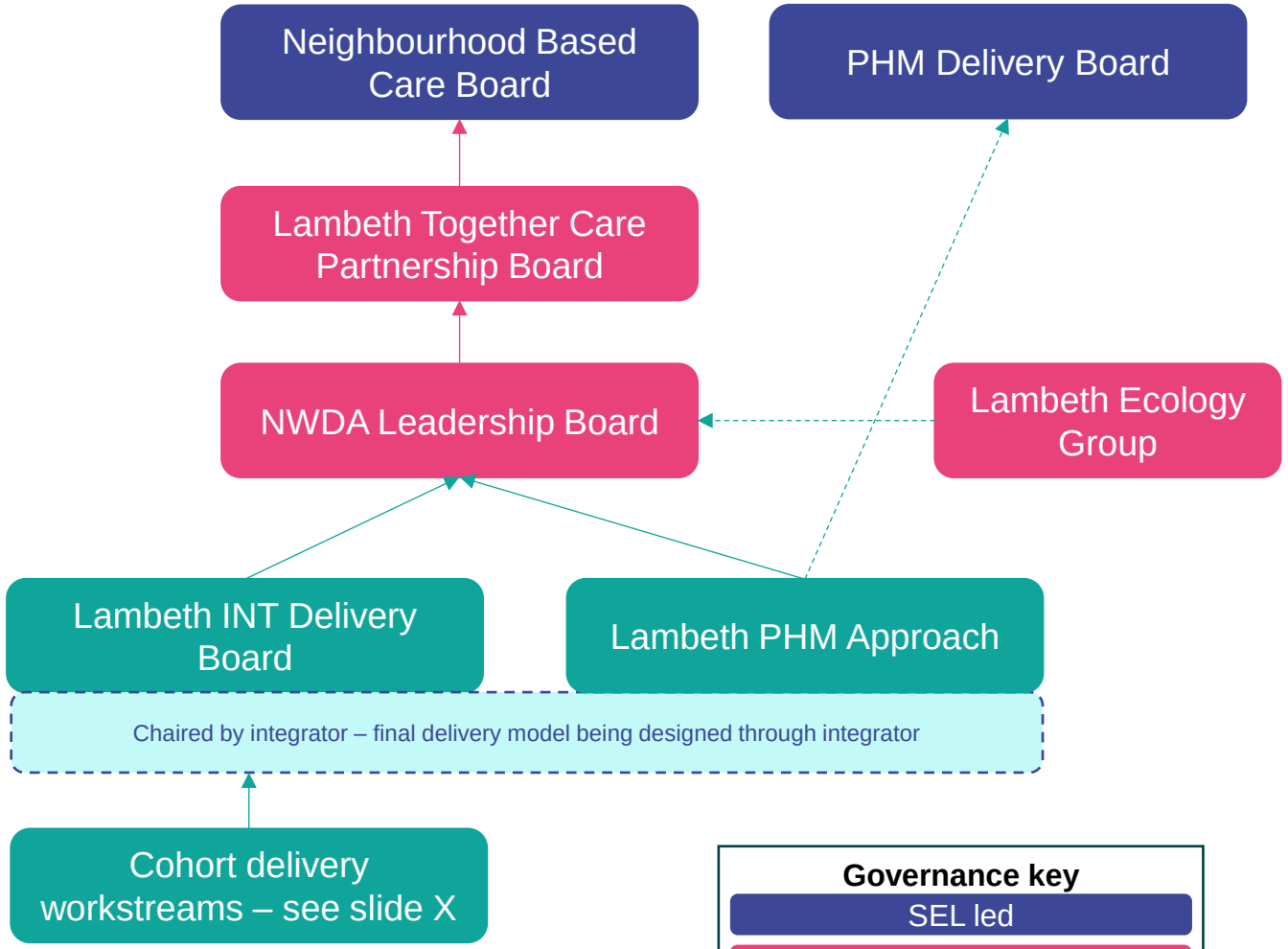
The Lambeth Together Care Partnership Board holds overall accountability for delivering integrated neighbourhood teams within Lambeth, bringing together all system partners to ensure that we have the right model to deliver a neighbourhood health service for our residents.

Overall responsibility has been delegated to our Lambeth Together Delivery Alliances, with each alliance looking at a specific population cohort and overarching ownership sitting with the NWDA.

Our integrator in Lambeth is initially a 12 month partnership between GSTT and the LGPPA. Due diligence is currently being undertaken to develop the model of the integrator and is expected to be signed off in July 2025, when the 12 months will officially start. The integrator will be expected to deliver on INTs and will hold responsibility for the INT delivery function as well as the working groups for the existing cohorts. Project resource will be provided from the existing Lambeth Together alliances as well as capacity identified by the integrator.

The Ecology Group is a network of Lambeth-based community leaders who head up resident-led organisations and initiatives. These leaders will act as a steering and advisory group, guiding how integrated neighbourhood working takes shape locally.

There will also be reporting to SEL governance through the Neighbourhood Based Care Board and the SEL PHM Delivery Board. Other emerging and intersecting governance will be captured as it develops.



Integrator function

Lambeth has agreed a partnership integrator model between GSTT and the LGPPA for the first 12 months of delivery for integrated neighbourhood teams. The integrator model needs to align to the key criteria (see right) as laid out by SEL ICB and be formally endorsed by the Lambeth Together Care Partnership.

GSTT and the LGPPA are currently undergoing development work and are expecting to have a Memorandum of Understanding for endorsement by the Lambeth Together Care Partnership Board in July 2025 before signing and commencing delivery. The detail of the integrator form contained within the MOU will be inserted into this document once it is signed off. The MOU will specify the contribution of each partner to the delivery of the integrator functions and include reference to the 250k of seed funding that the integrator will hold to develop the function.

It is also expected that the integrator will undertake a maturity matrix exercise throughout the summer of 2025. More detail of this will be inserted into the document as it is released.

Work in progress – to be updated in July 2025 in line with MOU development and SEL requirements.

Key criteria

- **Lead the delivery of INTs, driving the test and learn approach and engagement with communities:**
- **Support operational coordination**
- **Facilitate population health management**
- **Address interface issues and share learning**
- **Drive equity in access and outcomes**
- **Support system sustainability and resilience .**
- **Provide essential infrastructure for neighbourhoods**

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Overview of INT approach

Working in partnership for a healthier borough

Our neighbourhoods

North Lambeth & Stockwell

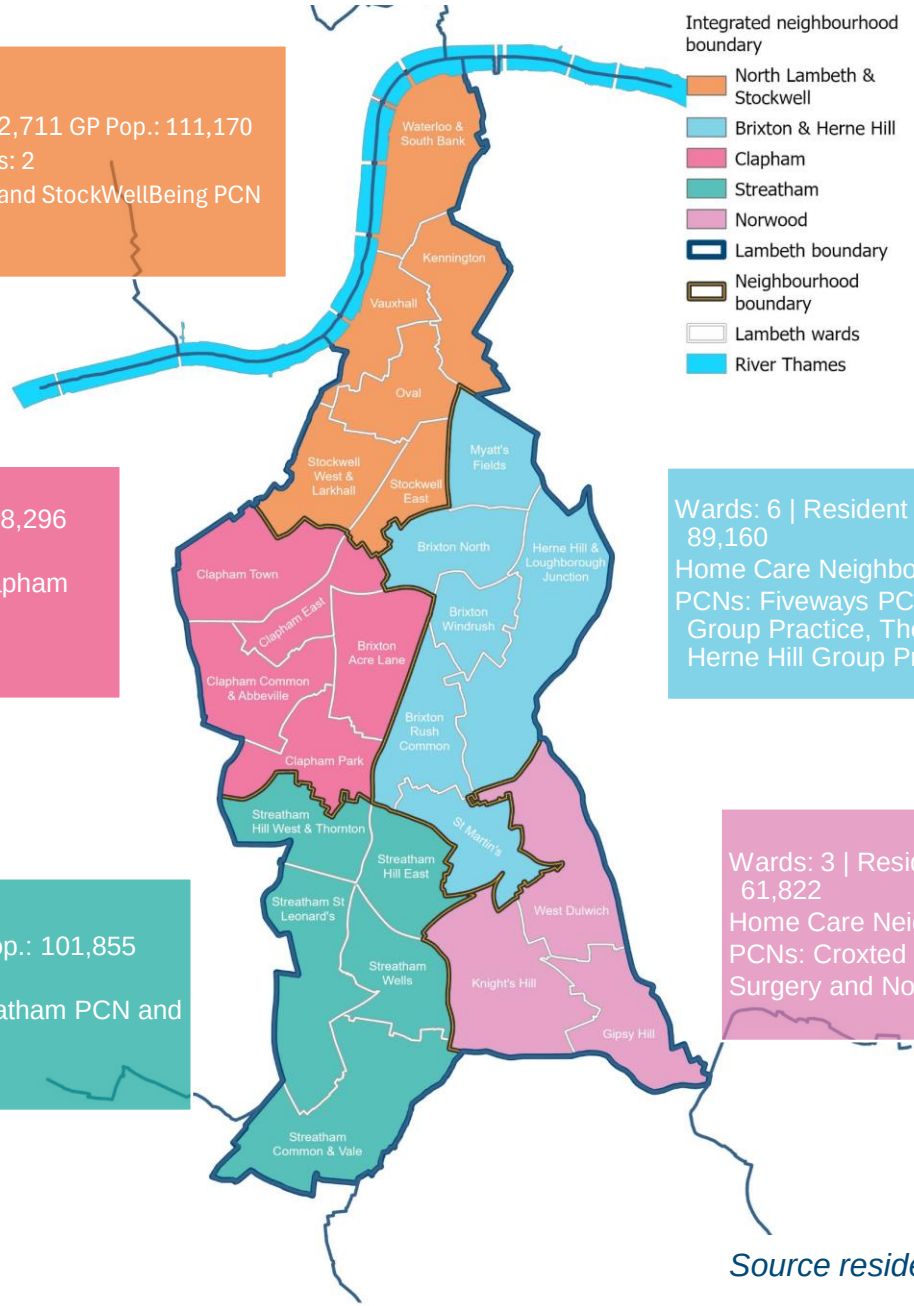
Wards: 6 | Resident Pop.: 72,711 GP Pop.: 111,170
Home Care Neighbourhoods: 2
PCNs: North Lambeth PCN and StockWellBeing PCN

Clapham

Wards: 5 | Resident Pop.: 63,729 GP Pop.: 88,296
Home Care Neighbourhoods: 2
PCNs: Brixton & Clapham Park PCN and Clapham PCN.

Streatham

Wards: 5 | Resident Pop.: 63,990 GP Pop.: 101,855
Home Care Neighbourhoods: 1
PCNs: Streatham PCN, AT Medics Streatham PCN and HBD PCN (Prentis Medical Centre).



Brixton and Herne Hill

Wards: 6 | Resident Pop.: 78,666 GP Pop.: 89,160
Home Care Neighbourhoods: 2
PCNs: Fiveways PCN and HBD PCN (Brixton Hill Group Practice, The Deerbrook Surgery and Herne Hill Group Practice).

Norwood

Wards: 3 | Resident Pop.: 38,544 GP Pop.: 61,822
Home Care Neighbourhoods: 1
PCNs: Croxted PCN and HBD PCN (Knights Hill Surgery and North Wood Group Practice).

Builds on our existing neighbourhood models in Primary Care Networks (PCNs), Neighbourhood Nursing and Home Care. Aligned pragmatically with Lambeth Council Town centres and Family Hubs.

Close alignment with our Thriving neighbourhoods, bringing together our VCFSE and community partners.

Source resident population: Census 2021, table TS007 - Age by single year

Our neighbourhoods

We have five neighbourhoods in Lambeth, aligned to our existing service provision and our ‘town centres’ as identified by residents. Our neighbourhoods also align to the existing Thriving networks across Lambeth, creating links with VCFSE and community partners.

Each neighbourhood has identified neighbourhood leads from partners, as well as other leads who will be brought into the work as required (e.g. subject matter experts who may consult on one population group but are not part of the neighbourhood team as a whole).

As part of the INT development, each neighbourhood has had:

- A detailed data pack prepared to support a population health management approach
- An asset map prepared, highlighting all community assets within the area
- Started having neighbourhood leadership meetings to understand how to approach neighbourhoods within this space

Throughout 2025, these neighbourhoods will work up an integrated neighbourhood team delivery approach for each of the population groups, tailoring the approach to their specific needs and building on their local strengths.

Practices by neighbourhoods

Neighbourhood	GP Practices
North Lambeth and Stockwell	**North Lambeth PCN:** Lambeth Walk Group Practice, Hurley Clinic, Waterloo Health Centre, The Vauxhall Surgery, South Lambeth Road GP, Mawbey Group Practice **Stockwellbeing PCN:** Binfield Road Surgery, Springfield Medical Centre, Beckett House Practice, Grantham Health Centre, Stockwell Group Practice
Clapham	**Clapham PCN:** Sandmere Road Practice, Clapham Family Practice, Dr Curran & Partners, Grafton Square Surgery **Brixton and Clapham Park PCN:** Hetherington Group Practice, Pavilion Medical Centre, Clapham Park Group Practice
Brixton and Herne Hill	**Fiveways PCN:** Corner Surgery, Herne Hill Road Medical Practice, Vassall Medical Centre, Minet Green **HBD PCN:** Akerman Medical Practice, Herne Hill Group Practice, Brixton Hill Group Practice, Deerbrook Surgery
Streatham	**Streatham PCN:** Streatham Common Practice; The Vale Surgery, Palace Road Surgery, The Exchange Surgery, Valley Road Surgery, Streatham Hill Group Practice **AT Medics PCN:** Edith Cavell Surgery, Streatham High Practice **HBD PCN:** Prentis Medical Centre
Norwood	**Croxted PCN:** Paxton Green Group Practice, Old Dairy Health Centre, Brockwell Park Surgery **HBD PCN:** Knight's Hill Surgery, North Wood Group Practice

Approach to insights & intelligence

Intelligence packs will be iteratively developed to support neighborhoods as their needs evolve.

Use the Population Health Management (PHM) cycle to guide neighborhood team development.

Responsive to neighborhood-specific requests for additional data and insights.

Built on learning from other boroughs and national exemplars.

Develop metrics to track operational delivery and outcomes, drawing on logic models and theory of change frameworks to ensure alignment between activity, outputs, and intended impact.

Close collaboration with the SEL PHM programme and system partners to develop integrated datasets across health and care, and make best use of wider system intelligence resources.

Incorporate risk stratification tools (e.g. via Ardens) to help identify and target those most in need.

Find solutions to information governance (IG) considerations to enable appropriate data sharing across partners.

Take an agile approach to data, recognising when it is 'good enough' to inform action rather than waiting for perfection, which may delay progress unnecessarily.

Support both short-term improvements and longer-term transformation.

Distinguish between what can be delivered locally by neighbourhood teams and what is best addressed at system level.

Recognise that different groups will require different data frontline operational (e.g. patient lists, caseloads) vs strategic popn. insights

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Delivery plans

Working in partnership for a healthier borough

Overview of INT delivery plans

This section lays out the programme plans for the development of the initial integrated neighbourhood teams in Lambeth. These plans identify the areas for exploration over the next six months to develop the interventions for each population group. These will then be reviewed in January 2026 to understand how this can be fully delivered. Lambeth is taking a proactive, community focus to INTs, and therefore each INT will demonstrate how it is incorporating prevention and community engagement into its approach.

Lambeth is going to focus on four INT models. This is the three national priority cohorts of frailty, multiple long term conditions and children & young people. However there is also an addition of mental health as a priority for the borough – both as an enabler for all our INTs but also as a targeted piece of work. We recognise that current mental health support is delivered on a different neighbourhood basis to that agreed within Lambeth, so the work for the next 6 months will be led by the LWNA and SLaM to understand alignment to the INT model.

Not all of our neighbourhoods will be rolling out INTs for each population group at the same time. Instead there will be some areas that act as pilot sites, developing the INT model through an iterative process which can then be rolled out across the borough. We expect that this will happen over the 2026/27 financial year, but this will be reviewed as the INTs are developed.

Initial INT neighbourhood focus (noting that this is all for development over the next 6 months)**:**

- **North Lambeth & Stockwell:** Multiple Long Term Conditions
- **Clapham:** Multiple Long Term Conditions
- **Brixton and Herne Hill:** Frailty
- **Streatham:** Multiple Long Term Conditions
- **Norwood:** Children and Young People

INT programme – by neighbourhoods

See governance slide X

Lambeth INT Delivery function

Led by integrator – reporting into Lambeth Together. Confirmation on final model to be inserted, linked into delivery conversations alongside Southwark partners.

North Lambeth and Stockwell

- Initial focus on MLTC
- Aligned to Renal Cardiometabolic & PEACS

Clapham

- Initial focus on MLTC
- Aligned to Renal Cardiometabolic

Brixton and Herne Hill

- Initial focus on frailty
- Aligned to frailty prototype in Minet Green / Fiveways

Streatham

- Initial focus on MLTC
- Aligned to Renal Cardiometabolic

Norwood

- Initial focus on CYP
- Aligned to women and girls health hub

Addressing wider determinants of health / primary prevention

- Approach to addressing wider determinants of health delivered across all neighbourhoods and with a life-course approach, and with neighbourhood focus where appropriate e.g. healthy schools, healthy eating, physical activity, health protection, stop smoking, age-friendly Lambeth etc

Community engagement

- Working with communities embedded into all our work, linking into the Thriving Communities model

Frailty INT

Relevant neighbourhood/s	*Brixton and Herne Hill*
Programme team	*Emily Perry, Josepha Reynolds, Cathy Ingram, Tania Kalsi, Richard Outram, Jay Patel,*
Governance	*Future INT reporting structure feeding into the NWDA Leadership Board*

How will this work incorporate prevention?	1. *The frailty prototype is focused on prevention by providing holistic frailty assessments and support to prevent mild, moderate or severe frailty worsening.* 2. *The predictive data project aims to be able to predict residents who are likely to fall in the next 12-months in order to provide targeted interventions to prevent the individuals' falls risk.*
How will this work engage with communities?	1. *Through the frailty prototype we are engaging with communities through the outreach pathway by working with local community groups where we know there are greater health inequalities to run holistic frailty assessment day events to support residents at risk of mild, moderate or severe frailty.* 2. *We will need to work with communities to develop targeted falls prevention interventions when we are able to predict the people at risk of falls through the predictive data project.*

Outline of the INT model	How is this taking a PHM approach	Resourcing
1. ***Holistic community frailty prototype*** • *Inreach pathway – identification of complex patients by GP practices who are moderately/severely frail in order to provide holistic frailty assessments and support. These patients are discussed at a MDT meeting on a monthly basis and bringing in relevant teams across the system where needed (e.g. community nursing, OT, ASC* • *Outreach pathway – working with community groups with residents who are known to experience health inequalities / where there are likely to be frail residents to provide outreach holistic frailty assessment and follow up support.* • *The next 6-months will focus on developing the MDT and gaining buy-in from relevant teams to better support patients/residents holistic needs.* • *EMIS and Epic data as well as manual data collection in order to measure impact and outcome measures* • *Future model to form part of the implementation of the SEL frailty framework* 2. ***Predictive data project*** • This project builds on the frailty prototype as it is focused on bringing together data on residents from the Brixton and Herne Hill Neighbourhood to ensure a health inequalities focus • The next 6 months is about gaining partner buy-in and establishing joint SRO's across the system, as well as developing a detailed project plan and exploring data sharing agreements across partners • *Data from across system partners will be used to develop a model to predict the residents at risk of a fall in next 12 months*	Both projects are taking a PHM as they are focused on working in the most deprived neighbourhood and are supporting some of the boroughs residents with the most complex needs.	Holistic community frailty prototype – recurrent funding through Live Longer Better programme Funding for 2 x frailty CCPLs (one secondary and one primary care) Predictive data project – no delivery funding Project support from NWDA and ICTT@ GSTT

	Key steps to December 2025 – working to INT by end of year	Date	RAG
1	Frailty prototype: to commence the INT delivery model with a second GP practice	Sept	
2	Frailty prototype: preliminary review of impact and outcome measures	Dec	
3	Predictive data project: identify SRO's from across partners (GSTT, Council – ASC/Public Health/Digital, KCH)	July	
4	Predictive data project: develop detailed and robust project plan with outcome measures	Sept	
5	Predictive data project: identify key datasets across partnership organisations	Sept	

Key challenges/risks
Securing partner buy-in to drive forwards the predictive data project
IG and data sharing across partners to develop the predictive data model
Capacity to scale up within the neighbourhood to deliver the frailty prototype as the complexity of patients' needs has meant that the scale up has slowed
Access to data to be able to measure impact of the frailty prototype
Capacity/funding to develop target interventions to prevent falls

Multiple Long Term Condition INT

Relevant neighbourhood/s	*North Lambeth & Stockwell; Clapham; Streatham*
Programme team	*Josepha Reynolds, NWDA Project Manager*
Governance	*Future INT reporting structure feeding into the NWDA Leadership Board*

How will this work incorporate prevention?	1. *Bringing in Vital 5 work to support prevention and early identification within the community* 2. *Proactive and holistic support for people to MLTCs to prevent further escalation*
How will this work engage with communities?	1. *Continuing community outreach days around LTCs – currently rotating MSK Community Days across the neighbourhoods* 2. *Working closely with grassroots VCS to support the work – including regular engagement and understanding incorporation into identification and support of the cohort*

Outline of the INT model	How is this taking a PHM approach	Resourcing
INT model to be developed over the next 6 months, building on established existing work around MLTCs within Lambeth. Expecting that the approach will consistent of the following elements and build on existing work that has happened in Lambeth regarding MLTCs (focusing on the Renal Cardiometabolic model of care and PEACS learning): • Data led approach, using shared datasets to identity areas of focus • Proactive case identification of patients, focusing on combined risk instead of individual conditions e.g. CVD • Holistic support using clinical and operational resources, including ARRS roles and voluntary & community sector • Integrated support from all partners, including primary, community, secondary and mental health. • Creation of an MDT model to ensure integrated review of patients.	1. Data based approach to understand the MLTCs to prioritise populations. 2. Ensuring outreach addresses inequalities within access and experience – recognising that support might vary depending on the neighbourhood that it is being delivered in. 3. Developing clear impact measures to understand the success of any intervention.	• Project resource to come from NWDA and ICTT @ GSTT • Working group to consistent of leads from relevant neighbourhoods and subject matter experts, including community and secondary care • Working with existing LTC and NWDA CCPLs

	Key steps to December 2025 – working to INT by end of year	Date	RAG
1	Formation of MLTC working group with SME & neighbourhood leads	July 25	
2	Review existing learning from MLTC models in Lambeth (RCM & PEACS) and other SEL examples to inform the work (linked to SEL MLTC framework)	July 25	
3	Review robust dataset around MLTCs to identify LTC cluster to target (e.g. CVD)	July 25	
4	Complete options appraisal for MLTC model, agreeing recommended version	Oct 25	
5	Create SOP for MLTC INTs, aiming for delivery from April	Dec 25	

Key challenges/risks
Sustainable funding for identified LTC model
Challenges around data sharing across organisational interfaces
Demonstrating system impact for all partners and corresponding impact on resourcing
System capacity to test new ways of working alongside BAU

CYP INT

Relevant neighbourhood/s	All five Lambeth neighbourhoods (aligned with Family Hubs & Council Town Centres) for CHILDS Norwood neighbourhood testing new models
Programme team(s)	CHILDs, CYP Alliance, Evelina London Children's Hospital, King's College Hospital, Family Hub representatives, Primary Care Networks.
Governance	CYP Network Group reporting into INT Reporting Structure, accountability to CYPA, GSTT, KCH.

How will this work incorporate prevention?	1. Early identification/intervention for frequent paediatric ED attenders (e.g., respiratory conditions). 2. Proactive community-based care, using CHILDs health packs and tailored support. 3. Aligning with preventative Family Hub services (perinatal mental health, early parenting support).
How will this work engage with communities?	1. Regular stakeholder workshops (first in August 2025) involving community, voluntary, education and family representatives. 2. Utilise existing Family Hub networks to ensure local community voice in INT design and implementation. 3. Ongoing collaboration with Healthwatch Lambeth and other community forums.

Outline of the INT model	How is this taking a PHM approach	Resourcing
1. Build integrated teams using CHILDS Framework (integrated GP, paediatricians, nursing teams). 2. Co-location and integration with Family Hub services (early years, emotional wellbeing, parenting). 3. Initial targeted intervention: addressing repeat paediatric ED attendances (Evelina London, Kings College Hospitals). 4. Expand progressively to cover broader complex CYP needs (for example bio-psycho-social needs, neurodisabilities, mental health). 5. Data-driven approach for prioritisation of interventions and resource allocation.	1. Population Health Management data used to identify priority CYP cohorts. 2. Targeted interventions based on detailed data (repeat ED attendance, complex needs profiles). 3. Proactive and preventative service planning tailored to neighbourhood-level CYP needs.	1. Initial resources via existing CYP Alliance and CHILDS capacity and stakeholder commitment. 2. Analytical/data support from public health teams, hospital BI teams and primary care.

	Key steps to December 2025 – working to INT by end of year	Date	RAG
1	Formation of CYP Integration Network (CYPIN) working group	06/25	
2	Complete detailed analysis of repeat paediatric ED attendances	07/25	
3	Hold CYP Integrated Neighbourhood Teams stakeholder workshop	09/25	
4	Finalise CYP INT operational plan for pilot (using CHILDs)	10/25	
5	Commence CYP INT pilot implementation (initial ED cohort)	12/25	

Key challenges/risks
Ensuring consistent stakeholder engagement and participation.
Resource constraints across health, social care and voluntary sectors.
Data-sharing challenges across multiple providers; early data governance agreement needed.

Mental Health INT

Relevant neighbourhood/s	*Existing SLaM neighbourhoods to be aligned with identified Lambeth neighbourhoods – part of development plan*
Programme team	*LWNA leadership team – Emma Porter & Guy Swindle* *CHILDS delivery team – Eleanor Wyllie*
Governance	*LWNA Alliance Leadership Team and Community Development Oversight Group and SLaM's Community Care Development Group*

How will this work incorporate prevention?	1. *More support delivered in communities to prevent escalation and mental health crisis* 2. *Working with communities to provide sustainable support*
How will this work engage with communities?	1. *Aligned to PCREF triple leadership approach, bringing in a service user and community representation alongside clinical leadership* 2. *Building on strong existing relationships with Certitude and Thames Reach (partners in LLWNA), Black Thrive, Mosaic Clubhouse and other VCSEs*

Outline of the INT model	How is this taking a PHM approach	Resourcing

1. Delivery of community care neighbourhood model, building on existing work within LLWNA – led by SLaM
• *Reorganising community mental health services into neighbourhoods, building on learning from LLWNA and work within Lewisham*
• *Aligns to reset of LLWNA priorities to include focus on reducing the number of known people presenting in crisis and inequalities*
• *Creating minimum standard offer with 8 components to reduce hand offs and ensure people have their needs met in one place:*
  • *All offers, where possible, in the centre*
  • *Intake / front door function within the centre*
  • *Active caseload management*
  • *Proactive crisis intervention and daily crisis slots*
  • *Care built on personal relationships & using DIALOG+*
  • *Integrated VCSE working via formal & informal partnerships*
  • *Suite of interventions with focus on active delivery*
  • *Specialist roles within the core team*
 	
2. Expansion of CHILDS model to incorporate mental health case discussions – led by Evelina, King's, SLaM and general practice
• *Building on existing neighbourhood model to better support children and young people with mental health needs – covering all of Lambeth (but delivered across three different groups of PCNs vs five Lambeth neighbourhoods).*
	• Approach is based on data demonstrating where there are inequalities in access and experience with existing patients as well as at a borough level	LLWNA delivery resource
		
		SLAM - Senior managers and VCSE funding pot
		
		CHILDS delivery team – dedicated CAMHS psychiatrist resource

	Key steps to December 2025 – working to INT by end of year	Date	RAG
1	Launching Lambeth delivery group to create delivery plan for community care model	Jun 25	
2	Delivery plan to be designed for implementation of community care model	Jun 25	
3	CHILDS model to incorporate monthly mental health case discussion	Jun 25	
4	Review how existing living well centres could align to other INT delivery models	Dec 25	

Key challenges/risks
Existing MH neighbourhoods (north, south west and south east) are not co-terminus with newly agreed Lambeth neighbourhoods – needs consideration of how to manage in the future

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Comms and engagement

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Comms & engagement

System and partner engagement

Our approach for engaging internal and external stakeholders will be adapted according to what needs to be communicated and at what time. This will include regular progress updates to key partnership boards including but not limited to the Neighbourhood and Wellbeing Delivery Alliance Board, Lambeth Together Executive Group, Lambeth Together Care Partnership Board. This will also include partner settings including Lambeth Clinical Cabinet, GSTT INT Delivery Committee and Improving the Health of our Population Committee and Lambeth Council Management Board.

Over the next 6 months we will also be engaging key system partners including our neighbourhood leads, community services, General Practice, community pharmacy, social care, housing and the Thriving Community networks. The objectives are to:

- Ensure that all relevant stakeholders are fully informed and engaged with the development of the programme as it progresses, and are aware of the interfaces and impact on broader pieces of work/parts of the system
- Enable all key stakeholders to input and feedback on aspects of the programme
- Drive effective collaboration among all stakeholders and the System sectors involved
- Promote and achieve the aims, objectives and benefits of the programme

Patient, public and community engagement

We are working with Healthwatch Lambeth to deliver a programme of patient, public and community engagement to:

- Increase awareness and understanding INTs among residents, service users, carers and community members.
- Develop comprehensive public and community feedback and insights including expectations, concerns, and preferences.
- Reflect local priorities on what success would look like to support establishment of metrics to evaluate the success of the INTs
- Inform mapping of community-based assets and strengths that can work with and support our neighbourhood working and supplement our core INTs at the grassroots, hyper-local level in each neighbourhood.
- Achieve a high level of public and community participation in the engagement activities, including views from diverse demographic groups, ensuring inclusivity.
- Inform the development of the comms narrative outlining what we aim to achieve through more joined-up and integrated working at a neighbourhood level.

Lambeth together

Next steps

Working in partnership for a healthier borough

Our next steps

- This pack sets out the position for developing integrated neighbourhood teams from July – December 2025. This will ensure that by January 2026 there will be worked up integrated neighbourhood team models for each of the population groups identified within Lambeth.
- There is significant work to undertake over these 6 months to ensure that we understand what we are going to deliver, how this is going to provide value to all of our partners, and how we are going to demonstrate success. We will also link into learning across SEL, including from other places and dovetailing with the wider population health management work which is being developed.
- Alongside this work, there are also important changes which will impact on our work and be incorporated into the INT development:
    - The NHS 10 year plan is expected to be released and will provide additional guidance for our approach to integrated neighbourhood teams.
    - There will also be additional clarity on the future ICB operating model and any further expectations around a neighbourhood health provider.
    - Lambeth's integrator model will be agreed by Lambeth Together Care Partnership Board, with final details being inserted into this document as they are agreed.
- In January 2026 we will therefore review the programme development against the national guidance to ensure that we are on track to deliver our designed neighbourhood model by the 2026/27 financial year.