LAMBETH TOGETHER CARE PARTNERSHIP (FORMERLY LAMBETH TOGETHER STRATEGIC BOARD)

AGENDA

Please note that the agenda ordering may be changed at the meeting.

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Lambeth Together Care Partnership Board

Title	**Lambeth Together Assurance Sub-Group**
Meeting Date	7th November 2024
Author	Warren Beresford – Associate Director Health and Care Planning and Intelligence Jo Fernandes – Planning Intelligence and Improvement Manager
Lead	Oge Chesa - Director of Primary Care and Transformation, on behalf of Jasmina Lijesevic – Lambeth Together Board Lay Member

This item is for;

☒	**Information**	☐	**Discussion**	☐	**Decision**	☐	**Ratification**

Recommendations;

The Lambeth Together Care Partnership Board is asked to note the report from the Lambeth Together Assurance Sub-Group and the associated Integrated Assurance Report presented on 10th September 2024

What other groups or committees have considered this item to date?

None

Summary and Impact on Inequalities

Purpose:

The purpose of this paper is to update the Lambeth Together Care Partnership on our ongoing assurance arrangements.

Lambeth Together Health and Care Plan Focus Points:

At the 10th September 2024 meeting the Lambeth Together Assurance Group (LTAG) meeting agenda centred around two outcomes which the partnership is aiming to achieve through delivery of the 'Our Health, Our Lambeth, As Lambeth Together's health and care plan'.

These were

- Outcome O - *People who are homeless, or at risk of becoming homeless, (including rough sleepers and refugees) have improved health*
- Outcome E - *People have healthy and fulfilling sexual relationships and good reproductive health*
- Outcome L - *Women have positive experiences of maternal healthcare and do not experience a disproportionate maternal mortality rate*

Integrated Assurance Report

Time was also given at the meeting to review the Lambeth Together Integrated Assurance Report.

Some of the key points noted and discuss were as follows;

- Data indicates that the Health and Wellbeing Bus service is effectively reaching a higher proportion of Black residents compared to Census data, successfully engaging a group facing significant health inequalities.
- There has been an improvement in blood pressure control among Black and minority ethnic residents, with an increase from 38.7% (23,289) in August 2023 to 40.7% (24,241) in 2024.
- The Lambeth Living Well Centres have seen a sharp rise in the number of service users accessing Short-Term Support and Focused Support, increasing by 52 (+27%) and 24 (+48%), respectively.
- Ageing Well funding has been secured for 2024/25 to support project resources aimed at addressing barriers, including collaborating with primary care to identify people in the last year of life and improving uptake of Universal Care Plans.
- GP appointment rates are slightly above the levels recorded for the same period last year.
- The proportion of STI tests among young men under 25 has decreased, and while testing rates for users from Black, Asian, and multi-ethnic backgrounds have remained steady, they are still lower than their share of the general population.
- Challenges in end-of-life care include varying levels of capacity and professional confidence within primary care to initiate Personal Care Support Plan (PCSP) conversations, as well as variable data across Primary Care Networks (PCNs).

- Learning Disability (LD) and Severe Mental Illness (SMI) health checks are currently behind last year's progress.

- Virtual ward capacity is below the planned levels.

- NHS Health Check outcomes for Q1 2024/25 were impacted by the Synnovis cyber-attack.
- There have been ongoing issues with access to breast cancer screening due to local capacity constraints.

- In 2023/24, Lambeth's Single Point of Access (SPA) experienced a significant increase in caseload, leading to longer waiting times. While the caseload has more than halved since its peak in May, a high proportion of referrals still face long waiting times.

Risk Register

The group reviewed the risk register and noted that, at that time, there were 13 active risks listed on the Lambeth Together risk register.

- Since September, two risks have been closed. One was related to capacity within the Lambeth Together programme, which has been addressed by having a full staffing complement, the end of industrial action, and the implementation of a New Ways of Working plan to better manage capacity moving forward.
- The second closed risk concerned estates and business continuity for the Lambeth Walk Medical Centre. The practices successfully relocated from the existing premises without any disruption to patient care.
- All finance-related risks are being monitored with additional oversight by the ICB Finance team.
- The active Lambeth Together risks continue to fall within the ICB threshold, with no need for escalation to the ICB.

A total of 8 actions were recorded in the meeting minutes, and each one has been actively followed up with the respective leads for further progress.

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Lambeth Together

Integrated Assurance Report

10 September 2024

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Our Health, Our Lambeth

Lambeth Together health and care plan 2023-28

Impact measures performance trend (1)

Outcom	Impact measure	Target/Pla	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24		Comments
A	Smoking prevalence reduction	Plan							13.4%	13.3%	13.2%	13.2%	13.1%		Target to reduce by 1% from 22/23 year end (13.4%). Data source is Office for Health Improvement and Disparities (OHID) Prevalence but as only annual it's proposed that we use SELICB Vital 5 dashboard
	Proportion of opiate users that left treatment successfully in the previous 12 months and do not re-present to treatment within 6 months.	Actual							5.4%						Year end 22/23 = 4.8%. National Drug Treatment Monitoring System (NDTMS - OHID) data
	Proportion of non-opiate users that left treatment successfully in the previous 12 months and do not re-present to treatment within 6 months.	Actual							27.7%						Year end 22/23 = 39.6% National Drug Treatment Monitoring System (NDTMS - OHID) data
	Proportion of alcohol users that left treatment successfully in the previous 12 months and do not re-present to treatment within 6 months.	Actual							38.6%						Year end 22/23 = 38.6% National Drug Treatment Monitoring System (NDTMS - OHID) data
	Proportion of alcohol and non-opiate users that left treatment successfully in the previous 12 months and do not re-present to treatment within 6 months.	Actual							34.5%						Year end 22/23 = 31.0% National Drug Treatment Monitoring System (NDTMS - OHID) data
B	Uptake of the NHS Health Check for all eligible adults	Actual	4.7%	5.2%	5.8%	6.3%	6.9%	7.7%	8.4%	0.7%	1.3%	1.9%			
		Plan	4.5%	5.3%	6.2%	6.6%	7.3%	7.9%	8.7%	0.7%	1.8%	2.6%	3.3%		monitor vs previous year
		Variance	0.1%	-0.1%	-0.3%	-0.3%	-0.4%	-0.2%	-0.2%	0.0%	-0.5%	-0.7%			
	Number of social prescribing referrals	Actual				7,746	7,604	7,418	6,104	6,020	5,899	5,708			Source = PH app on EZ analytics. Need to check for accuracy (sounds high volume)
	Percentage of low-income residents coping financially	Actual	78.8%			79.6%			78.2%			79%			
C	Proportion of Lambeth registered children by age 1 that have received all primary immunisations	Actual	87.8%			86.9%			88.0%						
		Plan	89.2%			90.6%			88.1%						
		Variance	-1.40%			-3.70%			-0.10%						
	Proportion of Lambeth registered children by age 2 that have received one dose of MMR	Actual	83.3%			84.5%			83.5%						
		Plan	85.7%			86.2%			84.3%						
		Variance	-2.40%			-1.70%			-0.80%						
	Proportion of school-age vaccination consent forms returned to the vaccination provider. (Deferred)	Actual													
		Plan													
		Variance													
	Proportion of Lambeth registered population who are over the age of 65 receiving immunisation for Flu	Actual		48.01%	54.26%	56.34%	57.28%	57.75%							
		Plan		48.83%	53.71%	57.06%	58.67%	60.21%							Proposed trajectory submitted to SELICB for SELICB corp objective. A/W feedback. 23/24 plan was to achieve higher than 22/23
		Variance		-0.82%	0.55%	-0.72%	-1.39%	-2.46%							
D	Provisionally agreed - Number of Entering treatment with Short-Term Support with Living Well Centres.	Actual										193	245		
		Plan											52		Against previous month's position
	Provisionally agreed - Number of Entering treatment with Focused Support with Living Well Centres.	Actual										50	74		Against previous month's position
		Plan											24		
F	Uptake of SMI health checks	Actual	29%	34%	40%	46%	54%	60%	68%	3%	9%	10%	13%		
		Plan	30%	35%	40%	45%	50%	55%	60%	5.0%	10.0%	15.0%	20.0%		National Target = 60% at year end
		Variance	-1.3%	-1.4%	-0.4%	1.2%	4.1%	5.2%	8.0%	-2.0%	-1.5%	-5.4%	-7.1%		
	Uptake of LD/AHC health checks	Actual	38.9%	46.3%	55.2%	56.7%	68.5%	77.5%	84.6%	5.7%	10.3%	16.4%	20.2%		
		Plan	37.5%	43.8%	50.0%	56.3%	62.5%	68.8%	75.0%	6.3%	12.6%	18.9%	25.2%		National Target = 75% at year end
		Variance	1.4%	2.5%	5.2%	0.4%	6.0%	8.7%	9.6%	-0.6%	-2.2%	-2.5%	-5.0%		
	Proportion of Bowel Cancer screening for those aged 60-74 (Coverage)	Actual	60.6%	60.7%	61.1%	61.0%									
		Plan	59.5%	59.8%	60.0%	60.0%	60.2%	60.4%	60.6%						Plan = same period in 22/23
		Variance	1.1%	0.9%	1.1%	1.0%									
	Proportion of cervical Cancer Screening aged 25-64 (Coverage)	Actual	62.6%	62.7%	62.8%	62.8%	62.7%	62.8%	62.9%	63.0%					
		Plan	63.2%	62.9%	62.8%	62.7%	62.6%	62.8%	63.0%	62.8%					Plan = same period in 22/23
		Variance	-0.6%	-0.2%	0.0%	0.1%	0.1%	0.0%	-0.1%	0.2%					
	Proportion of breast cancer screening for women aged 47-73 (Coverage)	Actual	46%	46%	46%	46%									
		Plan	41%	42%	42%	42%	42%	42%	43%						Plan = same period in 22/23
		Variance	4.8%	4.0%	3.5%	3.2%									
G	Proportion of people with Type 2 diabetes who receive 8 checks on an annual basis	Actual	55.3%	60.8%	66.5%	70.0%	74.1%	79.2%	81.7%	15.1%	22.7%	24.1%	27.8%		
		Plan	38.5%	44.9%	51.3%	57.8%	64.2%	70.6%	77.0%	6.4%	12.8%	19.3%	25.7%		Local target = 77% by year end (set to straight line trajectory)
		Variance	16.8%	15.9%	15.2%	12.3%	9.9%	8.6%	4.7%	8.7%	9.9%	4.8%	2.1%		
	Cardiovascular dashboard, HYP aged 79 or under and last BP is less than or equal to 140/90 this FY	Actual	47.3%	52.6%	56.5%	58.8%	62.3%	66.4%	68.7%	10.6%	22.1%	31.1%	38%		
		Plan	38.5%	44.9%	51.3%	57.8%	64.2%	70.6%	77.0%	6.4%	12.8%	19.3%	25.7%		National target = 77% by year end (set to straight line trajectory)
		Variance	8.8%	7.7%	5.2%	1.1%	-1.8%	-4.2%	-8.3%	4.2%	9.3%	11.9%	12.4%		
	Cardiovascular dashboard, HYP aged 80 or over and last BP is less than or equal to 150/90 this FY	Actual	59.7%	65.2%	69.8%	72.4%	76.0%	79.1%	81.7%	16.1%	29.4%	40%	48%		
		Plan	38.5%	44.9%	51.3%	57.8%	64.2%	70.6%	77.0%	6.4%	12.8%	19.3%	25.7%		National target = 77% by year end (set to straight line trajectory)
		Variance	21.2%	20.3%	18.5%	14.6%	11.8%	8.5%	4.7%	9.7%	16.5%	20.6%	21.9%		
	Proportion of people over age of 65 who are taking 10 or more medicines, having a medication review	Actual								2%	5%	7.5%	10.5%		
		Plan													Plan/target TBA
		Variance													

The above table is not showing all impact measures across each outcome. For some measures, we are not able to display this information using this visual format, or data processes/ flows are being refined/ validated. We will aim to fully integrate all impact measures on a scorecard to allow a full visual presentation of measures activity.
Some of the Plans/trajectories/targets are provisional and subject to change

Impact measures performance trend (2)

Outcom	Impact measure	Target/Pla	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24		Comments
H	Proportion of referrals to the Living Well Network Alliance Single Point of Access, which were processed during the month (i.e. triaged, referred onwards or otherwise responded to) within 72 hours.	Actual								-	-	20%	13%		In 23/24 we were reporting on SPA WT for Urgent referrals. In 24/24 there will be a new methodology on SPA WT to better capture activity from referral to 1st contact
	Access to Lambeth Talking Therapies for Black African and Caribbean residents to ensure they are as least as good as those of White residents	Actual	24.3%			23.1%			24.4%						% of black users by Ethnicity
		Plan	21.7%			21.7%			21.7%						% of Black users by Ethnicity as per 2021 Census population rate
		Variance	2.6%			1.4%			2.7%						
	Number of children and young people waiting longer than 52 weeks for an assessment and commencing treatment with Child and Adolescent Mental Health Services	Actual	34												Due to the implementation of a new Patient Electronic System (EPIC) we have been unable to report on this measure. Effort have been made to reenact this report stream and we will work with secondary partners
J	Number of appointments in General Practice	Actual	168,244	155,258	165,319	133,406	171,212	166,166	159,787	166,166	165,670	149,688			
		Plan								140,251	158,393	171,023	161,092		1.5% increase vs 23/24 monthly profiled against 23/24
		Variance								25,915	7,277	- 21,335			
	Improve access to healthcare professionals through increased use of community pharmacies - GPs and NHS 111 direct people to pharmacies to support people with minor ailments and advice around self-care and common clinical conditions	Actual	>200	>300	>300	>300	>400	>800	>900						No of service users access to Community Pharmacy scheme
		Plan													
		Variance													
	Capacity of virtual wards	Actual	130	144	148	147	158	165	224	209	177	166	198		
		Plan	185	185	201	201	201	231	231	231	233	233	234		
		Variance	- 55	- 41	- 53	- 54	- 43	- 66	- 7	- 22	- 56	- 67	- 36		
	Proportion of virtual wards being used	Actual	70%	78%	74%	73%	72%	71%	97%	90%	76%	71%	85%		
		Plan	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%		
		Variance	-10.0%	-2.0%	-6.0%	-7.0%	-8.0%	-9.0%	17.0%	10.0%	-4.0%	-9.0%	5.0%		
K	Number of people with an intermediate care offer	Actual	52	62	61	46	47	68	35						
		Plan	55	64	53	65	63	56	58						
		Variance	- 3	- 2	8	- 19	- 16	12	- 23						Plan = same period previous year
	Percentage of people who have completed reablement that has resulted in no formal support or support at a reduced level	Actual	84%	76%	80%	83%	85%	81%	79%						
		Plan	81%	67%	74%	71%	73%	68%	78%						Plan = same period previous year
		Variance	3%	9%	6%	12%	12%	13%	1%						
	Proportion of carers of the users of Adult Social Care Services are offered a carers assessment	Actual	97%	98%	97%	97%	90%	93%	100%						
		Plan	94%	93%	94%	97%	94%	95%	98%						
		Variance	3%	5%	3%	0%	-4%	-2%	2%						
	No of people identified as being in their last year of life on practice registers	Actual	1,954			1,953			1,988			2013			
		Plan	1,696			1,705			1,651			1937			Plan = same period in 22/23
		Variance	258			248			337			76			
	Proportion of people with Personalised Care and Support Plan(PCSP)/UCP	Actual	47%			48%			48%			49%			
		Plan	37%			40%			42%			46%			Plan = same period in 22/23
		Variance	10%			8%			6%			3%			
M	Rate of uptake for an Annual Health Check and Health Action Plan for those with LDA	Actual	34.2%	40.3%	49.2%	51.9%	64.2%	74.5%	83.1%	5.2%	9.6%	14%	20%		
		Plan	37.5%	43.8%	50.0%	56.3%	62.5%	68.8%	75.0%	6.3%	12.5%	18.8%	25.0%		
		Variance	-3.3%	-3.4%	-0.8%	-4.4%	1.7%	5.7%	8.1%	-1.1%	-2.9%	-4.6%	-5.5%		
	Weeks waiting for an ASD diagnosis for children and young people	Actual		84		96						63			Waiting times on ARD assessment at June 24 was 64 weeks, and provisonal data for Aug 24 stands at 60 weeks wait (n-960). Due to the implementation of a new Patient Electronic System (EPIC) we have been unable to report on this measure. Effort have been made to reenact this report stream and we will work with secondary partners
N	Percentage of service users reporting a positive experience of using mental health services, feeling they have benefited from support and are more independent and in control of their lives,	Actual	78%	85%	76%	82%	62%	74%	73%						
		Plan													
		Variance													
O	Percentage of people resettled into longer-term accommodation	Actual	3%			3%			5%			4%			
		Plan													
		Variance													
	Number of rough sleepers brought into accommodation	Actual	58			78			52			44			
	Proportion of people living in our supported housing that are registered	Actual	79%			90%			92%			90%			
	services.	Actual	14%			20%			25%			23%			
	Refer people to drug treatment services upon their release from prison, and	Actual							41%						24/25 Year-end ambition is to reach 55% (historical data shows 2021 -21% ; 2022-21%)

The above table is not showing all impact measures across each outcome. For some measures, we are not able to display this information using this visual format, or data processes/ flows are being refined/ validated. We will aim to fully integrate all impact measures on a scorecard to allow a full visual presentation of measures activity.
Some of the Plans/trajectories/targets are provisional and subject to change

Health and Care Plan: Key headlines (1)

	Outcome	Key Headlines
A	***People maintain positive behaviours that keep them healthy***	NHS Health Check outcomes for 2024/25 Q1 was impacted by the Synnovis Cyber-attack that effectively halted the service from the 6th of June as bloods could not be processed. The expectation is that the impact will continue into Q2 as recovery efforts continue. Public Health continues to work with GP's on resurrecting the core service as well as working on implementing the NHS Digital Healthcheck and Workplace CVD Healthcheck pilots rolled out by DHSC.
B	***People are connected to communities which enable them to maintain good health***	The council has in place a comprehensive evidence-informed cost of living response plan to mitigate the impact of the crisis for our most vulnerable residents in 2024/25 which has launched since the last reporting period. The response plan includes providing holiday provision for children in receipt of free school meals, funding to voluntary and community sector organisations and targeted support for residents known to be most impacted by poverty in the borough (disabled residents, lone parents, residents with mental ill-health).
C	***People are immunised against vaccine preventable diseases***	National COVER reporting lacks insights into vaccination inequalities. The UKHSA's health equity audit identified avoidable disparities in the UK vaccination system. A local audit in Lambeth also highlighted inequalities in vaccination coverage and timeliness. Data from ongoing measles outbreaks show that nearly half of those affected are female, mostly children under 17, with a median age of 6 or 7, with a notable concentration in the most deprived areas.
D	***People have healthy mental and emotional wellbeing***	The monthly picture for Lambeth Living Well Centres shows the number of service users accessing Short-Term Support and Focused Support rising sharply by 52 (+27%) and 24 (+48%) respectively. This is largely due to the efforts to clear of a backlog of waiting referrals to Lambeth SPA. Incoming referrals deemed inappropriate by both services remain high and joint efforts are underway to help the referring teams identify the correct pathway first time.

Health and Care Plan: Key headlines (2)

	Outcome	Key Headlines
E	***People have healthy and fulfilling sexual relationships and good reproductive health***	Public Health Outcomes Framework data shows that STI diagnosis rates are continuing to increase, both nationally and in Lambeth. In Lambeth, rates are now similar to pre-Covid levels. Alongside this testing rates have also increased with a 9% increase from 2022 to 2023. Local analysis show testing rates remain high in some populations who are disproportionately affected by STIs, such as GBMSM. Approximately 33% of STI tests taken in 2023 were by GBMSM. The proportion of STI tests taken by young men under 25, however, has decreased over time. The proportion of STI tests taken by users from a Black, Asian and multi-ethnic background has remained consistent over time however is lower than the proportion in the general population (32.6% in 2023).
F	***People receive early diagnosis and support on physical health conditions***	The NWDA is funding multiple PCN cancer awareness events in the next year to raise awareness. Also put forward multiple proposals to SELCA for funding to specifically target under represented groups (Latin American community and Somali community). There have been issues with access to breast screening and local capacity. The breast screening service are working to improve this including offering appointments outside of normal working hours and also facilitating those who require extra time due to disabilities. Further increasing access could help to increase screening rates. Also access to appointments for cervical screening can be a challenge. This can be improved by offering screening outside of normal practice hours at local extended access hubs or offering different appointment booking systems to increase ease of access.
G	***People who have developed long term health conditions have help to manage their condition and prevent complications***	More black and minority ethnic people have blood pressure control when comparing August 2023 to 2024 data; 38.7% (23,289) and 40.7% (24,241) respectively. NWDA Hypertension Oversight group has been developed to support co-ordination of activities to improve hypertension identification and management in Lambeth, with a focus on reducing health inequalities. The Diabetes app within EZ Analytics has been further updated for 24-25 to provide more detailed data on improvements of the measurement and recording of the care processes for Black African, Black Caribbean, Mixed White and Asian, Unknown or not stated ethnic groups.
H	***When emotional and mental health issues are identified; the right help and support is offered early and in a timely way***	In 2023/24 Lambeth Single Point of Access (SPA) saw a huge increase in caseload and, hence, waiting times have also grown significantly. Since peaking in May, the SPA caseload has been more than halved but the proportion of referrals on the list having long waiting times remains high. Consequently, the proportion of referrals completed remained low in July at 13%; far from the 95% target. This measure will only significantly improve when the backlog of long waiting cases is cleared, which if the current trend continues, will be around the end of 2024.

Health and Care Plan: Key Headlines (3)

	Outcome	Key Headlines
I	***People have access to joined-up and holistic health and care delivered in their neighbourhoods***	Main challenge is the data isn't recorded through EMIS and hard for clinicians to make onward referrals. We are working on a new provider to solve this problem and should soon be able to track opportunistic visitors of the bus health service into GP practice. On Beacon service, we are not able to refer directly into primary care. We are refining their service delivery model and growing relationships with local community pharmacy to refer people from beacon hubs into primary care.
J	***People know where to go to get the right help, and are treated at the right time, in the right place, for their needs***	General Practice continue to exceed the national threshold of 85% for patients being seen within 2 weeks. There has been a national rebranding of the GP-Community Pharmacy Consultation Service and other clinical services provided through community pharmacy to 'Pharmacy First'. This now includes 7 clinical conditions which can be assessed and treated through pharmacies, including provision of antibiotics and other treatments, hypertension checking service, contraceptive service and urgent medicines service. This is not to be confused with the local Pharmacy First Plus service, which addresses inequalities in access to medicines over the counter for a range of common conditions. The local service has been rebranded to Lambeth Pharmacy First Plus.
K	***Older adults are provided with the right health and care support at the right time, live healthy and active later lives and are supported to age well***	The majority of reablement referrals come via the hospital discharge route. We are increasing the number of people who are offered a reablement service via our front door team in Adult Social Care in order to offer reablement to people living in the community at home. This will help to offer a more equitable service for those residents living at home who may benefit from reablement care. There is a named linked physiotherapist from GSTT Rehab and Reablement Team working closely with the ASC front door managers to help identify appropriate referrals to reablement. For end-of-life identification and conversion to PSCP / UCP (K3 and K4) key challenges include varying levels of capacity and professional confidence within Primary Care to initiate PCSP conversations, as well as variable data across PCNs owing in part to different coding practice occurring in different practices within PCNs. SEL Ageing Well Funding secured for project resource to help address these barriers in 2024/25, by working with primary care to support identification of people in the last year of their life and uptake of Universal Care Plans.
L	***Women have positive experiences of maternal healthcare and do not experience a disproportionate maternal mortality rate***	Updates to follow

Health and Care Plan: Key Headlines (4)

	Outcome	Key Headlines
M	***People with learning disabilities and/or autism achieve equal life chances, live as independently as possible and have the right support from health and care services***	In 2023/24 the uptake of AHCs and health Action Plans exceed the target to reach 83.1%. Steady progress towards the same objective is seen as at July 2024, and we note that a larger proportion are completed towards the end of the financial year. Waiting times on ARD assessment at June 24 was 64 weeks, and provisional data for Aug 24 stands at 60 weeks wait (n-960). Due to the implementation of a new Patient Electronic System (EPIC) we have been unable to report on this measure. Effort have been made to reenact this report stream and we will work with secondary partners
N	***People using mental health support services can recover and stay well, with the right support, and can participate on an equal footing in daily life***	The most recently available suggests progress towards this outcome. In July LWNA's Community Living and Support Service worked with 114 service users with serious mental health conditions to live in the community. This compares with 103 in the previous month. The Community Living and Support Service (CLaSS) accepted fewer new clients in July (27) than in June (23) but its average weekly caseload fell (from 85 to 72). Data for LWNA's Individual Placement and Support (IPS) is delayed and will be reported as soon as it becomes available. Positive friends and family survey responses for LWNA as a whole were up to 82.5% in July, from 77.4% in June. ates to follow
O	***People who are homeless, or at risk of becoming homeless, (including rough sleepers and refugees) have improved health***	2023-24 saw a significant increase in rough sleeping across London. Analysis of the borough level data shows that Lambeth saw the highest ever number of rough sleepers recorded. The rough sleeping outreach team recorded contacts with 866 rough sleepers, compared with 623 in 2022-23 and 438 in 2021-22. Just under half of the 866 in 2023-24 were people who had never been recorded as sleeping rough before. Much of this has been attributed to the cost of living crisis and soaring accommodation costs in the capital, particularly in the private rented sector.

Finance

Finance: South East London ICB: Lambeth

Overall Finance Position (2024/25 M03)

	Year to date Budget £'000s	Year to date Actual £'000s	Year to date Variance £'000s	Annual Budget £'000s	Forecast Outturn £'000s	Forecast Variance £'000s
Acute Services	297	297	0	1,188	1,188	0
Community Health Services	6,978	6,976	2	27,911	27,902	9
Mental Health Services	5,734	5,955	(221)	22,936	22,936	0
Continuing Care Services	8,654	8,653	1	34,616	34,615	1
Prescribing	10,667	10,473	194	42,666	41,957	710
Prescribing Reserves	0		0	0	0	0
Other Primary Care Services	747	747	0	2,990	2,990	0
Other Programme Services	6	6	0	23	23	0
Programme Wide Projects	0	0	0	0	719	(719)
Delegated Primary Care Services	19,105	19,105	0	82,751	82,751	0
Corporate Budgets	881	784	97	3,419	3,322	97
Total	**53,068**	**52,996**	**73**	**218,499**	**218,402**	**97**

Overall Savings Position (2024/25 M03)

	Year to date Plan £'000s	Year to date Delivery £'000s	Year to date Variance £'000s	Annual Plan £'000s	Forecast Delivery £'000s	Forecast Variance £'000s
Efficiencies embedded within 2024-25 starting budgets	585	585	0	2,341	2,341	0
Continuing Care Services	361	1,276	916	1,442	1,442	0
Prescribing	122	306	184	1,393	1,600	207
Total	**1,067**	**2,167**	**1,099**	**5,176**	**5,383**	**207**

- The borough is reporting an overall £73k year to date underspend position and a forecast year-end position of £97k underspend at Month 03 (June 2024). The reported year to date position includes £221k overspend on Mental Health Services driven by increased Learning Disabilities (LD) costs , offset by underspends in Prescribing and Corporate Budgets. Borough LD Commissioner leading on savings and efficiencies schemes (including Provider-focused service and model reviews, High-cost joint health funded case reviews, etc.) to manage LD cost.

- The underlying key risks within the reported position relate to Mental Health (Learning Disabilities costs) , Continuing Healthcare, Prescribing, Delegated Primary Care budgets and further risk against the Integrated Community Equipment Service Contract (Health and Social Care). The borough is holding £719k allocation in the forecast position to mitigate potential cost pressures during the year as more data becomes available.

- The CHC team continues to deliver on reducing packages for high-cost (PLD and OP) cases including for 1:1 care, Fast track reviews, PHB clawbacks and reduction, and transfer of out of area placements.

- Prescribing information data is provided two months in arrears by the NHS Business Services Authority (previously PPA - Prescription Pricing Authority). The reported M03 position is based on M01 2024/25 actual data. The borough Medicines Optimisation team saving initiatives via local improvement schemes include undertaking visits to outlier practices, working with community pharmacy to reduce waste and over-ordering, etc.

- The 2024/25 borough minimum savings requirement is £3.9m and has a savings plan of £5.2m. In addition to the embedded efficiency (£2.3m) as part of the budget setting process, the borough has saving plans for both Continuing Healthcare (£1.4m) and Prescribing (£1.4m) budgets. Year to date delivery at M03 is £1.1m above plan due to profile of the which differs from actual delivery profile. The forecast delivery is £0.2m above plan due to additional Prescribing saving scheme identified.

Finance: Lambeth Council – ASC & Integrated Health Q1 2024/5 position

DIVISON	BUDGET 24/25 (£000)	FORECAST 24/25 (£000)	VARIANCE (£000)
ADULT SOCIAL CARE	107,355	114,809	7,454
INTEGRATED COMMISSIONING	133	133	-
SENIOR MGMT – INTEGRATED HEALTH & CARE	1,587	1,587	-
PUBLIC HEALTH	0	0	-

Service Group	Budget £'000	Forecast £'000	Variance £'000
Adults with Learning Difficulties	41,960	46,389	4,429
Adults with Physical Disabilities	12,195	17,103	4,908
Adults with Mental Health Needs	13,124	12,832	(292)
Supported Housing	776	776	0
Older People	26,553	30,893	4,340
Other – Adults	7,894	2,112	(5,782)
Supporting People	4,853	4,704	(149)
Total – Adult Social Care	**107,355**	**114,809**	**7,454**

£7.5m overspend in ASC mitigated through the use of non-ringfenced reserves and non-recurrent funding to ensure balanced outturn position.

Budget pressures relating almost solely to third party expenditure on packages of care.

Underspends in 'Other – Adults' and 'Adults with Mental Health Needs' are due to reserves and non-recurrent funding drawn down to these areas.

Main pressure areas:

- Significant pressures in Nursing Care (OP+PD), Home Care (OP + PD), and Supported Living/Accommodation (PD&LD) are the primary factors in the ASC overspend.
- Key contributing factors are higher acuity of new clients and greater numbers , and inflationary increase in new placements costs, impacting all areas but particular impact in OP Nursing Care.

Main mitigations:

- Systematic review of high-cost placements to ensure these are appropriate and whether lower care cost options can be developed or further increases can be limited
- Reducing residential placement referrals where possible and increasing support at home.
- Alternatives to supported living being sought in some high acuity cases.

Quality

NHSE Update on Synnovis Cyber Incident: Clinical Impact in South East London as of Thursday, 22nd August 2024

- The data for the eleventh week of the attack (12th – 18th August), shows that across the two most affected trusts, King's College Hospital NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust, 29 acute outpatient appointments and three elective procedures had to be postponed because of the attack. This means so far 1,696 elective procedures and 10,083 acute outpatient appointments have been postponed at King's College Hospital NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust since 3 June.

Returning testing services to Synnovis

- Synnovis has confirmed that they have successfully rebuilt their core IT systems. As a result, testing services for GP practices in Bexley, Lewisham and Greenwich returned to Synnovis on Thursday 15 August. This 'repatriation' has gone well so far, with services operating at pre-cyberattack levels and no significant issues reported. Testing services for the remaining three south east London boroughs, Bromley, Lambeth and Southwark, will repatriate to Synnovis in the coming weeks.

Blood transfusion services

- Full restoration of blood transfusion services remains planned for early autumn, meaning that mutual aid will continue to be required for planned operations and transplants to minimise the ongoing impact on patients.

Operational capacity in all laboratories overall compared with pre-cyber attack levels

- Most systems are now fully restored, with various services back to running at pre-cyber attack levels, including the majority of blood sciences, tissue sciences and genetics. Infection Sciences are expected to be up to full capacity by the end of August. Plans are on track to restore blood transfusion services by the autumn.

NHSE Update on Synnovis Cyber Incident: Clinical Impact in South East London as of Thursday, 22nd August 2024 (Cont'd)

The update shows that for the week 12 – 18 August 2024 that:

Planned Care (day case and inpatient treatments)
Across King's College Hospital NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust three elective procedures were postponed (compared to 13 the week beginning 5 August). None of these were cancer treatments (compared to three last week). It is still too early to understand the impact on 62-day performance or the faster diagnosis standard for the affected trusts.

Transplant Impacts
No organs were diverted for use by other trusts.

Maternity
No C-sections were postponed in the last week

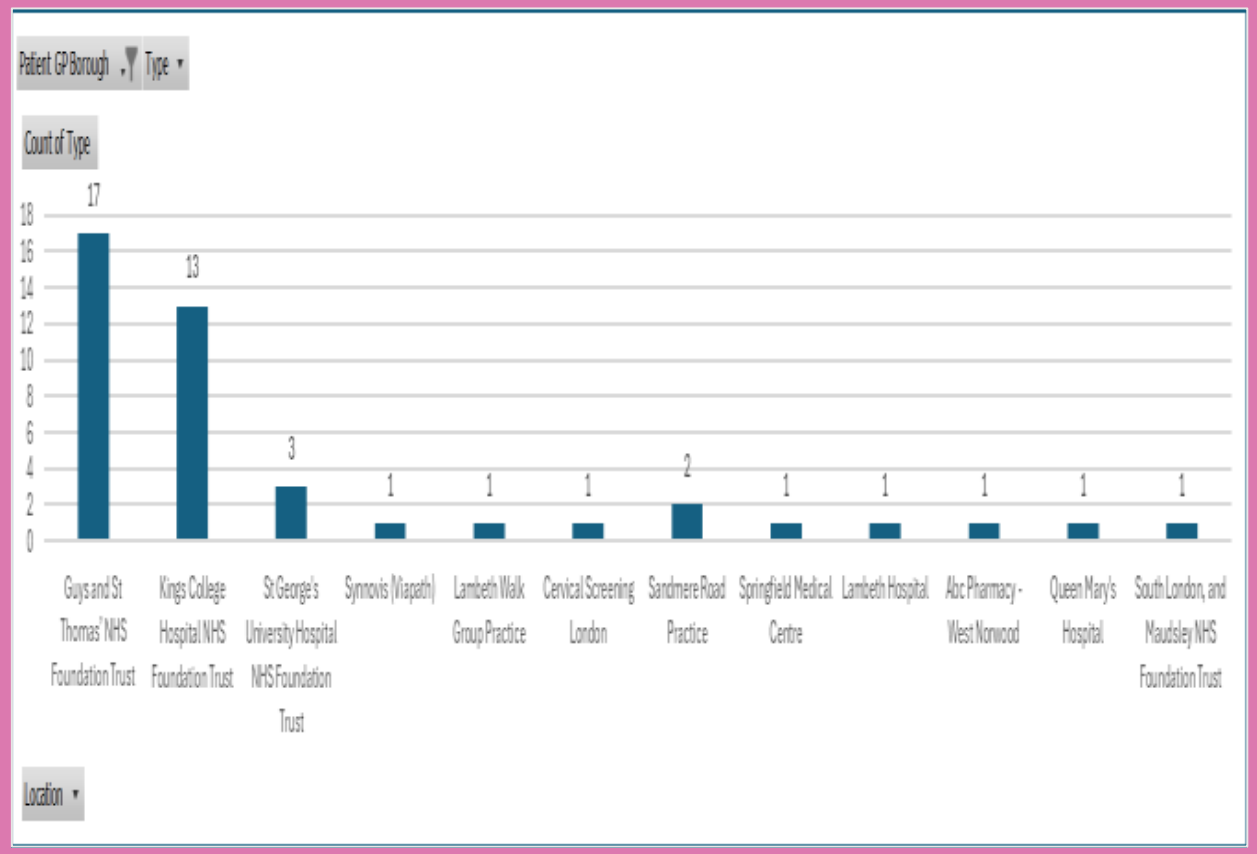
Outpatients
29 outpatient appointments were postponed in the last week (compared to 53 for the week 5-11 August). No community outpatient appointments have been postponed in the last week.

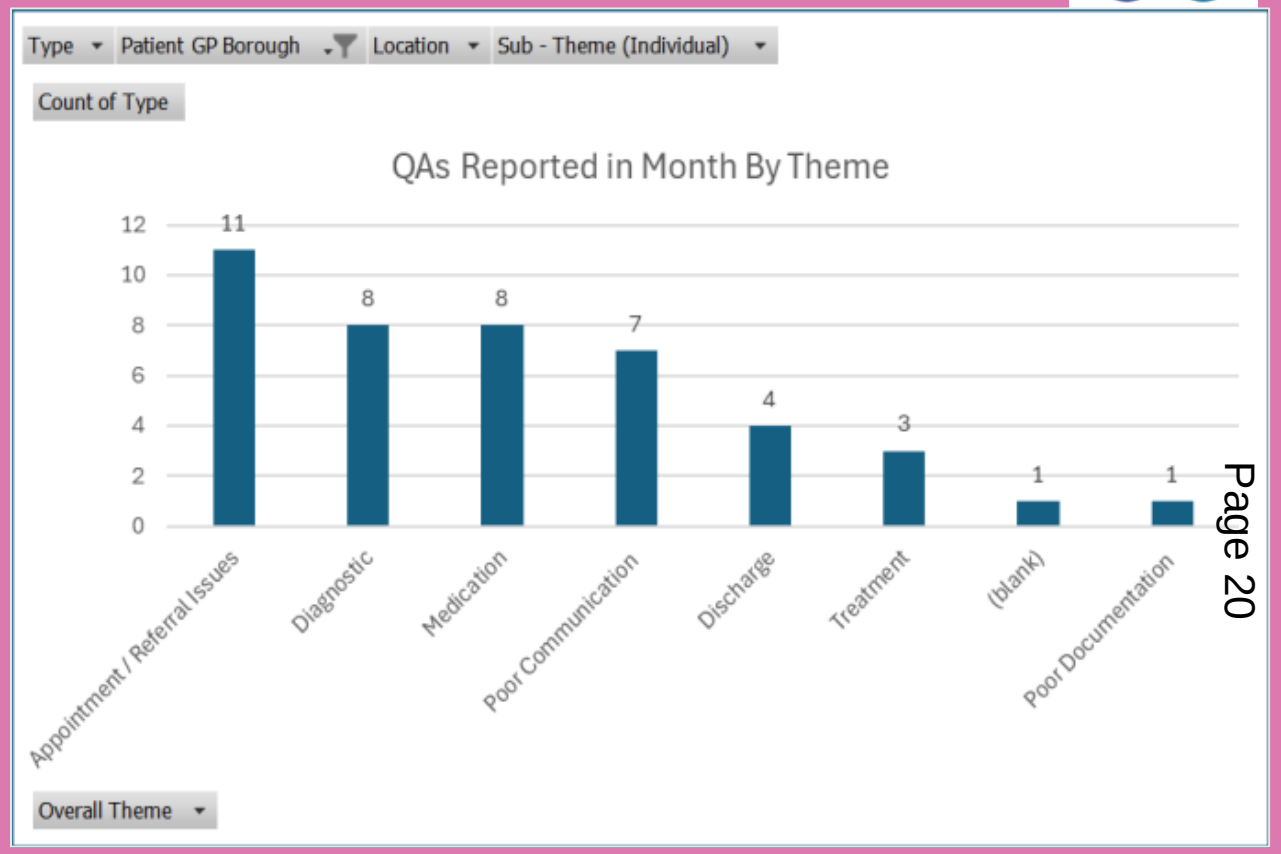
Laboratory blood testing capacity
South east London Synnovis laboratory blood testing capacity this week increased to 100 per cent capacity. Reporting on this figure will now cease in the future weeks.

Wider Impact
Synnovis provides specialist tests for other hospitals in the country. However, the material service impact remains in south east London. Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust remain in a critical incident, while Oxleas NHS Foundation Trust, Lewisham and Greenwich NHS Trust, Bromley Healthcare, and primary care services in south east London continues to be impacted and involved in the incident response

For more information, kindly visit:
https://www.england.nhs.uk/london/2024/08/22/update-on-cyber-incident-clinical-impact-in-south-east-london-thursday-22-august/

Quality Alerts Raised Against Lambeth Providers in July 2024





Actions taken by the ICB

- The Quality Team ensures that each alert raised is shared with relevant parties to resolve the issue.
- Any themes and concerns are included in the bulletin / quarterly reports and shared with stakeholders with a view to learning from the alerts to improve care and service provision.
- Medicines related alerts are tracked, reviewed and discussed with Borough Medicines Teams.

Risk Summary

Risk highlights

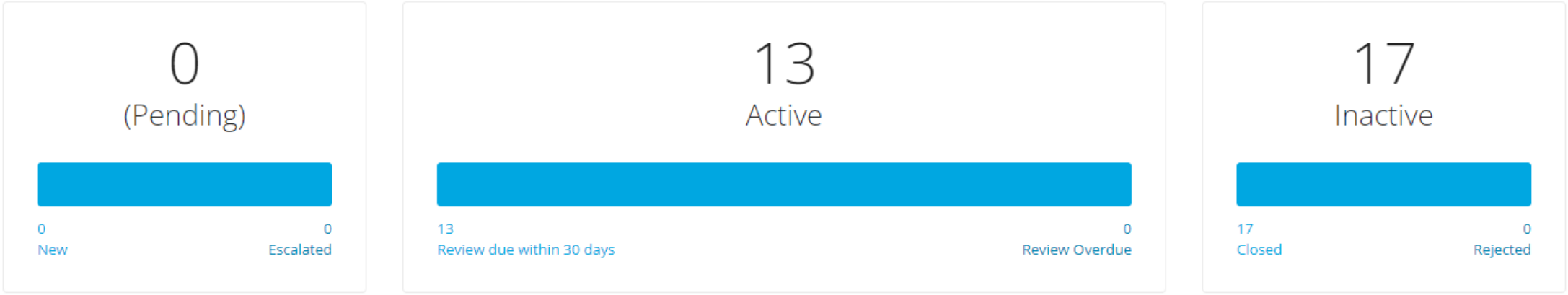
Director / lead	leads for the 7 priority areas, lead commissioners
Management Lead	Andrew Eyres, each of the leads for the 7 priority areas, lead commissioners
Data source / period	SEL BAF, Highlight reports x 7 / Enabler reports.

Lambeth Risk Register

- There are 13 active risks on the Lambeth Together risk register.
- The risks were reviewed in August and no significant changes or variation in risk evaluations were recorded since July's review.
- All Finance risks are subject to additional oversight and review by ICB Finance.
- All LT active risks (13) are currently within ICB threshold, hence no escalations to the ICB so in the current financial year.
- SEL Risk forum meeting is scheduled for September where risk leads will discuss Local Care Partnership risk updates and review SEL priorities against risk framework

Risk highlights

Director / lead	leads for the 7 priority areas, lead commissioners
Management Lead	Andrew Eyres, each of the leads for the 7 priority areas, lead commissioners
Data source / period	SEL BAF, Highlight reports x 7 / Enabler reports.



	Consequence				
Likelihood	Negligible	Minor	Moderate	Major	Catastrophic
Almost Certain	0	0	0	0	0
Likely	0	0	2	0	0
Possible	0	4	5	0	0
Unlikely	0	0	0	1	1
Rare	0	0	0	0	0

Risk highlights

Director / lead	leads for the 7 priority areas, lead commissioners
Management Lead	Andrew Eyres, each of the leads for the 7 priority areas, lead commissioners
Data source / period	SEL BAF, Highlight reports x 7 / Enabler reports.

Risk ID	Risk Title	Risk category	Current Rating	Target Rating	Risk Threshold	Next Review
128	CAMHS waiting times	Strategic	6	4	12	11/09/2024
129	Diagnostic waiting times for children and young people	Strategic	9	4	12	11/09/2024
135	Failure to safeguard adults	Clinical, Quality and Safety	6	6	12	11/09/2024
142	Immunisation Rates protect Children, including vulnerable groups from communicable diseases.	Strategic	12	3	9	11/09/2024
308	Lambeth Together Programme - Capacity for Transformation	Operational	6	4	12	11/09/2024
513	Failure to safeguard children and identify and respond appropriately to abuse.	Clinical, Quality and Safety	10	5	15	11/09/2024
514	PCC and Premises - Business Continuity â€“ Lambeth Walk Medical Centre	Clinical, Quality and Safety	9	9	12	11/09/2024
515	Community Equipment Services Budget and Performance.	Finance	8	4	12	11/09/2024
516	Achievement of Financial Balance 2024/25	Finance	9	6	12	11/09/2024
530	Unbudgeted costs linked to learning disability	Finance	6	6	9	11/09/2024
531	Continuing Health Care Budget and Performance	Finance	9	8	12	11/09/2024
534	Prescribing Budget and Performance	Finance	12	9	12	11/09/2024
542	Delivery of Efficiency Savings	Finance	9	6	12	11/09/2024

Lambeth Integrated Health and Care Directorate Business Plan Update

Integrated Health and Care Business Plan 24/25

Integrated Health and Care Business Plan 24/25	Percentage Complete
Adults Mental Health	
Access: Reduce wait times for initial assessment through monitoring and reviews.	25%
Health Inequalities: Increase performance of SMI health checks.	25%
Adults Transformation	
Cancer - Work collaboratively with primary care to increase the uptake of cancer screening.	25%
Adults with Learning Disabilities	
Focus on LDA Health Inequalities.	25%
NHSE Learning Disability and Autism Programme.	25%
Financial Savings (IHC)	
Financial Savings	25%
Good health & wellbeing with an improved healthy life expectancy for those with the poorest outcomes Adults Commissioning	
Quality and safety: Improve standards and oversight through PAMMS	25%
Good health & wellbeing with an improved healthy life expectancy for those with the poorest outcomes Children and Young People	
Design and deliver a Single Point of Access (SPA) for Children and Young People	50%
Pull together a comprehensive dataset for Lambeth women using maternity services.	50%
Recommission Domiciliary Care and CHC framework.	50%
Support Special Educational Needs and/or Disabilities (SEND) inspection preparation.	75%
Long Term Conditions Optimisation	
Deliver Long Term Conditions Optimisation Prioritites	25%
Medicines Optimisation	
Deliver Medicines Optimisation Priorities	25%
People and Workforce (IHC)	
Increase the diversity of our leadership team.	25%
Primary Care	
Delivery Plan for recovering Access to Primary Care.	25%
Strengthening General Practice by integrating services to deliver joined up care to patients.	25%
Promoting independence, personalisation and best value CQC assessment	
CQC readiness	25%
Public Health Objective	
HDRC - Implement Lambeth HEART programme of training and research development	50%
Health Protection - Continue the delivery of the new childhood vaccination in new spaces pilot	25%
Sexual Health - Refreshed service offer	25%
Staying Healthy - An Age Friendly borough where people can live healthy and active later lives.	25%
Staying Healthy - Implement and embed approaches to improve access to health improvement services.	25%
Substance Misuse - Continued embedding of the Combatting Drugs Partnership.	25%

The Integrated Health and Care (IHC) Business Plan is a process that sits one tier below the Council's Borough Plan.

The latter document details the strategic vision of the Council from 2023-26. The IHC directorate produces a plan that expresses their planned deliverables on mid to long term objectives in support of specific goals of the Borough Plan. These activities are informed by NHS Priorities and Operational Planning agenda at a national and system level, Lambeth Health and Wellbeing Strategy and other guidance documents.

The table provides a summary of Q1 position across the areas of focus within the 24/25 plan. All actions has been listed as Green and none of the actions was escalated for support, trajectories are on target to meet year-end objectives.

Appendix:
Health and Care Plan Outcomes:
Detailed assurance narrative

A. People maintain positive behaviours that keep them healthy

Alliance and Programmes	**Staying Healthy (owner) with contributions from LWNA, LDA, and Sexual Health programmes**
Update Month	**September 2024**

What does the data/intelligence indicate around progress against the outcome?	NHS Health Check outcomes for 2024/25 Q1 was impacted by the Synnovis Cyber-attack that effectively halted the service from the 6th of June as bloods could not be processed. The expectation is that the impact will continue into Q2 as recovery efforts continue. 12.67% of patients who had a Health Checks in Q1 were referred to lifestyle services or prescribed medication including of which 28 were prescribed statins, 21 referred to the National Diabetes Prevention Programme (NDPP) and 24 to weight management. 4.5% were diagnosed with a health condition (hypertension 19 patients, diabetes 6 patients and Chronic Kidney Disease 1 patient) and put onto appropriate registers. 83% were identified with Low 10-year CVD risk, 13% with Moderate risk and 4% with High risk and all given appropriate advice and support.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	The Lambeth population that are eligible for an NHS Health Check is around 90,000 people. Current data shows uptake is largely in line with the demographics of that eligible cohort: • White: Eligible 52% (incl. White British 25% and White Other 21%), Uptake 52% (incl. White British 31% and White Other 21%) • Black: Eligible 20%, Uptake 18% • Asian: Eligible 6%, Uptake 8% • 40-50 age group: Eligible 59%, Uptake 57% • 51-60 age group: Eligible 29%, Uptake 32% • 61+ age group: Eligible 12%, Uptake 11% This demonstrates the opportunity to pick up risk factors at an earlier stage and to start prevention early. • Female: Eligible 43%, Uptake 51% • Male: Eligible 57%, Uptake 49%
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	The aforementioned critical incident meant that only urgent bloods in Lambeth were being processed via the other provider HSL (not Synnovis). As a result, a lot of long-term condition work was on hold, some practices were doing this work but postponing the blood component until routine testing comes back on-line (possibly September). NHS health checks may be seen as less of a priority than long term condition management. Public Health continues to work with GP's on resurrecting the core service as well as working on implementing the NHS Digital Healthcheck and Workplace CVD Healthcheck pilots rolled out by DHSC.

B. People are connected to communities which enable them to maintain good health

Alliance and Programmes	**NWDA (owner) with contributions from CYP and Staying Healthy**
Update Month	**September 2024**

What does the data/intelligence indicate around progress against the outcome?	The percentage of people within the council's Low Income Family Tracker identified as 'coping' financially has increased in the past month to 78.9% (only a month's new data is available since the last reporting period).
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Improving financial resilience is an important social determinant of health.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	The financial wellbeing of residents continues to be challenged due to wider economic factors linked primarily to austerity, inflation and the welfare benefits system not keeping pace with the costs of essentials (e.g. Universal Credit (allowances and two-child policy), the freezing of Local Housing Allowance, Healthy Start Vouchers being insufficient to meet the cost of formula). The council has in place a comprehensive evidence-informed cost of living response plan to mitigate the impact of the crisis for our most vulnerable residents in 2024/25 which has launched since the last reporting period. The response plan includes providing holiday provision for children in receipt of free school meals, funding to voluntary and community sector organisations and targeted support for residents known to be most impacted by poverty in the borough (disabled residents, lone parents, residents with mental ill-health).

C. People are immunised against vaccine preventable diseases

Alliance and Programmes	**Staying Healthy (owner) with contributions from NWDA**
Update Month	**September 2024**

*What does the data/intelligence indicate around **progress against the outcome?***	2024/25 Q1 data is scheduled for publication on 26 September. However, achieving herd immunity in Lambeth continues to be a challenge. London is experiencing a significant rise in measles cases, particularly among children under 17 and more frequently in deprived areas. Lambeth has the highest number of cases, some of which require hospitalisation. Sub-optimal vaccination uptake is a key factor in disease transmission. In response, Lambeth is working with partners to boost awareness and promote the free NHS MMR vaccination. Our strategy includes targeted interventions, improved call and recall systems, and community engagement to enhance vaccination rates and safeguard public health. Key initiatives include partnering with VCFS organisations for community-led projects, the Christmas card and "Celebrate & Protect" projects to enhance GP call and recall processes, the "Vaccination in New Spaces" initiative to improve access and availability, and a peer-to-peer support programme. We are also leveraging key assets like early years settings to raise awareness among parents and caregivers about the crucial importance of vaccinations for their children's health.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	National COVER reporting lacks insights into vaccination inequalities. The UKHSA's health equity audit identified avoidable disparities in the UK vaccination system. A local audit in Lambeth also highlighted inequalities in vaccination coverage and timeliness. Data from ongoing measles outbreaks show that nearly half of those affected are female, mostly children under 17, with a median age of 6 or 7, with a notable concentration in the most deprived areas.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Vaccination challenges stem from complex and interacting factors, including intrapersonal (such as vaccine fatigue and hesitancy, health beliefs and health literacy), community (such as religious, cultural and gender norms), and institutional elements (such as access & registration, culturally specific services, vaccination funding and delivery). Quality assurance of systems and processes would be beneficial; including confirmation that targeted call / recall is underway and that there are adequate vaccination clinics (with minimal or no access issues), with regular updates. A number of initiatives are in place to address vaccine inequalities, ranging from enhancing primary care call-and-recall processes to delivering community-led initiatives.

D. People have healthy mental and emotional wellbeing

Alliance and Programmes	**LWNA and CYPA (owners)**
Update Month	**September 2024**

What does the data/intelligence indicate around progress against the outcome?	The monthly picture for Lambeth Living Well Centres shows the number of service users accessing Short-Term Support (STS) and Focused Support (FS) rising sharply by 52 (+27%) and 24 (+48%) respectively. This is largely due to referrals released from the Lambeth SPA caseload as focused efforts to reduce the backlog of long-waiting cases. Incoming referrals deemed inappropriate by both services remain high and a project is underway to help referrers identify the correct pathway first time. The mean numbers of days between referral for STS and the second attended care contact rose slightly in July. However, this remains 0.6 days below the mean wait time for 2023/24. There are concerns that the use of attended contacts in Lambeth SPA may be impacting the quality of this data, and a project is being initiated to address these concerns.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	The relative figures for Black service user accessing Short-Term and Focused Support services in the Living Well Centres, suggests that they enter the service requiring a more intensive level of support than White service users. In July, Black service user access to STS is almost exactly in line with the Lambeth population (at 22.0%). However, access to the more intensive FS service continues to be more than twice what the borough demographics would suggest. Actual demand from the Black community is not clear, but data shows that access to Focused Support grew quite sharply around January 2023, suggesting increasing demand. Prior to this time around 48% of the caseload were Black service users but this quickly rose to about 53% where it remains to date.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	The data does not provide evidence of any unequal provision, once service users are on the LWC's caseload. Average waiting times for a second appointments with STS in 2024/45 to date are slightly shorter for Black service users than those identifying as White (23.4 and 27.7 days respectively). This might be expected if Black service users, on average, present with more significant problems. The inequality evident in the composition of Short-Term Support and Focused Support caseloads lies more in social conditions and the lack of services to effectively address deteriorating mental health among service users from the Black community at a much earlier stage.

E. People have healthy and fulfilling sexual relationships and good reproductive health

Alliance and Programmes	**Sexual Health**
Update Month	**September 2024**

*What does the data/intelligence indicate around **progress against the outcome?***	There has been no new data for impact measures in this outcome since last report. Public Health Outcomes Framework data shows that STI diagnosis rates are continuing to increase, both nationally and in Lambeth. In Lambeth, rates are now similar to pre-Covid levels. Alongside this testing rates have also increased with a 9% increase from 2022 to 2023.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Local analysis show testing rates remain high in some populations who are disproportionately affected by STIs, such as GBMSM. Approximately 33% of STI tests taken in 2023 were by GBMSM. The proportion of STI tests taken by young men under 25, however, has decreased over time. The proportion of STI tests taken by users from a Black, Asian and multi-ethnic background has remained consistent over time however is lower than the proportion in the general population (32.6% in 2023).
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Implementation of an outreach service delivered by an alliance of clinical and non-clinical providers to increase awareness and promote uptake of prevention and treatment services, specifically targeting young people, Black and multi-ethnic heritage groups and marginalised communities. Development of a comms strategy to increase awareness of services, particularly to under-represented groups.
Additional Comments	

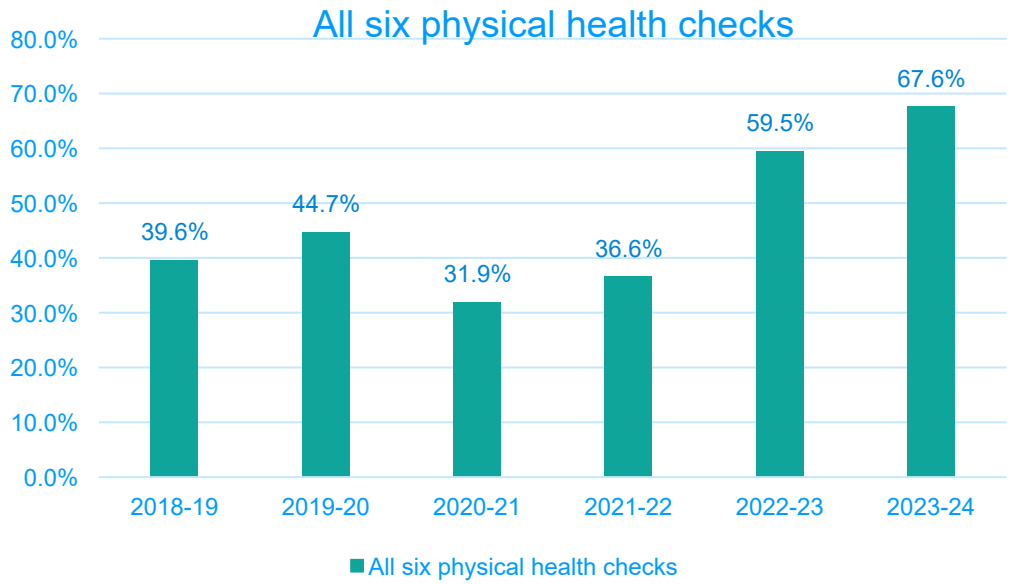
F. People receive early diagnosis and support on physical health conditions

Alliance and Programmes	**NWDA(owner) with contributions from Staying Healthy, LWNA, LDA and Sexual Health**
Update Month	**September 2024**

What does the data/intelligence indicate around progress against the outcome?	1. Bowel Cancer screening aged 60-74-Upward trend. Most recent data shows upward trend with 61.0% screened (December '23) compared to 50.0% in December 2019. Above national target of 60% screened. 2. Cervical Cancer screening aged 25-64-Stable in the past year with most recent data showing rate of 63.0% in March 2024 compared to 62.8% in April 2023 but down from 66.7% in April 2019. National target is 80% 3. Breast cancer screening aged 50-70-Upward trend in the past year. Most recent data shows 54.8% screened in December 2023 which is an increase from 50.9% in December 2022. Not returned to pre-covid levels which were 61% in December 2019. Below national target of 80%. Source for all of above is the SEL screening dashboar
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	1. Bowel Cancer screening aged 60-74-Data shows lower screening rates for those with learning disability and severe mental illness. Lowest screening rates in those from 1st deprivation quintile, lower screening rates for those of black, mixed, Asian and "other" ethnicity compared to white population. Comparing most recent data with 2 years ago shows increased screening rates for black, mixed, Asian and "other" ethnicities and also increased screening rates for those with LD and SMI 2. Cervical Cancer screening aged 25-64-Current data shows highest screening in those with black ethnicity (70.8%), then white (68.9%) and then significantly lower for mixed (63.2%), Asian (56.9%) and other (52.3%). Significantly lower for those with LD (49.5%) compared to non-LD (65.6%). Rates have not improved in past 2 years. 3. Breast cancer screening aged 50-70-1st deprivation quintile have lowest rates. White (57.0%) and black (56.7%) ethnicity have similar rates, lower in Asian (53.2%), mixed (50.1%) and "other" (47.1%) ethnicities, Significantly lower in LD (40.1%) compared to non-LD (55.0) and SMI (41.7%) compared to non-SMI (55.3%). Compared to 2 years ago SMI rate has improved but LD has declined.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Numerous challenges. Important to raise public awareness. There are ongoing campaigns locally and nationally to raise awareness. In particular those aimed at groups with lower screening rates (eg. SELCA MMC campaign). The NWDA is funding multiple PCN cancer awareness events in the next year to raise awareness. Also put forward multiple proposals to SELCA for funding to specifically target under represented groups (Latin American community and Somali community). There have been issues with access to breast screening and local capacity. The breast screening service are working to improve this including offering appointments outside of normal working hours and also facilitating those who require extra time due to disabilities. Further increasing access could help to increase screening rates. Also access to appointments for cervical screening can be a challenge. This can be improved by offering screening outside of normal practice hours at local extended access hubs or offering different appointment booking systems to increase ease of access.

F. People receive early diagnosis and support on physical health conditions

OUTCOME F (85): Primary care to implement a quality improvement plan with the Living Well Network Alliance to ensure delivery of SMI health checks in line with national targets and local quality metrics



- Commissioners are working with colleagues in SLaM's Health Check Liaison Team which engages with people not engaging with physical and mental health support and treatment, including AHCs.
- Collaborative development of a local information sharing template from SLaM teams (HCLT, Clozapine Service etc) to general practice have led to improvements in data held on EMIS
- Plans to collaborate with LWNA to support the physical health of people from ethnic minorities

F. People receive early diagnosis and support on physical health conditions

OUTCOME F (86): Undertake targeted promotion of SMI health checks to patients and carers particularly from black and minority ethnic communities

- An audit is underway to be completed in September. The audit will identify people who have not had an annual health check since 2021.
- Early findings suggest that people from ethnic minorities, and black people in particular, feature highly in the cohort. The audit findings will inform engagement with stakeholders and a subsequent plan to address inequalities identified.
- Stakeholders include individuals, families, carers, SLaM/LWNA, Mosaic Clubhouse, primary care, voluntary/charity organisations

F. People receive early diagnosis and support on physical health conditions

OUTCOME F (87): Work with health and care partners to ensure access to and delivery of LDA health checks in line national targets and quality metrics

	18/19	19/20	20/21	21/22	22/23	23/24
Number on LD register (aged 14+)	1346	1469	1402	1465	1510	1648
Number of checks completed	1008	1042	953	1169	1308	1370
Percentage completed	74.9%	70.9%	68.0%	79.8%	86.6%	83.1%

- An engagement and communications plan is in place ensuring stakeholders receive appropriate information in the most appropriate way and have opportunity to provide feedback and participate in developing
- Plans are to use existing fora, media and connections that are familiar and trusted
- Stakeholders include individuals, families, carers, SLaM/LWNA, primary care, voluntary/charity organisations, special schools and SENCOs, day and residential facilities

F. People receive early diagnosis and support on physical health conditions

OUTCOME F (88): Personalised care: improve % of people with LDA an agreed Health Action Plan (HAP) following identified

- Lambeth data measures the number of health checks and accompanying HAPs completed as a single metric.
- 83% of the LDA register had an annual health check and a HAP in 2023/24
- Lambeth has met or surpassed the 75% target for 4 out of the past 6 years (comparison with other boroughs)
- Focus now to explore the quality of health checks and action plans with a view to rolling out a programme of peer reviews with GPs and practice nurses

F. People receive early diagnosis and support on physical health conditions

OUTCOME F (89): Promotion of AHC amongst target population especially those from black and minority ethnic groups e.g. Big Health Week

- An audit is underway to be completed in September. The audit will identify people who have not had an annual health check since 2021.
- Early findings suggest that people from ethnic minorities, and black people in particular, feature highly in the cohort. The audit findings will inform engagement with stakeholders and a subsequent plan to address inequalities identified.
- Stakeholders include individuals, families, carers, SLaM/LWNA, primary care, voluntary/charity organisations, special schools and SENCOs, day and residential facilities

OUTCOME F (93): Improvements in SMI and LDA AHCs to include discussions and encouragement to take up cancer screenings

National Cancer Screenings: LDA

	2021-22			2022-23			2023-24			
	LD	Autism	Both	LD	Autism	Both	LD	Autism	Both	SEL population
Bowel 60% target	43.1%	48.3%	**45.7%**	48.4%	54.8%	**51.6%**	48.3%	46.8%	**47.6%**	59.26%
Breast 80% target	43.4%	38.9%	**41.2%**	40.7%	56.0%	**48.4%**	41.9%	60.7%	**51.3%**	50.01%
Cervical 80% target	51.4%	64.7%	**58.1%**	48.5%	60.9%	**54.7%**	49.4%	63.9%	**56.7%**	65.38%

National Cancer Screenings: SMI

	2021-22	2022-23	2023-24
Bowel 60% target	42.2%	41.8%	45.2%
Breast 80% target	40.7%	51.6%	36.0%
Cervical 80% target	72.4%	71.3%	72.5%

- Area for future focus and development
- Bowel and breast are national programmes managed by NHSE
- Cervical screenings are performed in general practice

G. People who have developed long term health conditions have help to manage their condition and prevent complications

Alliance and Programmes	**NWDA (Owner)**
Update Month	**September 2024**

What does the data/intelligence indicate around progress against the outcome?	Blood pressure control measures for both age groups are cumulative measures starting from April 2024. Improvement of blood pressure control has continued whilst hypertension detection and diagnosis has increased. Improvements have been made year on year as well as in September. Continued work over the year is required to improve to the Health and Care Plan outcome of 77% blood pressure control (140mmHg/90mmHg) in people aged 79 years and under by FY2024-25. Lambeth joined the national "May Measurement Month" campaign and the Inspire event in July promoting identification of high blood pressure and highlighting the Community Pharmacy Blood Pressure Check Service in support of more blood pressure checking in the community . Blood pressure checks were offered to members of the public by colleagues from the Lambeth Medicines Optimisation team, community pharmacists, acute and the Lambeth Health and Wellbeing bus team. We are joining the Know Your Numbers Week campaign Sept 2nd to 8th utilising the Health and Wellbeing Bus at Brixton Civic Centre to raise the importance of blood pressure checking for staff and the public. The Lambeth ambition for the proportion of people with Type 2 diabetes, who meet all 8 Care Process metrics, is to reach a minimum of 77% or improve from baseline (National Diabetes Audit 22-23 percentage) by 10 percentage points. The measuring period aligns to the National Diabetes Audit 15 month measuring period January 2024 to March 2025 and is cumulative over this period. Improvements are being made as the year progresses. Providers of the NHS Diabetes Prevention Programme joined Lambeth Country Show and Inspire event in July to promote prevention of diabetes and promote healthy lifestyle information. Problematic polypharmacy (prescribing of 10 or more concurrent medicines) increases the risk of drug interactions and adverse drug reactions (ADR), impairing medication adherence and impacting on a patient's quality of life, this risk increases with the number of prescribed medicines a patient is on and when specific therapeutic combinations are concurrently prescribed. In conjunction with the patient, SMRs provide a holistic medication review to ensure prescribed medicines are safe, effective and personalised to patients' current needs. SMRs improve outcomes, reduce unnecessary or inappropriate prescribing and polypharmacy, reduce harm and improve patient outcomes. The number of coded Structured Medication Reviews (SMR) in Lambeth for patients who are 65 years or over and prescribed 10 or more medicines is being tracked to indicate progress. There is an increasing trend of people over the age of 65 who are taking 10 or more medicines received a structured medication review in the first quarter of 2024-25. At 15th August 2024, a total of 425 of the 3284 (12.94%) patients have had a SMR since 1st April 2024.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	More black and minority ethnic people have blood pressure control when comparing August 2023 to 2024 data; 38.7% (23,289) and 40.7% (24,241) respectively. NWDA Hypertension Oversight group has been developed to support co-ordination of activities to improve hypertension identification and management in Lambeth, with a focus on reducing health inequalities. Current data from the EZA Cardiovascular app shows that hypertension control in the Black African, Black Caribbean, Mixed White and Asian, Unknown or not stated ethnic groups is improving, with comparable rates of target blood pressures being reached across all ethnicities. In addition, year on year performance across target ethnicities and all ethnicities has increased. The Diabetes app within EZ Analytics has been further updated for 24-25 to provide more detailed data on improvements of the measurement and recording of the care processes for Black African, Black Caribbean, Mixed White and Asian, Unknown or not stated ethnic groups. Overprescribing can lead to increased harm from unnecessary or inappropriate prescribing. By ensuring medicines are being used appropriately, we can reduce adverse effects, hospitalisation and improve outcomes, which may impact on those with greater health inequalities. The data shows a continual increase in SMRs conducted since inclusion in the 2023/24 Medicines Optimisation Section (of the Lambeth GP Improvement Scheme), and we continue to work with colleagues across SEL on reducing inappropriate prescribing and polypharmacy as further evidence emerges.

G. People who have developed long term health conditions have help to manage their condition and prevent complications

Alliance and Programmes	**NWDA (Owner)**
Update Month	**September 2024**

*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Challenges include General Practice capacity, access, recovery following software incidents across SEL patient awareness and engagement. General Practice is being supported to focus on improvements in these outcomes through the Lambeth General Practice Improvement Scheme – LTC section and Premium Specification KPIs focusing on completion of the 8 Care Processes and Enhanced Prevention. Access to the EZ Analytics apps will help practices to prioritise patient cohorts for review. Utilisation of engagement opportunity for example Know Your Numbers Week. Introduction of AnalyseRx over the coming months, a software solution integrated with EMIS Web will support General Practice to proactively identify and easily action Medicines and LTC optimisation opportunities across our patient population Improving awareness and utilisation of the Blood Pressure at Community Pharmacy service will improve access for patients and release capacity in General Practice to focus on complex LTC management.

H. When emotional and mental health issues are identified; the right help and support is offered early and in a timely way

Alliance and Programmes	**LWNA and CYPA (owners)**
Update Month	**September 2024**

What does the data/intelligence indicate around progress against the outcome?	In 2023/24 Lambeth Single Point of Access (SPA) saw a huge increase in caseload and, hence, waiting times have also grown significantly. Since peaking in May, the SPA caseload has been more than halved but the proportion of referrals on the list having long waiting times remains high. Consequently, the proportion of referrals completed remained low in July at 13%; far from the 95% target. This measure will only significantly improve when the backlog of long waiting cases is cleared, which if the current trend continues, will be around the end of 2024. Equalities data for 2024/25 Q1 shows the first appointment measure for Black service user access to the Lambeth Taking Therapy Service (LTT) services as being 3.6 percentage points higher than would be suggested by Lambeth population alone, which is better than that for the White population. Recovery for Black service users however, at 43.1%, continues to fall well short of the 50% recovery rate target, the whole service average and the 55.2% reported for White service users. Reliable improvement and recovery metrics show a similar pattern.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	The is some variation by ethnicity in achievement against the 3-day waiting target for Lambeth SPA, but the target is met for Black service users more frequently than for White service users, suggesting more severe issues for that community being addressed with greater urgency. Access data for Lambeth Talking Therapy does not suggest any inequalities, with the specific exception of the Black African community, who are underrepresented by 1.0 percentage points compared to the Lambeth population. Recovery rates however suggest that the service is more closely aligned with the needs of White service users than with those from the global majority, who tend to start treatment with higher severity scores. Tracking this measure over multiple financial years suggests this inequality has been reduced during 2023/24 and progress continues to be made in 2024/45 first quarter when session attendance has been largely equalised across groups.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Recent changes to Lambeth SPA organisation and processes, together with additional support, have begun to successfully reduce the Lambeth SPA caseload. The excessive caseload will keep waiting times high until such time as the backlog of some very long waiting introductions is addressed. However, rapid progress is now being made and with additional focus on selecting the most appropriate pathway first time, it is realistic to think that achievement will be far closer to target by the end of 2024. Lambeth Talking Therapies focus in 2024/25 will be on improving overall recovery rates, maintaining the increase in session numbers for clients from a global majority and ensure that clients from all ethnic groups have 50% recovery rate and 67% reliable improvement rate.

I. People have access to joined-up and holistic health and care delivered in their neighbourhoods

Alliance and Programmes	**NWDA (Owner) with contributions from LWNA and CYPA**
Update Month	**September 2024**

*What does the data/intelligence indicate around **progress against the outcome?***	HWBus: That there is demand in community settings to access Mental Health and Welfare advice. There is consistent uptake across the two services. Beacon: That the project is reaching high numbers of people each month.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	HWBus: The service is reaching a higher number of our black residents compared to the Census and as such reaching group of people who experience high levels of health inequalities. Beacon: same as above
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	HWBus: Main challenge is the data isn't recorded through EMIS and hard for clinicians to make onward referrals. We are working on a new provider to solve this problem and should soon be able to track opportunistic visitors of the bus health service into GP practice. Beacon: Not able to refer directly into primary care. Are refining their service delivery model and growing relationships with local community pharmacy to refer people from beacon hubs into primary care.
Additional Comments	

J. People know where to go to get the right help, and are treated at the right time, in the right place, for their needs (2/2)

Alliance and Programmes	**NWDA (Owner) with contribution from Substance Misuse**
Update Month	**September 2024**

What does the data/intelligence indicate around progress against the outcome?	General Practice continue to exceed the national threshold of 85% for patients being seen within 2 weeks. General Practice will continue to secure investment through the Primary Care Recovery plan to deliver additional appointments and improve care navigation. Through the strengthening General Practice programme, powered by data syrup and APEX, Lambeth will assess opportunities to improve continuity of care alongside additional access.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Ethnicity/ demographic data is still not available through nationally mandated tools – it remains unclear is the national GP Appointment Data (GPAD) will develop these modules over time to test assumptions. In the interim other local tools continue to be explored to ascertain capability and adaptability, we can use in the absence of a national databank.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Patient expectation and satisfaction, nationally, regionally and locally continues to be challenging. During 2023/24 General Practice will have provided more patient contacts then at any time since the NHS formed with 19% more patient contact than pre-covid. Productivity remains exceptionally high and arguably more resilient compared to other parts of the Health and care system, however we acknowledge patient access remains both a national and local priority and one that concerns our local residents. Leveraging investment through the Access Recovery programme – practices will deploy better telephony, improve signposting/ care navigation and explore alternative consultation methodologies to enhance the patient journey and reduce the 8am rush. Practices can access limited funding to support internal change management to help practices get the most out of digital opportunities, and equally important, post deployment, work with patients and staff to improve the experiences of those using these services.

J. People know where to go to get the right help, and are treated at the right time, in the right place, for their needs

Alliance and Programmes	**NWDA (Owner) with contribution from Substance Misuse**
Update Month	**September 2024**

What does the data/intelligence indicate around progress against the outcome?	The Lambeth Pharmacy First Plus Service addresses and supports the health inequalities in Lambeth in relation to the impact of the cost-of-living crisis on the ability of the local population to self-care and buy medicines available over the counter for minor and self-limiting conditions in line with NHS England guidance. Community Pharmacy have undertaken 2036 consultations between March 2023 and July 2024 with Lambeth residents/registered patients to provide advice and guidance on self-care and supply of medicines where appropriate. The NHS Pharmacy First Service (previously known as GP-Community Pharmacy Consultation Service) increases GP capacity through triaging of low-acuity conditions to community pharmacy. GP referrals to NHS Pharmacy First supports the national approach to increasing GP access. Data from service launch in January 2024 to May 2024 shows a positive increase in use. The National Pharmacy First service and local Pharmacy First Plus Service increases access to general practice, through provision of self-care advice and any necessary treatments directly via pharmacies for people at higher risk of health inequalities or higher deprivation.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Data from May 2024 shows most interventions (1419) have taken place for people whose registered post code district falls within IMD decile 1 to 3 which shows the service is accessed by the target population - those with the highest deprivation. Data to date, demonstrates that if people did not have access to the Lambeth Pharmacy First Plus Service, 71.3% of patients would have visited general practice to request the medication on prescription and 26.4% would have gone without medication , as they are unable to buy the medicines over the counter to deal with minor conditions due to the current cost of living crisis. People who are receiving support through universal credit, income support, the NHS Low Income Scheme or are under the age of 16 years old, are the top social vulnerability eligibility groups accessing Lambeth Pharmacy First Plus Service in May 2024. General Practice feedback has been that the service has a had a positive impact for patients and reduced GP appointments for minor conditions. Demographic Data of service users during June to July is under review and will be shared in the next LTAG report.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Initial usage of the NHS Pharmacy First Service was slow due to IT issues and training needs. Increased promotion of both the Lambeth Pharmacy First Plus service and the NHS Pharmacy First through local bulletins, practice visits and webinars has helped to increase understanding and usage of the Services. The Medicines Optimisation Team has collaborated with the Local Authority Cost of Living Programme Lead to discuss continual and increased promotion of the Lambeth Pharmacy First Plus service to residents. Community Pharmacy Neighbourhood Leads (CPNLs) have been engaging with general practice and their peers to provide clinical leadership and support the national access priority, which has supported increases in referrals.
Additional Comments	There has been a national rebranding of the GP-Community Pharmacy Consultation Service and other clinical services provided through community pharmacy to 'Pharmacy First'. This now includes 7 clinical conditions which can be assessed and treated through pharmacies, including provision of antibiotics and other treatments, hypertension checking service, contraceptive service and urgent medicines service. This is not to be confused with the local Pharmacy First Plus service, which addresses inequalities in access to medicines over the counter for a range of common conditions. The local service has been rebranded to Lambeth Pharmacy First Plus.

J. People know where to go to get the right help, and are treated at the right time, in the right place, for their needs

J4. Improve access to healthcare professionals through increased use of community pharmacies - GPs and NHS 111 direct people to pharmacies to support people with minor ailments, advice around self-care and common clinical conditions Number of people accessing healthcare professionals through increased use of community pharmacies

Lambeth Pharmacy First Plus Service Total number of patient interventions	
Mar-23	125
Apr-23	97
May-23	148
Jun-23	257
Jul-23	155
Aug-23	111
Sep-23	124
Oct-23	115
Nov-23	84
Dec-23	105
Jan-24	110
Feb-24	132
Mar-24	125
Apr-24	66
May-24	87
June-24	112
Jul-24	83
Total – 2036	

	31 January 2024	29 February 2024	31 March 2024	30 April 2024	31 May 2024*	TOTAL
Total Pharmacy First consultations (includes referrals to the 7 Clinical Pathways, Minor Illness and Urgent Medicine Supply service)	**39**	**1308**	**1576**	**1585**	**1543**	**6079**

*** Most recent data supplied by NHS England at time of writing report**

Top 3 social vulnerability eligibility criteria for accessing Lambeth Pharmacy First Service (May 24):
(June to July data under analysis at time of writing report)

1. Universal credit (44.8%)
2. Patients aged under 16 years (23%)
3. Income support (16.1%)

K. Older adults are provided with the right health and care support at the right time, live healthy and active later lives and are supported to age well

Alliance and Programmes	**NWDA (Owner)**
Update Month	**September 2024**

What does the data/intelligence indicate around progress against the outcome?	The number of accepted referrals to Reablement has continued to decrease during Q1 of this financial year.. The Reablement service have been triaging people on their waiting list by telephoning people at home. The result is that a large number of people are reporting they no longer require therapy and they have been removed from the waiting list, or they do not require therapy at this time. This has led to a significant decrease in the waiting list and the number of accepted referrals. There is also work happening in the Discharge Operational Delivery Group (DODG) working with therapists on the acute wards about the criteria for referring to reablement. This will help to reduce the number of people being referred to the service who are not appropriate. The number of people who have a reduced need for care at the end of a period of Reablement remains high and this is positive. The percentage for people with a reduced need for care at the end of Reablement during quarter 1 is now 87%. We are now counting those people referred for therapy only (no care needs). This has increased the number of people who have a reduced need for care at the end of the service and has improved our performance. We have a high performance rate for the proportion of carers of service users who were offered a carer's assessment. The baseline is 98% and the latest overall position is 100%. We have also identified a member of staff in each team to be Carer's Champions and this will help to raise awareness of carers in the teams. We have a staff event on 25 July 2024 focusing on Carers and carers have been invited to the event to speak about their lived experience as a carer. For Outcome K3 and K4 (palliative and end of life care improvement measures), the Lambeth Q1 24/25 data demonstrates a further increase of 1% on Q4 23/24 measures for people identified as being in their last year of life on practice registers (K3) and Proportion of people with Personalised Care and Support Plan(PCSP)/UCP (K4). Since Q1 22/23, these measures have increased by 40% and 157% respectively, but the rate of increase has slowed since Q1 23/24.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	The majority of reablement referrals come via the hospital discharge route. We are increasing the number of people who are offered a reablement service via our front door team in Adult Social Care in order to offer reablement to people living in the community at home. This will help to offer a more equitable service for those residents living at home who may benefit from reablement care. There is a named linked physiotherapist from GSTT Rehab and Reablement Team working closely with the ASC front door managers to help identify appropriate referrals to reablement.

K. Older adults are provided with the right health and care support at the right time, live healthy and active later lives and are supported to age well

Alliance and Programmes	**NWDA (Owner)**
Update Month	**September 2024**

*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	The Discharge Operational Delivery Group (DODG) has a dedicated workstream looking at the reablement pathway from the ward to the internal flow hub and then on to the service to try and improve the process and ensure referrals to the service are appropriate. This work has been with GSTT only to date although we are hoping to begin this work with KCH. There has been an increase in weekend discharges as a result of this work. Since the introduction of Epic/Apollo we are yet to receive discharge data broken down by borough and pathway from the acute hospitals. This work is in progress. For end-of-life identification and conversion to PSCP / UCP (K3 and K4) key challenges include varying levels of capacity and professional confidence within Primary Care to initiate PCSP conversations, as well as variable data across PCNs owing in part to different coding practice occurring in different practices within PCNs. SEL Ageing Well Funding secured for project resource to help address these barriers in 2024/25, by working with primary care to support identification of people in the last year of their life and uptake of Universal Care Plans.

M. People with learning disabilities and/or autism achieve equal life chances, live as independently as possible and have the right support from health and care services

Alliance and Programmes	**LDA (Owner)**
Update Month	**September 2024**

*What does the data/intelligence indicate around **progress against the outcome?***	In 2023/24 the uptake of AHCs and health Action Plans exceed the target to reach 83.1%. Steady progress towards the same objective is seen as at July 2024, and we note that a larger proportion are completed towards the end of the financial year. Waiting times on ARD assessment at June 24 was 64 weeks, and provisional data for Aug 24 stands at 60 weeks wait (n-960). Due to the implementation of a new Patient Electronic System (EPIC) we have been unable to report on this measure. Effort have been made to reenact this report stream and we will work with secondary partners
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Ethnicity data on difference level or AHC update, doesn't indicate a major difference between ethnicity groups, however as we know from many studies that people from Black, South Asian and minority ethnic backgrounds face poorer outcomes from health and care and shorter life expectancies, and we suspect this data set does not describe the full picture. An equalities informed communications plan co-produced with community groups is planned, expected Q3 2024/25.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Accurate equalities data on uptake of AHCs and Health Actions Plans, and the impact on tackling health inequalities is a challenge. Multi-year uptake data and clinically led audits are planned with results due Q2 2024/25

N. People using mental health support services can recover and stay well, with the right support, and can participate on an equal footing in daily life

Alliance and Programmes	**LWNA (Owner)**
Update Month	**September 24**

What does the data/intelligence indicate around progress against the outcome?	The most recently available suggests progress towards this outcome. In July LWNA's Community Living and Support Service worked with 114 service users with serious mental health conditions to live in the community. This compares with 103 in the previous month. The Community Living and Support Service (CLaSS) accepted fewer new clients in July (27) than in June (23) but its average weekly caseload fell (from 85 to 72). Data for LWNA's Individual Placement and Support (IPS) is delayed and will be reported as soon as it becomes available. Positive friends and family survey responses for LWNA were up to 82.5% in July, from 77.4% in June.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Not all data relating to the current measures readily support equalities analysis. IPS performance reports and friends and family survey, for example do not currently reference ethnicity, but the ethnic composition of the CLaSS caseload highlights the unequal distribution of serious mental illness between ethnicities in the borough. The proportion of CLaSS service users from the Black community rose to 52% in July, from 48%, such movements in a relatively small data set may not be significant. However, comparing this figure to the 21.7% of Lambeth population which is Black and aged18-64, indicates the extent of the issue. Historically, there has been concern about the disproportion use of restrictive practices, rapid tranquilisation and seclusion with inpatients from the Black community. At present, access to this data is still being affected by a technical issue with the data feed between the relevant source and reporting systems. Once this is rectified these measures will be monitored closely here.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	The caseloads of CLaSS, Focused Support and inpatient services all include a similarly large and disproportionate number of Black service users. This is in contrast with the numbers found in the caseloads of services more tailored to the needs of those with less severe problems, which generally match more closely the proportions that would be expected given the ethnic composition of the Lambeth population. This suggests that the primary challenge is to engage with Black service users earlier in the development of their mental health problems with culturally appropriate services, that will reduce the severity of their difficulties in the future. This is obviously well known, but it bears repeating and consideration in the planning and design of every service.

O. People who are homeless, or at risk of becoming homeless, (including rough sleepers and refugees) have improved health

Alliance and Programmes	**Homeless Health (Owner) with contributions from LWNA and Substance Misuse**
Update Month	**September 2024**

What does the data/intelligence indicate around ***progress against the outcome?***	2023-24 saw a significant increase in rough sleeping across London. Analysis of the borough level data shows that Lambeth saw the highest ever number of rough sleepers recorded. The rough sleeping outreach team recorded contacts with 866 rough sleepers, compared with 623 in 2022-23 and 438 in 2021-22. Just under half of the 866 in 2023-24 were people who had never been recorded as sleeping rough before. Much of this has been attributed to the cost of living crisis and soaring accommodation costs in the capital, particularly in the private rented sector. **Demographics** Age Ranges – 60% of rough sleepers were aged between 26-45, 21% 46-55, 12% 55+ and 7% 18-25 Gender – 85% male, 14% female, 1% unknown, similar to average across London Ethnicity - 53% White, 25% Black/Black British, 6% Asian/Asian British, 4% Mixed Nationalities – 52% UK, 27% Europe, 10% Africa, Rest Americas and Asia To note, there has been a large decline in Romany/Gypsy rough sleeping numbers across London since 2021 with no case being recorded in Lambeth last year. Despite the challenges brought about by higher numbers of new rough sleepers the population classed as LOS (living on the street) has remained fairly constant throughout this year at 30-40. Lambeth has see considerable success in assisting our T1000 cohort (the most entrenched rough sleepers across London). Of our cohort of 15 only 1 is currently rough sleeping. Utilising the new Lambeth Housing First scheme, spot purchasing supported housing bed spaces for some individuals without entitlement to public funding and exploring reciprocal options with other borough have contributed to tis success
Does the data/intelligence identify any ***health inequalities and whether they are reducing?***	Throughout the year there has been considerable focus on quarterly monitoring of health KPI's resulting in 92% of supported housing clients being registered with a GP The % of people engaging with mental health services has doubled since the start of the year with teams such as START, Psychology in Hostels and the Integrated Health Network increasing inreach into supported housing
What are the ***challenges hindering any progress*** *and* ***are there actions which can be taken*** *to address these?*	Challenges remain in sourcing affordable and quality housing for move on from Supported Housing. Working with clients to accept accommodation in Outer London or beyond partly mitigates against this but it is an accepted problem for all London boroughs with much competition for properties across the whole Housing Needs sector including Temporary Accommodation.

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