LAMBETH TOGETHER CARE PARTNERSHIP (FORMERLY LAMBETH TOGETHER STRATEGIC BOARD)

Date: Thursday 6 March 2025
Time: 1.00 pm
Venue: Brixton Tate Library, SW2 1JQ

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Members of the Committee

Dr Dianne Aitken, Lambeth Together Care Partnership Board Co-Chair. Neighbourhood and Wellbeing Delivery Alliance Clinical and Care Professional Lead, GP
Dr Nozomi Akanuma, Living Well Network Alliance Clinical and Care Professional Lead, South London and Maudsley NHS Foundation Trust
Andrew Carter, Corporate Director of Children's Services, Lambeth Council
Councillor Judith Cavanagh, Young People`s Champion, Lambeth Council
Paul Coles, Chief Executive, Age UK, Lambeth
Eugenie Dadie, Patient and Public Voice Member
Louise Dark, Chief Executive Integrated and Specialist Medicine, Guy's and St Thomas (GSTT) NHS Foundation Trust
Councillor Jacqui Dyer, Lambeth Together Care Partnership Board Co-Chair / Cabinet Member for Healthier Communities (job-share), Lambeth Council
Andrew Eyres, Place Executive Lead Lambeth, South East London Integrated Care Board and Corporate Director, Integrated Health, and Care, Lambeth Council
Sarah Flanagan, Patient and Public Voice Member
Therese Fletcher, Managing Director, GP Federations
Penelope Jarrett, Chair, Lambeth Local Medical Committee, GP
Lilian Latinwo-Olajide, Programme Director, Black Thrive, Lambeth
Jasmina Lijesevic, Lambeth Together Care Partnership Board Lay Member
Julie Lowe, Site Chief Executive, Kings College Hospital NHS Foundation Trust
Raj Mitra, Children and Young People's Alliance Clinical and Care Professional Lead, GP
Bimpe Oki, Acting Director of Public Health, Lambeth Council
Richard Outram, Director of Adult Social Care, Lambeth Council
Folake Segun, Chief Executive, Healthwatch Lambeth
George Verghese, Co-Chair of the Lambeth Primary Care Clinical Cabinet, GP
Councillor Timothy Windle, Cabinet Member for Healthier Communities (Job-Share), Lambeth Council

Further Information

If you require any further information or have any queries please contact: Email: lambethbusinesssupport@selondonics.nhs.uk

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AGENDA

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Lambeth Together

Integrated Assurance Report

21 January 2025

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Our Health, Our Lambeth

Lambeth Together health and care plan 2023-28

Lambeth Together Health and Care Plan Scorecard – January 2025

ID	Outcome	Measures tracked	Jan-25 Measures Reported with a target			Vs previous update	Nov-24 % measures on track (where have a target)4	Comments
A	*People maintain positive behaviours that keep them healthy*	6	2	1	50%	–	50%	
B	*People are connected to communities which enable them to maintain good health*	4	2	2	100%	–	100%	
C	*People are immunised against vaccine preventable diseases*	2	2	0	0%	–	0%	Flu, Y1 and Y2 Child Imms uptake tracking below SEL plan/previous years trajectory
D	*People have healthy mental and emotional wellbeing*	4	3	2	67%	–	67%	Average waiting time for LWNA Short term support as at Sep24 is 1.7 weeks above plan
E	*People have healthy and fulfilling sexual relationships and good reproductive health*	2	2	2	100%	↑	-	progress against plan. STI testing and diagnoses rate is monitored via quarterly GumCAD reports.
F	*People receive early diagnosis and support on physical health conditions*	5	5	3	60%	–	60%	One Cancer screening programme tracking above national target. SMI & LD Annual Health checks on a trajectory to meet year-end targets
G	*People who have developed long term health conditions have help to manage their condition and prevent complications*	4	3	3	100%	–	100%	
H	*When emotional and mental health issues are identified; the right help and support is offered early and in a timely way*	4	3	2	67%	–	67%	CAHMS report frequency impacted by EPIC transition
I	*People have access to joined-up and holistic health and care delivered in their neighbourhoods*	2	2	2	100%	–	100%	
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*	3	3	2	67%	–	67%	
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*	5	5	4	80%	–	80%	
L	*Women have positive experiences of maternal healthcare and do not experience a disproportionate maternal mortality rate*	0	0	0	-		-	Reporting functions impacted by EPIC transition, deep dive presentation in Sept 24 provided snapshot report on LMNS BI activity.
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*	3	1	1	100%	–	100%	Activity on LD education and employment support will be provided in March 25 deep dive, earlier report shared at LTEG in Oct.
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*	5	3	1	33%	–	33%	
O	*People who are homeless, or at risk of becoming homeless, (including rough sleepers and refugees) have improved health*	5	0	0	-	–	-	
	Total	54	36	25	69%	↑	64%	

Health and Care Plan: Key headlines (1)

	Outcome	Key Headlines
A	***People maintain positive behaviours that keep them healthy***	NHS Health checks outcomes for Q2 24-25 was significantly impacted by the Synovis lab Cyber-attack that effectively halted the service from the 6th of June to around September 24 as bloods could not be processed. The expectation is that the impact will continue for the rest of the financial year albeit to a lesser extent as recovery efforts continue. 10.5% of patients had a Health Check in Q1 were referred to lifestyle services or prescribed medication. On health checks uptake delivery, we can note current data shows uptake is largely in line with the demographics of that eligible cohort.
B	***People are connected to communities which enable them to maintain good health***	We can note that whilst the percentage of residents financially coping have reduced, the percentage of residents in crisis, at risk or struggling has not increased and, instead, the percentage of residents who were coping and have now left the dataset have increased. This is likely to indicate that residents' financial situations have improved to the point where they are no longer in receipt of means-tested benefits.
C	***People are immunised against vaccine preventable diseases***	Achieving herd immunity and meeting the locally set target of 90% remains a challenge in Lambeth. The most recent data published for Quarter 2 of 2024/25 shows that the uptake of the DTaP/IPV/Hib vaccine, offered to babies at 8, 12, and 16 weeks of age, stands at 84.7%. Additionally, uptake for the first dose of the MMR vaccine is at 79.5%. Other boroughs in South-East London have also reported uptake rates below 90%.
D	***People have healthy mental and emotional wellbeing***	The number of service users accessing Short-Term Support (STS) through the Lambeth Living Well Centres fell by 8 (-7%) from November. Numbers accepted into Focused Support (FS) rose by 20 (+69%), returning to typical levels after a low point the previous month. Lambeth Single Point of Access (SPA) is now consistently making fewer referrals to STS after reducing the backlog of long-waiting. The number of incoming referrals deemed inappropriate by both services is also reduced.

Health and Care Plan: Key headlines (2)

	Outcome	Key Headlines
E	***People have healthy and fulfilling sexual relationships and good reproductive health***	The Q2 2024 activity GP LARC data shows a good increase in activity within GP practices with 1,765 units of activity compared to 337 in the same quarter last year, although not all PCNs wish to provide this activity, most of the alternative activity is being referred into the current LARC Hub. Commissioners will work on transitioning the current model now that the procurement process has been completed. The new EZ Analytics report on GP LARC activity data by demographics has been delayed. We hope it should be available for next quarter to allow us to report activity via demographics such as ethnicity and age and monitor if there is any decrease or increase in inequalities across PCNs. A new Termination of Pregnancy (TOPs) dashboard has been developed by the PH Health Intelligence team allowing us to view TOPs by age and ethnicity. The data show a higher rate of abortions in Black and Multi-ethnic residents compared to White ethnicities. Going forward we will be able to monitor trends and work with services to improve ethnicity recording.
F	***People receive early diagnosis and support on physical health conditions***	On Annual Health Checks there's been a good progress from Q2 and on a par with achievement at the same time last year. On track to achieve the SMI target (60%) and the LD target (75%) as a minimum and anticipate reaching 23/24 achievement of 68% for SMI and 83% for LD. On Pre-Exposure Prophylaxis (PrEP) activity, we can note that at the end of November 2024, 703 residents had newly started on PrEP and 3,511 residents were continuing to use PrEP, the activity trend remains level over time. The majority of activity takes place at the central London clinic provided by Chelsea and Westminster NHS Trust, with the second largest proportion of activity provided by GSTT. On cancer screening programmes intelligence on inequalities, see further detail on slide narrative.
G	***People who have developed long term health conditions have help to manage their condition and prevent complications***	Deep dive - See additional information enclosed with LTAG pack against this outcome. 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
H	***When emotional and mental health issues are identified; the right help and support is offered early and in a timely way***	Since peaking in May-24 at just over 900, the SPA caseload has been cut by 70%. Wait times have also been reduced significantly, although they remain far higher than target. The proportion of referrals completed within 3 days rose from 16.6% at the end of the second quarter (Jul-Sep) to 24.9% at the end of the third (Oct-Dec). This measure will only improve significantly when the team is responding to introductions as they arrive, without a significant backlog awaiting admin screening or triage. Lambeth Talking Therapies (LTT) equalities data for 2024/25 for Q2 and Q3 are not yet available. Data for 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.

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***	The activity from Health & Wellbeing bus rose in Q3, we noted a slight decrease with 121 sessions. This may be attributed to festive period as previous data confirms a dip around December. Beacon service activity also saw a decrease in Q3, however, there were additional pop-up activity that happened over the period.
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***	On GP appointments we continue to meet SELs commitment to increase GP access by 1.5% for the duration of 2024/25 and data suggest we remain on target to do so. On Community Pharmacy, data from November 2024 shows most interventions (1898) 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, 66% of patients would have visited general practice to request the medication on prescription, 33% would have gone without medication and 1% would have visited A&E or an Urgent Care Centre. 33% 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. On virtual Wards, one of the main barriers that has been identified is awareness of what the service is and what it can provide. 'Step up' access is via referral in the community from health and social care professionals including General Practitioners and the London Ambulance service to prevent avoidable admissions. 'Step down' referrals are received from KCH and GSTT Emergency Departments, Same Day Emergency Care, Urgent Treatment Centres and direct from ward admissions to enable earlier supported discharges.
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***	On challenges we note the following, • 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. There has been some work to increase the number of weekend discharges at GSTT. This has decreased slightly in the last month and we are reviewing the process. • 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.
L	***Women have positive experiences of maternal healthcare and do not experience a disproportionate maternal mortality rate***	The adoption of a new Electronic Patient Record system at Guy's & St Thomas' and King's College Hospitals continues to disrupt performance reporting for maternity services across South East London. While work to stabilise the system is ongoing, regular reporting has yet to resume.

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***	The implementation of a new Electronic Patient Record system at Guy's & St Thomas' Hospital has disrupted performance reporting for the Autism and Related Disorders Diagnostic Service. No update has been provided by the Evelina Communities Team for system partners at this stage. However, local monitoring of performance, governance, and safety continues to ensure that services remain safe and operational. In 2023/24 the Learning Disabilities uptake of Annual Health Checks and health Action Plans exceed the target to reach 83.1%. Steady progress towards the same objective is seen as at 1 January 2025 of 54.68%, and we note that a larger proportion are completed towards the end of the financial year.
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***	In the third quarter, Q3 October to December, LWNA's Community Living and Support Service accepted 48 new service users with serious mental health conditions to support them to leave inpatient care and live in the community. This compares with 85 in the previous quarter. Data for LWNA's Individual Placement and Support (IPS) shows that in Q2 16 service users were supported to find paid employment compared to 12 in Q1, however both remain well below the original target of 36 per quarter. Restrictive incidents and seclusions have remained at 29 per month throughout Q3 Oct-Dec (+21%) from a mean average of 33 per month in Q2 Jul-Sep. which is 9% below the median value since April 2023.
O	***People who are homeless, or at risk of becoming homeless, (including rough sleepers and refugees) have improved health***	The number of residents now registered with GP's is at its highest. This has been achieved through contract monitoring and consistent messaging to Providers to ensure each resident is being supported to register when being accommodated in their service. There is a slight increase in those engaged in mental health services and again this is through a combination of ensuring referrals to appropriate services are being made and ensuring providers are capturing this in monitoring reports. Both ensure we are improving health for homeless/former homeless people. The number of rough sleepers accommodated increased due to Severe Weather Emergency Protocol (SWEP) activation and emergency accommodation being available, CRISIS at Christmas being opened and more clients accessing No Second Night Out (pan London service) Lambeth operate an "In For Good" principle when SWEP is activated (other boroughs do not) so when SWEP is deactivated clients are not asked to leave accommodation until they have an appropriate offer of move on. This increases the likelihood of people addressing health issues and being referred to appropriate services.

Finance

Finance: South East London ICB: Lambeth

Overall Finance Position (2024/25 M08)

	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	801	792	9	1,202	1,188	14
Community Health Services	18,797	18,821	(24)	28,195	28,282	(87)
Mental Health Services	15,396	15,781	(384)	23,094	23,560	(466)
Continuing Care Services	23,077	22,872	206	34,616	34,205	411
Prescribing	28,722	28,689	33	42,666	42,666	0
Other Primary Care Services	2,657	2,599	59	3,986	3,898	88
Delegated Primary Care Services	52,694	52,694	0	87,088	87,088	0
Corporate Budgets	2,516	2,228	288	4,012	3,709	303
Total	**144,661**	**144,474**	**187**	**224,859**	**224,596**	**264**

Overall Savings Position (2024/25 M08)

	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	1,561	1,561	0	2,341	2,341	0
Continuing Care Services	961	1,775	814	1,442	1,775	333
Prescribing	789	1,484	695	1,393	1,864	471
Total	**3,311**	**4,820**	**1,509**	**5,176**	**5,980**	**804**

- The borough is reporting an overall £187k year to date underspend position and a forecast £264k underspend position at Month 08 (November 2024). The reported year to date position includes £384k overspend on Mental Health Services and £24k overspend on Community Health Services mainly driven by increased cost of the Cardiovascular Diagnostics contract, offset by underspends in Corporate, Continuing Health Care (CHC) and other Budgets.
- The current underlying key risks within Lambeth's finance position relate to - costs for Cardiovascular Diagnostics Services, Interpreting Services, Mental Health (including learning disabilities) budgets and further risk against the Integrated Community Equipment Service Contract (Health and Social Care). Prescribing, Mental Health and CHC have savings schemes.
- Mental Health budget year to date overspend is driven by increased ADHD, Section 12 assessments claims, Mental Health and Learning Disabilities (LD) placement expenditure, and mitigated by constraining investments. Borough Commissioners leading on savings and efficiencies schemes (including Provider focused service and model reviews, High-cost joint health funded case reviews, etc. to manage cost.
- 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. Work is ongoing to establish better value costs. The number of active CHC and FNC clients at M08 is 589.
- Prescribing information data is provided two months in arrears by the NHS Business Services Authority (previously PPA - Prescription Pricing Authority). The borough is reporting a year to date underspend position of £33k and forecast breakeven at month 08 (November 2024) based on six months 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. This is being linked with the wider SEL work being undertaken.
- 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 M08 (November 2024) is £1.5m above plan due to plan profile which differs from actual delivery profile. The forecast delivery is £0.8m above plan.

Finance: Lambeth Council – ASC & Integrated Health M6 2024/5 position

- **ASC** – latest forecast is showing an overspend of £7.455m, predominantly driven by overspend against client expenditure budgets.
- **Key pressures:**
  - Adults with Learning Difficulties & Adults with Physical Disabilities
    - Supported Accommodation placement costs are most significant pressure area
  - Older People
    - Nursing Care & Home Care – increased year-on-year activity in nursing care, particularly in 85+ age group, and inflation in fee rates for spot placements
  - Adults with Mental Health Needs
    - Supported Living, residential care and nursing care
- **In year cost and demand management review:**
  - Increased reviews and panels, reviewing cost of new packages of support and high-cost packages
  - Targeted reviews and right-sizing care approach to ensure support is appropriate
- **Integrated Health & Care budget:**
  - Breakeven position – partially funded by use of reserves to fund additional capacity in Integrated Commissioning teams and to move to new established structure with Public Health commissioning

Division	Budget £'000	Forecast £'000	Variance £'000
Adults with Learning Difficulties	42,210	46,994	4,784
Adults with Physical Disabilities	14,899	18,070	3,171
Adults with Mental Health Needs	11,025	12,635	1,610
Supported Housing	776	668	(108)
Older People	29,253	33,507	4,244
Other – Adults	10,829	4,573	(6,246)
Supporting People	4,853	4,853	0
Adult Social Care Directorate	**113,845**	**121,300**	**7,455**

Division	Budget £'000	Forecast £'000	Variance £'000
Integrated Commissioning	**133**	**133**	**0**
Senior Management	**1,587**	**1,587**	**0**
Public Health	**0**	**0**	**0**
Integrated Health & Care Directorate	**1,665**	**1,665**	**0**

Quality

See document enclosed with LTAG pack

(Reference Enclosed E)

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

- As of December, there were 14 active risks on the South East London Risk register for Lambeth.
- Since the last update, the following risk was opened:
  - Primary Care GP Collective Action (Current score – 9)
- SEL Risk forum took place in November and risk leads met to discuss risks across SEL, receive updates from risk leads and review Local Care Partnership comparative report, no significant changes noted at this time.
- Risk 513 - *Inadequate resource in safeguarding structure*, was adjusted recently. The following details were updated following discussion of the risk at the Executive Committee on 8 January 2025. The risk title was updated, as well as controls to reflect most up to date situation. Risk score reduced to 8 as the consequence is now less impactful with the recruitment nearly finalised and excellent mitigation in place w/ On-call Paediatrician filling the space.

Risk highlights

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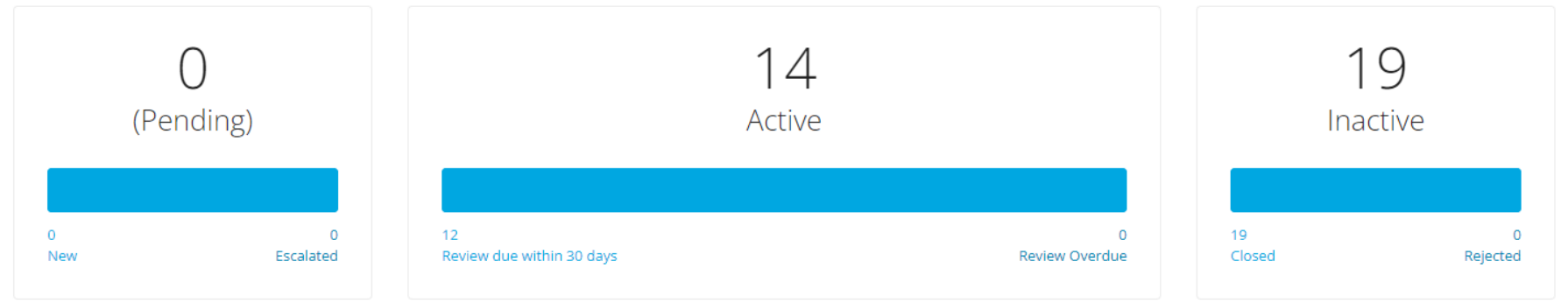

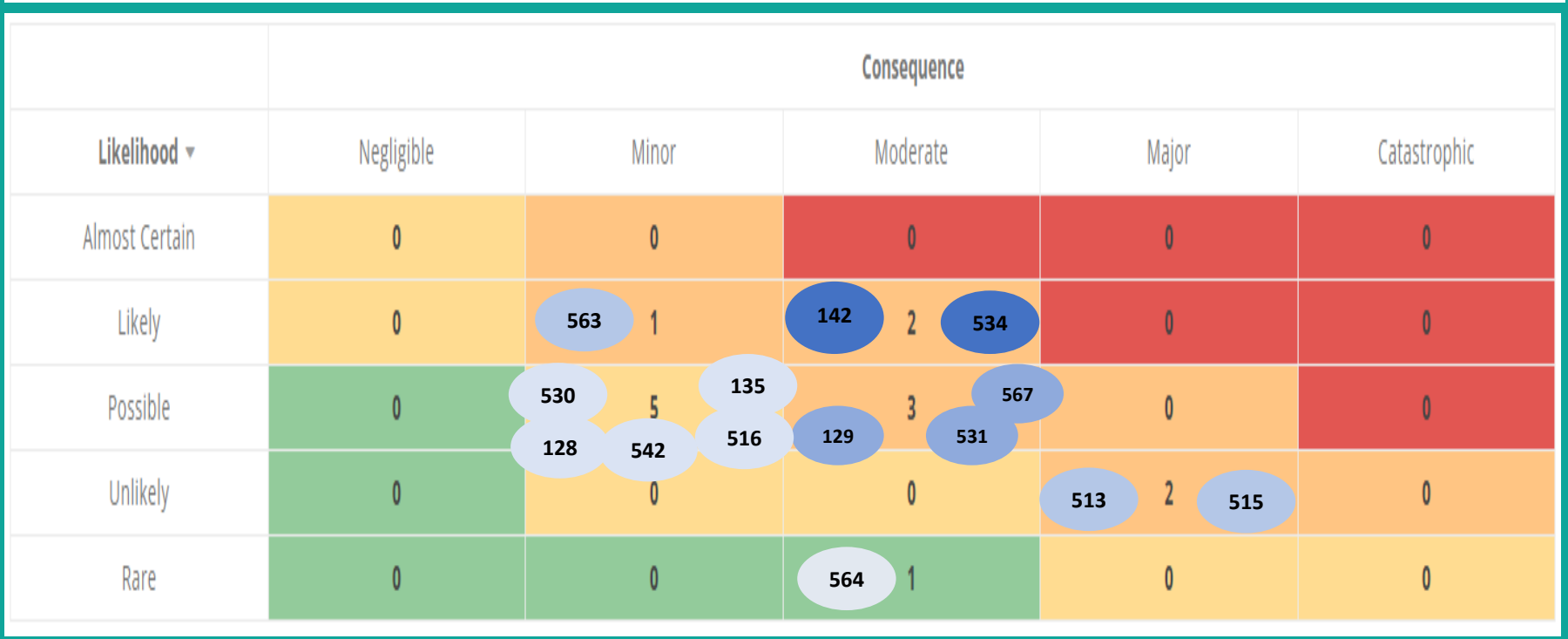

Lighter low risk score, darker higher risk score

ID	Type
128	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities
129	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities
135	Clinical, Quality and Safety
142	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities
513	Clinical, Quality and Safety
515	Finance
516	Finance
530	Finance
531	Finance
534	Finance
542	Finance
563	Finance
564	Operational: relating to the effective day to day running of the ICB organisation
567	Operational: relating to the effective day to day running of the ICB organisation

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.

ID	Title	Current Risk Grading
142	Immunisation Rates protect Children, including vulnerable groups from communicable diseases.	12
534	Prescribing Budget and Performance	12
129	Diagnostic waiting times for children and young people	9
531	Continuing Health Care Budget and Performance	9
567	Primary Care GP Collective Action	9
513	Inadequate resource in safeguarding structure	8
515	Community Equipment Services Budget and Performance.	8
563	Interpreting Services Overspend	8
128	CAMHS waiting times	6
135	Failure to safeguard adults	6
516	Achievement of Financial Balance 2024/25	6
530	Unbudgeted costs linked to learning disability	6
542	Delivery of Efficiency Savings	6
564	Interpreting Services Procurement	3

Lambeth Integrated Health and Care Directorate Business Plan Update

Integrated Health and Care Business Plan 24/25

Row Labels	Sum of Percentage Complete
Adults Mental Health	
Access: Reduce wait times for initial assessment through monitoring and reviews.	50%
Health Inequalities: Increase performance of SMI health checks.	50%
Adults Transformation	
Cancer - Work collaboratively with primary care to increase the uptake of cancer screening.	50%
Adults with Learning Disabilities	
Focus on LDA Health Inequalities.	50%
NHSE Learning Disability and Autism Programme.	50%
Financial Savings (IHC)	
Financial Savings	50%
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	50%
Long Term Conditions Optimisation	
Deliver Long Term Conditions Optimisation Prioritites	50%
Medicines Optimisation	
Deliver Medicines Optimisation Priorities	50%
People and Workforce (IHC)	
Increase the diversity of our leadership team.	50%
Primary Care	
Delivery Plan for recovering Access to Primary Care.	50%
Strengthening General Practice by integrating services to deliver joined up care to patients.	50%
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	50%
Sexual Health - Refreshed service offer	50%
Staying Healthy - An Age Friendly borough where people can live healthy and active later lives.	50%
Staying Healthy - Implement and embed approaches to improve access to health improvement services.	50%
Substance Misuse - Continued embedding of the Combatting Drugs Partnership.	50%

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 Q2 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.

At the time of writing this report we are finalising Q3 submission, this information will be available in March's report.

As we approach 25/26 (Year 3) of Borough Plan, we will be engaging with service leads over next weeks, to review plans for 25/26. Council colleagues have shared Corporate Performance Refresh - KPIs and Directorate Business Plans schedule and we will keep the group updated once plans are finalised and ratified.

South East London ICB Corporate Objectives & delegated assurance metrics

South East London ICB Corporate Objectives & delegated assurance metrics

Standard	Period covered in report	Comparator	Benchmark	Current performance	SEL Average	Above/below SEL average?	SEL Borough rank
Dementia diagnosis rate	Nov-24	National standard	67%	76%	70.3%	Above	1
IAPT discharge	Oct-24	Operating plan	585	595	N/A	N/A	-
IAPT reliable improvement	Oct-24	Operating plan	67%	65%	68%	Below	6
IAPT reliable recovery	Oct-24	National standard	48%	48%	48%	Above	2
SMI Healthchecks	Q2	Local trajectory	66%	50%	47.4%	Above	2
LD and Autism - Annual health checks	Nov-24	Local trajectory	689	892	N/A	N/A	-
Bowel Cancer Coverage (60-74)	May-24	Corporate Objective	62%	62%	67.0%	Below	6
Cervical Cancer Coverage (25-64 combined)	Jun-24	Corporate Objective	63%	63%	66.9%	Below	6
Breast Cancer Coverage (50-70)	May-24	Corporate Objective	57%	56%	61.7%	Below	6
Percentage of patients with hypertension treated to NICE guidance	Dec-24	Corporate Objective	70%	65%	64.0%	Above	3
Flu vaccination rate over 65s	Nov-24	Corporate Objective	55.00%	49.50%	58.2%	Below	5
Flu vaccination rate under 65s at risk	Nov-24	Corporate Objective	29.30%	25.60%	28.8%	Below	5
Appointments seen within two weeks	Nov-24	Operating plan	91%	92%	89.0%	Above	2

The SEL ICB assurance team produce a report to be used by Boroughs as part of their local assurance processes. The report

- shows the position against key areas of local performance vs national targets, agreed trajectories and other comparators.
- covers a range of metrics where Local Care Partnerships either have a direct delegated responsibility for delivery, play a key role in wider SEL systems or are an agreed SEL corporate objective.

Appendix:
Health and Care Plan Outcomes: Detailed assurance narrative

Impact measures performance trend (1)

Outcome	Impact measure	Target/Pla	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Year to Date	Comments
A		Actual										12.6%	12.6%		12.5%		Data source - SEL Vital 5 dashboard - Of those with a smoking status, 30,451 (12.48%) are recorded as smoking in the past 5 years.
		Plan				13.4%	13.3%	13.2%	13.2%	13.1%	13.0%	12.9%	12.8%	12.7%	12.7%		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 SEL ICB Vital 5 dashboard
	Smoking prevalence reduction	Variance										-0.3%	-0.3%		-0.2%		
	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%			5.9%			6.5%					Latest update is for October 2023 to September 2024
	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%			27.0%			30.4%					Latest update is for October 2023 to September 2024
	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%			39.9%			40.9%					Latest update is for October 2023 to September 2024
	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%			35.2%			38.8%					Latest update is for October 2023 to September 2024
		Actual	6.3%	6.9%	7.7%	8.4%	0.2%	0.5%	0.6%	0.6%	1.0%	1.3%	2.0%	2.5%	3.2%		
		Plan	6.6%	7.3%	7.9%	8.7%	0.7%	1.8%	2.6%	3.3%	4.1%	4.7%	5.2%	5.8%	6.3%		Plan = same period in 23/21
	Uptake of the NHS Health Check for all eligible adults	Variance	-0.35%	-0.35%	-0.21%	-0.24%	-0.45%	-1.30%	-2.03%	-2.64%	-3.09%	-3.44%	-3.24%	-3.37%	-3.07%		
B		Actual	79.6%			78.2%			78.9%			74.8%			74.7%		
		23/24							77.9%			78.8%			79.6%		Plan = same period in 23/25
	Percentage of low-income residents coping financially	Variance							1.0%			-4.00%			-4.90%		
D	**Number of Entering treatment with Short-Term Support with Living Well Centres.**	Actual					165	171	132	193	238	180	159	122	114		
		Variance						6	-39	61	45	-58	-21	-37	-8		Against previous month's position
	Number of Entering treatment with Focused Support with Living Well Centres.	Actual					54	54	32	47	44	50	46	29	49		
		Variance						-	-22	15	-3	6	-4	-17	20		
		Actual					24.1	25.1	25.4	25.2	28.4	27.6	25.9	22.8	24.5		Average time from receivedby STS to second contact NB not yet from received by SPA)
		Plan					26.0	26.0	26.0	26.0	26.0	26.0	26.0	26.0	26.0		Target = 26 days (local ambition)
	Provisionally agreed - LWNA Short Term Waiting Time	Variance						0.9	0.5	0.8	-2.4	-1.7	0.1	3.2	1.5		

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Impact measures performance trend (2)

Outcome	Impact measure	Target/Pla	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Year to Date	Comments
F	Uptake of SMI health checks	Actual	46%	54%	60%	68%	3%	9%	10%	13%	18%	24%	32%	38%	43%		
		Plan	45%	50%	55%	60%	5.0%	10.0%	15.0%	20.0%	25%	30%	35%	40%	45%		National Target = 60% at year end
		Variance	1.2%	4.1%	5.2%	8.0%	-2.0%	-1.5%	-5.4%	-7.1%	-6.6%	-5.7%	-3.2%	-2.0%	-1.6%		
	Uptake of LD/AHC health checks	Actual	56.7%	68.5%	77.5%	84.6%	5.7%	10.3%	16.4%	20.2%	31.0%	38.6%	46.8%	52%	59%		
		Plan	56.3%	62.5%	68.8%	75.0%	6.3%	12.6%	18.9%	25.2%	31.5%	37.8%	44.1%	50.4%	56.7%		National Target = 75% at year end
		Variance	0.4%	6.0%	8.7%	9.6%	-0.6%	-2.2%	-2.5%	-5.0%	-0.4%	0.9%	2.7%	1.9%	2.7%		
	Proportion of Bowel Cancer screening for those aged 60-74 (Coverage)	Actual	61.0%														
		Plan	60.0%	60.2%	60.4%	60.6%											Plan = same period in 22/23
		Variance	1.0%														
	Proportion of cervical Cancer Screening aged 25-64 (Coverage)	Actual	62.8%	62.7%	62.8%	62.9%	63.0%										
		Plan	62.7%	62.6%	62.8%	63.0%	62.8%										Plan = same period in 22/23
		Variance	0.1%	0.1%	0.0%	-0.1%	0.2%										
	Proportion of breast cancer screening for women aged 47-73 (Coverage)	Actual	46%														
		Plan	42%	42%	42%	43%											Plan = same period in 22/23
		Variance	3.2%														
	Percentage of eligible people receiving an HIV test whilst attending Emergency Departments	Actual															
		Plan															
		Variance															
G	Proportion of people with Type 2 diabetes who receive 8 checks on an annual basis	Actual	70.0%	74.1%	79.2%	81.7%	15.1%	22.7%	24.1%	27.8%	36%	43%	51%	57%	62%		
		Plan	57.8%	64.2%	70.6%	77.0%	6.4%	12.8%	19.3%	25.7%	32.1%	38.5%	44.9%	51.3%	57.8%		Local target = 77% by year end (set to straight line trajectory)
		Variance	12.3%	9.9%	8.6%	4.7%	8.7%	9.9%	4.8%	2.1%	3.4%	4.3%	5.6%	5.8%	4.0%		
	Cardiovascular dashboard, HYP aged 79 or under and last BP is less than or equal to 140/90 this FY	Actual	58.8%	62.3%	66.4%	68.7%	10.6%	22.1%	31.1%	38%	43.7%	48.1%	52.5%	56.4%	60%		
		Plan	57.8%	64.2%	70.6%	77.0%	6.4%	12.8%	19.3%	25.7%	32.1%	38.5%	44.9%	51.3%	57.8%		National target = 77% by year end (set to straight line trajectory)
		Variance	1.1%	-1.8%	-4.2%	-8.3%	4.2%	9.3%	11.9%	12.4%	11.6%	9.6%	7.6%	5.1%	1.8%		
	Cardiovascular dashboard, HYP aged 80 or over and last BP is less than or equal to 150/90 this FY	Actual	72.4%	76.0%	79.1%	81.7%	16.1%	29.4%	40%	48%	54.3%	59.2%	64.7%	69.2%	72%		
		Plan	57.8%	64.2%	70.6%	77.0%	6.4%	12.8%	19.3%	25.7%	32.1%	38.5%	44.9%	51.3%	57.8%		National target = 77% by year end (set to straight line trajectory)
		Variance	14.6%	11.8%	8.5%	4.7%	9.7%	16.5%	20.6%	21.9%	22.2%	20.7%	19.7%	17.8%	14.4%		
	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%	14.9%	19.9%	20.9%	28.9%	31.2%		
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					18.3%	13.4%	19.8%	7.6%	12.4%	16.6%	25.30%	23.40%	24.90%		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	24.4%			25.3%			25.3%								% of black users by Ethnicity
		Plan	21.7%			21.7%			21.7%								% of Black users by Ethnicity as per 2021 Census population rate
		Variance	2.7%			3.6%			3.6%								
	Recovery rates for Lambeth Talking Therapies for Black African and Caribbean residents to ensure they are as least as good as those of White residents	Actual	46.7%			43.1%			43.1%								
		Plan	48.0%			48.0%			48.0%								
		Variance	-1.3%			-4.9%			-4.9%								
	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							36	40	42						Latest information extracted from Sept 24 SLAM CAMHS report

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Impact measures performance trend (3)

Outcome	Impact measure	Target/Pla	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Year to Date	Comments
I	Health and Wellbeing Bus - No of interactions - Welfare Advice and Mental Health session	Actual							102			129			106		
		Plan															
		Variance										27			- 23		Against previous quarter's position
	CVD Workplace service - Health Checks	Actual							767			190				957	Intelligence from the previous CVD project showed that in 60 days of service, the team delivered 767 Health checks. The new CVD Workplace pilot (Health Checks at Work)starting in Oct 24 will have 3 types of health checks delivered (Type: 1. Light touch 2. CVD assessment 3. Full NHS health check) wiht the aim of achieving 4,200 health checks in the last two quarters of 24/25.
	Beacons service - No of interactions - Health & Wellbeing sessions and Hi 5	Hi 5 sessions							556			535			343	1,434	
		Health & Wellbeing sessions							141			182			118	441	
		Variance							-			20			- 256		Against previous quarter's position
J	Number of appointments in General Practice	Actual	133,406	171,212	166,166	159,787	166,166	165,670	149,688	170,573	159,787	163,524	194,806	171,242		1,341,456	
		Plan					137,079	158,464	168,495	158,711	163,515	158,057	155,258	165,319	133,406	1,264,898	1.5% increase vs 23/24 monthly profiled against 23/24
		Variance					29,087	7,206	- 18,807	11,862	- 3,728	5,467	39,548	5,923		76,558	
		%					21%	5%	-11%	7%	-2%	3%	25%	4%		6%	
	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	>300	>400	>800	>900	1,626	1,709	1,589	1,704	1,667	1,816	1,565			11,676	April to October data shbows the total Pharmacy First consultations (includes referrals to the Clinical Pathways, Minor Illness and Urgent Medicine Supply service)
	Capacity of virtual wards	Actual	147	158	165	224	209	177	166	198	180	185	173	236	210		
		Plan	201	201	231	231	231	233	233	234	235	237	237	241	241		
		Variance	- 54	- 43	- 66	- 7	- 22	- 56	- 67	- 36	- 55	- 52	- 64	- 5	- 31		
	Proportion of virtual wards being used	Actual	73%	72%	71%	97%	90%	76%	71%	85%	77%	92%	73%	98%	87%		
		Plan	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%		
		Variance	-7.0%	-8.0%	-9.0%	17.0%	10.0%	-4.0%	-9.0%	5.0%	-3.0%	12.0%	-7.0%	18.0%	7.0%		
K	Number of people with an intermediate care offer	Actual	46	47	68	35	44	41	38	37	46	34	59	54			
		Plan	65	63	56	58	53	62	60	62	41	52	62	61			
		Variance	- 19	- 16	12	- 23	- 9	- 21	- 22	- 25	5	- 18	- 3	- 7			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	83%	85%	81%	79%	86%	89%	84%	92%	90%	90%	88%	89%			
		Plan	71%	73%	68%	78%	75%	79%	92%	78%	91%	84%	76%	80%			Plan = same period previous year
		Variance	12%	12%	13%	1%	11%	10%	-8%	14%	-1%	6%	12%	9%			
	Proportion of carers of the users of Adult Social Care Services are offered a carers assessment	Actual	97%	90%	93%	100%	100%	100%	100%	100%	100%	100%	100%	100%			
		Plan	97%	94%	95%	98%	100%	99%	99%	98%	98%	97%	98%	97%			
		Variance	0%	-4%	-2%	2%	0%	1%	1%	2%	2%	3%	2%	3%			
	No of people identified as being in their last year of life on practice registers	Actual	1,953			1988			2013			2082			2045		
		Plan	1,705			1651			1937			1954			1953		Plan = same period in 22/23
		Variance	248			337			76			128			92		
	Proportion of people with Personalised Care and Support Plan(PCSP)/UCP	Actual	48%			48%			49%			46%			45%		
		Plan	40%			42%			46%			47%			48%		Plan = same period in 22/23
		Variance	8%			6%			3%			-1%			-3%		

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Impact measures performance trend (4)

Outcome	Impact measure	Target/Pla	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Year to Date	Comments
M	Rate of uptake for an Annual Health Check and Health Action Plan for those with LDA	Actual	51.9%	64.2%	74.5%	83.1%	5%	10%	14%	19%	27%	35%	41%	47%	55%		
		Plan	56.3%	62.5%	68.8%	75.0%	6.3%	12.5%	18.8%	25.0%	31.3%	37.5%	43.8%	50.0%	56.3%		
		Variance	-4.4%	1.7%	5.7%	8.1%	-1.1%	-2.9%	-4.6%	-5.5%	-3.8%	-2.8%	-2.3%	-2.7%	-1.6%		
	Weeks waiting for an ASD diagnosis for children and young people	Actual	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
	Numbers of people with severe mental illness are supported to live in their own home	Actual	14			10			12			16			15		Number of service users starting paid employmenet during each quarter
		Plan	36			36			36			36			36		
		Variance	-22			-26			-24			-20			-21		
N	Number of people per year are supported by the Living Well Network Alliance into paid employment	Actual	60			95			54			85			48		Number of service users (unique Trust IDs) from referrals accepted during each quarter
		Variance	60			95			54			85			48		
	Number of referrals Living Well Network Alliance teams make for service users to additional support routes (such as education, training and employment support, Community Support, Alcohol Advice, Smoking, Benefits advice, Dietician, Family Support)	Actual										549			416		
	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	82.0%	62.0%	74.0%	73.0%	89.2%	74.6%	77.4%	82.5%	87.0%	78.8%	76.7%	76.3%			From PEDIC
		Plan	78.4%	78.4%	78.4%	78.4%	78.4%	78.4%	78.4%	78.4%	78.4%	78.4%	78.4%	78.4%			Mean value Sep-23 to Sep-24
		Variance	3.6%	-16.4%	-4.4%	-5.4%	10.8%	-3.8%	-1.0%	4.1%	8.6%	0.4%	-1.7%	-2.1%			
	Seclusions and restrictive interventions on inpatient setting	Actual	20	18	38	36	43	49	39	33	40	27	29	29	29		Restrictive incidents + seclusions
		Plan	33	33	33	33	33	33	33	33	33	32	32	32	32		Median value Apr-23 to Dec-24
		Variance	13	15	-5	-3	-10	-16	-6	-	-7	5	3	3	3		
O	Percentage of people resettled into longer-term accommodation	Actual	3%			5%			4%			4%			4%		
		Plan				5%			3%			3%			3%		Plan = same period previous year
		Variance				-			0			0			0		
	Number of rough sleepers brought into accommodation	Actual	78			52			44			33				129	
		Plan				38			71			58			58	225	Plan = same period previous year
		Variance				14			-27			-25			-58	-96	
	Proportion of people living in our supported housing that are registered with a GP	Actual	90%			92%			90%			97%			98%		
		Plan				74%			75%			79%			90%		Plan = same period previous year
		Variance				18%			15%			18%			8%		
	Rate of residents in supported housing engaged with mental health support services.	Actual	20%			25%			23%			24%			24%		
		Plan				12%			12%			14%			20%		
		Variance				13%			11%			10%			4%		
	Refer people to drug treatment services upon their release from prison, and what proportion then complete their treatment.	Actual				41%			52%								Lastest data covers period of July 2023 to June 2024 24/25 Year-end ambition is to reach 55% (historical data shows 2021 -21% ; 2022-21%)
		Variance							11%								Against previous data available

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A. People maintain positive behaviours that keep them healthy

Tracks Smoking prevalence reduction, Proportion of Substance Misuse successful treatments and NHS Health checks activity - recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

Alliance and Programmes	Staying Healthy (owner) with contributions from LWNA, LDA, and Sexual Health programmes

What does the data/intelligence indicate around progress against the outcome?	NHS Healthcheck outcomes for Q2 24-25 was significantly impacted by the Synovis lab Cyber-attack that effectively halted the service from the 6th of June to around September 24 as bloods could not be processed. The expectation is that the impact will continue for the rest of the financial year albeit to a lesser extent as recovery efforts continue. 10.5% of patients who had a HC in Q1 were referred to lifestyle services or prescribed medication including of which 33 were prescribed statins, 7 were prescribed Antihypertensives, 16 referred to the NDPP and 13 to weight management. 6.7% were diagnosed with a health condition (hypertension 14 patients, diabetes 2 patients and non-diabetic Hyperglycaemia 28 patients) and put onto appropriate registers. 85% were identified with Low 10-year CVD risk, 13% with Moderate risk and 2% 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 24% and White Other 27%), Uptake 53% (incl. White British 31% and White Other 22%) • Black: Eligible 20%, Uptake 20% • Asian: Eligible 6%, Uptake 6% • 40-50 age group: Eligible 60%, Uptake 55% • 51-60 age group: Eligible 28%, Uptake 31% • 61+ age group: Eligible 12%, Uptake 14% This demonstrates the opportunity to pick up risk factors at an earlier stage and to start prevention early. • Female: Eligible 43%, Uptake 52% • Male: Eligible 57%, Uptake 48%
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Due to the aforementioned critical incident, practices are now working to recover to a Business-as-usual position however NHS health checks may be seen as less of a priority than Long term condition management in the recovery process. Furthermore, the NHS Healthcheck service was recommissioned in Spring 24 on a 2-year basis with the intention that year 2 would focus on the PCN's and Lambeth commissioners agreeing and developing an at scale model to deliver to the service in the most optimal way, focussing on our key priorities. The on-going impact of the situation highlighted above may affect time scales of implementing this new model ahead of any future recommissioning exercise. Commissioners continue to work with the PCNs on recovering the core offer. Practice representation is now formalised on the Lambeth Healthcheck Steering group to facilitate strategic goals including implementing the At Scale Model

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

Tracks Social Prescribing, Low Income support tracker and Residents Survey measures - recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

Alliance and Programmes	**NWDA (owner) with contributions from CYP and Staying Healthy**
What does the data/intelligence indicate around progress against the outcome?	Whilst the percentage of residents financially coping have reduced, the percentage of residents in crisis, at risk or struggling has not increased and, instead, the percentage of residents who were coping and have now left the dataset have increased. This is likely to indicate that residents' financial situations have improved to the point where they are no longer in receipt of means-tested benefits.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	The reduction of people in the dataset is indicative of an improvement in those financially coping without localised benefits. 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, continuing high inflation for food and energy and the welfare benefits system not keeping pace with the costs of essentials (e.g. Universal Credit (allowances and two-child policy), Healthy Start Vouchers being insufficient to meet the cost of infant formula). The council continues to deliver crisis support to residents through the council's Cost of Living programme 2024/25 as well as working to provide longer-term responses to reducing the instance and impact of poverty in the borough through a Tackling Poverty action plan, currently in development with the borough's communities.

C. People are immunised against vaccine preventable diseases

Tracks Children Immunisations rates and Flu Immunisation- recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

Alliance and Programmes	Staying Healthy (owner) with contributions from NWDA
What does the data/intelligence indicate around ***progress against the outcome?***	Achieving herd immunity and meeting the locally set target of 90% remains a challenge in Lambeth. The most recent data published for Quarter 2 of 2024/25 shows that the uptake of the DTaP/IPV/Hib vaccine, offered to babies at 8, 12, and 16 weeks of age, stands at 84.7%. Additionally, uptake for the first dose of the MMR vaccine is at 79.5%. Other boroughs in South-East London have also reported uptake rates below 90%.
Does the data/intelligence identify any ***health inequalities and whether they are reducing?***	National COVER reporting does not provide sufficient insights into vaccination inequalities. A health equity audit by UKHSA has identified avoidable disparities within the UK vaccination programme. Additionally, a local audit in Lambeth highlighted inequities in vaccination coverage and timeliness, which informs our engagement strategies to ensure our efforts are directed where they are most needed.
What are the ***challenges hindering any progress*** *and* ***are there actions which can be taken*** *to address these?*	Challenges in vaccination arise from a complex interplay of factors, including intrapersonal elements (such as vaccine fatigue, hesitancy, health beliefs, and health literacy), community influences (such as religious, cultural, and gender norms), and institutional factors (such as access and registration issues, culturally tailored services, and vaccination funding and delivery). We continue to implement various initiatives to address vaccine inequities, ranging from strengthening primary care call-and-recall systems to launching community-led initiatives.

C. People are immunised against vaccine preventable diseases

C1. Proportion of Lambeth registered children by age 2 that have received all primary immunisations and 1 dose of MMR

Lambeth LA	23/24				24/25	
	Q1	Q2	Q3	Q4	Q1	Q2
DTaP/IPV/Hib at 12 months	84.8	87.8	86.9	88	86.5	84.7
PCV booster at 24 months	83.8	82.7	84	83.3	78.1	78.5
MMR 1 at 24 months	85.3	83.3	84.5	83.5	79.9	79.5
Hib/MenC at 24 months	85.3	83.4	84.6	84	79	79

South-East London 24/25 Q2

Local Authority	12m denom.	DTaP/IPV/Hib at 12 months		24m denom.	PCV booster at 24 months		MMR 1 at 24 months		Hib/MenC at 24 months		5Y denom.	MMR2 at 5 years		DTaP/IPV at 5 years	
		n	%		n	%	n	%	n	%		n	%	n	%
Bexley	694	616	88.8	737	600	81.4	625	84.8	617	83.7	922	687	74.5	673	73
Bromley	903	810	89.7	893	774	86.7	776	86.9	781	87.5	1063	862	81.1	798	75.1
Greenwich	938	820	87.4	976	796	81.6	829	84.9	815	83.5	1056	765	72.4	724	68.6
Lambeth	**970**	**822**	**84.7**	**965**	**758**	**78.5**	**603**	**79.5**	**762**	**79**	**984**	**689**	**70**	**623**	**63.4**
Lewisham	903	783	86.7	983	818	83.2	834	84.8	827	84.1	1013	778	76.8	701	69.2
Southwark	791	690	87.2	889	678	76.3	696	78.3	692	77.8	896	650	72.5	546	60.9

D. People have healthy mental and emotional wellbeing

Tracks Community organisations training on MH Awareness and Suicide prevention, Short Term and Focused support number entering treatment and waiting times- recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

Alliance and Programmes	LWNA and CYPA (owners)

What does the data/intelligence indicate around progress against the outcome?	The number of service users accessing Short-Term Support (STS) through the Lambeth Living Well Centres fell by 8 (-7%) from November. Numbers accepted into Focused Support (FS) rose by 20 (+69%), returning to typical levels after a low point the previous month. Lambeth Single Point of Access (SPA) is now consistently making fewer referrals to STS after reducing the backlog of long-waiting. The number of incoming referrals deemed inappropriate by both services is also reduced. The mean number of days between referral to STS and the second attended care rode by 1.7 days in December from 22.8 days in November (+7%) but this remains 1.5 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 work is underway 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, supports the view that they enter the service requiring a more intensive level of support than White service users. In December, Black service user access to STS is in line with recent months and the Lambeth population (at 22.4%). However, with 21 of 47 accepted referrals where ethnicity is stated (45%) access to the more intensive FS service for Black service users is almost 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 notably shorter for Black service users than those identifying as White (23.7 and 33.7 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

Tracks rate of STI testing & diagnoses, Sexual health activity on contraception, abortions by ethnic demography and Primary care LARC uptake- recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

Alliance and Programmes	Sexual Health

What does the data/intelligence indicate around ***progress against the outcome?***	The Q2 2024 activity GP LARC data shows a good increase in activity within GP practices with 1,765 units of activity compared to 337 in the same quarter last year, although not all PCNs wish to provide this activity, most of the alternative activity is being referred into the current LARC Hub. Commissioners will work on transitioning the current model now that the procurement process has been completed. Secondary care LARC data from GSTT show activity is steady with just a slight reduction of 55 from Q2 24/25 compared to Q2 23/24.
Does the data/intelligence identify any ***health inequalities and whether they are reducing?***	The new EZ Analytics report on GP LARC activity data by demographics has been delayed. We hope it should be available for next quarter to allow us to report activity via demographics such as ethnicity and age and monitor if there is any decrease or increase in inequalities across PCNs. A new Termination of Pregnancy (TOPs) dashboard has been developed by the PH Health Intelligence team allowing us to view TOPs by age and ethnicity. The data show a higher rate of abortions in Black and Multi-ethnic residents compared to White ethnicities. Going forward we will be able to monitor trends and work with services to improve ethnicity recording.
What are the ***challenges hindering any progress*** *and* ***are there actions which can be taken*** *to address these?*	The data issues around EPIC, which are presenting the reporting of KPI service level data, are mainly affecting Kings now and commissioners have escalated the issue with Trust Executives and the service is now reporting improvements fortnightly.

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

Tracks SMI and LD Annual Health Checks, Cancer screening programme and Sexual Health activity (ED HIV & PrEP) - recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

Alliance and Programmes	NWDA(owner) with contributions from Staying Healthy, LWNA, LDA and Sexual Health

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% 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% in April 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 November 2019. Below national target of 80%. Source for all of above is the SEL screening dashboard. There are other sources but this is most accurate and comes from Open Exeter directly *NB-Data has not been updated since last submission for October/November and above data is most recent available
*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?*	There are numerous ongoing challenges. Firstly as mentioned above there is a lag in the data so we are 6-12 months behind with official data to see local rates which can lead to delays in identifying evolving issues. Due to workload and winter pressures it is difficult for primary care to take on additional screening promotion work. There are however numerous ongoing projects locally. SELCA are funding projects with IRMO (Latin American community) and LAMSOM (Somali community). They are also funding PCN projects to increase breast and cervical screening and also a PCN engagement event. The NWDA have also recently funding a successful PCN engagement event with plans for more in the future. The local breast screening service are also working to increase appointments outside of normal working hours to aim to screening rates.

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

Tracks SMI and LD Annual Health Checks, Cancer screening programme and Sexual Health activity (ED HIV & PrEP) - recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

Alliance and Programmes	**NWDA(owner) with contributions from Staying Healthy, LWNA, LDA and Sexual Health**
What does the data/intelligence indicate around progress against the outcome?	At the end of November 2024, 703 residents had newly started on PrEP and 3,511 residents were continuing to use PrEP, the activity trend remains level over time. The majority of activity takes place at the central London clinic provided by Chelsea and Westminster NHS Trust, with the second largest proportion of activity provided by GSTT
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	98.05% of residents are male, this split in gender has remained similar since the roll out of routine commissioning of PrEP, much of this activity is across the 25 – 45 age range. Very few women are accessing PrEP and more work needs to be done to ensure PrEP needs are identified in women going to Sexual Health clinics, we are also working on a communications strategy that will support improved communication and promotion about PrEP to women.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	PrEP clinical guidelines have recently been consulted on, currently PrEP is still only available within a specialist sexual health clinic, the proposed draft guidelines will enable PrEP to be available in non specialist settings, updated guidelines should be published in February. NHSE have also updated their medicines framework, which should also help non specialist providers obtaining the NHSE commissioned PrEP medication. Commissioners and clinicians started working together to develop a PrEP offer to health inclusion groups via the newly commissioned Outreach Alliance, in early December, this work will now continue and be developed through the mobilised services. Targeted promotional women for Black heritage women has also started to address unmet needs and improve education and awareness.

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

Tracks SMI and LD Annual Health Checks, Cancer screening programme and Sexual Health activity (ED HIV & PrEP) - recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

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

What does the data/intelligence indicate around progress against the outcome?	Good progress from Q2 and on a par with achievement at the same time last year. On track to achieve the SMI target (60%) and the LD target (75%) as a minimum and anticipate reaching 23/24 achievement of 68% for SMI and 83% for LD.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Audits of people with SMI who had not had a health check in the last 3 years identified the following: • 4.5% of the register had not engaged • 57% African/Caribbean; 25% White; 16% Other • 72% were male; 30% African/Caribbean males • 11% White people aged between 31-40 Audit of people with LD who had not had a health check in the last 3 years identified the following: • 10% of the register not engaged • 37% African/Caribbean; 32% White; 16% Other • 20% African/Caribbean females; 20% White males • 16% African/Caribbean people aged between 14-20 Comunication and engagement plans have been developed based on the results of the audits, includes working with community and voluntary partners, SENCO leads and schools, carers and carer organisations, materials and resources for individuals and carers and support and resources for GPs.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Ongoing issues with Synovis may impact the ability to perform routine blood tests required by the health checks. We will take our lead from Primary Care Commissioning regarding actions/mitigations.

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

Tracks Type 2 diabetes 8 Care Process, Cardiovascular indicators and Polypharmacy Structured Medication reviews activity - recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

Alliance and Programmes	NWDA (Owner)

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. 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 end of FY 2024-25. In September, Lambeth participated in the national "Know Your Numbers Week" campaign. An event was held at Lambeth Civic Centre where Lambeth Council and NHS South East London staff were offered free blood pressure checks. The blood pressure checks were provided by local Community Pharmacy colleagues and Health Champions from Lambeth Together's Health and Wellbeing Bus to raise awareness of hypertension risks and encourage regular checks. 142 staff had their blood pressure checked; 60 more received advice on testing options at pharmacies, GPs, or at home; 35 people had raised blood pressure, requiring follow-up action; an additional 28 were outside the normal range and were advised on lifestyle changes. Staff valued the opportunity to have the checks within their working day. 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 since 1st April 2024. At end of November, a total of 927 of the 3205 (29%, previously 20%) patients have had a SMR.
Does the data/intelligence identify any ***health inequalities and whether they are reducing?***	More black and minority ethnic people have been identified with hypertension when comparing December 2023 to December 2024 data; 23549 and 24437 respectively and within these cohorts better blood pressure control has been seen; 13,082 and 13,476 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. Note unable to access EZ Analytics at time of report production. 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

Tracks Diabetes 8 Care Process, Cardiovascular indicators and Polypharmacy Structured Medication reviews activity - recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

Alliance and Programmes	NWDA (Owner)

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.
Additional Comments	

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

Tracks LWNA Single Point of Access (SPA) waiting times activity, Equity of access and recovery rates for Lambeth Talking Therapies, and waiting times on Child and Young Adolescent Services (CAHMS) - recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

Alliance and Programmes	LWNA and CYPA (owners)

What does the data/intelligence indicate around progress against the outcome?	Since peaking in May-24 at just over 900, the SPA caseload has been cut by 70%. Wait times have also been reduced significantly, although they remain far higher than target. The proportion of referrals completed within 3 days rose from 16.6% at the end of the second quarter (Jul-Sep) to 24.9% at the end of the third (Oct-Dec) This measure will only improve significantly when the team is responding to introductions as they arrive, without a significant backlog awaiting admin screening or triage. Lambeth Talking Therapies (LTT) equalities data for 2024/25 for Q2 and Q3 are not yet available. Data for 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.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	There is some variation by ethnicity in achievement against the 3-day waiting target for Lambeth SPA, but in Q3 Oct-Dec the target was met more frequently for Black service users (27.2%) than for White (23.4%). This suggests that more severe issues among the Black community are being addressed more urgently. Lambeth Talking Therapy data for Q1 does not suggest any inequalities, except for the Black African community, which is 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?*	Changes to Lambeth SPA organisation and processes, together with additional support, have reduced the Lambeth SPA caseload and waiting times significantly, but following staff sickness, turnover and reduction in additional support due to funding considerations. Progress has slowed such that the SPA waitlist has remained almost level throughout Q3 Oct-Dec. Unless SPA staffing issues are addressed it is not clear when the backlog will be eliminated. Lambeth Talking Therapies will be focusing on improving the proportion of service users reporting recovery at time of discharge, maintaining the increase in session numbers for clients from a global majority and ensuring that clients from all ethnic groups have a 48% recovered at discharge rate.

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

Tracks Health and Wellbeing Bus (Welfare Advice and Mental Health sessions), CVD Workplace health checks and Beacon service H&W interactions - recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

Alliance and Programmes	**NWDA (Owner) with contributions from LWNA and CYPA**

What does the data/intelligence indicate around ***progress against the outcome?***	The bus interactions data show high figures for Q3 especially being in colder months. The welfare and MH outreach workers both had a slight decrease in 1-1 sessions as could be expected over this period. Beacon saw a decrease over this period as is expected due to decreased activity and attendance in December. However there were additional popup activity that happened over the period.
Does the data/intelligence identify any ***health inequalities and whether they are reducing?***	71% of people accessing the welfare advice had their issue dealt with. The largest concern for welfare advice was housing.
What are the ***challenges hindering any progress*** *and* ***are there actions which can be taken*** *to address these?*	The Vital 5 pilot is being operationalised. The Public Health Health Champion team is being trained early January with the view for starting the service by end of Jan. The biggest risk is delays in getting the EMIS template ready and discussions are underway between the GP Fed and Ardens.
Additional Comments	The Beacon Project is working closely with the Public Health team to evaluate the work.

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

Tracks General practice appointments, Community Pharmacy activity and Virtual Wards activity - recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

Alliance and Programmes	NWDA (Owner) with contribution from Substance Misuse

What does the data/intelligence indicate around progress against the outcome?

General Practice are required to deliver 1.5% growth – current rate is 4%.
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.

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 2625 consultations between March 2023 and November 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 October 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.

Lambeth and Southwark virtual wards continue to achieve the 80% occupancy target overall and have now achieved the minimum target of 240 bed capacity (40 – 50 beds per 100,000 pop.). Capacity expansion progress continues; 10 virtual ward beds now live at St Christopher's Palliative and EoL Care service which is contributing to a total of 241 beds. KCH IRT mobilisation delays due to progressing internal business case and recruitment – discussions in progress to update KCH IRT mobilisation plan. Teams reporting below target against occupancy have improved performance and are now achieving a steady increase in occupancy – this is due to reducing staff sickness/absence and the seasonal effect of the colder weather increasing in referrals for respiratory conditions. Utilisation of Remote Monitoring is improving in line with the delivery plan and the development of new clinical pathways in progress including; Sickle Cell, Premature rupture of membranes (PROMs), Diabetes blood glucose monitoring, TAVI day 0 Discharges and Surgical (GMS).

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

Tracks General practice appointments, Community Pharmacy activity and Virtual Wards activity - recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

Alliance and Programmes	NWDA (Owner) with contribution from Substance Misuse

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. On Community Pharmacy, data from November 2024 shows most interventions (1898) 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, 66% of patients would have visited general practice to request the medication on prescription, 33% would have gone without medication and 1% would have visited A&E or an Urgent Care Centre. 33% 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, are under the age of 16 years old or have income-based jobseeker's allowance are the top social vulnerability eligibility groups accessing Lambeth Pharmacy First Plus Service in November 2024. General Practice feedback has been that the service has a had a positive impact for patients and reduced GP appointments for minor conditions. On Virtual wards, access to Hospital @home services is available to all, there are no restrictions other than those defined by the clinical criteria which are applied as appropriate depending on the clinical pathway and team providing care. One of the main principles of the Lambeth and Southwark Hospital @home programme is to be data driven. A workstream is in progress with ICB colleagues is to: • Define and understand (potential) demand for hospital @home (Virtual Ward) services so that we can measure if our current capacity is appropriate or if there's a requirement for expansion • Define gaps and barriers to access following population health principles and outcomes and develop an appropriate population health approach to addressing any barriers that have been identified.

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

Tracks General practice appointments, Community Pharmacy activity and Virtual Wards activity - recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

Alliance and Programmes	NWDA (Owner) with contribution from Substance Misuse

*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	On virtual Wards, one of the main barriers that has been identified is awareness of what the service is and what it can provide. ‘Step up’ access is via referral in the community from health and social care professionals including General Practitioners and the London Ambulance service to prevent avoidable admissions. 'Step down' referrals are received from KCH and GSTT Emergency Departments, Same Day Emergency Care, Urgent Treatment Centres and direct from ward admissions to enable earlier supported discharges. The programme recognises that there is more work to be done to promote Hospital @home as a viable and safe Urgent and Emergency Care alternative to Emergency Department attendance or hospital admission and has embarked on a series of high-level engagements, including the Lambeth Together Board (7 November 2024) 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
Aug-24	65
Sept-24	96
Oct-24	95
Nov-24	138
Total – 2625	

	31 Jan 2024	29 Feb 2024	31 March 2024	30 April 2024	31 May 2024	30 June 2024	31 July 2024	31 Aug 2024	30 Sept 2024	31 Oct 2024	TOTAL
Total Pharmacy First consultations (includes referrals to the 7 Clinical Pathways, Minor Illness and Urgent Medicine Supply service)	649	1309	1604	1626	1709	1589	1704	1667	1816	1565	**15,238**

Top 3 social vulnerability eligibility criteria for accessing Lambeth Pharmacy First PlusService (Nov 24):

1. Universal credit (39%)
2. Patients aged under 16 years (29%)
3. Income-based Jobseeker's Allowance (10%)

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

Tracks Adult Social care indicators and Proportion of people identified as being in their last year of life on practice registers - recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

Alliance and Programmes	NWDA (Owner)

What does the data/intelligence indicate around progress against the outcome?	The number of accepted referrals to Reablement has increased since October 2024. As a result of work in the Discharge Operational Delivery Group a piece of work looking at eligibility criteria for reablement was completed with ward therapists. There is also a regular meeting to look at the reason for referrals to reablement which are declined by the service. The number of people who have a reduced need for care at the end of a period of Reablement has remained high and this is positive. The percentage for people with a reduced need for care at the end of Reablement continues to improve and is 89% at the end of November 2024. 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 continue to achieve 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. The overall trend for Lambeth end of life data outcomes K3 and K4 (palliative and end of life care improvement measures) is progress towards increased identification and uptake of advance care planning. This is across both the identified outcome measures for people identified as being in their last year of life on practice registers (45% increase Q1 22-23 to Q2 24-25) and Proportion of people with Personalised Care and Support Plan(PCSP)/UCP (22% increase Q1 22-23 to Q2 24-25). For Metric K3 (identification on practice registers), the total number increased by 3% from 2,013 to 2,082 in Q2 2024/25. For Metric K4 (PCSP/UCP), the total number increased by 24 but this represented a small decrease of -0.5% in the proportion of people on end of life registers with PCSP/UCP. This is because identification (K3) increased more sharply than PCSP/UCP (K4) increased in K2.
*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 is now 16% of the total number of referrals to Reablement which is a significant increase. 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

Tracks Adult Social care indicators and Proportion of people identified as being in their last year of life on practice registers - recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

Alliance and Programmes	NWDA (Owner)

*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. There has been some work to increase the number of weekend discharges at GSTT. This has decreased slightly in the last month and we are reviewing the process. 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 (£64k non-recurrent for 1 year) for project resource to help address these barriers, by working with primary care to support identification of people in the last year of their life and uptake of Universal Care Plans. Primary Care working with GP leads to mobilise project with a focus on creation of Clinical Lead Champion role, working with champions at GP level to increase completion and quality of UCP / ACP in Lambeth. 7 of 9 Primary Care Champions appointed to post across across PCN. Organising launch event with lead in late January 2025.

L. Women have positive experiences of maternal healthcare and do not experience a disproportionate maternal mortality rate

Tracks Continuity of maternity care, patient experience indicators on maternity care and other maternity indicators - recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

Alliance and Programmes	CYPA (Owner)

What does the data/intelligence indicate around ***progress against the outcome?***	The adoption of a new Electronic Patient Record system at Guy's & St Thomas' and King's College Hospitals continues to disrupt performance reporting for maternity services across South East London. While work to stabilise the system is ongoing, regular reporting has yet to resume. In response, the Children & Young People Alliance (CYPA) has prioritised governance and quality assurance during this period. This includes engaging with local and regional forums to maintain oversight and address any potential risks to service delivery. We continue to press colleagues in the system to resolve the reporting challenges as quickly as possible, recognising the importance of reliable data in driving improvements. Looking ahead, the CYPA remains committed to working with maternity providers and the Local Maternity and Neonatal System to ensure the timely restoration of performance data. Our efforts will also focus on strengthening maternity services to better serve Lambeth's communities, with an emphasis on safety, equity, and quality.

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

Tracks LD specialist unit discharges, LDA in education, work and supported employment, rate of uptake for an Annual Health Check and Health Action Plan and Waiting times for an ASD diagnosis for children and young people - recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

Alliance and Programmes	LDA (Owner)

What does the data/intelligence indicate around ***progress against the outcome?***	The implementation of a new Electronic Patient Record system at Guy's & St Thomas' Hospital has disrupted performance reporting for the Autism and Related Disorders Diagnostic Service. No update has been provided by the Evelina Communities Team for system partners at this stage. However, local monitoring of performance, governance, and safety continues to ensure that services remain safe and operational.. 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 1 January 2025 of 54.68%, and we note that a larger proportion are completed towards the end of the financial year.
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, and the first workshop took place in September 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 first results under analysis with results due Q3 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

Tracks Community Living and Support Service (CLaSS) and Individual Placement Service (IPS) activity, LWNA additional support routes service activity, patient experience measures and activity on Seclusions and restrictive interventions on inpatient setting - recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

Alliance and Programmes	LWNA (Owner)

What does the data/intelligence indicate around progress against the outcome?	In the third quarter, Q3 October to December, LWNA's Community Living and Support Service accepted 48 new service users with serious mental health conditions to support them to leave inpatient care and live in the community. This compares with 85 in the previous quarter. Data for LWNA's Individual Placement and Support (IPS) shows that in Q2 16 service users were supported to find paid employment compared to 12 in Q1, however both remain well below the original target of 36 per quarter. Restrictive incidents and seclusions have remained at 29 per month throughout Q3 Oct-Dec (+21%) from a mean average of 33 per month in Q2 Jul-Sep. which is 9% below the median value since April 2023. Positive friends and family survey responses for LWNA, across inpatient and community settings, were down to 76.3% in November (the latest available data point) from 76.7 in October and a mean average of 82.8% through Q2 Jul-Sep. After a strong Q2, November's results have fallen 2.1% below the mean value since September 2023.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	The latest data available from IPS for Q1 Apr-Jun and Q2 Jul-Sep indicate that Black service users are being placed at a lower rate than their white counterparts, but the sample size is too small and be statistically significant. This result will need to be established over a long period of time before conclusions can be drawn. 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 fell to 47.9% in September, from 52.0% in July, such movements in a relatively small data set may not be significant. However, when compared to the 21.7% of Lambeth population which is Black and aged 18-64, the scale of the problem is made clear. While the overall number of seclusions and restrictive incidents is tracked, analysis of this measure by ethnicity is currently blocked by systems issues. The reasons for this and a solution is being progressed urgently.
*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

Tracks Resettlements, rough sleepers brought to accommodation, GP registration, rate of engagement with mental health services in supported housing and Substance Misuse treatment completion upon release from prison - recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

Alliance and Programmes	**Homeless Health (Owner) with contributions from LWNA and Substance Misuse**
What does the data/intelligence indicate around ***progress against the outcome?***	The number of residents now registered with GP's is at its highest. This has been achieved through contract monitoring and consistent messaging to Providers to ensure each resident is being supported to register when being accommodated in their service. There is a slight increase in those engaged in mental health services and again this is through a combination of ensuring referrals to appropriate services are being made and ensuring providers are capturing this in monitoring reports. Both ensure we are improving health for homeless/former homeless people. The number of rough sleepers accommodated increased due to SWEP activation and emergency accommodation being available, CRISIS at Christmas being opened and more clients accessing No Second Night Out (pan London service) Lambeth operate an "In For Good" principle when SWEP is activated (other boroughs do not) so when SWEP is deactivated clients are not asked to leave accommodation until they have an appropriate offer of move on. This increases the likelihood of people addressing health issues and being referred to appropriate services.
What are the ***challenges hindering any progress*** *and* ***are there actions which can be taken*** *to address these?*	Ensuring each GP practise has a mental health specialist would assist providers with dealing with crisis management and referrals for support that do not meet the threshold for SPA.

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