Lambeth Together Care Partnership
Public Forum and Board Meeting in Public
Agenda Supplement Two

Thursday 11 July 2024 | 1:00pm – 5:00pm
Venue: Brixton House, Studio 4, 385 Coldharbour Ln, London SW9 8GL

AGENDA

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

Lambeth Together Care Partnership Board

Title	**Lambeth Together Assurance Sub-Group**
Meeting Date	11th July 2024
Author	Warren Beresford – Associate Director Health and Care Planning and Intelligence Jo Fernandes – Planning Intelligence and Improvement Manager
Lead	Oge Chesa – Director of Primary Care and Transformation

This item is for;

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

Recommendations;

The Lambeth Together Care Partnership Board is asked to;

1. Note the report from the Lambeth Together Assurance Sub-Group and the associated Integrated Assurance Report presented on 21st May 2024

2. Endorse the recalibrated Health and Care Plan impact measures proposed for for monitoring the Health and Care Plan in the year ahead.

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

None

Summary and Impact on Inequalities

Purpose:

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

Lambeth Together Health and Care Plan Focus Points:

At the 21st May 2024 meeting the Lambeth Together Assurance Group (LTAG) meeting agenda centred around one which the partnership is aiming to achieve through delivery of the 'Our Health, Our Lambeth, As Lambeth Together's health and

care plan'. This was Outcome I - *People have access to joined-up and holistic health and care delivered in their neighbourhoods*

The Assurance Group acknowledged the commendable work being undertaken in this area but recognised the need for improvement. The discussion focused on enhancing data capture to ensure progress towards the desired outcomes and to inform strategic decisions on where to invest further

Integrated Assurance Report

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

- 27 out of 41 metrics (66%) tracked in scorecard format are green, exceeding baseline/national targets or last year's cumulative position. This represents an decrease of 2 from the last report in March 2024

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

   Outcome A (keeping people healthy): The recent audit highlighted health inequalities, particularly among groups with higher smoking rates. This has informed the Draft Tobacco Control Plan, which was discussed at the Lambeth Tobacco Control Alliance launched on 16th April 2024

- **Outcome B (connected communities):** The percentage of residents reporting they are coping financially continues to be higher than the same period last year. However, social prescribing referral figures are lower than last year

- **Outcome C (vaccination and immunisations)** While there was an improvement in MMR uptake in Q2 2023/24, the rates are still lower than the same period the year before.

- **Outcome G (Long term conditions) F**or diabetes management, the proportion of people with Type 2 diabetes meeting all eight care processes has improved, with more individuals in Lambeth achieving blood pressure control compared to the same time last year. By the end of 2023/24, Lambeth met its ambition for patients aged 80 or over, but more work is needed for those aged 79 or under. There is ongoing focused work prioritising uncontrolled diabetes patients, particularly from Lambeth's Black and Minority ethnic populations.

- **Outcome K (supporting older adults)** Data indicates an increase in the number of people who have a reduced need for care at the end of a period of reablement. Following a change in reporting methodology after the ACS mock inspection, the percentage of people with a reduced need for care at the end of reablement improved to 88%. Additionally, we have a high performance rate for the proportion of carers of service users who were offered a carer's assessment.

- **Outcome O Homeless Health** Borough-level data shows that Lambeth recorded the highest-ever number of rough sleepers. The rough sleeping

outreach team contacted 866 rough sleepers in 2023/24, compared to 623 in 2022/23 and 438 in 2021/22. Nearly half of the 866 individuals in 2023/24 had never been recorded as sleeping rough before. This increase is largely attributed to the cost of living crisis and soaring accommodation costs in the capital, particularly in the private rented sector.

- **Outcome L women have positive experience of maternal healthcare** reported that the caseload midwifery model demonstrated significant improvements in maternal and new-born outcomes in the rates of total caesarean section (CS) and of preterm births.

Developing the Lambeth Together Health and Care Plan Assurance Process for 24/25.

During the meeting, the group agreed to recalibrate the impact measures to be monitored as part of the assurance process at LTAG meetings throughout the coming year and to also tidy up the synchronisation of LTEG and LTAG as part of ensuring that all outcomes/activities are feeding into an efficient assurance process.

The supplementary paper (appendix 2) provides details of the impact measure recalibration exercise and request that the board endorses these measures for monitoring the Health and Care Plan in the year ahead.

Synchronisation of the Lambeth Together Executive Groups and Assurance Group (LTEG and LTAG).

It was noted at the meeting that the group intends to inform the board of its plan to further refine the synchronisation between LTEG and LTAG. This effort aims to ensure that all outcomes and activities contribute to an efficient assurance process. This work is currently underway.

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Lambeth Together
Integrated Assurance Report

21 May 2024

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

Lambeth Together Health and Care Plan Scorecard – March 2024

"This report now presents the Lambeth Health and Care Plan impact measures in a 'Scorecard' format. This represents our initial effort to offer a concise, easily digestible overview of our progress in relation to the plan.

*By presenting the key metrics in this format, we aim to make it more **accessible for readers to grasp our progress**, sparing them the need to sift through the extensive details and intelligence underpinning our impact measures.*

*It's essential for readers to **acknowledge the limitations of the data presented in this manner**. The red/green rating, while valuable, may not fully encapsulate the complexity of our performance, as it predominantly compares the most recent reported status with the previous period. Since performance can fluctuate from month to month, the presented **data may lack statistical significance**. Moreover, it does not **provide insight into how close a metric is to meeting the desired goals**. Additionally, the **scorecard should be considered in conjunction with the contextual narrative provided** within the report.*

*This scorecard has been swiftly developed in response to the need for a concise assurance summary for the Health and Care Plan. Nevertheless, **we recognise the need for further refinement** to enhance the scorecard's sophistication in presenting these measures in the future."*

Note: Not all impact measures are able to be presented in a scorecard format. For additional detail, please refer to the appendix document

Lambeth Together Health and Care Plan Scorecard – May 2024

ID	Outcome	May 24 Measures Reported	May 24 Above/in line with Baseline	May 24 % measures abov/in line with baseline	March 24 Measures Reported	March 24 Above/in line with Baseline	March 24 % measures above/in line with baseline	May 24 vs Mar 24
A	People maintain positive behaviours that keep them healthy	2	1	50%	2	1	50%	0
B	People are connected to communities which enable them to maintain good health	3	1	33%	3	2	67%	-1
C	People are immunised against vaccine preventable diseases	1	0	0%	1	0	0%	0
D	People have healthy mental and emotional wellbeing	4	3	75%	4	1	25%	2
E	People have healthy and fulfilling sexual relationships and good reproductive health	1	1	100%	1	1	100%	0
F	People receive early diagnosis and support on physical health conditions	6	3	50%	6	4	67%	-1
G	People who have developed long term health conditions have help to manage their condition and prevent complications	4	3	75%	4	4	100%	-1
H	When emotional and mental health issues are identified; the right help and support is offered early and in a timely way	5	3	60%	5	4	80%	-1
I	People have access to joined-up and holistic health and care delivered in their neighbourhoods	1	0	0%	1	0	0%	0
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	100%	3	3	100%	0
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	4	80%	5	3	60%	1
L	Women have positive experiences of maternal healthcare and do not experience a disproportionate maternal mortality rate	0	0	-	0	0		0
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	1	1	100%	1	1	100%	0
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	1	1	100%	1	1	100%	0
O	People who are homeless, or at risk of becoming homeless, (including rough sleepers and refugees) have improved health	4	3	75%	4	4	100%	-1
	Total	**41**	**27**	**66%**	**41**	**29**	**71%**	**-2**

A. People maintain positive behaviours that keep them healthy

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

indicator ID	Measure	Latast period	Lastest period position	Previous period Position*	vs previous Period*	Lastest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
A4	number of respondents completing DrinkCoach survey	Nov-23	27	8	19	119	575	-456	Baseline = cumulative position at same point in 22/23	Increase

What does the data/intelligence indicate around progress against the outcome?	Latest stop smoking data from our commissioned services shows that 91 smokers set a quit date in Q3, with 58 successfully quitting which is slightly lower when compared to the same period last year, Q3 2022/23. It should be noted that the provider has been impacted by undergoing wholesale implementation of its new data recording system Epic in this period. The conversion rate remained in the 60th percentile which was broadly in line with the expectations and reached 97% of our target groups (Pregnant Mothers, Parents with children under the age of 5, Routine and Manual workers, Long Term Physical or Mental Health condition, chronic/complicated smokers)
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	The data in the Tobacco control plan highlights that although prevalence has reduced in the borough (22% in 2012 to 13.4% in 2022), progress has stagnated from 2018 and prevalence remains high amongst certain demographics such as deprived communities or those from some ethnic minority backgrounds.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Lambeth Tobacco control alliance launched 16th April 2024 where Lambeth Draft Tobacco plan was discussed and will continually be refined for 2024-2029 to address, amongst other things, health inequalities highlighted by the recent audit including tailored support for those groups with higher rates of smoking to remove any barriers for those who wishing to quit. Additional new monies for local stop smoking services have been allocated with the aim of reducing health inequalities in addition to reducing overall prevalence. This will include expanding eligibility of the specialist stop smoking service to groups with higher smoking prevalence and with inequitable stop smoking service access and outcomes.

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

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

indicator ID	Measure	Latest period	Lastest period position	Previous period Position*	vs previous Period*	Lastest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
B1	number of social prescribing unique contacts	Apr-24	368	491	-123	6,089	8,971	-2,882	Baseline = cumulative position at same point in 22/23	Increase
B2	Residents' wellbeing, use of community assets and social cohesion	Q2 23/24	82%	81%	1%	82%	82%	0%		Increase
B3	percentage of low-income residents coping financially	23/24 Q4	78.2%	79.0%	-0.8%	78.2%	76.2%	2.0%	Baseline = 22/23 Q4	Increase

What does the data/intelligence indicate around progress against the outcome?	**B1 Number of social prescribing unique contacts -** Slight decline in number of unique social prescribing contacts but still high demand for the service. Service demand often decreases around Spring so this could explain the 25% decrease from the previous period.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	**B1 Number of social prescribing unique contacts -** Reduction could demonstrate an improvement in health inequalities and less reliance on the service however, a primary referral to the Social Prescribing service continues to be for housing and sadly the housing crisis is not decreasing. This dip could in fact evidence that housing referrals into Social Prescribing services need further intervention than Link Workers can provide so referrers are needing to seek support elsewhere. Age UK Lambeth Link Workers report numerous housing referrals that are not appropriate for social prescribing, needing more specialist support and intervention, that then need to immediately refer onwards.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	**B1 Number of social prescribing unique contacts -** There is still not a centralised CRM system to record social prescribing casework. This continues to be discussed at Clinical Cabinet but no decision has been made yet.
Additional Comments	**B1 Number of social prescribing unique contacts -** Two PCNs have made the decision to change their social prescribing offer. One has decided not to recruit anymore Link Workers and will have other ARRs funded roles within the PCN provide social prescribing support and another has drastically reduced their offer with only one PT Link Worker. This will take effect from 01/05/24.

C. People are immunised against vaccine preventable diseases

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

indicator ID	Measure	Latast period	Lastest period position	Previous period Position*	vs previous Period*	Lastest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
C1	Proportion of Lambeth registered children by age 2 that have received all primary immunisations and 1 dose of MMR	23/24 Q3	84.5%	83.3%	1.2%	84.5%	86.2%	-1.7%	Baseline = same period last Year	Increase

| What does the data/intelligence indicate around **progress against the outcome?** | **C1 Proportion of Lambeth registered children by age 2 that have received all primary immunisations and 1 dose of MMR:** Childhood vaccination uptake remains below the WHO-recommended 95% for herd immunity. The risk of measles outbreaks persists. Prioritising the local goal of 90% is crucial for community protection. Strategic interventions, improved system processes and community engagement are key to closing the gap, requiring continued collaboration, streamlined communication, and concerted efforts to achieve the desired vaccination coverage for robust public health outcomes.

C3 Proportion of school-age vaccination consent forms returned to the vaccination provider : Suboptimal return of consent forms for in-school vaccinations hinders achieving national targets, risking preventable infections which impact school attendance. Crucial measures are needed to address this challenge, improve consent form return rates, and ensure the success of school-age vaccination initiatives for enhanced public health outcomes and broader community immunity. |
|---|---|
| Does the data/intelligence identify any **health inequalities and whether they are reducing?** | National (COVER) reporting lacks insights on vaccination inequalities. UKHSA's national health equity audit revealed the presence of avoidable inequalities within the UK vaccination system. A local health equity audit was also completed. It took a systematic approach to examining the areas and extent of inequalities in Lambeth's vaccination service to enable a data driven targeted engagement programme to be designed for those most need it. Inequalities in vaccination coverage and timeliness were found in Lambeth's childhood vaccination system. |
| What are the **challenges hindering any progress** and **are there actions which can be taken** to address these? | Vaccination challenges stem from complex and interacting factors, including intrapersonal (such as vaccine fatigue and hesitancy, health beliefs and health literacy), community (such as religious, cultural and gender norms), and institutional elements (such as access & registration, culturally specific services, vaccination funding and delivery). Assurance on the quality of systems and processes in place to deliver the universal offer would be beneficial. Plans to continue the delivery of Q&A/education sessions in trusted sites like children's centres, emphasizing the importance of vaccination for child health, are in place with funding secured until March 2025. |

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D. People have healthy mental and emotional wellbeing

	Alliance and Programmes	LWNA and CYPA (owners)
	Update Month	May 24

indicator ID	Measure	Latest period	Lastest period position	Previous period Position*	vs previous Period*	Lastest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
D2	number of community organisations and volunteers undertaking mental health awareness and suicide prevention training.	Q4 23/24	20	30	-10	172	169	3	In 22/23 there were 169 attendances at Lambeth Suicide Prevention Training,Suicide Prevention Level 1 (Adults - V4),Raising Awareness of Mental Health. The number of volunteers undertaking MH training increased in 23/24 with higher attendance with 2 sessions delivered in Q3 with 77 attendees.	Increase
D3	Number of People Entering into Treatment for Integrated Talking Therapies	Mar-24	659	659	-	11,307	11,676	-369	Access Year end target was 11,676, 3% behind year end threshold.	Increase
D3	proportion of people people referred starting treatment within 6 weeks	Mar-24	98%	98%	-	98%	75%	23%	Target for 23/24 is 75%	Increase
D3	proportion of people who complete treatment and recover	Mar-24	55%	55%	-	55%	50%	5%	Target for 23/24 is 50%	Increase

*What does the data/intelligence indicate around **progress against the outcome?***	After a strong January and February, IAPT access rates in March fell well below the target, with the result that the service finished the year 3% under the target for the financial year as a whole. The proportion of people starting treatment within 6 weeks continues to be well above the target at 98% for the past three quarters. The proportion of those completing treatment and recovered continues to improve steadily and, at 53% in the forth quarter, has been over the target for three consecutive quarters.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Further data is needed to comment on any inequalities in relation to suicide prevention training. Access rates for Black service users have during this financial year but the recovery rate for the Black community, despite some improvement, continue to be a cause of concern. Drop-out rates continue to improve thanks to actions taken to under an ongoing quality improvement project.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	The primary challenge continues to be that Black service users tend to come to the service with more significant problems than the all-service average. Increased admissions from the Black community has increased the proportion of those for whom the service will not provide enough support. Lambeth Talking Therapies has conducted interviews with everyone completing treatment and increased training for therapists. This focuses on the reasons why Black Service users may leave treatment before it is completed or otherwise not report themselves as recovered on completion.

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

Alliance and Programmes	Sexual Health
Update Month	May 2024

indicator ID	Measure	Latast period	Lastest period position	Previous period Position*	vs previous Period*	Lastest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
E3	Number of LARC uptake in Primary Ccare. No. IUD/S insertions	23/24 Q1	145	80	65	145	42	103	Baseline = Q2 22/23	Increase

*What does the data/intelligence indicate around **progress against the outcome**?*	Quarterly monitoring reports indicate the activity across GPs and within the LARC Hub have remained relatively consistent throughout the year, with the majority of LARC activity taking place within the Integrated Sexual Health Clinics (ISHC) throughout Q1 – 3 in 2023/24 for Lambeth residents, with a small reduction in the activity taking place at individual practice level, the under 25s remain a small cohort within the overall activity figures. The LARC Hub activity has remained relatively consistent across the quarters, with less activity taking place here and no emergency IUDs taking place within primary care settings, the Hub is open 2 days a week. In Q3 there were 309 appointments available with 246 appointments used. The data supplied in the above line is GP level activity for Q1.
*Does the data/intelligence identify any **health inequalities and whether they are reducing**?*	
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Improving the reporting of ethnicity and disability across the services would support us to identify more detail and actions on health inequalities. The availability of qualified LARC fitters has been an ongoing challenge across GPs and Practice Nurses (PN) and this activity has remained for purposes of contraception only. Commissioners are currently reprocuring the LARC Hub contract which includes paid training for GPs and PNs and has specified that the services can be made available for non-contraceptive purposes to support the ICB work to develop Women's Health Hub (WHH) pathways. Commissioners have also increased the payment tariffs for LARC activity within primary care and has increased the budget for the new LARC Hub.

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

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

indicator ID	Measure	Latest period	Lastest period position	Previous period Position*	vs previous Period*	Lastest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
F1	Uptake of the NHS Health Check for all eligible adults	Apr-24	931	788	143	8.4%	8.7%	-0.3%	Baseline = cumulative % uptake of those eligible vs position at same point in 22/23 Lastest position = total checks completed in month	Increase
F1	uptake of SMI health checks	Apr-24	377	413	-36	68.0%	61.0%	7.0%	Baseline = cumulative % uptake of those eligible vs position at same point in 22/23 Lastest position = total checks completed in month **National target at year end = 60%**	Increase
F1	Uptake of LD/AHC health checks	Apr-24	101	152	-51	84.6%	87.0%	-2.4%	Baseline = cumulative % uptake of those eligible vs position at same point in 22/23 Lastest position = total checks completed in month **National target at year end = 75%**	Increase
F2	proportion of Bowel Cancer screening for those aged 60-74	Jul-23	60.4%	60.5%	-0.1%	60.4%	60%	0.4%	Baseline = National Target	Increase
F2	proportion of Cervical Cancer Screening aged 25-64	Nov-23	62.8%	62.7%	0.1%	62.8%	80%	-17.2%	Baseline = National Target	Increase
F2	proportion of breast cancer screening for women aged 50-70	Jul-23	55.0%	55.4%	-0.4%	55.0%	80%	-25%	Baseline = National Target	Increase

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

F1.1 Uptake of the NHS Health Check for all eligible adults - NHS health check outcomes for Q3 remain broadly in line with previous Quarters. 10% of patients who had a check in Q3 were referred to lifestyle services or prescribed medication including 45 prescribed statins, 40 referred to the NDPP and 32 to weight management. 2% were diagnosed with a health condition (hypertension 17 patients, diabetes 10 patients and CKD 5 patients) and put onto appropriate registers. 83% were identified with Low 10-year CVD risk, 14% with Moderate risk and 3% with High risk and all given appropriate advice and support.

F1.2 Uptake of SMI health checks & F1.3 Uptake of LD/AHC health checks- 2023/24 targets for SMI and LD health checks were exceeded, as anticipated in the February report. There was a significant increase of 8% in SMI health checks indicating that more people accessed an annual check in 2023/24 than in the previous year. We've been working hard with practices to improve data quality for SMI health check and made them aware of the payment triggers of the incentive scheme

F2 Cancer Screening programme: The Catch 22 non-responder calling project will further support the uptake of bowel cancer screening. The Catch 22 multi-lingual facilitators have contacted over 8,000 Lambeth residents who have not participated in bowel screening. The project, including the extension is at its final stage, with the remaining kits being ordered on behalf of non- responders and an impeding evaluation of the impact. It is expected that there will be a further increase in uptake once the dashboard data is refreshed.

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

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

*Does the data/intelligence identify any **health inequalities** and whether they are reducing?*	**F1.1 Uptake of the NHS Health Check for all eligible adults %** - A new NHS health check data monitoring dashboard developed during Q3 demonstrates that uptake is broadly in line with population demographics. For example of those who have had a HC 26% are Black and 26% are White Other (both higher than borough average), whilst 28% are White British (lower than borough average). The dashboard will be used at PCN level to address gaps in access and uptake.
*What are the **challenges** hindering any progress and **are there actions which can be taken** to address these?*	**F1.1 Uptake of the NHS Health Check for all eligible adults & F1.2 Uptake of SMI health checks & F1.3 Uptake of LD/AHC health checks-** - Public Health are working to develop a PCN-led at-scale HC model to improve consistency of the offer across the borough and target underserved groups who are not accessing the service. This is likely to require PCN collaboration on data sharing and outreach/engagement. Work to improve the quality of data of the SMI register in practices will continue in 2024/25 with practices incentivised to further improve data quality as part of the local GP incentive scheme. Practices are also incentivised to perform additional assessments and follow-up interventions as specified in the National Technical Guidance and health outcomes are being monitored. Efforts to ensure health check information performed by SLaM teams is properly coded into patients' GP records. Significant increases in the size of the LD register due to national coding errors during November and December 2023, have levelled-out and was 1,648 at the end of March 2024. Work is planned to identify those who do not routinely attend for health checks and make plans to engage.

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

Alliance and Programmes	NWDA (Owner)
Update Month	Mary 2024

indicator ID	Measure	Latest period	Lastest period position	Previous period Position*	vs previous Period*	Lastest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
G1	proportion of people with Type 2 diabetes who receive 8 checks on an annual basis	Apr-24	82%	74%	8%	82%	77%	4.7%	Latest position = cumulative position year to date. Previous Period = same position for same period last year. **Baseline = National Target of 77%**	Increase
G3	Cardiovascular dashboard, HYP aged 79 or under and last BP is less than or equal to 140/90 this FY	Apr-24	69%	62%	7%	69%	77%	-8.0%	Latest position = cumulative position year to date. Previous Period = same position for same period last year. **Baseline = National Target of 77%**	Increase
G3	Cardiovascular dashboard, HYP aged 80 or over and last BP is less than or equal to 150/90 this FY	Apr-24	82%	76%	6%	82%	77%	5.0%	Latest position = cumulative position year to date. Previous Period = same position for same period last year. **Baseline = National Target of 77%**	Increase
G4	proportion of people over age of 75 who are taking 10 or more medicines, having a medication review	Apr-24	826	554	272	49.3%	1.4%	48%	Baseline = April 2023 position Lastest position = number of cumluative reviews completed in year	Increase

| *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 2023. Improvement is seen towards the 77% year-end target with more people in Lambeth having BP control than at the same time last year. At the end of 2023-24, the Lambeth met ambition for patients aged 80 or over, but more work is needed for those aged 79 or under. Focussed work continues in prioritising those cohorts who are not controlled and who are from the BAME population. Health Equity Champions have been recruited to support hypertension work as per PCN focus. Lambeth Together joined the national 'Know Your Numbers Week" public campaign in September where 117 staff took up the opportunity in Brixton Civic Centre to measure BPs. Promotion of the EZ analytics measure for reducing health inequality in hypertension, was discussed and promoted at LTC Update Webinar. 75% of community pharmacies have signed up to offer the national hypertension check service and service activity continues to grow. Focussed hypertension training events for primary care staff at non clinical Protected Learning Time and at nurse forum completed in December. CESEL have been providing support to PCNs and practices aligned to the work with Chronic Kidney Disease. Lambeth are joining the national May Measurement Month and through a series of events held in May, will highlight the Community Pharmacy Blood Pressure Check Service in support of more blood pressure checking in the community.

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 2023 to March 2024 and is cumulative over this period. The Lambeth ambition has been met with an average of 82%..
The number of Structured Medication Reviews (SMR) in Lambeth patients who are 75 years or over and prescribed 10 or more medicines is continuing to progressively increase. 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 undertaken as part of a patient-centred, holistic approach to healthcare have been shown to improve outcomes, reduce unnecessary or inappropriate prescribing and polypharmacy, reduce harm and improve patient outcomes. |
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G. People who have developed long term health conditions have help to manage their condition and prevent complications

Alliance and Programmes	NWDA (Owner)
Update Month	May 2024

*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	The Cardiovascular app within EZ analytics has been updated for 23-24 to provide more detailed ethnicity data. Current data 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 updated for 23-24 to capture ethnicity data. Currently data shows that the proportion of people from Black, Asian or other ethnicity groups who have had their 8 Care Processes measured and completed is increasing as more annual reviews are undertaken. Year on year performance across the measured groups has also increased. 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.

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

Alliance and Programmes	LWNA and CYPA (owners)
Update Month	May 2024

indicator ID	Measure	Latest period	Lastest period position	Previous period Position*	vs previous Period*	Lastest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
H1	average wait times for triage and initial assessment following a referral to the Living Well network Alliance Single Point of Access to be under 72 hours by 2024	Mar-24	10.2	8.9	1.3	7.3	36.1	-28.8	Baseline = April 23. Reporting average waiting time (in days) for urgent introductions only	Decrease
H2	access to Lambeth Talking Therapies for Black African and Caribbean residents	Q4 23/24	693	574	119	2565	2380	185	Baseline = New Black or Black British clients in 22/23 divided by 4 x 3 (for Q3)	Increase
H2	Recovery rates access to Lambeth Talking Therapies for Black African and Caribbean residents	Q4 23/24	47%	46%	1%	47%	45%	2%	Baseline = 22/23 recovery rate for Black or Black British clients	Increase
H5	Proportion of children and young people with eating disorders are seen by a clinician within 1 week for urgent appointments and 4 weeks for routine support	Oct-23	100.0%	100.0%	0.0%	100.0%	83.0%	17.0%	Baseline = National Target Lastest position = cumulative % within target vs position at same point in 22/23	Increase
H5	Number of children and young people waiting longer than 44 weeks for an assessment and commencing treatment with	Oct-23	17.0%	17.0%	0.0%	17.0%	12.3%	4.7%	Baseline = March 22/23 position	Decrease

*What does the data/intelligence indicate around **progress against the outcome?***	Wait times for triage and initial assessment slipped again in March but remain better than the April 2023 baseline. A business plan for significant change to address this issue has been presented by Alliance management and is being refined while implementation of the initial organisational and process changes has begun. Given budgeting arrangements, IAPT access is expected to be higher in the first half of the year and lower in the second. Access numbers, were high in January and February, due to a high number of incoming referrals following the December holiday period. However, access for March was well below the monthly target and the service was 3% below plan for the financial year as a whole. Actions taken under and IAPT quality improvement project have led to the recovery rate now being consistently over target for the second half of the financial year 2023-34.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	The data on wait times does not indicate any significant disparity in waiting times between service users based on their ethnicity. Access to Lambeth Talking Therapy for Black residents has historically been lower than expected given Lambeth demographics. However, the most recent data shows that efforts to address this are being effective, with Black access rates now being 2.8 percentage points higher than expected. Despite focused efforts to address the issue, the recovery rate for Black service users remains 5.3 percentage points under the whole service average. It should be noted however that this is an improvement of 1.7 percentage points against the baseline and 2022-23 result.

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

Alliance and Programmes	LWNA and CYPA (owners)
Update Month	May 2024

*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Reducing SPA wait times is highly sensitive to both staff numbers and team productivity, both of which were significantly reduced over the holiday period and continued to be depressed in the first quarter. A new Team Leader and Clinical Expert are now in post and a business case for significant organisational and process change has been presented to Alliance Leadership. Initial changes are in progress while the business case for the full change program is being refined and strengthened. The latest available data shows that IAPT has made significant progress in advancing access for Black services users, but recovery rates remain a challenge, with Black service users starting with more serious problems than the all-service average. The service has increased ethnicity awareness and trauma sensitivity training for therapists and continues to undertake exit interviews with service users not reporting themselves to be recovered, to better understand any specific issues that they encountered.

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

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

indicator ID	Measure	Latest period	Lastest period position	Previous period Position*	vs previous Period*	Lastest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
I1	usage of consultant connect by primary care	Jan-24	733	670	63	6,195	6,479	-284	Baseline = cumulative calls this financial year vs position at same point in 22/23	Increase

*What does the data/intelligence indicate around **progress against the outcome?***	Thriving Communities, Building Healthier Communities and the Health and Wellbeing Bus have secured funding to support delivery for the 2024/25 financial year 80+ health and wellbeing events held to date with more planned HWB Bus saw 8500+ people for 12 months up to Feb 24, visited 37 locations and attended 30 events Community MSK day held in March 2024 – invited 250 people along with VCS representatives Grassroots funding – working with 51 projects Renal cardiometabolic model of care is due to go live in June 2024 – linked to existing hepatology clinics there should be learning to share for future pieces of work Integration Working Group developing an options paper for how integrated neighbourhood teams could be approached in the borough, aligning with existing work around this area
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Relevant health inequalities are identified within the Health and Care Plan.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Long term funding remains a concern e.g. potential roll out of PEACS programme in additional PCNs to support residents living with Chronic Pain. Leads are working to understand how funding could be utilised most effectively. NWDA has agreed another 12 months of funding for the Community Connector role and we are out to recruit for the Engaging with Communities CCPL to support ambitions outlined above.
Additional Comments	Measures for this item to be reviewed to fully capture progress

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

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

indicator ID	Measure	Latest period	Lastest period position	Previous period Position*	vs previous Period*	Lastest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
J1	proportion getting an appointment with their GP practice within two weeks and this includes all populations and those who contact their practice urgently are assessed the same or next day according to clinical need	Feb-24	91.2%	90.1%	1.1%	91.2%	85.0%	6.2%	Previous Period = Year end position 22/23 Baseline = national target (85%)	Increase
J8	capacity of virtual wards	Mar-24	224	198	26	224	185	39	Baseline = Target capacity for that period (Target occupancy)	Increase
J8	proportion of virtual wards being used	Mar-24	97%	94%	3%	97%	80%	17%	Baseline = Target occupancy forthat period Previous position = Target capacity for that period	Increase

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

GP Practice appointments -General Practice continue to exceed the national threshold of 85% for patients being seen within 2 weeks. General Practice will continue to secure investment through the Primary Care Recovery plan to deliver additional appointments and improve care navigation. Through the strengthening General Practice programme, powered by data syrup and APEX, Lambeth will assess opportunities to improve continuity of care alongside additional access.

Virtual Wards - Phase 1: Capacity Expansion of the Lambeth and Southwark Virtual Wards programme has effectively been achieved. As of April 2024 the system is now providing a capacity of 231 virtual ward beds across 3 different providers and 11 teams, leaving just a balance of 9 beds to achieve the minimum target set by the NHSE virtual wards ambition. The decision in late March 2024 to support and allocate additional funding to the KCH IRT (Respiratory care) and St Christopher's (Pal/EoL Care) proposals for developing a virtual ward has resolved the issue regarding the inequitable service provision in our boroughs, and the additional contribution to the virtual ward bed capacity will mean Lambeth and Southwark will achieve the NHSE capacity target by July 2024. In addition the services collectively on balance are achieving the 80% occupancy target, meaning there is an efficient flow of patients, however it is noted that some teams contribute to this more than others.

J4 Number of people accessing healthcare professionals through increased use of community pharmacies & J5 Number of people using the community - The Lambeth Pharmacy First Plus Pilot was launched in March 2023 to address and support 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 1687 consultations between March 2023 and March 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 (GP-CPCS) whilst no longer incentivised via the national contract, supports the national approach to increasing GP access. 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.

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

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

*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	**GP Practice appointments -** 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. **Virtual Wards -** The issue regarding inequitable geographical coverage of some clinical pathways has been addressed with investment to IRT and St Christopher's to mobilise and implement their virtual wards. True demand of Virtual Ward services is not yet known and a key priority of the programme will be to analyse a population health approach to any inequalities that are not yet identified, and address them within the current service provision through a process of transformation and change management. The Remote Monitoring project continues to progress and learning will be shared in due course. Remote monitoring may well address any issues of extra capacity required to ensure patient volume can be managed appropriately and identified inequalities can be potentially be reduced through closer integrated working and patient choice. **J4 Number of people accessing healthcare professionals through increased use of community pharmacies & J5 Number of people using the community -** Data from March 2023 to March 2024 shows most interventions (1284) 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, 46% of patients would have gone without medication and 53% would have visited general practice to request the medication on prescription, as they are unable to buy the medicines over the counter to deal with minor conditions due to the current cost of living crisis. People who are receiving support through universal credit, income support, the NHS Low income Scheme or are under the age of 16 years old, are the top social vulnerability eligibility groups accessing Lambeth Pharmacy First Plus Service in March 2024.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	**GP Practice appointments -** Patient expectation and satisfaction, nationally, regionally and locally continues to be challenging. During 2023/24 General Practice will have provided more patient contacts then at any time since the NHS formed with 19% more patient contact than pre-covid. Productivity remains exceptionally high and arguably more resilient compared to other parts of the Health and care system, however we acknowledge patient access remains both a national and local priority and one that concerns our local residents. Leveraging investment through the Access Recovery programme – practices will deploy better telephony, improve signposting/ care navigation and explore alternative consultation methodologies to enhance the patient journey and reduce the 8am rush. Practices can access limited funding to support internal change management to help practices get the most out of digital opportunities, and equally important, post deployment, work with patients and staff to improve the experiences of those using these services.

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

What are the challenges hindering any progress and are there actions which can be taken to address these?

GP Practice appointments - Patient expectation and satisfaction, nationally, regionally and locally continues to be challenging. During 2023/24 General Practice will have provided more patient contacts then at any time since the NHS formed with 19% more patient contact than pre-covid. Productivity remains exceptionally high and arguably more resilient compared to other parts of the Health and care system, however we acknowledge patient access remains both a national and local priority and one that concerns our local residents.

Leveraging investment through the Access Recovery programme – practices will deploy better telephony, improve signposting/ care navigation and explore alternative consultation methodologies to enhance the patient journey and reduce the 8am rush.

Practices can access limited funding to support internal change management to help practices get the most out of digital opportunities, and equally important, post deployment, work with patients and staff to improve the experiences of those using these services.

Virtual Wards - Remote Monitoring utilisation remains challenging. A plan is in progress to implement further clinical pathways, however a more focused piece of work through Organisational Development needs to be able to reflect on and understand the barriers and establish a plan to encourage greater use of the new technology for the benefit of patient care and improving capacity within the system.

The intention of the programme is to progress to phase 3: Sustainability; Optimisation, scale-up and Integration. The programme to further develop and consolidate the Virtual Ward provision in Lambeth and Southwark with the following suggested objectives:
• To reduce variation in access, response and delivery to our population of virtual ward provision
• Ensure simplified referrals to services with potential consideration of a single point of access
• Ensure seamless transition between services, and specialities, and effective discharge from Virtual Ward services
• Optimise and increase the use of remote monitoring technology developing our approach and remote monitoring model
• Align with the Lambeth and Southwark's Single Point of Access to Same Day Urgent Care model development
• Align with SEL programme to define a Virtual Ward core offer and reduce variation

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

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

*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	**Virtual Wards (Cont.)** A Lambeth and Southwark Virtual Wards Summit has been arranged with seeks to: • Reflect on progress to date including : • How Lambeth and Southwark Virtual Wards Benchmark across SE London and Nationally • Measuring progress against our system maturity assessment • To co-design the longer-term vision of Integration and optimisation of virtual ward provision in Lambeth and Southwark; including new ways of working and wider ambition beyond achievements to date • Discuss and scope meaningful use of remote digital technology; opportunity for expanding remote monitoring offer and integration with EPIC • Increased promotion of both the Lambeth Pharmacy First Plus service and the Community Pharmacy Consultation Service (CPCS, now under the national Pharmacy First) is needed amongst local GP practices. The Medicines Optimisation Team has linked in with the Local Authority Cost of Living Programme Lead to discuss continual and increased promotion of the service to local residents. The Medicines and LTC Team is continually promoting the services via local bulletins to GP practices, has increased direct local communications to GP practices in areas of low engagement and with GP practices who support the IAC (Initial Accommodation Centre)/ Asylum Seekers Contingency and bridging hotels. • General Practice feedback has been that the pilot has a had a positive impact for patients and reduced GP appointments for minor conditions however access across all Lambeth Pharmacies is needed to improve equity of access. • Community Pharmacy neighbourhood leads (CPNLs) are being given additional hours to engage with general practice and their peers to provide clinical leadership and support the national access priority. • The Community pharmacy dashboard launched in October, providing CPNLs with up to date data to inform pharmacies and GP practices of referral, uptake and benchmarking rates of Community Pharmacy services, such as the GP-CPCS service. • The data feed for CPCS has been refreshed to reflect GP referrals to the national Pharmacy First scheme, and this has identified we are referring more people than previously understood. The updated data for 23-24 is reflected in the following data.
Additional Comments	**J4 Number of people accessing healthcare professionals through increased use of community pharmacies & J5 Number of people using the community -** There has been a national rebranding of the GP-CPCS and other clinical services provided through community pharmacy to 'Pharmacy First'. This now includes a 7 clinical conditions which can be assessed and treated through pharmacies, including provision of antibiotics and other treatments. This is not to be confused with the local Pharmacy First Plus pilot, which addresses inequalities in access to medicines over the counter for a range of common conditions. The local pilot has been rebranded to Lambeth Pharmacy First Plus.

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

Alliance and Programmes	NWDA (Owner)
Update Month	May 2024

indicator ID	Measure	Latast period	Lastest period position	Previous period Position*	vs previous Period*	Lastest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
K1	number of people with an intermediate care offer	Mar-24	35	47	-12	649	757	-108	Baseline = cumulative accepted referrals to reablement this financial year vs position at same point in 22/23	Increase
K1	number of people who have a reduced need for care at the end of this service.	Mar-24	79%	85%	-6.0%	79%	78%	1.0%	Baseline = March 23/24 position	Increase
K2	proportion of carers of the users of Adult Social Care Services are offered a carers assessment.	Mar-24	100%	90%	10.0%	100%	98%	2.0%	Baseline = March 23/24 position	Increase
K3	Proportion of people identified as being in their last year of life on practice registers	Q4 23/24	1,988	1,953	35	1,988	1,651	337	End of Life Register. Baseline = register as at Q4 22/23	Increase
K3	Proportion of people with Personalised Care and Support Plan(PCSP)/UCP	Q4 23/24	48%	48%		48%	42%	6%	Baseline = % of those on the End of Life Register at at Q4 22/23	Increase

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

On care offer, the number of accepted referrals to Reablement has continued to decrease. The Reablement service have been triaging people on their waiting list by telephoning people at home. The result is that a large number of people are reporting they no longer require therapy and they have been removed from the waiting list, or they do not require therapy at this time. This has led to a significant decrease in the waiting list and the number of accepted referrals.

There is also some work happening in the Discharge Operational Delivery Group (DODG) working with therapists on the acute wards about the criteria for referring to reablement. This will help to reduce the number of people being referred to the service who are not appropriate. The number of people who have a reduced need for care at the end of a period of Reablement has increased and this is positive. Following the mock inspection 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. At the time of this report we did not have the data for Therapy Only referrals. The percentage for people with a reduced need for care at the end of Reablement has improved and is now 88%.

We have a high performance rate for the proportion of carers of service users who were offered a carer's assessment. The baseline is 98% and the latest overall position is 100%. We have recently delivered a webinar to staff with a focus on Carers. 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.

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

Alliance and Programmes	NWDA (Owner)
Update Month	May 2024

*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	On care offer, the majority of reablement referrals come via the hospital discharge route. We are increasing the number of people who are offered a reablement service via our front door team in Adult Social Care in order to offer reablement to people living in the community at home. This will help to offer a more equitable service for those residents living at home who may benefit from reablement care.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	On care offer, 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. The calls to people on the waiting list has been described above. The DODG group have also been working on increasing the number of weekend discharges at GSTT and there has been an increase in weekend discharges as a result of this work.

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

Alliance and Programmes	CYPA (Owner)
Update Month	May 2024

*What does the data/intelligence indicate around **progress against the outcome?***	Due to the installation of a new Electronic Patient Record (EPR) system at Guy's & St Thomas' Hospital and King's College Hospital, the performance reporting of maternity services in South East London is currently on hold. The EPR is still in its stabilisation phase, and it is anticipated that service reporting will resume in June 2024. In the meantime, the Children & Young Person Alliance (CYPA) has concentrated on maintaining maternity quality and governance through various Lambeth forums, including Council Scrutiny, the Lambeth Together Executive Group, and more recently, the Lambeth Health and Wellbeing Board, where discussions on equality, inclusion, and diversity initiatives in maternity services took place. Additionally, the CYPA presented an in-depth maternity report to the Lambeth Together Assurance Group in March this year. The CYPA will continue to collaborate closely with maternity providers in Lambeth and the Local Maternity & Neonatal System to re-establish essential maternity performance data for our borough. The caseload midwifery model demonstrated significant improvements in maternal and new-born outcomes. Key metrics include a notable reduction in the total caesarean section (CS) rate (38.9% to 24.3%) and emergency CS rate (22.5% to 15.2%) among women receiving caseload care compared with traditional care. Additionally, preterm birth rates were significantly reduced (11.2% to 5.1% before 37 weeks gestation). These improvements suggest that caseload midwifery, particularly among high-risk groups such as mothers in higher deprivation quintiles and from BAME backgrounds, can markedly improve birth outcomes

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

Alliance and Programmes	LDA (Owner)
Update Month	May 2024

indicator ID	Measure	Latast period	Lastest period position	Previous period Position*	vs previous Period*	Lastest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
M3	rate of uptake for an Annual Health Check and Health Action Plan for those with LDA	Apr-24	83.1%	64.2%	18.9%	83.1%	85.0%	-1.9%	Baseline = cumulative position to date vs same period last year	Increase

*What does the data/intelligence indicate around **progress against the outcome?***	**M3 rate of uptake for an Annual Health Check and Health Action Plan for those with LDA -** Rate of uptake of AHC and HAP: The achievement of 83.1% in is excellent against a national target of 75%. While this is slightly behind the previous year (22/23: 85%), the actual number of checks completed has increased. Over the last 6 financial years Lambeth has met or exceeded the target, only failing to do so in 19/20 and 20/21 when there was major disruption due to the pandemic. **M1 Discharges from specialist inpatient units -** : Reducing the use of inpatient services: One-system data analysis of admissions and discharges across Lambeth within the ICS (adults only), showed that Adults: 14 patients were discharged to the community in the three years to March 2023 (after removing repeat admission/discharges).; In 2023/24 there were 3 admissions (autism diagnosis only) and 7 discharges
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	**M3 rate of uptake for an Annual Health Check and Health Action Plan for those with LDA -** Comparison of data on health indicators collected during AHCs shows: •In some areas people with LD are achieving slightly better outcomes than people in the general population as shown by indicators of management of hypertension and diabetes •Fewer people with a learning disability have a healthy weight compared to the rest of Lambeth **M1 Discharges from specialist inpatient units -** Proportion of those in most restrictive inpatient settings from BAME backgrounds has reduced from 54% in 2020/21 to 43% in 2023/24 showing a positive move away from using restrictive environments
*What are the **challenges hindering any progress** and are there actions which can be taken to address these?*	Market challenges can create barriers to people with challenging behaviour being discharged in 2023/24. Mitigation: through securing accommodation in London using capital funds released by NHSE; and proactive development work with care providers Access to informative and consistently reported data has been a challenge and work continues to access data from EMIS, and to report across the system on key messages. We now have access to bespoke in borough as well as SEL data re LD AHC's that allows detailed drill down including by PCN and demographic characteristics i.e. ethnicity, gender This will allow us to further target our work to those who are most disadvantaged with repost to health outcomes.

Alliance and Programmes	LWNA (Owner)
Update Month	May 24

indicator ID	Measure	Latast period	Lastest period position	Previous period Position*	vs previous Period*	Lastest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
N3	number of acute mental health inpatient readmissions within 30 days	Mar-24	0	4	-4	0	2	-2	Baseline = position at March 23	Reduce

What does the data/intelligence indicate around **progress against the outcome?**	Only three patients were readmitted within 30 days during the fourth quarter and none in March 2024. This is the first time there have been no 30-days readmissions during the month since the Alliance began tracking this metric in July 2018. This indicates that efforts to review discharge protocols continue to be successful in reducing readmissions.
Does the data/intelligence identify any **health inequalities and whether they are reducing?**	Analysis of 30-day readmissions measure does not include a breakdown by ethnicity, but it is very unlikely that any such analysis would be meaningful given the relatively low numbers involved.
What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?	Demand for inpatient beds increases year on year and, while capacity remains constant, there is inevitably pressure to discharge as soon as appropriate community support can be arranged and any risks can be assessed and managed. The need for multi-agency coordination around discharges is fully recognised. A process involving daily multi-agency meetings to review discharge plans is in place to ensure that discharged patients are both medically ready and have appropriate on-going support in place.

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

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

indicator ID	Measure	Latast period	Lastest period position	Previous period Position*	vs previous Period*	Lastest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
O1	number of people resettled into longer-term accommodation	Q3 23/24	3%	3%	0%	3%	5%	-2.0%	Baseline = Q4 22/23 position	TBA
O1	number of rough sleepers brought into accommodation	Q3 23/24	78	58	20	58	38	20	Baseline = Q4 22/23 position	TBA
O3	proportion of people living in our supported housing that are registered with a GP	Q3 23/24	90%	79%	11%	90%	74%	16%	Baseline = Q4 22/23 position	TBA
O4	rate of residents in supported housing engaged with mental health support services.	Q3 23/24	20%	14%	6%	20%	12%	8%	Baseline = Q4 22/23 position	TBA

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

2023-24 saw a significant increase in rough sleeping across London. The Greater London Authority (GLA) are yet to publish the annual Pan London figures, but analysis of the borough level data shows that Lambeth saw the highest ever number of rough sleepers recorded. The rough sleeping outreach team recorded contacts with 866 rough sleepers, compared with 623 in 2022-23 and 438 in 2021-22. Just under half of the 866 in 2023-24 were people who had never been recorded as sleeping rough before. Much of this has been attributed to the cost of living crisis and soaring accommodation costs in the capital, particularly in the private rented sector. Further analysis will be required, and commissioners will utilize the enhanced reporting now available on the CHAIN database.

There was a surge in numbers of people recorded as "Living On The Streets" (LOS) during the middle two quarters of the year. This was partially due to a change in the definition of LOS brought in by the government but also due to the wait for accommodation brought about by a large influx of new rough sleepers. This has now retuned to normal levels of around 19-20 partially due to the Severe Weather Emergency Protocol (SWEP) being mobilized in Q3.

The Vulnerable Adults Pathway and the DLUHC funded Rough Sleeping Initiative hotel accommodation continue to operate at full capacity with move on to independent accommodation remaining a real barrier due to competition and rising prices in the private rented sector.

The final two quarters of the year have seen a significant increase in GP registration in the Vulnerable Adults Pathway rising to 92% in Q4. The rate of residents engaging with mental health services has doubled since the start of the year to 25% in Q4.

On Substance Misuse, the data would indicate that there is an increase with the number of people seeking support for their drug or alcohol misuse problems – which is reflected in wider data telling us that numbers in treatment are on the rise. In addition to this, the new on-street engagement team have been working alongside the rough sleeping team to signpost people into treatment and support.

Finance

Finance: South East London ICB: Lambeth

Overall Finance Position (2023/24 M12)

	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	1,200	211	989	1,200	211	989
Community Health Services	25,540	25,010	530	25,540	25,010	530
Mental Health Services	21,503	21,333	170	21,503	21,333	170
Continuing Care Services	31,961	32,743	(782)	31,961	32,743	(782)
Prescribing	38,664	42,002	(3,338)	38,664	42,002	(3,338)
Prescribing Reserves	607			607	607	607
Other Primary Care Services	3,783	3,735	48	3,783	3,735	48
Other Programme Services	2,648	261	2,387	2,648	261	2,387
Delegated Primary Care Services	83,117	83,379	(262)	83,117	83,379	(262)
Corporate Budgets	5,811	4,787	1,024	5,811	4,787	1,024
Total	**214,833**	**213,460**	**1,373**	**214,833**	**213,460**	**1,373**

Overall Savings Position (2023/24 M12)

	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 2023-24 starting budgets	(2,325)	(2,325)	0	(2,325)	(2,325)	0
Additional Vacancy Factor	0	(1,044)	1,044	0	(1,044)	1,044
Continuing Care Services	(1,834)	(1,620)	(213)	(1,834)	(1,620)	(213)
Prescribing	(1,611)	(1,538)	(73)	(1,611)	(1,538)	(73)
Total	**(5,770)**	**(6,528)**	**758**	**(5,770)**	**(6,528)**	**758**

- The borough is reporting an overall £1.4m favourable variance for 2023-24 full year outturn position. The position includes £0.8m overspend on Continuing Healthcare, £2.7m overspend on Prescribing (inclusive of reserve) and £0.3m overspend on Delegated Primary Care, offset by underspends in some budget lines and including the impact of £6.5m savings delivered, recovery action (£2.9m) and implementing freeze on new financial commitments.

- The underlying key risks within the reported position relate to Prescribing, Continuing Healthcare, Delegated Primary Care and Integrated Community Equipment Service Contract.

- The number of active CHC and FNC clients at M12 was 573.

- Prescribing month 12 position is based on M10 2023/24 actual data as the PPA information is provided two months in arrears. The year end forecasted overspend of £2.7m is driven by increase in demand, price/supply pressures due to Cat M/ NCSO and Long-Term Condition drug prescribing. All ICBs are experiencing similar impact. The borough Medicines Optimisation team are working on saving initiatives via local improvement schemes including undertaking visits to outlier and selected practices to identify further opportunities around prescribing efficiencies, working with community pharmacy to reduce waste and over-ordering, etc. The team is delivering the savings plan as practices progress with local improvement plans in-year.

Finance: Lambeth Council – ASC & Integrated Health M12 position

	FULL YEAR BUDGET 23/24 (£000)	FULL YEAR OUTTURN 23/24 (£000)	VARIANCE (£000)
ADULT SOCIAL CARE	116,065	116,952	(1)
INTEGRATED COMMISSIONING	222	220	(2)
SENIOR MGMT – INTEGRATED HEALTH & CARE	2,168	2,168	-
PUBLIC HEALTH	418	418	-

ASC Service Groups	Full Year Budget (£000)	Full Year Outturn (£000)	Variance (£000)
ADULTS WITH LEARNING DIFFICULTIES	42,070	44,096	2,027
ADULTS WITH MENTAL HEALTH NEEDS	13,274	12,347	(927)
OLDER PEOPLE	29,078	33,079	4,001
OTHER – ADULTS	13,625	4,173	(9,452)
ADULTS WITH PHYSICAL DISABILITIES	12,447	17,195	4,748
SUPPORTED HOUSING	718	717	(1)
SUPPORTING PEOPLE	4,853	4,454	(398)

£6.6m overspend in ASC mitigated through the use of non-ringfenced reserves and non-recurrent funding to ensure balanced outturn position.

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

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

Main pressure areas:

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

Main mitigations:

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

Quality

SEL Insight from Third People's Panel survey - NHS 111

The survey was carried out in partnership with the NHS 111 programme to understand people's views and experiences of NHS 111 and determine how to improve patient access to care through this service. The findings will support the redesign of the NHS 111 service by informing the specification, as well as performance targets that will be set for the new service. The findings will inform the plans to improve patient experience and identify ways to overcome barriers that people face when using the service. The third South East London (SEL) People's Panel survey was carried out between November 2023 - January 2024. The South East London Integrated Care Board (SEL ICB) pays for and arranges the NHS 111 service on behalf of people living in south east London (SEL). The current arrangements run out in 2025 and therefore, the need to put in place a new NHS 111 service to begin in September 2025.

A total of 194 People Panel members responded, representing a response rate of 18.5% of the panel. In addition, the survey was also promoted to members of the public and received 213 additional responses. The report includes combined finding and recommendations. Follow the link below for the full report.

South East London People's Panel survey 3 report | Let's Talk Health and Care South East London (letstalkhealthandcareselondon.org)

Key Findings

- Findings show that although people generally have a good understanding of the role of the NHS 111 service, more promotion is needed around the service's capabilities.
- More than 50% of respondents reported having used the service within the past year, with the majority choosing to access the service via telephone.
- The primary reasons for accessing the NHS 111 service included seeking clarity on the urgency of their conditions (34%), utilising it as an alternative to the GP service during out-of-hours periods (30%), or when unable to secure a timely appointment (19%).
- Those who had used the service acknowledged and appreciated the helpful advice and support provided once they had spoken with a clinician but expressed concerns about long wait times for callbacks.
- Overall, the majority of respondents expressed satisfaction with the service received, as they were able to obtain the necessary advice and/or care. However, some individuals reported dissatisfaction, flagging issues such as not receiving the advice or care needed, frustration with the triage process, and long waits for callbacks.

New NHS 111 service

- The majority of respondents prefer telephone (rather than online) access to NHS 111 services, finding it more accessible, easier to explain their concerns, and more reassuring to speak directly with a person.

- Among the survey respondents, over 69% expressed a preference for receiving a callback as soon as the clinician is available (rather than at a prearranged time) to obtain the help and advice they need. Of these, 55% indicated a preference for callbacks as soon as the clinician is available at any time, day or night, while 13% preferred this during daytime hours only. Preferences for callbacks varied depending on the health condition, urgency of the situation, and other pre-existing complex health issues.
- Respondents emphasised the importance of receiving callbacks within 4 hours for non-urgent issues and within 30 minutes for urgent health conditions.
- Language barriers, digital exclusion, and accessibility challenges for individuals with physical and sensory impairments, as well as socioeconomic deprivation, were identified as the most common barriers to using the service or limiting access to it.
- Over 80% (326) of respondents said that they value the service, considering NHS 111 an essential resource. They expressed their desire to continue having access to the service in the future. Some examples of respondents' comments about the importance of the service are noted below:

'Yes. I have found 111 exceptionally helpful, informative and efficient.'

'Yes, as an autistic person I hate going to A&E. Too many people overwhelms me and I know this would make my situation a lot worse'

'It is an extremely essential part of the health service especially since the pandemic and I am unable to get a face-to-face appointment with my doctor- I feel lucky to have this service available because of this'

Next steps

The NHS 111 service survey results are supporting the redesign of the NHS 111 service for south east London. Feedback from the survey respondents allows SEL ICB to evaluate the current NHS 111 service from the patient perspective, as well as ensuring that in the redesign those elements that patients value are kept and change things where possible to further improve things for patients.
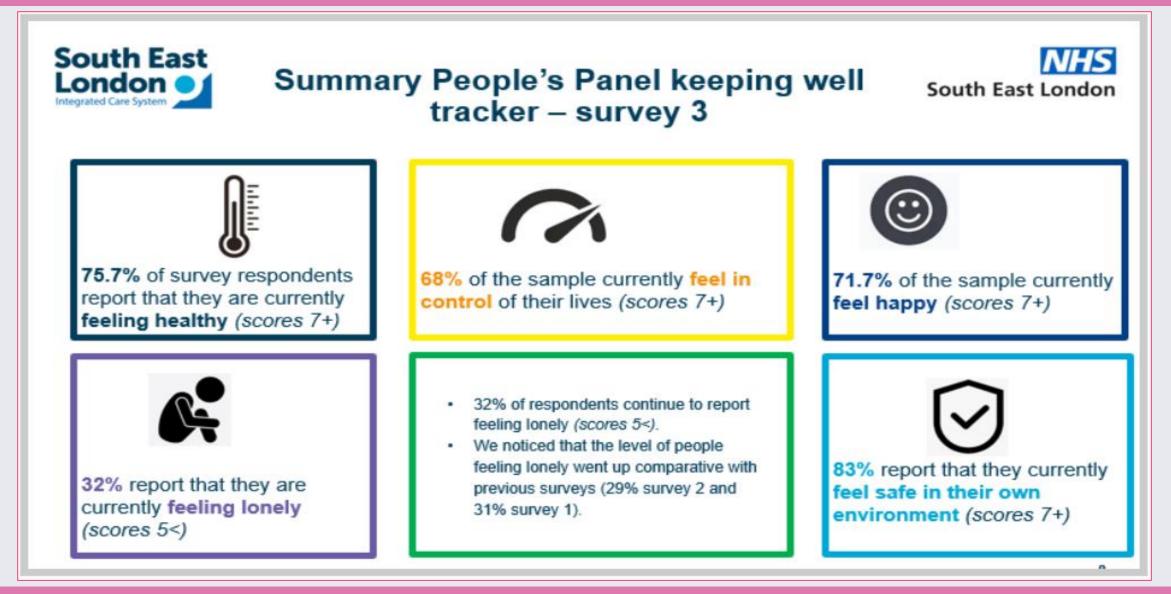
The findings will inform SEL ICB's approach to developing the specification, as well as performance targets that will be set for the new service. The ICB will continue to collect feedback on its proposals and adapt to respond to the needs of the people and communities in south east London.

This report will inform the ICB's plans to improve patient experience of using the service and identify ways to overcome barriers that people are facing when using the service. The ICB will be working with south east London borough colleagues to shape the service models based on recommendations from this report.

South East London
Integrated Care System

NHS
South East London

Summary People's Panel keeping well tracker – survey 3

75.7% of survey respondents report that they are currently **feeling healthy** (scores 7+)

68% of the sample currently **feel in control** of their lives (scores 7+)

71.7% of the sample currently **feel happy** (scores 7+)

32% report that they are currently **feeling lonely** (scores 5<)

- 32% of respondents continue to report feeling lonely (scores 5<).
- We noticed that the level of people feeling lonely went up comparative with previous surveys (29% survey 2 and 31% survey 1).

83% report that they currently **feel safe in their own environment** (scores 7+)

Quality Alerts for Lambeth Apr-23 to Apr-24 (13mths)

Issues reported

Issue	Count
CANCER /2WW REFERRAL ISSUES	112
APPOINTMENT / TREATMENT DELAY	74
DELAYED TEST RESULTS	43
POOR COMMUNICATION	37
MEDICATION/PRESCRIBING	30
GENERAL REFERRAL ISSUES	26
DELAYED DIAGNOSIS	21
IT ISSUES IMPACTING PATIENT SAFETY	15
FAILURE TO FOLLOW UP	15
ADMIN ERROR / IG BREACH	14
POOR /NO DISCHARGE SUMMARY	12
UNSAFE/INAPPROPRIATE DISCHARGE	5
POSSIBLE FAILURE OF ADEQUATE CARE	4
DIAGNOSTIC IMAGING INCIDENTS	2
DISTRICT NURSING ISSUES	2
EQUIPMENT	2
FAILURE OR DELAY IN MATERNITY SERVICES	1

Most frequently reported QAs:

- **Cancer 2WW referral issues –** 112 incidents reported, 73 of those were raised by acute trusts for incorrect referral forms being submitted to dermatology and other referral errors. The remainder relate to delays in appointments and outcomes from consultations due to capacity and industrial action.

- **Appointment/ treatment delays –** 74 incidents reported in the period, 64 were for acute trusts across 35 specialities.

- **Delayed test results –** 43 incidents reported, the highest number of alerts were in relation to pathology (12) and interventional radiology (10).

Actions taken by the ICB

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

Lessons Learnt from Quality Alerts in Lambeth

General referral issues 7872

Three duplicate x-ray referrals sent by a GP to two local trusts - all were identical apart from the urgency of the final request. When this was identified the team cancelled duplicates and booked an appointment. This posed a risk of duplication of exposure which can be deemed CQC reportable under IR(ME)R legislation.

Response from the practice

After the GP had completed the original referral, the patient asked if this could be changed to another trust, so the GP completed the second referral to the preferred trust. The Doctor then decided that he wanted to increase the urgency of the referral, and therefore did a third referral now marked as urgent. The practice was unaware of any way to cancel a referral, so are looking for advice on how to do this once it has been raised through ICE so that they can then share this learning with the team and prevent future occurrences.

IT issues impacting patient safety 7900

FIT result visible to GP <10 and was coded as normal. The patient made an appointment about an abnormal FIT as her NHS app showed result is 10 and is abnormal. Viewing the lab coding results you cannot see the out-of-range bar or an absolute result of 10, just <10 so clinician has coded as normal. If you go into investigations for the patient in EMIS can see <10 but range bar is shown as red and you still cannot see value of 10 shown on patient's app which clearly shows a result of 10.

Response from the trust:

This was investigated by the Reference Biochemistry laboratory also by the IT Team. The laboratory confirmed that the result issued on Epic was 'normal' (less than 10).

IT were asked to review this from an interface perspective and gave the following response: 'The NHS app is outside of our control, the result sent is displaying correctly in EMIS Web. Abnormal FITQ results will send a flag which displays in EMIS Web as abnormal'. Review Completed: 05-Apr-2024.

Action Taken: The IT team would advise the GP to contact their local IT to investigate the link between EMIS Web and the NHS App.

Risk Summary

Risk highlights

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

Lambeth Risk Register
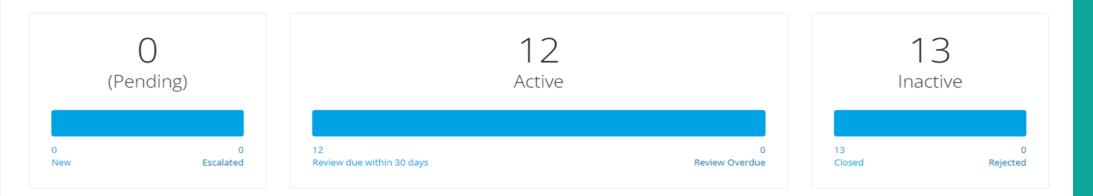
- There are 12 active risks on the Lambeth Together risk register.

- The risk register has been reviewed and updated to reflect current risk assessment. This report summarises the position as of 30th April 2024.

- No material changes in risk evaluation since March 2024, and no new risks added to the risk register.

- The relocation risk events at Lambeth Walk have subsided, but engagement is continuing with the local community and other relevant stakeholders.

- CHC overspend is identified as a risk in the current year

- Safeguarding of adults and children are identified and rated as moderate risks for the year in progress.

- All of the active risks are within ICB threshold, hence no escalations to the ICB is expected over the coming months.

- No GP practice estates or relocation risk is anticipated in Q1 2024/25.

- Work is ongoing to expand the LT risk register to include partnership and alliance risks. An ICB initiated process is ongoing and is expected to roll out in Q2 2024/25.

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 Place Risk Register

0 (Pending)
0 New	0 Escalated

12 Active
12 Review due within 30 days	0 Review Overdue

13 Inactive
13 Closed	0 Rejected

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

Consequence

Risk highlights

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

Risk #	Title	Risk Category	Current Rating	Target Rating	Risk Threshold	Next Review
127	CAMHS waiting times	Strategic	6	3	12	04/06/2024
128	Diagnostic waiting times for children and young people	Strategic	6	4	12	04/06/2024
132	Unbudgeted costs linked to learning disability 2024/25	Finance	6	6	12	04/06/2024
135	Safeguarding of Adults	Clinical, Quality and Safety	6	6	9	04/06/2024
142	Immunisation Rates	Strategic	12	3	12	04/06/2024
308	Lambeth Together, Capacity for Transformation	Operations	6	4	15	04/06/2024
318	Continuing Healthcare Budget and Performance 2024/25	Finance	8	8	12	04/06/2024
473	Prescribing Budget and Performance 2024/25	Finance	9	6	12	04/06/2024
513	Children Safeguarding & Protection from abuse	Strategic	10	5	12	04/06/2024
514	Business Continuity & Premises risk - Lambeth Walk Medical Centre relocation	Clinical, Quality and Safety	9	9	9	04/06/2024
515	Comminuty Equipment services Budget and Performance 2024/25	Finance	8	4	12	04/06/2024
516	Achievement of Financial Balance 2024/25	Finance	12	6	12	04/06/2024

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.

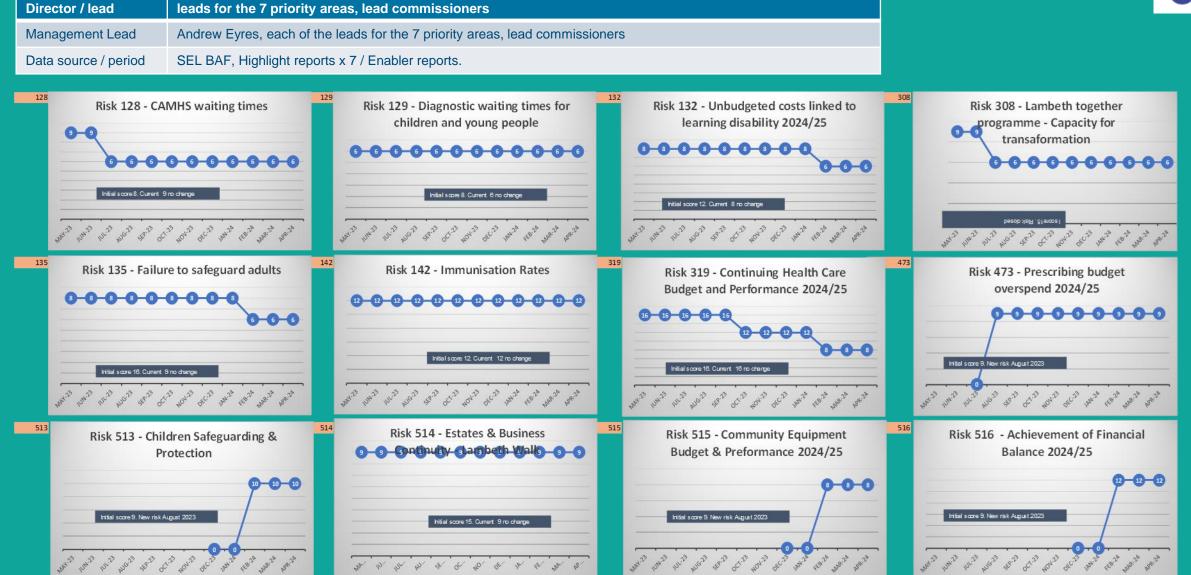**128** — Risk 128 - CAMHS waiting times
Initial score 8. Current 9 no change

129 — Risk 129 - Diagnostic waiting times for children and young people
Initial score 8. Current 6 no change

132 — Risk 132 - Unbudgeted costs linked to learning disability 2024/25
Initial score 12. Current 8 no change

308 — Risk 308 - Lambeth together programme - Capacity for transaformation
Iscore15 : Risk closed

135 — Risk 135 - Failure to safeguard adults
Initial score 16. Current 9 no change

142 — Risk 142 - Immunisation Rates
Initial score 12. Current 12 no change

319 — Risk 319 - Continuing Health Care Budget and Performance 2024/25
Initial score 16. Current 16 no change

473 — Risk 473 - Prescribing budget overspend 2024/25
Initial score 9. New risk August 2023

513 — Risk 513 - Children Safeguarding & Protection
Initial score 9. New risk August 2023

514 — Risk 514 - Estates & Business Continuity - Lambeth Walk
Initial score 15. Current 9 no change

515 — Risk 515 - Community Equipment Budget & Preformance 2024/25
Initial score 9. New risk August 2023

516 — Risk 516 - Achievement of Financial Balance 2024/25
Initial score 9. New risk August 2023

Lambeth Integrated Health and Care Directorate Business Plan Update

Integrated Health and Care Business Plan Q4 23/24

Q4 Inphase business plan actions	▼ .Percentage Complete
⊟ Adult Mental HealthGood health & wellbeing with an improved healthy life expectancy for those with the poorest outcomes	
Access: Reduce wait times for initial assessment through monitoring and reviews.	100%
Health Inequalities: Increase performance of SMI health checks.	100%
⊟ Adults CommissioningGood health & wellbeing with an improved healthy life expectancy for those with the poorest outcomes	
Quality and safety: Improve standards and oversight through PAMMS	75%
⊟ Adults TransformationGood health & wellbeing with an improved healthy life expectancy for those with the poorest outcomes	
Cancer - Work collaboratively with primary care to increase the uptake of cancer screening	100%
⊟ Adults with Learning DisabilitiesGood health & wellbeing with an improved healthy life expectancy for those with the poorest outcomes	
Focus on LDA Health Inequalities	100%
NHSE Learning Disability and Autism Programme	100%
⊟ Children and Young PeopleGood health & wellbeing with an improved healthy life expectancy for those with the poorest outcomes	
Design and deliver a Single Point of Access (SPA) for Children and Young People	50%
Pull together a comprehensive dataset for Lambeth women using maternity services.	100%
Recommission Domiciliary Care and CHC framework.	100%
Support Special Educational Needs and/or Disabilities (SEND) inspection preparation.	100%
⊟ Good health & wellbeing with an improved healthy life expectancy for those with the poorest outcomesLong Term Conditions Optimisation	
Long Term Conditions optimisation: Reducing health inequalities and improving access.	100%
⊟ Good health & wellbeing with an improved healthy life expectancy for those with the poorest outcomesMedicines Optimisation	
Medicines value: Identify high-value, quality initiatives for medicines optimisation	100%
⊟ Good health & wellbeing with an improved healthy life expectancy for those with the poorest outcomesPrimary Care and Transformation	
Deliver a Primary Care Commissioning programme	100%
Ensure the continuation of high quality access to general practice.	75%
⊟ Good health & wellbeing with an improved healthy life expectancy for those with the poorest outcomesPublic Health	
Health Determinant Research Collaboration - Staff training and development	100%
Health Protection - Redesign childhood Immunisations to meet challenge of low uptake	100%
Sexual Health - Re-modelling South East London Sexual Health Trust Contracts	90%
Staying Healthy - Develop and implement approaches to improve access to health improvement Services	100%
Staying Healthy - To make Lambeth an Age Friendly Borough	100%
Substance Misuse - Further development and embedding of the Combatting Drugs Partnership	100%

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 the areas of focus within the 23/24 plan. In Q4, we can report 80% of IHC business plan actions were completed with remaining 20%, recording an amber status. The reasons for not meeting year end objectives are multifactorial, ranging from programmes delays due to the complexity with delivery of specific milestones, optimisation workstreams continuing in 24/25 and impact on reporting structures due to EPIC implementation.

Lambeth Together Health and Care Plan Assurance

Process review for 2024/25

Introduction

At the last Lambeth Together Partnership Board meeting on 9th May, the board approved the updated Lambeth Together Health and Care Plan for 2024/25.

Following this, colleagues within the Lambeth Together Assurance Group agreed to recalibrate the existing impact measures to ensure delivery against the plan's outcomes. These measures will be monitored as part of the assurance process at LTAG meetings throughout the coming year.

The purpose of this report is to share with the Lambeth Together Partnership Board the details of the impact measure recalibration exercise and request that the board endorses these measures to monitor the Health and Care Plan for the year ahead.

Summary of proposed impact measures for 2024/25

Outcome	Outcome Description	Aliance/ Programme	Impact Measure	Target description/ agreement	Rationale
A	People maintain positive behaviours that keep them healthy	Staying Healthy	Proportion of opiate / non-opiate / alcohol users that left alcohol treatment successfully in the previous 12 months and do not re-present to treatment within 6 months.	Track against 23/24 baseline	During Year 1, the review process removed five impact measures. The mid-year review revealed data source challenges for weight management, smoking, BMI, and substance misuse. As a result, the team proposed measures aligned with Public Health programmes with reliable data sources.
			Smoking prevalence reduction	Smoking prevalence reduction by 1% (end of 24/25)	For NHS Health Checks, a new PCN model will replace the GP Federation model in 2024/25, so there are no set targets for that year. Partners will develop a new delivery model for 2025/26, focusing on high-risk groups and reducing inequalities
			Uptake of the NHS Health Check for all eligible adults	Monitoring activity in 24/25 due to implementation of new service delivery model	
B	People are connected to communities which enable them to maintain good health	NWDA	Number of social prescribing unique contacts	Work in progress to agree target with Age UK	During Year 1, the review process determined the removal of one impact measure. This measure related to the economic status (inactive) of people with long-term conditions (physical and mental health). Challenges with data sharing agreements and primary care systems not being tailored to consistently and accurately capture this information meant that reporting for this indicator is currently unavailable.
			Percentage of low-income residents coping financially	TBC	
			Residents' wellbeing, use of community assets and social cohesion	Monitor survey's results against last quarter findings	
C	People are immunised against vaccine preventable diseases	Staying Healthy	1) Proportion of Lambeth registered children by age 1 that have received all primary immunisations, and 2) Proportion of Lambeth registered children by age 2 that have received one dose of MMR	Track immunisatons update across both cohort against 23/24 activity (Target 90%)	The review process during Y1 determined deferral of one impact measure and Children Immunisations measure was adapted to better reflect age cohort uptake. Impact measure on School Vaccination consent forms will be developed for reporting through LTAG in Year 2. Commissioners will work with service provider to mitigate data quality concerns.
			Proportion of Lambeth registered population who are over the age of 65 receiving immunisation for Flu	Track immunisatons update across both cohort against 23/24 activity	
			Proportion of school-age vaccination consent forms returned to the vaccination provider.	Deferred (for further info see slide 11)	
D	People have healthy mental and emotional wellbeing	LWNA/ CYPA	Number of community organisations and volunteers undertaking mental health awareness and suicide prevention training	Track activity against 23/24 baseline	The review process during Y1 determined removal of one impact measure. One other measure had been removed during mid-year review process.
			Provisionally agreed - Number of Entering treatment with Short-Term Support with Living Well Centres.	Activity tracking	The measure on outcomes of access to children and young people that access emotional wellbeing support was challenging from data sources perspective, lack of performance framework alignment across AQP providers and low levels of data completeness and accurateness. We will continue to support CYPA colleagues with a view to introduce in the future measures to allow reporting and understanding of acticity in the space of children and young people emotional wellbeing support.
			Provisionally agreed - Number of Entering treatment with Focused Support with Living Well Centres.	Activity tracking	
			Provisionally agreed - LWNA Short Term Waiting Time	Activity tracking	
E	People have healthy and fulfilling sexual relationships and good reproductive health	Sexual Health	Number of LARC uptake in primary care	TBC	The Year 1 review process deferred one impact measure to Year 3. Currently, we cannot report on the demographic breakdown of access to abortion providers. Data source mapping and reporting are being developed with the Public Health Intelligence team in Year 2. This will consolidate business intelligence on this activity, enabling a better understanding of system pressures, inequalities, and service delivery
			Proportions of different ethnicities accessing contraception through SHL	Annual report at year-end (local ambition TBC)	
			Rates of STI diagnoses	TBC	
			Rates of STI testing	TBC	

The team will work with alliance and programmes to define targets where appropriate throughout the year.

Summary of proposed impact measures for 2024/25

Outcome	Outcome Description	Alliance/ Programme	Impact Measure	Target description/ agreement	Rationale
F	People receive early diagnosis and support on physical health conditions	NWDA	Number of new PrEP users (and continuers) resident in Lambeth	TBC	The review process during Year 1 resulted in the removal of one impact measure. Specifically, the impact measure for urgent referrals for suspected cancer cases was removed following changes in NHSE guidance on the cancer diagnosis pathway.
			Percentage of eligible people receiving an HIV test whilst attending Emergency Departments	Track activity from GSTT/KCH activity reports	
			Proportion of Bowel Cancer screening for those aged 60-74	60%	Regarding NHS Health Checks for the eligible population, a new PCN model of delivery will be introduced in 2024/25, transitioning from the GP Fed model. Consequently, there are no set targets for 2024/25. Partners will develop a new, scalable model of delivery for Year 2 (2025/26) with a focus on targeting at-risk groups and reducing inequalities. This measure will be moved to Outcome A due to its preventative nature
			Proportion of breast cancer screening for women aged 50-70	80%	
			Proportion of cervical Cancer Screening aged 25-64	80%	
			Uptake of LD/AHC health checks	TBC	
			Uptake of SMI health checks	TBC	
G	People who have developed long term health conditions have help to manage their condition and prevent complications	NWDA	Cardiovascular dashboard, HYP aged 79 or under and last BP is less than or equal to 140/90 this FY	77%	There were no changes to the impact measures under this outcome in Year 1.
			Cardiovascular dashboard, HYP aged 80 or over and last BP is less than or equal to 150/90 this FY	77%	At the year-end review, partners agreed to remove the impact measure on the ethnicity profile of the Chronic Pain register. After monitoring this data from 2022/23 to 2023/24, it was evident that the ethnicity profile had remained consistent with little to no variation over time.
			Proportion of people over age of 65 who are taking 10 or more medicines, having a medication review	Continue to increase the proportion of SMRs completed	Following the success of Structured Medication Reviews for individuals over 75 years old in 2023/24, the team has expanded the age group cohort for this impact measure in 2024/25.
			Proportion of people with Type 2 diabetes who receive 8 checks on an annual basis	Maintain or reach a minimum of 77% of all 8 Care Process completion OR increase completion by 5 percentage points compared to baseline (23-24)	
H	When emotional and mental health issues are identified; the right help and support is offered early and in a timely way	LWNA/ CYPA	Access to Lambeth Talking Therapies for Black African and Caribbean residents to ensure they are as least as good as those of White residents	TBC	During Year 1's review process, three impact measures were identified for removal.
			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.	Access to be under 72h	One measure was already being reported, while another measure on Eating Disorders waiting times was removed because this service is commissioned by SEL ICB, and LCP has limited influence over its delivery pathway.
			Number of children and young people waiting longer than 52 weeks for an assessment and commencing treatment with Child and Adolescent Mental Health Services	TBC	The remaining measure focused on inpatient re-admissions. Data from Year 1 indicated low numbers of readmissions in 2023/24. For further details, refer to May's Assurance report.
			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	TBC	Additionally, the impact measure concerning CAMHS waiting times was adjusted from waits longer than 44 weeks to 52 weeks, aligning with NHSE guidance for 2024/25.
I	People have access to joined-up and holistic health and care delivered in their neighbourhoods	NWDA	Provisionally agreed - Health and Wellebing Bus - No of interactions - Welfare Advice and Mental Health session	Activity tracking	The review process during Y1 determined creation of two impact measures and continuing to report on one. We will continue to report on Consultant Connect activity with a view to better understand primary and secondary care communications. Following discussions with alliance partners it was decided we would be introducing impact measures in Year 2 closely aligned with neighbourhood working, particularly in the area of phsyical and mental wellbeing focusing on vital 5, welfare advice and other holistic components.
			Provisionally agreed - CVD Workplace service - Employers acceptance of CVD Assessment offer (no of CVD assessments delivered and no of assessment who required F/up)	Activity tracking	
			Provisionally agreed - Beacons service - No of interactions - Health & Wellbeing sessions and Hi 5	Activity tracking	

The team will work with alliance and programmes to define targets where appropriate throughout the year.

Summary of proposed impact measures for 2024/25

Outcome	Outcome Description	Aliance/ Programme	Impact Measure	Target description/ agreement	Rationale
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	NWDA	Capacity of virtual wards	Activity tracking	No changes were made to impact measures under this outcome in Year 1.

GP appointment activity from 2022/23 to 2023/24 consistently showed compliance above 90% for appointments within two weeks. Consequently, the impact measure for GP appointments within 2 weeks will be discontinued in Year 2. Instead, we will continue reporting the number of GP appointments for the Lambeth registered population, aiming for a 1.5% increase by the end of the year.

The impact measure for Urgent Community Response referrals will be removed in Year 2 as it is no longer an NHSE Single Oversight Framework indicator or a SEL priority.

Similarly, the impact measure for alcohol and drug-related Emergency Department attendances will also be removed in Year 2 due to issues with the GSTT EPIC report.

The Community Pharmacy Consultation Service has been replaced by NHS England's new umbrella service branded as "Pharmacy First," which includes various Community Pharmacy services. The data now reflects the Lambeth Pharmacy First Plus/Self-care Service and National Pharmacy First referral data for 2024-25. |
			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	TBC	
			Number of appointments in General Practice	Increase activity for 24/25 by 1.5%	
			Proportion of virtual wards being used	80%	
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	NWDA	Number of people who have a reduced need for care at the end of this service.	Activity tracking	No changes were made to impact measures under this outcome in Year 1.

Impact measures under the Adult Social Care (ASC) service line will carry over to Year 2. Partners discussed potentially introducing measures related to ASC Carers Strategy actions, but given the qualitative nature of the intelligence and ongoing finalisation of action plans and recommissioning contracts, Year 1 impact measures will be maintained.

The impact measure on the percentage of Lambeth Residents' Survey respondents aged 65+ describing their health as good will be discontinued in Year 2 due to its annual nature, limited sample size, and availability of other more insightful sources of intelligence.

Similarly, the impact measure on the proportion of uptake of Flu vaccinations in people known to be Carers will be |
			Number of people with an intermediate care offer	Activity tracking	
			Proportion of carers of the users of Adult Social Care Services are offered a carers assessment	90%	
			Proportion of people identified as being in their last year of life on practice registers	TBC	
			Proportion of people with Personalised Care and Support Plan(PCSP)/UCP	TBC	
L	Women have positive experiences of maternal healthcare and do not experience a disproportionate maternal mortality rate	CYPA	Continuity of Care	TBC	No changes were made to impact measures under this outcome in Year 1. We encountered challenges with reporting maternity data during this period, attributed to factors such as the implementation of a new patient record system by local providers, updates to the maternity services dataset, and a review of business intelligence resources by the SEL BI team.

Moving forward, impact measures will be refined to focus on the continuity of antenatal and post-natal plans, excluding intrapartum care. Reports will be accessible through LMNS/SEL BI analytics. |
| | | | Infant and maternal mortality | TBC | |
| | | | Patient experience indicators on maternity care | TBC | |
| 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 | LDA | Number of supported employment and supported internships we create through our health and care partners. | Track activity against 23/24 baseline | No changes were observed in Year 1 regarding impact measures under this outcome. We acknowledge challenges encountered with the impact measure on Autism Spectrum Disorders (ASD) waiting times, primarily due to local providers implementing a new patient record system.

Moving forward, we will focus on enhancing intelligence related to Annual Health Checks (AHC) and Health Action Plans for those with Learning Disabilities and Autism (LDA). This effort will centre on conducting audits to ensure the quality of AHCs and reaching out to seldom heard groups to improve engagement and outcomes. |
			Proportion of people with LDA in work or education	Track activity against 23/24 baseline	
			Rate of uptake for an Annual Health Check and Health Action Plan for those with LDA	TBC	
			Waiting times for an ASD diagnosis for children and young people	TBC	

The team will work with alliance and programmes to define targets where appropriate throughout the year.

Summary of proposed impact measures for 2024/25

Outcome	Outcome Description	Aliance/ Programme	Impact Measure	Target description/ agreement	Rationale
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	LWNA	Number of people per year are supported by the Living Well Network Alliance into paid employment	TBC	The decision to remove a measure related to readmissions, as discussed in Outcome H, was based on data indicating low numbers of readmissions in 2023/24. Partners were satisfied with progress in this area and agreed to discontinue this measure moving forward.\n\nAdditionally, we are implementing changes to the reporting methodology for employment and supported living measures to more accurately reflect the collaborative efforts of the LWNA partnership.\n\nRegarding restrictive interventions and seclusion, the focus is on reducing inequities for Black service users. The provider aims to achieve a 5% reduction in these inequities year on year.
			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)	Track activity against 23/24 baseline	
			Number 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,	Track activity against 23/24 baseline	
			Numbers of people with severe mental illness are supported to live in their own home	TBC	
			TBC - proposal seclusions and restrictive interventions on inpatient settings	TBC	
O	People who are homeless, or at risk of becoming homeless have improved health	Homeless	number of people resettled into longer-term accommodation	TBC	No changes were made to impact measures under this outcome in Year 1. We are currently awaiting proposals from partners regarding trajectories and targets for Year 2 impact measures.
			Number of rough sleepers brought into accommodation	TBC	
			Proportion of people living in our supported housing that are registered with a GP	TBC	
			Rate of residents in supported housing engaged with mental health support services.	TBC	
			Refer people to drug treatment services upon their release from prison, and what proportion then complete their treatment.	Engagement ambiton at 55%	

The team will work with alliance and programmes to define targets where appropriate throughout the year.