LAMBETH TOGETHER CARE PARTNERSHIP (FORMERLY LAMBETH TOGETHER STRATEGIC BOARD)

Date: Thursday 15 May 2025
Time: 1.00 pm
Venue: Brixton Library, Brixton Oval, London, SW2 1JQ

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Members of the Committee

Di Aitken	Lambeth Together Care Partnership Board Co-Chair. Neighbourhood and Wellbeing Delivery Alliance Clinical and Care Professional Lead, GP
Nozomi Akanuma	Living Well Network Alliance Clinical and Care Professional Lead, South London and Maudsley NHS Foundation Trust
Cllr David Bridson	Cabinet Member for Healthier Communities (job-share), Lambeth Council
Andrew Carter	Corporate Director of Children's Services, Lambeth Council
Paul Coles	Chief Executive, Age UK, Lambeth
Fiona Connolly	Corporate Director Housing & Adults Social Care, Lambeth Council
Eugenie Dadie	Patient and Public Voice Member
Louise Dark	Chief Executive Integrated and Specialist Medicine, Guy's and St Thomas (GSTT) NHS Foundation Trust
Andrew Eyres	Place Executive Lead Lambeth, South East London Integrated Care Board and Corporate Director, Integrated Health, and Care, Lambeth Council
Sarah Flanagan	Patient and Public Voice Member
Therese Fletcher	Managing Director, Lambeth GP Federation
Ruth Hutt	Director of Public Health, Lambeth Council
Penelope Jarrett	Chair, Lambeth Local Medical Committee, GP
Lilian Latinwo-Olajide	Programme Director, Black Thrive, Lambeth
Jasmina Lijesevic	Lambeth Together Care Partnership Board Lay Member
Julie Lowe	Site Chief Executive, Kings College Hospital NHS Foundation Trust
Cllr Nanda Manley-Brown	Lambeth Together Care Partnership Board Co-Chair / Cabinet Member for Healthier Communities (job-share), Lambeth Council
Raj Mitra	Children and Young People's Alliance Clinical and Care Professional Lead, GP
Ade Odunlade	Chief Operating Officer, South London and Maudsley NHS Foundation Trust
Folake Segun	Chief Executive, Healthwatch Lambeth
George Verghese	Co-Chair of the Lambeth Primary Care Clinical Cabinet, GP

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

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AGENDA

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

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Lambeth Together Care Partnership
Public Forum and Board Meeting in Public

Thursday 15 May 2025, 1:00pm – 5:00pm
Brixton Tate Library

AGENDA

THIS MEETING IS IN PERSON ONLY

Members of the public are welcome and encouraged to attend the Public Forum and observe the Board Meeting.

Agenda Item No. and Time	Agenda Item Title	Attachment / Supporting Information	Agenda Item Lead
1 p.m.	**Public Forum**		
60 mins	**Welcome and introductions** **The Public Forum and how to take part** **Questions from the public**		
2 p.m.	**Board Meeting in Public**		
1.	**Introductions** ▫ Welcome, introductions and apologies		**Dr Di Aitken** *Co-Chair*
2.	**Declarations of Interest** ▫ Members of the Board are asked to declare any interests on items included in this agenda		**Dr Di Aitken** *Co-Chair*
3.	**Review of Minutes** ▫ Members of the Board are asked to approve minutes and review any matters arising from the Lambeth Together Care Partnership Board meeting in Public on 6 March 2025	Paper enc.	**Dr Di Aitken** *Co-Chair*
4. 2:10pm (10 mins)	**Place Executive Lead Report** ▫ Members of the Board are asked to receive an update on key developments since the last	Paper enc.	**Andrew Eyres** *Place Executive Lead Lambeth, Corporate Director, Integrated Health, and Care, Lambeth Council and South East London Integrated Care Board*

Agenda Item No. and Time	Agenda Item Title	Attachment / Supporting Information	Agenda Item Lead
	Lambeth Together Care Partnership Board meeting in Public on 6 March 2025		
5. 2.20pm (35 mins)	**Deep Dive – Homeless Health** Members of the Board are asked to; ▫ Approve the progress report on the work of the Homeless Health programme against 'Our Health. Our Lambeth' activities and outcomes ▫ Endorse and support the recommissioning plans for the Vulnerable Adults housing pathway and rough sleeping outreach service	Paper enc.	**Emma Casey** *Lead Commissioner - Housing Needs*
6. 2:55pm (30 mins)	**Deep Dive - Sexual Health** Members of the Board are asked to; ▫ To approve the progress report on the work of the sexual health programme against 'Our Health, Our Lambeth' activities and outcomes ▫ To endorse the promotion of our sexual health services, including the outreach service and Find Sexual Health ▫ To work in collaboration to achieve our outcomes within the sexual health strategy	Paper enc.	**Nancy Padwick** *Strategic Lead for Sexual Health* **Jessica Engen** *Consultant in Public Health; Turning Point*
3:25 (10 mins)	**BREAK**		
7. 3.35pm (50 mins)	**Business Planning: Second Annual Review Our Health Our Lambeth** Members of the Board are asked to; ▫ Approve the second annual review of Our Health, Our Lambeth and the 2025/26 action plan ▫ Approve the final integrator model for Integrated Neighbourhood Teams (INTs) as agreed by the Neighbourhood and Wellbeing Delivery Alliance ▫ Note the 2025/26 SEL ICB (Lambeth) budget and 2025/26 Lambeth Council budget for	Paper enc & att.	**Alex Jackson** *Lambeth Together Programme Lead*

Agenda Item No. and Time	Agenda Item Title	Attachment / Supporting Information	Agenda Item Lead
	health and social care and support the expenditure plans		
8. 4.25pm (10 mins)	**Lambeth Together Primary Care Commissioning Committee (PCCC)** Members of the Board are asked to; ▫ Note the update on discussions held at the Primary Care Commissioning Committee on 19 March 2025 ▫ Ratify decisions made at the Primary Care Commissioning Committee on 19 March 2025	Paper enc.	**Jasmina Lijesevic** *Lambeth Together Board Lay Member*
9. 4.35pm (10 mins)	**Lambeth Together Assurance Group (LTAG) Update** Members of the Board are asked to; ▫ Note the report from the Lambeth Together Assurance Sub-Group and the associated Integrated Assurance Report presented on 18th March 2025	Paper enc & att.	**Jasmina Lijesevic** *Lambeth Together Board Lay Member*
10. 4.45pm (10 mins)	**Questions from the public**		
11. 4.55pm	**AOB** **Close** Date of next meeting: **3 July 2025** Public forum: 1pm-2pm Board meeting in Public: 2pm-5pm		**Dr Di Aitken** *Co-Chair*

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Lambeth together

Lambeth Together

Integrated Assurance Report

18 March 2025

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Our Health, Our Lambeth

Lambeth Together health and care plan 2023-28

Lambeth Together Health and Care Plan Scorecard – March 2025

			Mar-25				Jan-25	
ID	Outcome	Measures tracked	Measures Reported with a target	On plan/ target	% measures on track (where have a target)	Vs previous update	% measures on track (where have a target)	Comments
A	*People maintain positive behaviours that keep them healthy*	6	2	1	50%	–	50%	
B	*People are connected to communities which enable them to maintain good health*	4	2	2	100%	–	100%	
C	*People are immunised against vaccine preventable diseases*	2	2	0	0%	–	0%	Flu, Y1 and Y2 Child Imms uptake tracking below SEL plan/previous years trajectory
D	*People have healthy mental and emotional wellbeing*	4	3	1	33%	↓	67%	Average waiting time for LWNA Short term support as at February 25 is 1.8 weeks below plan.
E	*People have healthy and fulfilling sexual relationships and good reproductive health*	2	2	2	100%	↑	100%	LARC activity is monitored via EZ and SH team maintain a log, commentary support progress against plan. STI testing and diagnoses rate is monitored via quarterly GumCAD reports.
F	*People receive early diagnosis and support on physical health conditions*	5	5	3	60%	–	60%	One Cancer screening programme tracking above national target. SMI & LD Annual Health checks on a trajectory to meet year-end targets
G	*People who have developed long term health conditions have help to manage their condition and prevent complications*	4	3	2	67%	↓	100%	Cardiovascular measures slightly behind February's planned acitvity.
H	*When emotional and mental health issues are identified; the right help and support is offered early and in a timely way*	4	3	2	67%	–	67%	CAHMS report frequency impacted by EPIC transition
I	*People have access to joined-up and holistic health and care delivered in their neighbourhoods*	2	2	2	100%	–	100%	No changes since Q3 reported position
J	*People know where to go to get the right help, and are treated at the right time, in the right place, for their needs*	3	3	2	67%	–	67%	
K	*Older adults are provided with the right health and care support at the right time, live healthy and active later lives and are supported to age well*	5	5	4	80%	–	80%	
L	*Women have positive experiences of maternal healthcare and do not experience a disproportionate maternal mortality rate*	0	0	0	-		-	Reporting functions impacted by EPIC transition, deep dive presentation in Sept 24 provided snapshot report on LMNS BI activity.
M	*People with learning disabilities and/or autism achieve equal life chances, live as independently as possible and have the right support from health and care services*	3	1	1	100%	–	100%	Activity on LD education and employment support will be provided in March 25 deep dive, earlier report shared at LTEG in Oct.
N	*People using mental health support services can recover and stay well, with the right support, and can participate on an equal footing in daily life*	5	3	1	33%	–	33%	
O	*People who are homeless, or at risk of becoming homeless, (including rough sleepers and refugees) have improved health*	5	0	0	-	–	-	
	Total	54	36	23	64%	↓	69%	

Health and Care Plan: Key headlines (1)

	Outcome	Key Headlines
A	***People maintain positive behaviours that keep them healthy***	In Q3 2024-2025, there was a significant improvement in activity following the transitional stage of the new contracting model in Q1 and the impact of the Synovis lab cyber-attack in late Q1 through Q2 Practices continue to work to recover to a Business-as-usual position after the critical incident highlighted at the end of Q1. The NHS Healthcheck service was recommissioned in Spring 24 on a 2-year basis with the intention that the 2nd year would focus on the PCN's and Lambeth commissioners agreeing and developing an at scale model to deliver the service in the most optimal way, focussing on our key priorities. Practice representation is now formalised on the Lambeth Healthcheck Steering group to facilitate strategic goals including implementing the At Scale Model and targeting priority groups.
B	***People are connected to communities which enable them to maintain good health***	There is a continued high demand for social prescribing across Lambeth. Age UK Lambeth continues to see an increase in the number of referrals into the service. Within one PCN (Croxted) there have already been 65 referrals in 2025 demonstrating a clear need for social prescribing support in the borough.
C	***People are immunised against vaccine preventable diseases***	Achieving herd immunity and meeting the locally set target of 90% remains a challenge in Lambeth. The most recent data published for Quarter 2 of 2024/25 shows that the uptake of the DTaP/IPV/Hib vaccine, offered to babies at 8, 12, and 16 weeks of age, stands at 84.7%. Additionally, uptake for the first dose of the MMR vaccine is at 79.5%. Other boroughs in South-East London have also reported uptake rates below 90%. There are no updates to report for Outcome C at this time. The Q3 data has not yet been released, and remedial actions are still ongoing.
D	***People have healthy mental and emotional wellbeing***	The Lambeth Living Well Centres' Short-Term Support service (STS) started helping 131 new people in February, slightly fewer than in the previous month (133). The number of people Focused Support (FS) started supporting in February fell by much more, to 36 from 57 in January. Reducing the waiting list of the Lambeth Single Point of Access over the summer led to SPA referring high numbers to STS last summer. After falling to 50-60 in recent months the number of referrals rose significantly in January to 108.

Health and Care Plan: Key headlines (2)

	Outcome	Key Headlines
E	***People have healthy and fulfilling sexual relationships and good reproductive health***	Annual data has been released by UKHSA. The data show a 5% increase in the rate of LARC prescriptions since the previous year. (42.2 per 1000 women aged 15-44 in 2023 vs 40 per 1000 women in 2022). This is significantly higher than the London rate of 33.6 per 1000 and similar to the England average. Local service data show in Q3 there were 813 LARC appointments used in GP and the LARC Hub. There was an error in reporting Q2 data in the last report due to a user error. Over the last three quarters activity has remained stable which suggests access is currently stable. As the new Hub service mobilizes in the next quarter and the GP contracts enters it's second year, with the attached training offer, we will hope to see increased in activity, suggesting increased access.
F	***People receive early diagnosis and support on physical health conditions***	On Annual Health Checks there's a good progress from January and on track to achieve SMI and LD national health check targets by end of March. On Prep activity, at the end of January 2025, 834 residents had newly started on PrEP and 3,951 residents were continuing to use PrEP. The activity trend and clinic usage remains the same as the last reporting period.
G	***People who have developed long term health conditions have help to manage their condition and prevent complications***	The impact measures under this outcome are showing positive progress against year-end objectives. More black and minority ethnic people have been identified with hypertension when comparing February 2024 to February 2025 data; 23724 and 24843 respectively and within these cohorts, blood pressure control has remained consistent with higher absolute numbers in comparison to the previous year; 14,978 and 15,608 respectively. The Diabetes app within EZ Analytics has been further updated for 24-25 to provide more detailed data on improvements of the measurement and recording of the care processes for Black African, Black Caribbean, Mixed White and Asian, Unknown or not stated ethnic groups. Data is comparable to the previous year, noting the increase in diabetes population and the challenges faced during 2024-25.
H	***When emotional and mental health issues are identified; the right help and support is offered early and in a timely way***	In May 2024, just over 900 people were waiting for Lambeth SPA. In February 2025, that number has fallen to 365. People are now getting support sooner than they were in May, but they are still waiting too long. More introductions are being processed within 3 days (up to 22.4% in February from 17.6% in January). However, the average wait for people in February was 16.1 days, against a target of no-one waiting longer than 14.0 days. Lambeth Talking Therapies will keep focusing on having more new clients access the service who are then assesses as being recovered and showing significant improvement in their symptoms when they complete treatment (i.e. are in "Reliable Recovery"). The LTT service is also working to increase session numbers for Black clients and ensure that reliable recovery rates are consistently over 48% for all ethnic groups. Deep dive - See additional information on CAMHS enclosed with LTAG pack against this outcome.

Health and Care Plan: Key Headlines (3)

	Outcome	Key Headlines
I	***People have access to joined-up and holistic health and care delivered in their neighbourhoods***	The Beacon data shows that a rising number of HI-5 interactions are converting into health and wellbeing sessions, reflecting an overall improvement in our outreach efforts. A significant number of people have been directed to local resources for accessing statutory services within the borough. Additionally, there has been a notable increase in signposting to general practitioners (GPs) and primary care networks (PCNs).
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***	Community Pharmacy have undertaken 2,824 consultations between March 2023 and January 2025 with Lambeth residents/registered patients to provide advice and guidance on self-care and supply of medicines where appropriate. The NHS Pharmacy First Service (previously known as GP-Community Pharmacy Consultation Service) increases GP capacity through triaging of low-acuity conditions to community pharmacy. GP referrals to NHS Pharmacy First supports the national approach to increasing GP access. Data from service launch in 31 January 2024 to 31 January 2025 shows a positive increase in use. The Medicines Optimisation Team has collaborated with the Local Authority Cost of Living Programme Lead to discuss continual and increased promotion of the Lambeth Pharmacy First Plus service to residents. Community Pharmacy Neighbourhood Leads (CPNLs) have been engaging with general practice and their peers to provide clinical leadership and support the national access priority, which has supported increases in referrals.
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***	SEL Ageing Well Funding secured for project resource to help address these barriers, by working with primary care to support identification of people in the last year of their life and uptake of Universal Care Plans. Primary Care working with GP leads to mobilise project with a focus on creation of Clinical Lead Champion role, working with champions at GP level to increase completion and quality of UCP / ACP in Lambeth. 7 of 9 Primary Care Champions appointed to post across PCN. Organising launch event with lead in late January 2025.
L	***Women have positive experiences of maternal healthcare and do not experience a disproportionate maternal mortality rate***	The adoption of a new Electronic Patient Record system at Guy's & St Thomas' and King's College Hospitals continues to disrupt performance reporting for maternity services across South East London. While work to stabilise the system is ongoing, regular reporting has yet to resume.

Health and Care Plan: Key Headlines (4)

	Outcome	Key Headlines
M	***People with learning disabilities and/or autism achieve equal life chances, live as independently as possible and have the right support from health and care services***	Update to follow
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***	InUpdate to follow
O	***People who are homeless, or at risk of becoming homeless, (including rough sleepers and refugees) have improved health***	Recommissioning of the Vulnerable Adults Pathway is due to commence in April 2025, this includes changes to contract monitoring frameworks and KPI's including health outcomes. A continued focus on GP registration across the Vulnerable Adults Pathway (maintaining 90% or above) registration with dentists, engagement with mental health services and substance use services. The number of residents registered with GP's continues to be at its highest level. This has been achieved through contract monitoring and consistent messaging to Providers to ensure each resident is being supported to register when being accommodated in their service. SWEP (Severe Weather Emergency Protocol) continues to be activated when temperatures fall to zero or below and all rough sleepers are supported by our outreach team to accept emergency accommodation. Rough sleepers can then be assessed fully and access health services as required.

Finance

Finance: South East London ICB: Lambeth

Overall Finance Position (2024/25 M10)

	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	990	729	261	1,188	875	313
Community Health Services	23,525	23,597	(72)	28,230	28,275	(45)
Mental Health Services	19,305	19,704	(399)	23,166	23,819	(653)
Continuing Care Services	28,847	28,499	348	34,616	34,071	545
Prescribing	35,694	35,392	303	42,666	42,588	78
Other Primary Care Services	3,351	3,011	340	4,022	3,614	408
Delegated Primary Care Services	65,971	66,560	(589)	87,212	87,919	(707)
Corporate Budgets	3,264	2,941	323	4,012	3,668	344
Total	**180,948**	**180,434**	**513**	**225,112**	**224,829**	**283**

Overall Savings Position (2024/25 M10)

	Year to date Plan £'000s	Year to date Delivery £'000s	Year to date Variance £'000s	Annual Plan £'000s	Forecast Delivery £'000s	Forecast Variance £'000s
Efficiencies embedded within 2024-25 starting budgets	1,951	1,951	0	2,341	2,341	0
Continuing Care Services	1,202	1,879	677	1,442	1,879	437
Prescribing	1,091	1,806	715	1,393	1,873	480
Total	**4,244**	**5,636**	**1,392**	**5,176**	**6,093**	**917**

- The borough is reporting an overall £513k year to date underspend position and a forecast £283k underspend position at Month 10 (January 2025). The reported forecast position includes £653k overspend on Mental Health Services, £45k overspend on Community Health Services mainly driven by increased cost of the Cardiovascular Diagnostics contract and £707k overspend on Delegated Primary Care Services driven by locum reimbursements, retainer scheme and list size growth, offset by underspends in other budget lines.
- The main underlying key risks within the 2024-25 Lambeth's finance position relate to - Mental Health (including learning disabilities) and Delegated Primary Care Services budgets.
- Mental Health budget year to date overspend is driven by increased ADHD, Section 12 assessments claims, Mental Health and Learning Disabilities (LD) placement expenditure, and mitigated by constraining investments. Borough Commissioners leading on savings and efficiencies schemes (including Provider focused service and model reviews, High-cost joint health funded case reviews, etc. to manage cost.
- Delegated Primary Care Services year to date and forecast overspend position is driven by locum reimbursements, retainer scheme and list size growth.
- The CHC team continues to deliver on reducing packages for high-cost (PLD and OP) cases including for 1:1 care, Fast track reviews, PHB clawbacks and reduction, and transfer of out of area placements. Work is ongoing to establish better value costs. The number of active CHC and FNC clients at M10 is 583.
- Prescribing information data is provided two months in arrears by the NHS Business Services Authority (previously PPA - Prescription Pricing Authority). The borough is reporting a YTD underspend position of £303k and forecast £78k underspend at month 10 (January 2025) based on eight months actual data. The borough Medicines Optimisation team saving initiatives via local improvement schemes include undertaking visits to outlier practices, working with community pharmacy to reduce waste and over-ordering, etc. This is being linked with the wider SEL work being undertaken.
- The 2024/25 borough minimum savings requirement is £3.9m and has a savings plan of £5.2m. In addition to the embedded efficiency (£2.3m) as part of the budget setting process, the borough has saving plans for both Continuing Healthcare (£1.4m) and Prescribing (£1.4m) budgets. Year to date delivery at M10 is £1.4m above plan due to plan profile which differs from actual delivery profile. The forecast delivery is £0.9m above plan.

Finance: Lambeth Council – ASC & Integrated Health M9 2024/5 position

- **ASC** – latest forecast is showing an overspend of £8.382m, predominantly driven by overspend against client expenditure budgets.
- **Key pressures:**
  - Adults with Learning Difficulties & Adults with Physical Disabilities – high-cost supported accommodation placements
  - Older People - Nursing Care & Home Care – combination of increased year-on-year activity in nursing care, and inflation in fee rates for spot placements
  - Adults with Mental Health Needs - supported accommodation, residential care and nursing care high-cost placements
- **In year cost and demand management review:**
- Due to significant in-year pressures in the Council, all departments asked to focus on reducing overspends in-year. Key review areas continue to be:
  - Enhanced authorization levels for placement requests and changes, reviewing cost of new packages of support and high-cost packages
  - Targeted reviews and right-sizing care approach to ensure support is appropriate
- **Savings –** ASC has committed to make £3m savings in 2024/25, and further £3.47m in 2025/26 now agreed.
- **Integrated Health & Care budget:**
  - Breakeven position – partially funded by use of reserves to fund additional capacity in Integrated Commissioning teams and to move to new established structure with Public Health commissioning
  - Agreed savings for 2025/26 - £596k

Division	Budget £'000	Forecast £'000	Variance £'000
Adults with Learning Difficulties	42,348	47,924	5,576
Adults with Physical Disabilities	14,899	17,578	2,679
Adults with Mental Health Needs	11,124	12,179	1,055
Supported Housing	780	780	0
Older People	29,513	36,188	6,675
Other – Adults	11,346	3,927	(7,419)
Supporting People	4,853	4,669	(184)
Adult Social Care Directorate	**114,863**	**123,245**	**8,382**

Division	Budget £'000	Forecast £'000	Variance £'000
Integrated Commissioning	**222**	**222**	**0**
Senior Management	**1,577**	**1,577**	**0**
Public Health	**0**	**0**	**0**
Integrated Health & Care Directorate	**1,799**	**1,799**	**0**

Quality

Update to follow

Risk Summary

Risk highlights

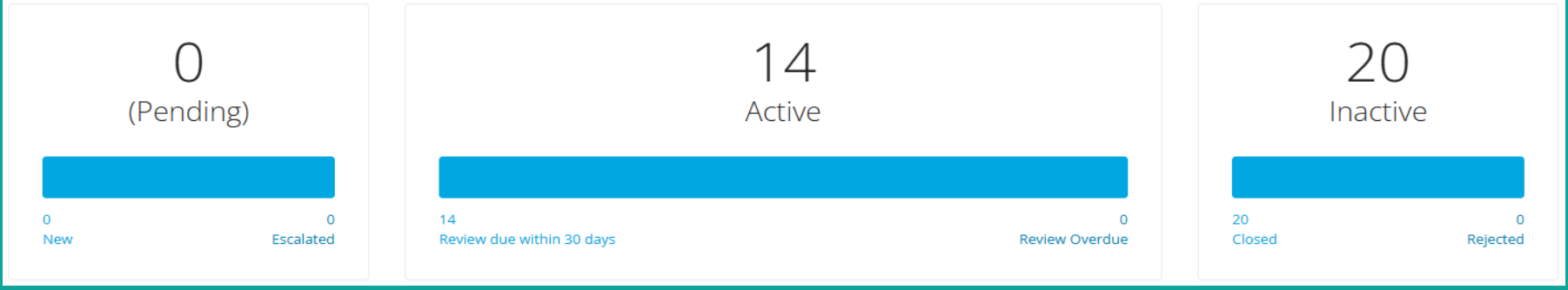
Director / lead	leads for the 7 priority areas, lead commissioners
Management Lead	Andrew Eyres, each of the leads for the 7 priority areas, lead commissioners
Data source / period	SEL BAF, Highlight reports x 7 / Enabler reports.

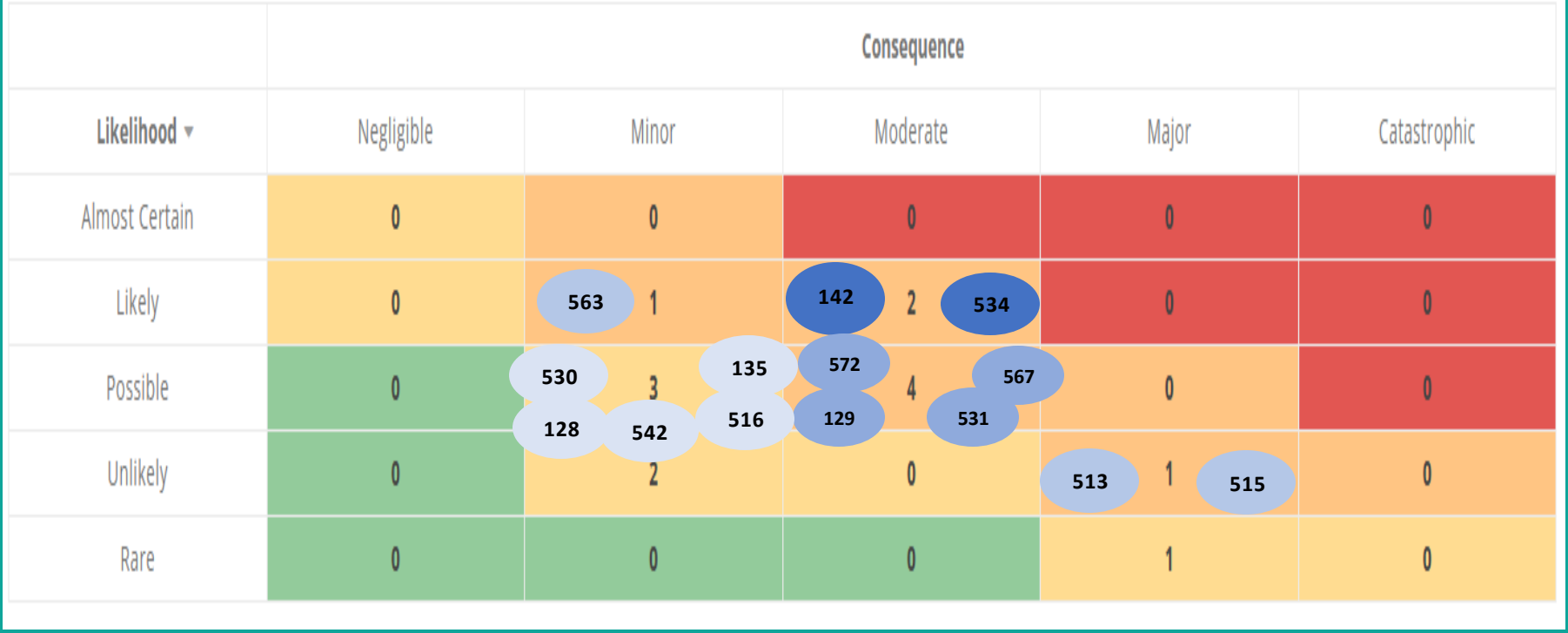
Lambeth Risk Register

- As of February, there were 14 active risks on the South East London Risk register for Lambeth.
- See below Lambeth risk register updates since the last report:
  - A risk under Primary care service line was closed. The risk on Interpreting Services procurement was closed in February, procurement process has been completed, contract awarded in January 25 and the new contract will be implemented from the 1st April 25.
  - Increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population - Seasonal Flu Vaccination (current score – 9)
- SEL Risk forum took place in January and risk leads met to discuss risks across SEL, receive updates from risk leads and review Local Care Partnership comparative report, no significant changes noted at this time. Following this meeting the SEL risk lead met with SEL Partnership Executive leads (PELs) in February and the following updates were provided in relation to two outstanding actions,
  - **GP collective action risk (567) –** this has been reduced in score to 6 by Greenwich (by reducing the likelihood). There was agreement that this score change was appropriate as the risk has not materialised. Risk lead (Peter L) to link with other Primary Care LCP leads to assess and decide on following Greenwich steps on score reduction.
  - **Interpreting services overspend (563)** – clarification was sought that the current risk score for this risk remains accurate at 8. Risk lead (Peter L) informs this information was reviewed in February and score reflects accurately current risk grade threshold.

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.





Lighter low risk score, darker higher risk score

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

Risk highlights

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

Risk ID	Risk Title	Sum of Current Rating
128	*CAMHS waiting times*	6
129	*Diagnostic waiting times for children and young people*	9
135	*Failure to safeguard adults*	6
142	*Immunisation Rates protect Children, including vulnerable groups from communicable diseases.*	12
513	*Inadequate resource in safeguarding structure*	8
515	*Community Equipment Services Budget and Performance.*	4
516	*Achievement of Financial Balance 2024/25*	4
530	*Unbudgeted costs linked to learning disability*	6
531	*Continuing Health Care Budget and Performance*	9
534	*Prescribing Budget and Performance*	12
542	*Delivery of Efficiency Savings*	4
563	*Interpreting Services Overspend*	8
567	*Primary Care GP Collective Action*	9
572	*Increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population - Seasonal Flu Vaccination*	9

Lambeth Integrated Health and Care Directorate Business Plan Update

Integrated Health and Care Business Plan 24/25

Row Labels	Sum of Percentage Complete
Adults Mental Health	
Access: Reduce wait times for initial assessment through monitoring and reviews.	75%
Health Inequalities: Increase performance of SMI health checks.	75%
Adults Transformation	
Cancer - Work collaboratively with primary care to increase the uptake of cancer screening.	75%
Adults with Learning Disabilities	
Focus on LDA Health Inequalities.	75%
NHSE Learning Disability and Autism Programme.	75%
Financial Savings (IHC)	
Financial Savings	75%
Good health & wellbeing with an improved healthy life expectancy for those with the poorest outcomes Adults Commissioning	
Quality and safety: Improve standards and oversight through PAMMS	100%
Good health & wellbeing with an improved healthy life expectancy for those with the poorest outcomes Children and Young People	
Design and deliver a Single Point of Access (SPA) for Children and Young People	50%
Pull together a comprehensive dataset for Lambeth women using maternity services.	75%
Recommission Domiciliary Care and CHC framework.	50%
Support Special Educational Needs and/or Disabilities (SEND) inspection preparation.	100%
Long Term Conditions Optimisation	
Deliver Long Term Conditions Optimisation Prioritites	75%
Medicines Optimisation	
Deliver Medicines Optimisation Priorities	75%
People and Workforce (IHC)	
Increase the diversity of our leadership team.	75%
Primary Care	
Delivery Plan for recovering Access to Primary Care.	75%
Strengthening General Practice by integrating services to deliver joined up care to patients.	75%
Public Health Objective	
HDRC - Implement Lambeth HEART programme of training and research development	75%
Health Protection - Continue the delivery of the new childhood vaccination in new spaces pilot	100%
Sexual Health - Refreshed service offer	75%
Staying Healthy - An Age Friendly borough where people can live healthy and active later lives.	75%
Staying Healthy - Implement and embed approaches to improve access to health improvement services.	75%
Substance Misuse - Continued embedding of the Combatting Drugs Partnership.	75%

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 Q3 position across the areas of focus within the 24/25 plan. All actions has been listed as Green and none of the actions was escalated for support, trajectories are on target to meet year-end objectives.

As we approach 25/26 (Year 3) of Borough Plan, we have been engaging with service leads over the past weeks to review plans for 25/26. We will be finalising these plans ensuring they align with LT Health and Care plan and national guidance. We will keep the group updated once plans are finalised and ratified.

South East London ICB Corporate Objectives & delegated assurance metrics

South East London ICB Corporate Objectives & delegated assurance metrics

Standard	Period covered in report	Comparator	Benchmark	Current performance	SEL Average	Above/below SEL average?	SEL Borough rank
Dementia diagnosis rate	Dec-24	National standard	67%	77.6%	70.2%	Above	1
IAPT discharge	Nov-24	Operating plan	585	500	N/A	N/A	-
IAPT reliable improvement	Nov-24	Operating plan	67%	68%	67%	Above	2
IAPT reliable recovery	Nov-24	National standard	48%	53%	48%	Above	1
SMI Healthchecks	Q2	Local trajectory	66%	50%	47.4%	Above	2
LD and Autism - Annual health checks	Nov-24	Local trajectory	689	892	N/A	N/A	-
Bowel Cancer Coverage (60-74)	May-24	Corporate Objective	62%	62%	67.0%	Below	6
Cervical Cancer Coverage (25-64 combined)	Jun-24	Corporate Objective	63%	63%	66.9%	Below	6
Breast Cancer Coverage (50-70)	May-24	Corporate Objective	57%	56%	61.7%	Below	6
Percentage of patients with hypertension treated to NICE guidance	Dec-24	Corporate Objective	70%	65%	64.0%	Above	3
Flu vaccination rate over 65s	Dec-24	Corporate Objective	58.0%	52.7%	68.1%	Below	5
Flu vaccination rate under 65s at risk	Dec-24	Corporate Objective	31.3%	28.2%	28.8%	Below	5
Appointments seen within two weeks	Dec-24	Operating plan	91.0%	90%	89.6%	Above	3

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

- shows the position against key areas of local performance vs national targets, agreed trajectories and other comparators.
- covers a range of metrics where Local Care Partnerships either have a direct delegated responsibility for delivery, play a key role in wider SEL systems or are an agreed SEL corporate objective.
- Note that some of the metrics reported are not as timely as those reported within the Lambeth Heath and Care Plan. Also South East London Benchmarks may not align with Lambeth agreed trajectories.

Appendix:
Health and Care Plan Outcomes:
Detailed assurance narrative

Impact measures performance trend (1)

Outcome	Impact measure	Target/Pla	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Year to Date	Comments
A	Smoking prevalence reduction	Actual										12.6%	12.6%		12.5%		12.4%		Data source - SEL Vital 5 dashboard (as of February 25) - Of those with a smoking status, 30,,177 (12.37%) are recorded as smoking in the past 5 years.
		Plan				13.4%	13.3%	13.2%	13.2%	13.1%	13.0%	12.9%	12.8%	12.7%	12.7%	12.6%	12.5%		Target to reduce by 1% from 22/23 year end (13.4%). Data source is Office for Health Improvement and Disparities (OHID) Prevalence but as only annual it's proposed that we use SEL ICB Vital 5 dashboard
		Variance										-0.3%	-0.3%		-0.2%		-0.1%		
	Proportion of opiate users that left treatment successfully in the previous 12 months and do not re-present to treatment within 6 months.	Actual				5.4%			5.9%			6.5%			5.7%				Latest update is for January 24 to December 24
	Proportion of non-opiate users that left treatment successfully in the previous 12 months and do not re-present to treatment within 6 months.	Actual				27.7%			27.0%			30.4%			33.2%				Latest update is for January 24 to December 24
	Proportion of alcohol users that left treatment successfully in the previous 12 months and do not re-present to treatment within 6 months.	Actual				38.6%			39.9%			40.9%			41.4%				Latest update is for January 24 to December 24
	Proportion of Alcohol and non-opiate users that left treatment successfully in the previous 12 months and do not re-present to treatment within 6 months.	Actual				34.5%			35.2%			38.8%			36.7%				Latest update is for January 24 to December 24
	Uptake of the NHS Health Check for all eligible adults	Actual	6.3%	6.9%	7.7%	8.4%	0.2%	0.5%	0.6%	0.6%	1.0%	1.3%	2.0%	2.5%	3.2%				Plan = same period in 23/21
		Plan	6.6%	7.3%	7.9%	8.7%	0.7%	1.8%	2.6%	3.3%	4.1%	4.7%	5.2%	5.8%	6.3%	6.9%	7.7%		
		Variance	-0.35%	-0.35%	-0.21%	-0.24%	-0.45%	-1.30%	-2.03%	-2.64%	-3.09%	-3.44%	-3.24%	-3.37%	-3.07%				
B	Percentage of low-income residents coping financially	Actual	79.6%			78.2%			78.9%			74.8%			74.7%				Plan = same period in 23/25
		23/24							77.9%			78.8%			79.6%				
		Variance							1.0%			-4.00%			-4.90%				
D	Number of Entering treatment with Short-Term Support with Living Well Centres.	Actual					165	171	132	193	238	180	159	122	114	133	131		Against previous month's position
		Variance						6	-39	61	45	-58	-21	-37	-8	19	-2		
	Number of Entering treatment with Focused Support with Living Well Centres.	Actual					54	54	32	47	44	50	46	29	49	57	36		
		Variance						-	-22	15	-3	6	-4	-17	20	8	-21		
	Provisionally agreed - LWNA Short Term Waiting Time	Actual					24.1	25.1	25.4	25.2	28.4	27.6	25.9	22.8	24.5	17.5	24.2		Average time from receivedby STS to second contact NB not yet from received by SPA)
		Plan					26.0	26.0	26.0	26.0	26.0	26.0	26.0	26.0	26.0	26.0	26.0		Target = 26 days (local ambition)
		Variance						0.9	0.5	0.8	-2.4	-1.7	0.1	3.2	1.5	8.5	1.8		

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Some of the Plans/trajectories/targets are provisional and subject to change

Impact measures performance trend (2)

Outcome	Impact measure	Target/Pla	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Year to Date	Comments
F	Uptake of SMI health checks	Actual	46%	54%	60%	68%	3%	9%	10%	13%	18%	24%	32%	38%	43%	50%	57%		
		Plan	45%	50%	55%	60%	5.0%	10.0%	15.0%	20.0%	25%	30%	35%	40%	45%	50%	55%		National Target = 60% at year end
		Variance	1.2%	4.1%	5.2%	8.0%	-2.0%	-1.5%	-5.4%	-7.1%	-6.6%	-5.7%	-3.2%	-2.0%	-1.6%	0.3%	2.0%		
	Uptake of LD/AHC health checks	Actual	56.7%	68.5%	77.5%	84.6%	5.7%	10.3%	16.4%	20.2%	31.0%	38.6%	46.8%	52%	59%	66%	73%		
		Plan	56.3%	62.5%	68.8%	75.0%	6.3%	12.6%	18.9%	25.2%	31.5%	37.8%	44.1%	50.4%	56.7%	63.0%	69.3%		National Target = 75% at year end
		Variance	0.4%	6.0%	8.7%	9.6%	-0.6%	-2.2%	-2.5%	-5.0%	-0.4%	0.9%	2.7%	1.9%	2.7%	2.9%	4.1%		
	Proportion of Bowel Cancer screening for those aged 60-74 (Coverage)	Actual	61.0%																
		Plan	60.0%	60.2%	60.4%	60.6%													Plan = same period in 22/23
		Variance	1.0%																
	Proportion of cervical Cancer Screening aged 25-64 (Coverage)	Actual	62.8%	62.7%	62.8%	62.9%	63.0%												
		Plan	62.7%	62.6%	62.8%	63.0%	62.8%												Plan = same period in 22/23
		Variance	0.1%	0.1%	0.0%	-0.1%	0.2%												
	Proportion of breast cancer screening for women aged 47-73 (Coverage)	Actual	46%																
		Plan	42%	42%	42%	43%													Plan = same period in 22/23
		Variance	3.2%																
G	Proportion of people with Type 2 diabetes who receive 8 checks on an annual basis	Actual	70.0%	74.1%	79.2%	81.7%	15.1%	22.7%	24.1%	27.8%	36%	43%	51%	57%	62%	67%	72%		
		Plan	57.8%	64.2%	70.6%	77.0%	6.4%	12.8%	19.3%	25.7%	32.1%	38.5%	44.9%	51.3%	57.8%	64.2%	70.6%		Local target = 77% by year end (set to straight line trajectory)
		Variance	12.3%	9.9%	8.6%	4.7%	8.7%	9.9%	4.8%	2.1%	3.4%	4.3%	5.6%	5.8%	4.0%	3.1%	1.2%		
	Cardiovascular dashboard, HYP aged 79 or under and last BP is less than or equal to 140/90 this FY	Actual	58.8%	62.3%	66.4%	68.7%	10.6%	22.1%	31.1%	38%	43.7%	48.1%	52.5%	56.4%	60%	63%	66%		
		Plan	57.8%	64.2%	70.6%	77.0%	6.4%	12.8%	19.3%	25.7%	32.1%	38.5%	44.9%	51.3%	57.8%	64.2%	70.6%		National target = 77% by year end (set to straight line trajectory)
		Variance	1.1%	-1.8%	-4.2%	-8.3%	4.2%	9.3%	11.9%	12.4%	11.6%	9.6%	7.6%	5.1%	1.8%	-1.3%	-4.4%		
	Cardiovascular dashboard, HYP aged 80 or over and last BP is less than or equal to 150/90 this FY	Actual	72.4%	76.0%	79.1%	81.7%	16.1%	29.4%	40%	48%	54.3%	59.2%	64.7%	69.2%	72%	75%	78%		
		Plan	57.8%	64.2%	70.6%	77.0%	6.4%	12.8%	19.3%	25.7%	32.1%	38.5%	44.9%	51.3%	57.8%	64.2%	70.6%		National target = 77% by year end (set to straight line trajectory)
		Variance	14.6%	11.8%	8.5%	4.7%	9.7%	16.5%	20.6%	21.9%	22.2%	20.7%	19.7%	17.8%	14.4%	10.9%	7.7%		
	Proportion of people over age of 65 who are taking 10 or more medicines, having a medication review	Actual					2%	5%	7.5%	10.5%	14.9%	19.9%	20.9%	28.9%	31.2%	37%	41%		
H	Proportion of referrals to the Living Well Network Alliance Single Point of Access, which were processed during the month (i.e. triaged, referred onwards or otherwise responded to) within 72 hours.	Actual					18.3%	13.4%	19.8%	7.6%	12.4%	16.6%	25.30%	23.40%	24.90%	18%	22%		In 23/24 we were reporting on SPA WT for Urgent referrals. In 24/24 there will be a new methodology on SPA WT to better capture activity from referral to 1st contact
	Access to Lambeth Talking Therapies for Black African and Caribbean residents to ensure they are as least as good as those of White residents	Actual	24.4%			25.3%			25.3%			23.60%			24.10%				% of black users by Ethnicity
		Plan	21.7%			21.7%			21.7%			21.7%			21.7%				% of Black users by Ethnicity as per 2021 Census population rate
		Variance	2.7%			3.6%			3.6%			1.9%			2.4%				
	Recovery rates for Lambeth Talking Therapies for Black African and Caribbean residents to ensure they are as least as good as those of White residents	Actual	46.7%			43.1%			43.1%			45.0%			49.2%				
		Plan	48.0%			48.0%			48.0%			48.0%			48.0%				
		Variance	-1.3%			-4.9%			-4.9%			-3.0%			1.2%				
	Number of children and young people waiting longer than 52 weeks for an assessment and commencing treatment with Child and Adolescent Mental Health Services	Actual							36	40	42					33			Latest information extracted from Deep dive report - LTAG March - enclosed document E

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Some of the Plans/trajectories/targets are provisional and subject to change

Impact measures performance trend (3)

Outcome	Impact measure	Target/Pla	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Year to Date	Comments
I	Health and Wellbeing Bus - No of interactions - Welfare Advice and Mental Health session	Actual							102			129			106				
		Variance										27			- 23				Against previous quarter's position
	CVD Workplace service - Health Checks	Actual							767			190						957	Intelligence from the previous CVD project showed that in 60 days of service, the team delivered 767 Health checks. The new CVD Workplace pilot (Health Checks at Work)starting in Oct 24 will have 3 types of health checks delivered (Type: 1. Light touch 2. CVD assessment 3. Full NHS health check) wiht the aim of achieving 4,200 health checks in the last two quarters of 24/25.
	Beacons service - No of interactions - Health & Wellbeing sessions and Hi 5	Hi 5 sessions							556			535			343			1,434	
		Health & Wellbeing sessions							141			182			118			441	
		Variance							-			20			- 256				Against previous quarter's position
J	Number of appointments in General Practice	Actual	133,406	171,212	166,166	159,787	166,166	165,670	149,688	170,573	159,787	163,524	194,806	171,242	157,189	186,600		1,685,245	
		Plan					137,079	158,464	168,495	158,711	163,515	158,057	155,258	165,319	133,406	171,212	166,166	1,569,516	1.5% increase vs 23/24 monthly profiled against 23/24
		Variance					29,087	7,206	- 18,807	11,862	- 3,728	5,467	39,548	5,923	23,783	15,388		50,625	
		%					21%	5%	-11%	7%	-2%	3%	25%	4%	18%	9%		7%	
	Improve access to healthcare professionals through increased use of community pharmacies - GPs and NHS 111 direct people to pharmacies to support people with minor ailments and advice around self-care and common clinical conditions	Actual	>300	>400	>800	>900	1,626	1,709	1,589	1,704	1,667	1,820	1,647	2150	2308	2343		16,220	April to January data shbows the total Pharmacy First consultations (includes referrals to the Clinical Pathways, Minor Illness and Urgent Medicine Supply service)
	Capacity of virtual wards	Actual	147	158	165	224	209	177	166	198	180	185	173	236	210	212			
		Plan	201	201	231	231	231	233	233	234	235	237	237	241	241	241			
		Variance	- 54	- 43	- 66	- 7	- 22	- 56	- 67	- 36	- 55	- 52	- 64	- 5	- 31	- 29			
	Proportion of virtual wards being used	Actual	73%	72%	71%	97%	90%	76%	71%	85%	77%	92%	73%	98%	87%	88%			
		Plan	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%			
		Variance	-7.0%	-8.0%	-9.0%	17.0%	10.0%	-4.0%	-9.0%	5.0%	-3.0%	12.0%	-7.0%	18.0%	7.0%	8.0%			
K	Number of people with an intermediate care offer	Actual	46	47	68	35	44	41	38	37	46	34	59	54	36	62	53		
		Plan	65	63	56	58	53	62	60	62	41	52	62	61	46	47	68		
		Variance	- 19	- 16	12	- 23	- 9	- 21	- 22	- 25	5	- 18	- 3	- 7	- 10	15	- 15		Plan = same period previous year
	Percentage of people who have completed reablement that has resulted in no formal support or support at a reduced level	Actual	83%	85%	81%	79%	86%	89%	84%	92%	90%	90%	88%	89%	88%	87%	86%		
		Plan	71%	73%	68%	78%	75%	79%	92%	78%	91%	84%	76%	80%	83%	85%	81%		Plan = same period previous year
		Variance	12%	12%	13%	1%	11%	10%	-8%	14%	-1%	6%	12%	9%	5%	2%	5%		
	Proportion of carers of the users of Adult Social Care Services are offered a carers assessment	Actual	97%	90%	93%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
		Plan	97%	94%	95%	98%	100%	99%	99%	98%	98%	97%	98%	97%	97%	90%	93%		
		Variance	0%	-4%	-2%	2%	0%	1%	1%	2%	2%	3%	2%	3%	3%	10%	7%		
	No of people identified as being in their last year of life on practice registers	Actual	1,953			1988			2013			2082			2045				
		Plan	1,705			1651			1937			1954			1953				Plan = same period in 22/23
		Variance	248			337			76			128			92				
	Proportion of people with Personalised Care and Support Plan(PCSP)/UCP	Actual	48%			48%			49%			46%			45%				
		Plan	40%			42%			46%			47%			48%				Plan = same period in 22/23
		Variance	8%			6%			3%			-1%			-3%				

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Impact measures performance trend (4)

Outcome	Impact measure	Target/Pla	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Year to Date	Comments
M	Rate of uptake for an Annual Health Check and Health Action Plan for those with LDA	Actual	51.9%	64.2%	74.5%	83.1%	5%	10%	14%	19%	27%	35%	41%	47%	55%	62%	70%		
		Plan	56.3%	62.5%	68.8%	75.0%	6.3%	12.5%	18.8%	25.0%	31.3%	37.5%	43.8%	50.0%	56.3%	62.5%	68.8%		
		Variance	-4.4%	1.7%	5.7%	8.1%	-1.1%	-2.9%	-4.6%	-5.5%	-3.8%	-2.8%	-2.3%	-2.7%	-1.6%	-1.0%	1.5%		
	Weeks waiting for an ASD diagnosis for children and young people	Actual	96						63										Waiting times on ARD assessment at June 24 was 64 weeks, and provisonal data for Aug 24 stands at 60 weeks wait (n-960). Due to the implementation of a new Patient Electronic System (EPIC) we have been unable to report on this measure. Efforts have been made to reenact this report stream and we will work with secondary partners
N	Numbers of people with severe mental illness are supported to live in their own home	Actual	14			10			12			16			15				Number of service users starting paid employmenet during each quarter
		Plan	36			36			36			36			36				
		Variance	-22			-26			-24			-20			-21				
	Number of people per year are supported by the Living Well Network Alliance into paid employment	Actual	60			95			54			85			48				Number of service users (unique Trust IDs) from referrals accepted during each quarter
		Variance	60			95			54			85			48				
	Number of referrals Living Well Network Alliance teams make for service users to additional support routes (such as education, training and employment support, Community Support, Alcohol Advice, Smoking, Benefits advice, Dietician, Family Support)	Actual										549			416				
	Percentage of service users reporting a positive experience of using mental health services, feeling they have benefited from support and are more independent and in control of their lives,	Actual	82.0%	62.0%	74.0%	73.0%	89.2%	74.6%	77.4%	82.5%	87.0%	78.8%	76.7%	76.3%	77.8%	82.5%			From PEDIC
		Plan	78.4%	78.4%	78.4%	78.4%	78.4%	78.4%	78.4%	78.4%	78.4%	78.4%	78.4%	78.4%	78.4%	78.4%			Mean value Sep-23 to Sep-24
		Variance	3.6%	-16.4%	-4.4%	-5.4%	10.8%	-3.8%	-1.0%	4.1%	8.6%	0.4%	-1.7%	-2.1%	-0.6%	4.1%			
	Seclusions and restrictive interventions on inpatient setting	Actual	20	18	38	36	43	49	39	33	40	27	29	29	31	43	24		Restrictive incidents + seclusions
		Plan	33	33	33	33	33	33	33	33	33	32	32	32	32	32	32		Median value Apr-23 to Dec-24
		Variance	13	15	-5	-3	-10	-16	-6	-	-7	5	3	3	1	-11	8		
O	Percentage of people resettled into longer-term accommodation	Actual	3%			5%			4%			4%			4%				
		Plan				5%			3%			3%			3%				Plan = same period previous year
		Variance				-			0			0			0				
	Number of rough sleepers brought into accommodation	Actual	78			52			44			33						129	
		Plan				38			71			58			58			225	Plan = same period previous year
		Variance				14			-27			-25			-58			-96	
	Proportion of people living in our supported housing that are registered with a GP	Actual	90%			92%			90%			97%			98%				
		Plan				74%			75%			79%			90%				Plan = same period previous year
		Variance				18%			15%			18%			8%				
	Rate of residents in supported housing engaged with mental health support services.	Actual	20%			25%			23%			24%			24%				
		Plan				12%			12%			14%			20%				
		Variance				13%			11%			10%			4%				
	Refer people to drug treatment services upon their release from prison, and what proportion then complete their treatment.	Actual				41%			52%			49.19%							Latest update is for period of October 23 until September 24 24/25 Year-end ambition is to reach 55% (historical data shows 2021 -21% ; 2022-21%)
		Variance							11%			-3%							Against previous data available

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

A. People maintain positive behaviours that keep them healthy

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

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

What does the data/intelligence indicate around progress against the outcome?	In Q3 2024-2025, there was a significant improvement in activity following the transitional stage of the new contracting model in Q1 and the impact of the Synovis lab cyber-attack in late Q1 through Q2. A total of 1,493 health checks (HCs) were completed, compared to 1,315 in the same period of 2023-2024. The impact of these events is expected to continue for the rest of the financial year, though to a lesser extent as recovery efforts progress. Key outcomes include: • 18% of patients who had a health check in Q3 were referred to lifestyle services or prescribed medication. This includes 89 patients prescribed statins, 29 prescribed antihypertensives, 94 referred to the National Diabetes Prevention Programme (NDPP), 7 referred to smoking cessation services, 1 referred to alcohol services, and 50 referred to weight management. • 13% of patients were diagnosed with a health condition and added to appropriate registers. This includes 36 patients with hypertension, 13 with diabetes, 4 with chronic kidney disease (CKD), and 137 with non-diabetic hyperglycaemia. • 81% of patients were identified with low 10-year cardiovascular disease (CVD) risk, 17% with moderate risk, and 2% with high risk. All patients received appropriate advice and support.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	The Lambeth population that are eligible for an NHS Health Check is around 90,000 people. Current data shows uptake is largely in line with the demographics of that eligible cohort: • White: Eligible 51% (incl. White British 22% and White Other 29%), Uptake 53% (incl. White British 30% and White Other 23%) • Black: Eligible 18%, Uptake 19% • Asian: Eligible 6%, Uptake 6% • 40-50 age group: Eligible 60%, Uptake 55% • 51-60 age group: Eligible 28%, Uptake 32% • 61+ age group: Eligible 12%, Uptake 13% This demonstrates the opportunity to pick up risk factors at an earlier stage and to start prevention early. • Female: Eligible 43%, Uptake 53% • Male: Eligible 57%, Uptake 47%
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Practices continue to work to recover to a Business-as-usual position after the critical incident highlighted at the end of Q1. The NHS Healthcheck service was recommissioned in Spring 24 on a 2-year basis with the intention that the 2nd year would focus on the PCN's and Lambeth commissioners agreeing and developing an at scale model to deliver the service in the most optimal way, focussing on our key priorities. The on-going impact of the situation highlighted above may impact time scales of implementing this new model ahead of any future recommissioning exercise. Commissioners continue to work with the PCNs on recovering the core offer.. Practice representation is now formalised on the Lambeth Healthcheck Steering group to facilitate strategic goals including implementing the At Scale Model and targeting priority groups.

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

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

Alliance and Programmes	NWDA (owner) with contributions from CYP and Staying Healthy
What does the data/intelligence indicate around progress against the outcome?	There is a continued high demand for social prescribing across Lambeth. Age UK Lambeth continues to see an increase in the number of referrals into the service. Within one PCN (Croxted) there have already been 65 referrals in 2025 demonstrating a clear need for social prescribing support in the borough.
Does the data/intelligence identify any health inequalities and whether they are reducing?	Continued engagement in social prescribing support suggests Lambeth residents are accessing support to help address health inequalities. However, AUKL Social Prescribing Link Workers (SPLWs) are reporting often the presenting needs of the residents goes beyond the scope of the social prescribing service. More casework is required or the services are no longer available in Lambeth to signpost/ refer to due to wider economic factors. SPLWs address what they can within the remit of their role but the lack of wider support could suggest there are limits to what can be done to address health inequalities.
What are the challenges hindering any progress and are there actions which can be taken to address these?	Currently there is no centralised CRM system to accurately capture social prescribing referrals. Data was previously recorded on Elemental but this has now been moved to Emis. Sadly, Emis does not have the same functions as a CRM / case management system so it is not as easy to record case work and social prescribing support as it was previously. Conversations are underway to explore accessing Emis data to compare and review social prescribing across the borough but this is still in the exploratory stage.
Additional Comments	There are specialist social prescribing services delivered through AUKL - Financial Link Workers and Gambling Link Workers. This more specialist, targeted support helps to address some of the gaps and needs clients are presenting that the traditional social prescribing model cannot always address/ support with.

C. People are immunised against vaccine preventable diseases

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

Alliance and Programmes	Staying Healthy (owner) with contributions from NWDA
What does the data/intelligence indicate around ***progress against the outcome?***	Achieving herd immunity and meeting the locally set target of 90% remains a challenge in Lambeth. The most recent data published for Quarter 2 of 2024/25 shows that the uptake of the DTaP/IPV/Hib vaccine, offered to babies at 8, 12, and 16 weeks of age, stands at 84.7%. Additionally, uptake for the first dose of the MMR vaccine is at 79.5%. Other boroughs in South-East London have also reported uptake rates below 90%. There are no updates to report for Outcome C at this time. The Q3 data has not yet been released, and remedial actions are still ongoing.
Does the data/intelligence identify any ***health inequalities and whether they are reducing?***	National COVER reporting does not provide sufficient insights into vaccination inequalities. A health equity audit by UKHSA has identified avoidable disparities within the UK vaccination programme. Additionally, a local audit in Lambeth highlighted inequities in vaccination coverage and timeliness, which informs our engagement strategies to ensure our efforts are directed where they are most needed.
What are the ***challenges hindering any progress*** *and* ***are there actions which can be taken*** *to address these?*	Challenges in vaccination arise from a complex interplay of factors, including intrapersonal elements (such as vaccine fatigue, hesitancy, health beliefs, and health literacy), community influences (such as religious, cultural, and gender norms), and institutional factors (such as access and registration issues, culturally tailored services, and vaccination funding and delivery). We continue to implement various initiatives to address vaccine inequities, ranging from strengthening primary care call-and-recall systems to launching community-led initiatives.

D. People have healthy mental and emotional wellbeing

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

Alliance and Programmes	LWNA and CYPA (owners)
What does the data/intelligence indicate around progress against the outcome?	The Lambeth Living Well Centres' Short-Term Support service (STS) started helping 131 new people in February, slightly fewer than in the previous month (133). The number of people Focused Support (FS) started supporting in February fell by much more, to 36 from 57 in January. Reducing the waiting list of the Lambeth Single Point of Access over the summer led to SPA referring high numbers to STS last summer. After falling to 50-60 in recent months the number of referrals rose significantly in January to 108. People attending a second STS appointment in February had waited an average of 24.2. This is 6.7 days longer than the average wait in the quieter month of January but still 1.8 days shorter than the average wait in 2023/24. Lambeth SPA is working to ensure that attended appointments are correctly recorded so that the STS wait is as accurate as possible.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	The relative figures for Black service user accessing Short-Term and Focused Support services in the Living Well Centres, supports the view that they enter the service requiring a more intensive level of support than White service users. In December, Black service user access to STS is in line with recent months and the Lambeth population (at 22.4%). However, with 21 of 47 accepted referrals where ethnicity is stated (45%), access to the more intensive FS service for Black service users is almost twice what the borough demographics would suggest. On average, STS sees Black service users more quickly for a second appointment than their White counterparts (waiting 22.6 and 28.3 days respectively). This may be suggesting that Black services users typically present with more severe problems that require more urgent attention. If true, this would align with very high proportion of Black people being supported by the more intensive Focused Support service
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	We believe that the high numbers of Black people using more intensive services is driven by the social and economic factors that disproportionally affect those communities. We are using the PCREF framework to engage with our local communities and build trust to improve access, experience and outcomes. Better access for Black people to services while in the early stages of their illness will, reduce the need for more intensive forms of support.

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

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

Alliance and Programmes | **Sexual Health**

What does the data/intelligence indicate around ***progress against the outcome?***	Annual data has been released by UKHSA. The data show a 5% increase in the rate of LARC prescriptions since the previous year. (42.2 per 1000 women aged 15-44 in 2023 vs 40 per 1000 women in 2022). This is significantly higher than the London rate of 33.6 per 1000 and similar to the England average. Local service data show in Q3 there were 813 LARC appointments used in GP and the LARC Hub. There was an error in reporting Q2 data in the last report due to a user error. Over the last three quarters activity has remained stable which suggests access is currently stable. As the new Hub service mobilizes in the next quarter and the GP contracts enters it's second year, with the attached training offer, we will hope to see increased in activity, suggesting increased access. TOPS data is updated until November 2024. This shows 1224 TOP. 44% of these were people who had a previous TOPs. With the new TOPS dashboard we will be able to monitor the proportion of subsequent TOPS, across ethnicity and PCNS. This can be an indicator of unmet contraceptive need. Regarding STI rates, the UKHSA annual data refresh shows increases in the rates of all STIs apart from genital warts.
Does the data/intelligence identify any ***health inequalities and whether they are reducing?***	Through the TOPS dashboard (data up to November 24) we can see a higher proportion of repeat TOPs is in Black heritage women (37%) compared to White heritage women (19%). This will continue to be monitored over time to understand the trend.
What are the ***challenges hindering any progress*** *and* ***are there actions which can be taken*** *to address these?*	Regarding data issues around EPIC reported in the last update, the action taken by commissioners has improved the quality of reporting at Kings. The annual UKHSA data release continues to show Lambeth has the highest rates of STIs in England and inequalities persist. However, Lambeth also has the highest testing rates. A refreshed joint strategy is being developed which will be accompanied by a new borough based action plan. The outreach service is now up and running and beginning to establish connections and operating locations.

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

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

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

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

1. Bowel Cancer screening aged 60-74-Upward trend. Most recent data shows upward trend with 61.0% screened (December '23) compared to 50% in December 2019. Above national target of 60% screened.
2. Cervical Cancer screening aged 25-64-shows slight increase in the past year with most recent data showing rate of 63% in April 2024 compared to 62.8% in April 2023 but down from 66.7% in April 2019. National target is 80%
3. Breast cancer screening aged 50-70-Upward trend in the past year. Most recent data shows 54.8% screened in December 2023 which is an increase from 50.9% in December 2022. Not returned to pre-covid levels which were 61% in November 2019. Below national target of 80%.

Source for all of above is the SEL screening dashboard. There are other sources but this is most accurate and comes from Open Exeter directly. Looking at other sources pulled from primary care data which is more up to date but may include inaccuracies shows current bowel screening at 58.9%, Cervical at 63.9 and Breast at 58.4.

There's a good progress from January and on track to achieve SMI and LD national health check targets by end of March.

On Prep activity, tt the end of January 2025, 834 residents had newly started on PrEP and 3,951 residents were continuing to use PrEP. The activity trend and clinic usage remains the same as the last reporting period.

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

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

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

*Does the data/intelligence identify any **health inequalities and whether they are reducing?***

1. Bowel Cancer screening aged 60-74-Data shows lower screening rates for those with learning disability and severe mental illness. Lowest screening rates in those from 1st deprivation quintile, lower screening rates for those of black, mixed, Asian and ”other” ethnicity compared to white population. Comparing most recent data with 2 years ago shows increased screening rates for black, mixed, Asian and “other” ethnicities and also increased screening rates for those with LD and SMI
2. Cervical Cancer screening aged 25-64-Current data shows highest screening in those with black ethnicity (70.8%), then white (68.9%) and then significantly lower for mixed (63.2%), Asian (56.9%) and other (52.3%). Significantly lower for those with LD (49.5%) compared to non-LD (65.6%). Rates have not improved in past 2 years.
3. Breast cancer screening aged 50-70-1st deprivation quintile have lowest rates. White (57.0%) and black (56.7%) ethnicity have similar rates, lower in Asian (53.2%), mixed (50.1%) and “other” (47.1%) ethnicities, Significantly lower in LD (40.1%) compared to non-LD (55.0) and SMI (41.7%) compared to non-SMI (55.3%). Compared to 2 years ago SMI rate has improved but LD has declined.

Key findings of audits of people who did not have a health check in the last 3 years:

SMI

72% of those who hadn’t attended for an SMI health check were male

30% of those who didn’t attend for an SMI health check were African

LD

Two largest groups who didn’t attend for an LD health check were black females and white males

A disproportionately high number of Black African and Caribbean people under 30 didn’t have an LD health check

A plan to reach out to carers, voluntary sector and communities has been developed and is being implemented.

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

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

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

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

There are numerous ongoing challenges on cancer programmes. Firstly as mentioned above there is a lag in the data so we are 6-15 months behind with official data to see local rates which can lead to delays in identifying evolving issues. Due to workload and winter pressures it is difficult for primary care to take on additional screening promotion work. There are however numerous ongoing projects locally. SELCA are funding projects with IRMO (Latin American community) and LAMSOM (Somali community). They are also funding PCN projects to increase breast and cervical screening and also a PCN engagement event which is taking place at the end of February. The NWDA have also funded a successful PCN engagement event with another funding event upcoming soon. The local breast screening service are also working to increase appointments outside of normal working hours to aim to increase screening rates. The final report from the recent Catch 22 bowel screening initiative has been completed and we will work with the local bowel screening team to feedback and work on the areas identified for improvement.

On SMI and LD, the February 2024 position was higher and this likely reflects external issues with accessing Synovis laboratory facilities. These groups can experience issues engaging with physical health interventions, their GP etc and if blood testing wasn't available for their appointment, they may not attend a second time for phlebotomy. This may impact the probability of achieving above the national targets.

On Prep we are still awaiting updated clinical guidance, in the meantime commissioners have started to procure a digital online PrEP pilot, following the successful launch of this pilot model in East London.
Commissioner are continuing to work with clinicians with a specialist interest to develop community access for residents through our community outreach.

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

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

Alliance and Programmes	NWDA (Owner)

What does the data/intelligence indicate around progress against the outcome?	Blood pressure control measures for both age groups are cumulative measures starting from April 2024. Improvement of blood pressure control has continued whilst is cumulative over this period. Steady progress is being made towards the Lambeth ambition percentage despite challenges faced during the financial year. Problematic polypharmacy (prescribing of 10 or more concurrent medicines) increases the risk of drug interactions and adverse drug reactions (ADR), impairing medication adherence and impacting on a patient's quality of life, this risk increases with the number of prescribed medicines a patient is on and when specific therapeutic combinations are concurrently prescribed. In conjunction with the patient, SMRs provide a holistic medication review to ensure prescribed medicines are safe, effective and personalised to patients' current needs. SMRs improve outcomes, reduce unnecessary or inappropriate prescribing and polypharmacy, reduce harm and improve patient outcomes. The number of coded Structurehypertension detection and diagnosis has increased. Improvements have been made year on year. Continued work over the year is required to improve to the Health and Care Plan outcome of 77% blood pressure control (140mmHg/90mmHg) in people aged 79 years and under by end of FY 2024-25. The Lambeth ambition for the proportion of people with Type 2 diabetes, who meet all 8 Care Process metrics, is to reach a minimum of 77% or improve from baseline (National Diabetes Audit 22-23 percentage) by 10 percentage points. The measuring period aligns to the National Diabetes Audit 15 month measuring period January 2024 to March 2025 and d Medication Reviews (SMR) in Lambeth for patients who are 65 years or over and prescribed 10 or more medicines is being tracked to indicate progress. There is an increasing trend of people over the age of 65 who are taking 10 or more medicines received a structured medication review since 1st April 2024. At end of January, a total of 1218 of the 3258 (37%, previously 29%) patients have had a SMR.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	More black and minority ethnic people have been identified with hypertension when comparing February 2024 to February 2025 data; 23724 and 24843 respectively and within these cohorts, blood pressure control has remained consistent with higher absolute numbers in comparison to the previous year; 14,978 and 15,608 respectively. NWDA Hypertension Oversight group has been developed to support co-ordination of activities to improve hypertension identification and management in Lambeth, with a focus on reducing health inequalities. Current data from the EZA Cardiovascular app shows that hypertension control in the Black African, Black Caribbean, Mixed White and Asian, Unknown or not stated ethnic groups is improving, with comparable rates of target blood pressures being reached across all ethnicities. In addition, year on year performance across target ethnicities and all ethnicities has increased. The Diabetes app within EZ Analytics has been further updated for 24-25 to provide more detailed data on improvements of the measurement and recording of the care processes for Black African, Black Caribbean, Mixed White and Asian, Unknown or not stated ethnic groups. Data is comparable to the previous year, noting the increase in diabetes population and the challenges faced during 2024-25. Overprescribing can lead to increased harm from unnecessary or inappropriate prescribing. By ensuring medicines are being used appropriately, we can reduce adverse effects, hospitalisation and improve outcomes, which may impact on those with greater health inequalities. The data shows a continual increase in SMRs conducted since inclusion in the 2023/24 Medicines Optimisation Section (of the Lambeth GP Improvement Scheme), and we continue to work with colleagues across SEL on reducing inappropriate prescribing and polypharmacy as further evidence emerges.

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

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

Alliance and Programmes	NWDA (Owner)

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

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

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

Alliance and Programmes	LWNA and CYPA (owners)

What does the data/intelligence indicate around progress against the outcome?	In May 2024, just over 900 people were waiting for Lambeth SPA. In February 2025, that number has fallen to 365. People are now getting support sooner than they were in May, but they are still waiting too long. More introductions are being processed within 3 days (up to 22.4% in February from 17.6% in January). However, the average wait for people in February was 16.1 days, against a target of no-one waiting longer than 14.0 days. Lambeth Talking Therapies (LTT) is now measuring access by the number of people completing treatment rather than attending a first appointment. By that measure, the service was at 93% of target in January, but almost exactly on target year to date, with 5,867 people having completed treatment. See additional information included in LTAG papers – Document E2 on CAMHS information
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Data for Lambeth SPA does not highlight any particular inequalities within the SPA process. In February 2025, Black service users were given onward referrals to Community Mental Health Services, Residential Care or other Trust services at similar rates to their White counterparts (33% and 30% respectively). On average, Black and White service users also waited for about the same length for time for a referral decision from Lambeth SPA (16.6 and 17.2 days respectively). Access to Lambeth Talking Therapies Recovery for Black service users has been steadily improving. In Q3 Oct-Dec 2024 24.1% of new clients identified themselves as Black, better than the 20.4% seen in 2021/22 and the 21.7% Black population of Lambeth. Session attendance and treatment completion are now roughly equal across groups. Reliable recovery rates for Black service users have also steadily improved throughout this year and in the most recent quarter were at 49.2% (1.2 points above target), but this is still 4.0 percentage points below the rate for White service users and 3.1 points below the average rate for the service as a whole.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Since May 2004, changes to the way Lambeth SPA works, together with additional support, have helped to reduce both the number of people waiting and how long they wait. But as of February 2025, progress has slowed and all available funding for additional support has now been used. As a result, the number of people waiting is slowly increasing again. An LWNA management working group has presented a case for change to the LWNA leadership and is currently remodelling the service to meet the needs of the community within the available budget. Lambeth Talking Therapies will keep focusing on having more new clients access the service who are then assesses as being recovered and showing significant improvement in their symptoms when they complete treatment (i.e. are in “Reliable Recovery”). The LTT service is also working to increase session numbers for Black clients and ensure that reliable recovery rates are consistently over 48% for all ethnic groups.

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

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

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

*What does the data/intelligence indicate around **progress against the outcome?***	The Beacon data shows that a rising number of HI-5 interactions are converting into health and wellbeing sessions, reflecting an overall improvement in our outreach efforts.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Beacon: A significant number of people have been directed to local resources for accessing statutory services within the borough. Additionally, there has been a notable increase in signposting to general practitioners (GPs) and primary care networks (PCNs),
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	**BUS:** The Vital 5 pilot is being delayed due to complexities over data capture. The provider have been working with the Vital 5 programme team and Southwark to develop new EMIS template. Interim solution is being discussed. **BEACON:** The team are making improvements in data capture and working closely with the PH team. They are developing new process for their reward card scheme that will see them be able to record improvements in BP and health measures over time. The reward card has already shown increase in activity and people returning to the hubs.
Additional Comments	The bus team are working with GSTT to deliver outreach activity for the new women and girls health hub. Delays in Vital 5 will impact this service and so discussions are being held to mitigate risks.

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

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

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

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

Lambeth and Southwark Hospital @home capacity maintained at 241 beds. KCH IRT continue to have mobilisation delays due to progressing internal business case and recruitment – discussions in progress to update KCH IRT mobilisation plan.

Some teams are consistently reporting over-utilisation against stated capacity, and some teams unable to achieve target occupancy against stated capacity due to lower than expected demand:
GSTT @home have a stated capacity of 82 beds, the reported 'Median' bed utilisation over the last 12 months is 85, meaning that 100% capacity against that figure would be 106 beds to enable that flex between periods of more or less demand whilst consistently achieving 80% utilisation. Similar for Pal@home (Palliative and End of Life Care night-sitting service) – referrals are received, mainly, from St Christopher's VW and community Palliative and End of Life care (10 beds), GSTT Pal/EoL Hospital @home service (10 beds) and GSTT @home.
GSTT IRT have requested a reduction in bed numbers due to a change in model from the original proposals means they have been unable to achieve target occupancy. IRT have been encouraged to explore other respiratory clinical pathways and opportunities.
To be confirmed/agreed. Changes to team capacity will consolidate the number of 'beds' to 267 beds, once KCH IRT is live.

Steering Group members considered 3 options regarding Remote Monitoring planning for 2025/26: 1. Close RM project, 2. Go to market 1 April 2025, and 3. Extend current contract for 1 year. In principle, the steering group have chosen to extend Doccla for a further year to provide extra time to development Lambeth and Southwark model aligned to Out of Hospital strategy development review against current technology in place and wider consideration. The steering group members were keen to see an increase in utilisation and have challenged teams to produce a plan of action, bring new clinical pathways onboard and to achieve the 80% target occupancy set by NHSE by end of April 2025. Formal evaluation in progress.

The Lambeth Pharmacy First Plus Service addresses and supports the health inequalities in Lambeth in relation to the impact of the cost-of-living crisis on the ability of the local population to self-care and buy medicines available over the counter for minor and self-limiting conditions in line with NHS England guidance. Community Pharmacy have undertaken 2824 consultations between March 2023 and January 2025 with Lambeth residents/registered patients to provide advice and guidance on self-care and supply of medicines where appropriate. The NHS Pharmacy First Service (previously known as GP-Community Pharmacy Consultation Service) increases GP capacity through triaging of low-acuity conditions to community pharmacy. GP referrals to NHS Pharmacy First supports the national approach to increasing GP access. Data from service launch in 31 January 2024 to 31 January 2025 shows a positive increase in use.
The National Pharmacy First service and local Pharmacy First Plus Service increases access to general practice, through provision of self-care advice and any necessary treatments directly via pharmacies for people at higher risk of health inequalities or higher deprivation.

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

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

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

Does the data/intelligence identify any ***health inequalities and whether they are reducing?***	Access to Hospital @home services is available to all, there are no restrictions other than those defined by the clinical criteria which are applied as appropriate depending on the clinical pathway and team providing care. One of the main principles of the Lambeth and Southwark Hospital @home programme is to be data driven. A workstream is in progress with ICB colleagues is to: Define and understand (potential) demand for hospital @home (Virtual Ward) services so that we can measure if our current capacity is appropriate or if there's a requirement for expansion Define gaps and barriers to access following population health principles and outcomes and develop an appropriate population health approach to addressing any barriers that have been identified. Data quality and compliance with the NHSE data Sitrep remains a priority and a work in progress. Additional data fields such as population demographics and diagnosis cohorts will provide a rich dataset to help support the objectives above. On Lambeth Pharmacy First Plus Service data from January 2025 shows most interventions (2061) 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, 70% of patients would have visited general practice to request the medication on prescription, 30% would have gone without medication. 30% would have gone without medication as they are unable to buy the medicines over the counter to deal with minor conditions due to the current cost of living crisis. People who are receiving support through universal credit, income support or are under the age of 16 years old are the top social vulnerability eligibility groups accessing Lambeth Pharmacy First Plus Service in January 2025. General Practice feedback has been that the service has a had a positive impact for patients and reduced GP appointments for minor conditions.

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

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

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

*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Initial usage of the NHS Pharmacy First Service was slow due to IT issues and training needs. Increased promotion of both the Lambeth Pharmacy First Plus service and the NHS Pharmacy First through local bulletins, practice visits and webinars has helped to increase understanding and usage of the Services. The Medicines Optimisation Team has collaborated with the Local Authority Cost of Living Programme Lead to discuss continual and increased promotion of the Lambeth Pharmacy First Plus service to residents. Community Pharmacy Neighbourhood Leads (CPNLs) have been engaging with general practice and their peers to provide clinical leadership and support the national access priority, which has supported increases in referrals.
Additional Comments	There has been a national rebranding of the GP-Community Pharmacy Consultation Service and other clinical services provided through community pharmacy to 'Pharmacy First'. This now includes 7 clinical conditions which can be assessed and treated through pharmacies, including provision of antibiotics and other treatments, hypertension checking service, contraceptive service and urgent medicines service. This is not to be confused with the local Pharmacy First Plus service, which addresses inequalities in access to medicines over the counter for a range of common conditions. The local service has been rebranded to Lambeth Pharmacy First Plus.

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

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

Lambeth Pharmacy First Plus Service Total number of patient interventions	
Mar-23	125
Apr-23	97
May-23	148
Jun-23	257
Jul-23	155
Aug-23	111
Sep-23	125
Oct-23	117
Nov-23	84
Dec-23	105
Jan-24	110
Feb-24	132
Mar-24	125
Apr-24	66
May-24	87
June-24	112
Jul-24	83
Aug-24	65
Sept-24	96
Oct-24	95
Nov-24	138
Dec-24	111
Jan-25	88
Total – 2632	

	29 Feb 2024	31 March 2024	30 April 2024	31 May 2024	30 June 2024	31 July 2024	31 Aug 2024	30 Sept 2024	31 Oct 2024	30 Nov 2024	31 Dec 2024	31 Jan 2025	TOTAL
Total Pharmacy First consultations (includes referrals to the 7 Clinical Pathways, Minor Illness and Urgent Medicine Supply service)	1308	1604	1626	1709	1589	1704	1667	1820	1647	2150	2308	2343	**21,475**

Top 3 social vulnerability eligibility criteria for accessing Lambeth Pharmacy First Plus Service (Jan 25):

1. Universal credit (33%)
2. Patients aged under 16 years (27%)
3. Income Support (10%)

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

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

Alliance and Programmes	NWDA (Owner)

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

The number of accepted referrals to Reablement has increased since October 2024. As a result of work in the Discharge Operational Delivery Group a piece of work looking at eligibility criteria for reablement was completed with ward therapists. There is also a regular meeting to look at the reason for referrals to reablement which are declined by the service.

The number of people who have a reduced need for care at the end of a period of Reablement has remained high and this is positive. The percentage for people with a reduced need for care at the end of Reablement continues to improve and is 88% at year end.
We are now counting those people referred for therapy only (no care needs). This has increased the number of people who have a reduced need for care at the end of the service and has improved our performance.

There has been a change in the way we deliver Reablement. The Rehab Support Workers (RSW's) in Intermediate Care Lambeth are now delivering personal care as well as exercise programmes.
When referrals for Reablement are sent to our Brokerage Team they will check if the RSW's have capacity to pick up the case. This is done daily.
We will be monitoring the outcome of these cases in the future and can report this back next time.
Where the RSW's do not have capacity we commission personal care via the neighbourhood home care agencies.

We continue to achieve a high performance rate for the proportion of carers of service users who were offered a carer's assessment. The baseline is 98% and the latest overall position is 100%. We have also identified a member of staff in each team to be Carer's Champions and this will help to raise awareness of carers in the teams.

The overall trend for Lambeth end of life data outcomes K3 and K4 (palliative and end of life care improvement measures) is progress towards increased identification and uptake of advance care planning. This is across both the identified outcome measures for people identified as being in their last year of life on practice registers (45% increase Q1 22-23 to Q2 24-25) and Proportion of people with Personalised Care and Support Plan(PCSP)/UCP (22% increase Q1 22-23 to Q2 24-25).

For Metric K3 (identification on practice registers), the total number increased by 3% from 2,013 to 2,082 in Q2 2024/25. For Metric K4 (PCSP/UCP), the total number increased by 24 but this represented a small decrease of -0.5% in the proportion of people on end of life registers with PCSP/UCP. This is because identification (K3) increased more sharply than PCSP/UCP (K4) increased in K2.

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

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

Alliance and Programmes	NWDA (Owner)

*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	The majority of reablement referrals come via the hospital discharge route. We are increasing the number of people who are offered a reablement service via our front door team in Adult Social Care in order to offer reablement to people living in the community at home. This is now 17% of the total number of referrals to Reablement which is a significant increase from 6% in the last year. This will help to offer a more equitable service for those residents living at home who may benefit from reablement care. There is a named linked physiotherapist from GSTT Rehab and Reablement Team working closely with the ASC front door managers to help identify appropriate referrals to reablement. For end-of-life identification and conversion to PSCP / UCP (K3 and K4) key challenges include varying levels of capacity and professional confidence within Primary Care to initiate PCSP conversations, as well as variable data across PCNs owing in part to different coding practice occurring in different practices within PCNs. SEL Ageing Well Funding secured (£64k non-recurrent for 1 year) for project resource to help address these barriers, by working with primary care to support identification of people in the last year of their life and uptake of Universal Care Plans. Primary Care working with GP leads to mobilise project with a focus on creation of Clinical Lead Champion role, working with champions at GP level to increase completion and quality of UCP / ACP in Lambeth. 7 of 9 Primary Care Champions appointed to post across Dacca PCN. Organising launch event with lead in late January 2025.

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

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

Alliance and Programmes	CYPA (Owner)

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

The 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 improve the process and ensure referrals to the service are appropriate. There has been some work to increase the number of weekend discharges at GSTT which was successful. However after some time the number of weekend discharges decreased slightly.
Following this the weekly wash up meeting after the weekend (to review those patients who were not discharged at the weekend as expected) has now been reinstated. We are hoping the number of weekend discharges will increase following this.

The introduction of a new Electronic Patient Record system at Guy's and St Thomas' and King's College Hospitals continues to affect performance reporting for maternity services across South East London. While efforts to stabilise the system are ongoing, regular reporting has not yet resumed. South East London Business Intelligence has confirmed that a working maternity data dashboard will be available soon, though unfortunately not in time for this assurance update.

During this period, work has focused on maintaining oversight and identifying any risks to service delivery. Looking ahead, there will be a focus on working with maternity providers and the Local Maternity and Neonatal System to restore performance data and strengthen maternity services, with an emphasis on safety, equity, and quality.

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

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

Alliance and Programmes	LDA (Owner)

*What does the data/intelligence indicate around **progress against the outcome?***	On reducing the use of inpatient services: One-system data analysis of admissions and discharges across Lambeth within the ICS (adults only), showed that • 17 patients were discharged to the community in the four years to March 2024 (after removing repeat admission/discharges). • In the last three years the number of people from Black backgrounds in the most restrictive hospital settings has decreased by 50%. We know historically there is an over-representation of Black people in the most restrictive setting, therefore this evidenced progress is very positive. Impact measure on employment demonstrates the number of people with LD as defined in the Adult Social Care Outcome Framework as in paid employment (22 people is 2.9% for 23/4). This is a steady increase from 21/22 of 1%, but is still below the national average of 5%. The rate of uptake of AHC and HAP: The achievement in 23/24 of 83.1% is excellent against a national target of 75%. 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. Autism waits have fallen despite the increase in the Autism waiting list. Driven by increased autism capacity and efficiency of booking clients.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	On LD service, of 5 sustainable discharges to the community in last three years all are Black British indicating a reduction in Black patients being over-represented in more restricted settings. In the last three years the number of people from Black backgrounds in the most restrictive hospital settings has decreased by 50%. We know historically there is an over-representation of Black people in the most restrictive setting, therefore this evidenced progress is very positive. Comparison of Learning Disabilities 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 • A disproportionately high number of Black African and Caribbean people under 30 didn’t have a health check. Impact measure on autism, no inequalities are highlighted in this data, there is no demographic breakdown.

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

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

Alliance and Programmes	LDA (Owner)

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

Prevention of crisis situations, placement breakdown and ultimately admission is a challenge faced nationally for the LDA cohort. The Lambeth system has responded with a range of prevention focussed interventions including using the Dynamic Support Register, Care Education and Treatment Reviews (CETRs) and making use of SEL commissioned services Behaviour Intensive Community Support service and the SEL Select Keyworker service.

Focused data on number of people with LDA in education is not currently available. Low employment figures compared to national average is being tackled through a pilot Supported Employment Service- procurement processes to commence in near future in coordination with Southwark and Lewisham, and a further review of existing services for effectiveness.

On LD AHC and AHP , better quality ethnicity data allows us to drill down in identify groups that are not taking up the health check. To improve awareness of the Annual Health Check a communications and engagement plan was launched working with people with learning disabilities, carers, schools and voluntary organisations, with particular focus on engagement with diverse and racialised communities

Since EPIC go live in October 2023, Evelina's Children's community has experienced challenges with data collect. Last update (June 2024) clear picture on activity and waiting list size was not available. A retrospective audit was undertaken to review waiting time and list sizes.

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

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

Alliance and Programmes	LWNA (Owner)

What does the data/intelligence indicate around progress against the outcome?	LWNA's Community Living and Support Service (CLaSS) helps people with serious mental health conditions to leave inpatient care and live in the community. In the third quarter October to December, CLaSS started working with 49 new people, fewer than the 85 new clients in the second quarter, June to September. LWNA's Individual Placement and Support (IPS) helps people with a serious mental illness find and sustain paid employment. The IPS service helped 15 people find work in the third quarter October to December, which is the best quarterly result of the financial year so far, though still much lower than the original target for the service of 36 placements per quarter. Restrictive incidents and seclusions for inpatients in February fell to 24, the lowest monthly total since December 2023 and well below the average of 32 from the previous financial year. Positive friends and family survey responses for LWNA, across both the inpatient and community settings, rose to 82.5%. This is another improvement on the average survey results from the previous financial year.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Of the referrals that the CLaSS service accepted in the third quarter, October to December, 43% were for Black services users, almost unchanged from the 44% seen in the previous two quarters. The numbers involved mean that such small improvements will not be statistically significant but there is a clear contrast to be drawn between that 44% and the roughly 22% of Lambeth's 18-64 population identifying in the census as Black. As CLaSS supports people moving on from inpatient care without appropriate accommodation, this inequality reflects the higher proportion of Black service users in this situation. Of the 314 restrictive incidents and seclusions reported for Lambeth acute inpatients in the first three quarters of 2024/25 (April to December), 186 (60%) were for Black patients who, in the same period made up 161 (38%) of the 334 accepted inpatients. In the first two months of the last quarter (January to February), there has been a significant fall in the figure to 46%, the lowest figure recorded. However, these figures are highly variable over time, with many of the incidents relating to a small number of individual patients being involved multiple times.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	The proportion of Black people engaging with LWNA's less intensive services is broadly in line with Lambeth demographics (22%), but Black people are over-represented among those accessing more intensive services such as inpatient care (38%) and Focused Support in the community (48%). LWNA is using the PCREF framework to engage with local communities and build trust to improve access, experience and outcomes. Improving access to early forms of support will reduce the level of inequality seen in the more intensive services.

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

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

Alliance and Programmes	Homeless Health (Owner) with contributions from LWNA and Substance Misuse

What does the data/intelligence indicate around ***progress against the outcome?***	Recommissioning of the Vulnerable Adults Pathway is due to commence in April 2025, this includes changes to contract monitoring frameworks and KPI's including health outcomes. A continued focus on GP registration across the Vulnerable Adults Pathway (maintaining 90% or above) registration with dentists, engagement with mental health services and substance use services. The number of residents registered with GP's continues to be at its highest level. This has been achieved through contract monitoring and consistent messaging to Providers to ensure each resident is being supported to register when being accommodated in their service. SWEP (Severe Weather Emergency Protocol) continues to be activated when temperatures fall to zero or below and all rough sleepers are supported by our outreach team to accept emergency accommodation. Rough sleepers can then be assessed fully and access health services as required.
What are the ***challenges hindering any progress*** *and* ***are there actions which can be taken*** *to address these?*	Challenges with access to specialist mental health pathway accommodation, means some individuals are spending periods of time rough sleeping while care act assessments are completed or waiting for appropriate voids to become available. Continued conversations with colleagues regarding barriers are taking place.

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