Lambeth Together

Integrated Assurance Report

13 May 2025

Contents Page

Our Health, Our Lambeth

Lambeth Together health and care plan 2023-28

Lambeth Together Health and Care Plan Scorecard – May 2025

ID	Outcome	Measures tracked	May-25			Vs previous update	Mar-25	Comments
			Measures Reported with a target	On plan/ target	% measures on track (where have a target)		% measures on track (where have a target)2	
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%	–	33%	Average waiting time for LWNA Short term support as at March 25 is 1.3 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	1	33%	↓	67%	Cardiovascular and Diabetes measures slightly behind YE objectives.
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 last 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	3	100%	↑	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	5	100%	↑	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%	
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	24	67%	↑	64%	

Health and Care Plan: Key headlines (1)

	Outcome	Key Headlines
A	***People maintain positive behaviours that keep them healthy***	Q4 2024-2025 saw continued improvement in activity following the transitional stage of the new contracting model in Q1 and the impact of the Synnovis lab cyber-attack in late Q1 through Q2 A total of 2,000 health checks (HCs) were completed, compared to 2,355 in the same period of 2023-2024. The expectation now is that 25-26 will be a more representative year for service delivery as practices continue to fully transition to a business-as-usual position. The NHS Healthcheck service was recommissioned in Spring 24 on a 2-year basis with the intention that the second year would focus on the PCNs and Lambeth commissioners agreeing and developing an at-scale model to deliver the service in the most optimal way, focussing on our key priorities.
B	***People are connected to communities which enable them to maintain good health***	The percentage of residents financially coping have reduced, the percentage of residents in crisis, at risk or struggling has not increased and, instead, the percentage of residents who were coping and have now left the dataset have increased. This is likely to indicate that residents' financial situations have improved to the point where they are no longer in receipt of benefits, as well as reflecting the move from localised benefits to Universal Credit.
C	***People are immunised against vaccine preventable diseases***	For the childhood vaccination programme, National data is currently unavailable. We understand that data cleansing is in progress and will continue to monitor for publication, providing updates as they become available. For flu vaccinations for over 65, although seasonal flu vaccinations are commissioned and provided by the NHS, we committed to contributing to a 2% increase on uptake in 2023/24 season through targeted outreach and engagement activities.
D	***People have healthy mental and emotional wellbeing***	Past data has highlighted that Black services users are under-represented in accessing the less intensive forms of support (like short-term support) and have a greater need to access intensive support (such a focused support and acute care). Data for the last two quarters shows a significant improvement in Black service users' access to short term support, and their use of focused support becoming more representative of the make up of the borough (Black people being 21.7% of the Lambeth adult population). In the quarter, January to March, Black services users made up 29.7% of those accessing short-term support (up 6.3% points) and 42.0% of those for focused support (down 7.3% points). The latest data on waiting times for a second appointment with STS shows no significant difference between Black and White service users.

Health and Care Plan: Key headlines (2)

	Outcome	Key Headlines
E	***People have healthy and fulfilling sexual relationships and good reproductive health***	UKSHA circulated a supplementary report to the Summary Profile of Local Authority Sexual Health Profiles (SPLASH) to local authorities. This report gives a more detailed breakdown of STIs and HIV data by demographics. The report covers 2023 and showed in 2023, 20.9% of diagnoses of new STIs made in Sexual Health Services (SHS) in Lambeth residents were in young people aged 15 to 24 years old. This compares to 41.5% in England. Overall, of those Lambeth residents diagnosed with a new STI in 2023, 76.3% were men and 23.7% were women (in SHSs and non-specialist SHSs; excluding diagnoses with no patient gender recorded). In people where sexual orientation was known, 57.6% of new STIs in Lambeth residents in 2023 were among GBMSM, this compares to 27.5% in England. The proportion of new STI's by ethnic group in Lambeth is White, 58.6%, Black 17.65%,Asian, 4.9%, Mixed 9.5%, other 4.2%, not specified 5.1%. Where recorded, 36.2% of new STIs diagnosed in Lambeth residents in 2023 were in people born overseas.
F	***People receive early diagnosis and support on physical health conditions***	The 2024/25 target was met for both SMI and LD. Performance was down on last year which was, in large part, due to issues accessing blood testing labs.
G	***People who have developed long term health conditions have help to manage their condition and prevent complications***	At the end of March 2025 76.1% of patients had their 8 Care Processes measured and recorded to support diabetes treatment and care, alongside the total number of people with a diagnosis of Type 2 diabetes increasing through 24-25 compared to April 2024. More black and minority ethnic people have been identified with hypertension when comparing March 2024 to March 2025 data; 23770 and 24872 respectively and within these cohorts, blood pressure control has remained consistent with higher absolute numbers in comparison to the previous year; 15,815 and 16,548 respectively.
H	***When emotional and mental health issues are identified; the right help and support is offered early and in a timely way***	The number of people waiting for Lambeth SPA at the end of March 2025 was 480 (up 32% from February). People are getting support sooner than they were in May 2024, when more than 900 people were waiting, but waiting times are still too long. More introductions are being processed within 3 days (up to 34.0% in March from 22.4% in February) and the average wait for people in March fell to 12.9 days, from 16.1 days in February. SPA is working to a target of no-one waiting longer than 14.0 days, but in March this was achieved for only 66% of people.

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***	Planned deep dive
J	***People know where to go to get the right help, and are treated at the right time, in the right place, for their needs***	On Hospital @home service, 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. Provider Business Informatics teams are working to support the virtual wards minimum dataset ensuring teams are able to meet the data specification and perform the submission process. On the Lambeth Pharmacy First Plus Service, data from March 2025 shows most interventions (2078) 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, 57% of patients would have visited general practice to request the medication on prescription, 42% would have gone without medication and 1% would have contacted Out of Hours service.
K	***Older adults are provided with the right health and care support at the right time, live healthy and active later lives and are supported to age well***	The 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. There has been a change in the way we deliver Reablement. 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.
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***	On reducing the use of inpatient services, One-system data analysis of admissions and discharges across Lambeth within the ICS (adults only), showed close 20 patients were discharged to the community in the four years to March 2024. 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 Annual Health Checks (AHC) 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. The rate of uptake of AHC and Health Action Plan (HAP), the achievement in 23/24 of 83.1% is excellent against a national target of 75%. We can confirm in 24/25 achievement of 80% despite challenges due to Synovis impact.
N	***People using mental health support services can recover and stay well, with the right support, and can participate on an equal footing in daily life***	The number of people waiting for Lambeth SPA at the end of March 2025 was 480 (up 32% from February). People are getting support sooner than they were in May 2024, when more than 900 people were waiting, but waiting times are still too long. More introductions are being processed within 3 days (up to 34.0% in March from 22.4% in February) and the average wait for people in March fell to 12.9 days, from 16.1 days in February. SPA is working to a target of no-one waiting longer than 14.0 days, but in March this was achieved for only 66% of people.
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.

Lambeth together

Finance

Finance: South East London ICB: Lambeth

Overall Finance Position (2024/25 M12)

Service Area	Annual Budget £'000s	Year-End Outturn Expenditure £'000s	Year-End Outturn Variance £'000s
Acute Services	1,188	978	210
Community Health Services	28,230	28,702	(471)
Mental Health Services	23,166	23,911	(745)
Continuing Care Services	34,616	33,579	1,037
Prescribing	42,666	42,602	64
Other Primary Care Services	4,141	3,730	412
Delegated Primary Care Services	89,271	90,094	(823)
Corporate Budgets	4,012	3,682	330
Total	**227,291**	**227,278**	**12**

Overall Savings Position (2024/25 M12)

	Annual Plan £'000s	Year-End Outturn Delivery £'000s	Year-End Outturn Variance £'000s
Efficiencies embedded within 2024-25 starting budgets	2,341	2,341	0
Continuing Care Services	1,442	1,955	513
Prescribing	1,393	2,179	786
Total	**5,176**	**6,475**	**1,299**

- The borough is reporting an overall draft 2024-25 year-end outturn underspend variance of £12k. The reported position includes £471k overspend on Community Health Services, £745k overspend on Mental Health Services (including learning disabilities) and £823k 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 Lambeth's finance position relate to - Mental Health (including learning disabilities) and Delegated Primary Care Services budgets.
- Mental Health budget 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-end outturn 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 year-end is 546.
- 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 forecast year-end outturn underspend of £64k at month 12 (March 2025) based on ten 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-end outturn delivery is £1.3m above plan

Finance: Lambeth Council – ASC & Integrated Health M11 2024/5 position

- ASC - M11 forecast predicts an overspend of £12.8m in 2024/25, which is unchanged from January (M10). The service has reserves of £3m which once applied will reduce the projected overspend to **£9.8m**
- The overspend is driven almost entirely by care & support package costs, with the largest pressures in Nursing Care (OP, PD, ALD), Residential Care (OP & LD) and Supported Living/Accommodation (PD & LD)
- Across all client groups, operational and commissioning staff have increased efforts to manage rising costs through several ‘ Managing Demand’ workstreams and Right Sizing Care reviews, with the largest positive impact in ALD. This work has stabilized the forecast approaching the end of the financial year.
- The underspend in ‘Other Adults Services..’ is due to ASC grant funding being forecast here before being distributed across client groups at the end of the financial year.
- ASC Savings target of £3m in 2024/25 achieved. A further £1.46m savings are committed in 2025/26 from ASC, and £596k from Integrated Health & Care.
- Public Health grant allocation for 2024/25 was £36,270,348 (net expenditure shown in table on RHS). Additional PHG of £690,803 announced late in the year at the end of Q3, funding higher than expected NHS pay awards

Division	Budget £'000	Forecast £'000	Variance £'000	Movement prior month £’000
Adults with Learning Disabilities	42,348	48,136	5,788	148
Adults with Physical Disabilities	14,899	17,565	2,666	318
Adults with Mental Health Needs	11,124	11,860	736	-319
Older People	29,513	36,403	6,890	87
Other Adults Service & Supported Housing	16,979	13,662	-3,317	-234
Adult Social Care Directorate	**114,863**	**127,627**	**12,764**	**0**

Division	Budget £'000	Forecast £'000	Variance £'000	Movement prior month £’000
Integrated Commissioning	222	222	0	0
Public Health	1,577	1,577	0	0
Senior Management IH&C	0	0	0	0
Integrated Health & Care Directorate	**1,799**	**1,799**	**0**	

Lambeth together

Quality

See enclosed with LTAG pack

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.

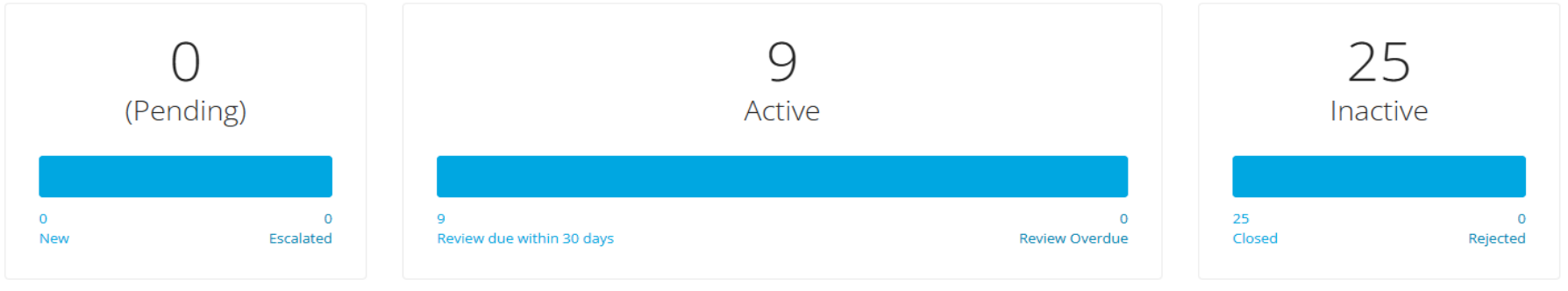
Lambeth Risk Register

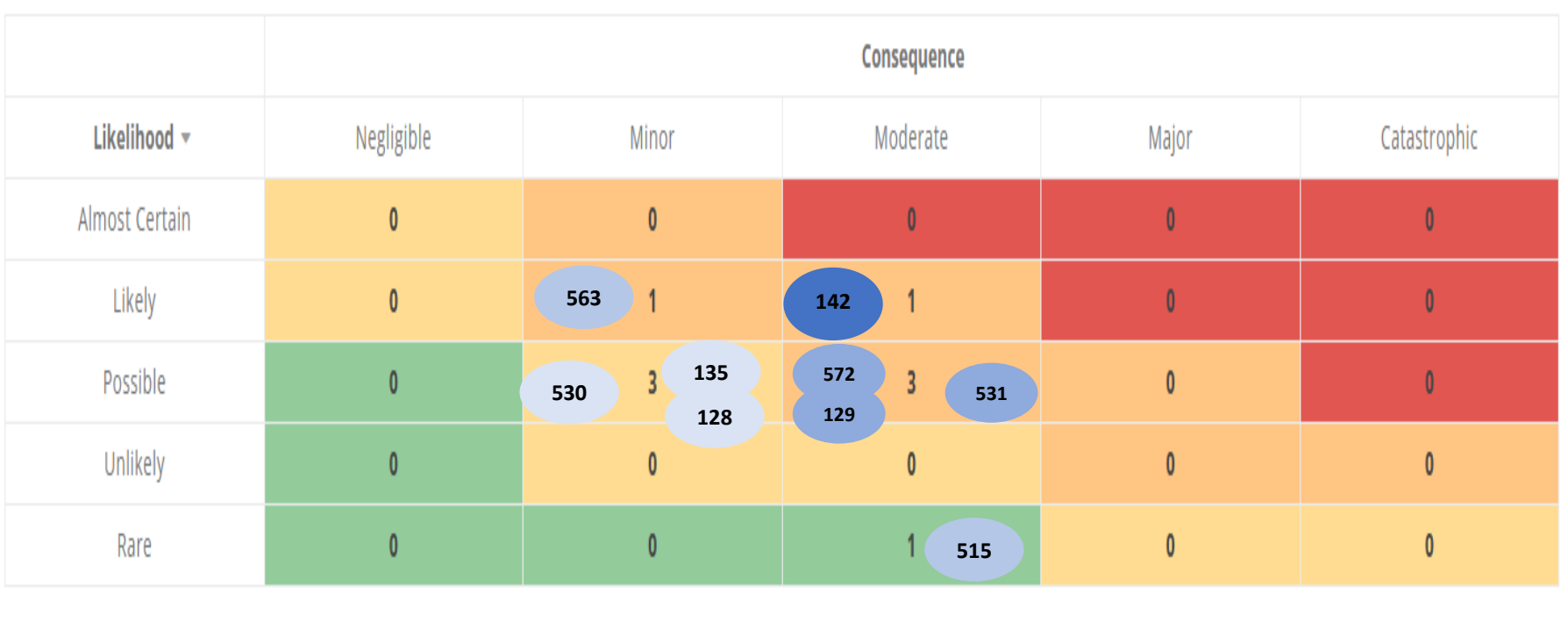
- As of April February, there were 9 active risks on the South East London Risk register for Lambeth.
- See below Lambeth risks closed since the last update to this group:
  - 513 - Inadequate resource in safeguarding structure
  - 516 - Achievement of Financial Balance 2024/25
  - 534 - Prescribing Budget and Performance
  - 542 - Delivery of Efficiency Savings
  - 567 - Primary Care GP Collective Action
- The above risks were closed due to low threshold, risks did not materialise and managed in year.

- SEL Risk lead have requested local partners to complete a “check and challenge” for all risks, supporting risk owners and sponsors to ensure all risks remain up-to-date and relevant. This exercise will take place in May to ensure 24/25 risks that are no longer relevant for 25/26 cycle are closed. Open new risks where relevant, particularly on finance areas likely to be impacted by efficiency demands.

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
515	Finance
530	Finance
531	Finance
563	Finance
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	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*
515	*Community Equipment Services Budget and Performance.*	*3*
530	*Unbudgeted costs linked to learning disability*	*6*
531	*Continuing Health Care Budget and Performance*	*9*
563	*Interpreting Services Overspend*	*8*
572	*Increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population - Seasonal Flu Vaccination*	*9*

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	Feb-25	National standard	67%	76.3%	69.9%	Above	1
IAPT discharge	Feb-25	Operating plan	585	475	N/A	N/A	-
IAPT reliable improvement	Feb-25	Operating plan	67%	69%	67%	Above	2
IAPT reliable recovery	Feb-25	National standard	48%	51%	47%	Above	1
SMI Healthchecks	Q3 24/25	Local trajectory	66%	54.6%	50.6%	Above	1
LD and Autism - Annual health checks	Feb-25	Local trajectory	1132	1263	N/A	N/A	-
Bowel Cancer Coverage (60-74)	Sep-24	Corporate Objective	62.6%	61.8%	67.7%	Below	6
Cervical Cancer Coverage (25-64 combined)	Jun-24	Corporate Objective	62.7%	63.3%	66.9%	Below	6
Breast Cancer Coverage (50-70)	Sep-24	Corporate Objective	58.1%	56.4%	62.3%	Below	6
Percentage of patients with hypertension treated to NICE guidance	Mar-25	Corporate Objective	71.9%	68%	67.0%	Above	3
Flu vaccination rate over 65s	Feb-25	Corporate Objective	60.0%	54.6%	63.1%	Below	5
Flu vaccination rate under 65s at risk	Feb-25	Corporate Objective	32.9%	29.9%	28.8%	Below	5
Appointments seen within two weeks	Feb-25	Operating plan	91.0%	91.5%	89.0%	Above	2

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

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

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.	100%
Health Inequalities: Increase performance of SMI health checks.	100%
Adults Transformation	
Cancer - Work collaboratively with primary care to increase the uptake of cancer screening.	100%
Adults with Learning Disabilities	
Focus on LDA Health Inequalities.	100%
NHSE Learning Disability and Autism Programme.	100%
Financial Savings (IHC)	
Financial Savings	100%
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.	60%
Recommission Domiciliary Care and CHC framework.	50%
Support Special Educational Needs and/or Disabilities (SEND) inspection preparation.	75%
Long Term Conditions Optimisation	
Deliver Long Term Conditions Optimisation Prioritites	100%
Medicines Optimisation	
Deliver Medicines Optimisation Priorities	100%
Primary Care	
Delivery Plan for recovering Access to Primary Care.	100%
Strengthening General Practice by integrating services to deliver joined up care to patients.	100%
Public Health Objective	
HDRC - Implement Lambeth HEART programme of training and research development	100%
Health Protection - Continue the delivery of the new childhood vaccination in new spaces pilot	100%
Sexual Health - Refreshed service offer	90%
Staying Healthy - An Age Friendly borough where people can live healthy and active later lives.	100%
Staying Healthy - Implement and embed approaches to improve access to health improvement services.	100%
Substance Misuse - Continued embedding of the Combatting Drugs Partnership.	100%

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

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

The table provides a summary of year end position across the areas of focus within the 24/25 plan. Most actions has been listed as Green, the actions listed as Amber note ongoing work which will continue in 25/26.

Appendix:
Health and Care Plan Outcomes: Detailed assurance narrative

Impact measures performance trend (1)

Outcome	Impact measure	Target/Pla	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Year to Date	Comments
		Actual							12.6%	12.6%		12.5%		12.4%	12.3%		Data source - SEL Vital 5 dashboard (as of March 25) - Of those with a smoking status, 30,090 (12.32%) 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%	12.4%		Target to reduce by 1% from 22/23 year end (13.4%). Data source is Office for Health Improvement and Disparities (OHID) Prevalence but as only annual it's proposed that we use SEL ICB Vital 5 dashboard
	Smoking prevalence reduction	Variance							-0.3%	-0.3%		-0.2%		-0.1%	-0.1%		
A	**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
		Actual	78.2%			78.9%			74.8%			74.7%			77.70%		
B		23/24				77.9%			78.8%			79.6%			78.2%		Plan = same period in 23/24
	Percentage of low-income residents coping financially	Variance				1.0%			-4.00%			-4.90%			-0.50%		
	Number of Entering treatment with Short-Term Support with Living Well Centres.	Actual		165	171	132	193	238	180	159	122	114	133	131	143		Against previous month's position
		Variance			6	-39	61	45	-58	-21	-37	-8	19	-2	12		
	Number of Entering treatment with Focused Support with Living Well Centres.	Actual		54	54	32	47	44	50	46	29	49	57	36	27		
D		Variance			-	-22	15	-3	6	-4	-17	20	8	-21	-9		
		Actual		24.1	25.1	25.4	25.2	28.4	27.6	25.9	22.8	24.5	17.5	24.2	27.3		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	26.0		Target = 26 days (local ambition)
	Provisionally agreed - LWNA Short Term Waiting Time	Variance			0.9	0.5	0.8	-2.4	-1.7	0.1	3.2	1.5	8.5	1.8	-1.3		

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

Impact measures performance trend (2)

Outcome	Impact measure	Target/Pla	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Year to Date	Comments
F	Uptake of SMI health checks	Actual	68%	3%	9%	10%	13%	18%	24%	32%	38%	43%	50%	57%	64%		
		Plan	60%	5.0%	10.0%	15.0%	20.0%	25%	30%	35%	40%	45%	50%	55%	60%		National Target = 60% at year end
		Variance	8.0%	-2.0%	-1.5%	-5.4%	-7.1%	-6.6%	-5.7%	-3.2%	-2.0%	-1.6%	0.3%	2.0%	3.7%		
	Uptake of LD/AHC health checks	Actual	84.6%	5.7%	10.3%	16.4%	20.2%	31.0%	38.6%	46.8%	52%	59%	66%	73%	83%		
		Plan	75.0%	6.3%	12.6%	18.9%	25.2%	31.5%	37.8%	44.1%	50.4%	56.7%	63.0%	69.3%	75%		National Target = 75% at year end
		Variance	9.6%	-0.6%	-2.2%	-2.5%	-5.0%	-0.4%	0.9%	2.7%	1.9%	2.7%	2.9%	4.1%	7.6%		
	Proportion of Bowel Cancer screening for those aged 60-74 (Coverage)	Actual															
		Plan	60.6%														Plan = same period in 22/23
		Variance															
	Proportion of cervical Cancer Screening aged 25-64 (Coverage)	Actual	62.9%	63.0%													
		Plan	63.0%	62.8%													Plan = same period in 22/23
		Variance	-0.1%	0.2%													
	Proportion of breast cancer screening for women aged 47-73 (Coverage)	Actual															
		Plan	43%														Plan = same period in 22/23
G	Proportion of people with Type 2 diabetes who receive 8 checks on an annual basis	Actual	81.7%	15.1%	22.7%	24.1%	27.8%	36%	43%	51%	57%	62%	67%	72%	76%		
		Plan	77.0%	6.4%	12.8%	19.3%	25.7%	32.1%	38.5%	44.9%	51.3%	57.8%	64.2%	70.6%	77%		Local target = 77% by year end (set to straight line trajectory)
		Variance	4.7%	8.7%	9.9%	4.8%	2.1%	3.4%	4.3%	5.6%	5.8%	4.0%	3.1%	1.2%	-1%		
	Cardiovascular dashboard, HYP aged 79 or under and last BP is less than or equal to 140/90 this FY	Actual	68.7%	10.6%	22.1%	31.1%	38%	43.7%	48.1%	52.5%	56.4%	60%	63%	66%	70%		
		Plan	77.0%	6.4%	12.8%	19.3%	25.7%	32.1%	38.5%	44.9%	51.3%	57.8%	64.2%	70.6%	77%		National target = 77% by year end (set to straight line trajectory)
		Variance	-8.3%	4.2%	9.3%	11.9%	12.4%	11.6%	9.6%	7.6%	5.1%	1.8%	-1.3%	-4.4%	-7%		
	Cardiovascular dashboard, HYP aged 80 or over and last BP is less than or equal to 150/90 this FY	Actual	81.7%	16.1%	29.4%	40%	48%	54.3%	59.2%	64.7%	69.2%	72%	75%	78%	81%		
		Plan	77.0%	6.4%	12.8%	19.3%	25.7%	32.1%	38.5%	44.9%	51.3%	57.8%	64.2%	70.6%	77%		National target = 77% by year end (set to straight line trajectory)
		Variance	4.7%	9.7%	16.5%	20.6%	21.9%	22.2%	20.7%	19.7%	17.8%	14.4%	10.9%	7.7%	4.1%		
	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%	47%		
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%	34%		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	25.3%			25.3%			23.60%			24.10%					% of black users by Ethnicity
		Plan	21.7%			21.7%			21.7%			21.7%					% of Black users by Ethnicity as per 2021 Census population rate
		Variance	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	43.1%			43.1%			45.0%			49.2%					
		Plan	48.0%			48.0%			48.0%			48.0%					
		Variance	-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

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

Impact measures performance trend (3)

Outcome	Impact measure	Target/Plan	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Year to Date	Comments
I	Health and Wellbeing Bus - No of interactions - Welfare Advice and Mental Health session	Actual				102			129			106			101		
		Variance							27			- 23			- 5		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			372	*1,806*	
		Health & Wellbeing sessions				141			182			118			249	*690*	
		Variance				-			20			- 256			160		Against previous quarter's position
J	Number of appointments in General Practice	Actual	159,787	166,166	165,670	149,688	170,573	159,787	163,524	194,806	171,242	157,189	186,600	167,637	176,726	2,029,608	
		Plan		137,079	158,464	168,495	158,711	163,515	158,057	155,258	165,319	133,406	171,212	166,166	159,787	1,895,469	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	1,471	16,939	59,259	
		%		21%	5%	-11%	7%	-2%	3%	25%	4%	18%	9%	1%	11%	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	>900	1,626	1,709	1,589	1,704	1,667	1,820	1,647	2,175	2,441	2,534	2,472	2,500	23,884	April to March data shbows the total Pharmacy First consultations (includes referrals to the 7 Clinical Pathways, Minor Illness and Urgent Medicine Supply service) -Total Pharmacy First consultations (includes referrals to the 7 Clinical Pathways, Minor Illness and Urgent Medicine Supply service)
	Capacity of virtual wards	Actual	224	209	177	166	198	180	185	173	236	210	212	184	220		
		Plan	231	231	233	233	234	235	237	237	241	241	241	267	267		
		Variance	- 7	- 22	- 56	- 67	- 36	- 55	- 52	- 64	- 5	- 31	- 29	- 83	- 47		
	Proportion of virtual wards being used	Actual	97%	90%	76%	71%	85%	77%	92%	73%	98%	87%	88%	69%	82%		
		Plan	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%		
		Variance	17.0%	10.0%	-4.0%	-9.0%	5.0%	-3.0%	12.0%	-7.0%	18.0%	7.0%	8.0%	-11.0%	2.0%		
K	Number of people with an intermediate care offer	Actual	35	44	41	38	37	46	34	59	54	36	62	53	63		
		Plan	58	53	62	60	62	41	52	62	61	46	47	68	35		
		Variance	- 23	- 9	- 21	- 22	- 25	5	- 18	- 3	- 7	- 10	15	- 15	28		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	79%	86%	89%	84%	92%	90%	90%	88%	89%	88%	87%	86%	88%		
		Plan	78%	75%	79%	92%	78%	91%	84%	76%	80%	83%	85%	81%	79%		Plan = same period previous year
		Variance	1%	11%	10%	-8%	14%	-1%	6%	12%	9%	5%	2%	5%	9%		
	Proportion of carers of the users of Adult Social Care Services are offered a carers assessment	Actual	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
		Plan	98%	100%	99%	99%	98%	98%	97%	98%	97%	97%	90%	93%	100%		
		Variance	2%	0%	1%	1%	2%	2%	3%	2%	3%	3%	10%	7%	0%		
	No of people identified as being in their last year of life on practice registers	Actual	1988			2013			2082			2045			2054		
		Plan	1651			1937			1954			1953			1988		Plan = same period in 22/23
		Variance	337			76			128			92			66		
	Proportion of people with Personalised Care and Support Plan(PCSP)/UCP	Actual	48%			49%			46%			45%			49%		
		Plan	42%			46%			47%			48%			48%		Plan = same period in 22/23
		Variance	6%			3%			-1%			-3%			1%		

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

Impact measures performance trend (4)

Outcome	Impact measure	Target/Pla	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Year to Date	Comments
M	Rate of uptake for an Annual Health Check and Health Action Plan for those with LDA	Actual	83.1%	5%	10%	14%	19%	27%	35%	41%	47%	55%	62%	70%	80%		
		Plan	75.0%	6.3%	12.5%	18.8%	25.0%	31.3%	37.5%	43.8%	50.0%	56.3%	62.5%	68.8%	75.0%		
		Variance	8.1%	-1.1%	-2.9%	-4.6%	-5.5%	-3.8%	-2.8%	-2.3%	-2.7%	-1.6%	-1.0%	1.5%	5.0%		
	Weeks waiting for an ASD diagnosis for children and young people	Actual				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	Number of people per quarter supported by the Living Well Network Alliance into paid employment (IPS)	Actual	10			12			16			15			8		Number of service users starting paid employmenet during each quarter
		Plan	36			36			36			36			36		
		Variance	-26			-24			-20			-21			-28		
	Number of people per quarter supported by the Living Well Network Alliance to stay in their own homes (ClaSS)	Actual	95			54			85			48			47		Number of service users (unique Trust IDs) from referrals accepted during each quarter
		Variance	95			54			85			48			-1		
	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			492		
	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	73.0%	89.2%	74.6%	77.4%	82.5%	87.0%	78.8%	76.7%	76.3%	77.8%	82.5%	83.1%	68.6%		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%		Mean value Sep-23 to Sep-24
		Variance	-5.4%	10.8%	-3.8%	-1.0%	4.1%	8.6%	0.4%	-1.7%	-2.1%	-0.6%	4.1%	4.7%	-9.8%		
	Seclusions and restrictive interventions on inpatient setting	Actual	36	43	49	39	33	40	27	29	29	31	43	24	31		Restrictive incidents + seclusions
		Plan	33	33	33	33	33	33	32	32	32	32	32	32	32		Median value Apr-23 to Dec-24
		Variance	-3	-10	-16	-6	-	-7	5	3	3	1	-11	8	1		
O	Percentage of people resettled into longer-term accommodation	Actual	5%			4%			4%			4%			6%		
		Plan	5%			3%			3%			3%			5%		Plan = same period previous year
		Variance	-			1%			1%			1%			1%		
	Number of rough sleepers brought into accommodation	Actual	52			44			33			55			62	246	
		Plan	38			71			58			58			52	277	Plan = same period previous year
		Variance	14			-27			-25			-3			10	-31	
	Proportion of people living in our supported housing that are registered with a GP	Actual	92%			90%			97%			98%			98%		
		Plan	74%			75%			79%			90%			92%		Plan = same period previous year
		Variance	18%			15%			18%			8%			6%		
	Rate of residents in supported housing engaged with mental health support services.	Actual	25%			23%			24%			24%			30%		
		Plan	12%			12%			14%			20%			25%		
		Variance	13%			11%			10%			4%			5%		
	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?	Q4 2024-2025 saw continued improvement in activity following the transitional stage of the new contracting model in Q1 and the impact of the Synnovis lab cyber-attack in late Q1 through Q2. A total of 2,000 health checks (HCs) were completed, compared to 2,355 in the same period of 2023-2024. The expectation now is that 25-26 will be a more representative year for service delivery as practices continue to fully transition to a business-as-usual position. Key outcomes include: • 22% of patients who had a health check in Q4 were referred to lifestyle services or prescribed medication. This includes 100 patients prescribed statins, 40 prescribed antihypertensives, 210 referred to the National Diabetes Prevention Programme (NDPP), 5 referred to smoking cessation services, 1 referred to alcohol services, and 55 referred to weight management. • 16% of patients were diagnosed with a health condition and added to appropriate registers. This includes 62 patients with hypertension, 20 with diabetes, 2 with chronic kidney disease (CKD), and 227 with non-diabetic hyperglycaemia. • 87% of patients were identified with low 10-year cardiovascular disease (CVD) risk, 12% with moderate risk, and 1% 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 54% (incl. White British 30% and White Other 24%) • Black: Eligible 18%, Uptake 18% • Asian: Eligible 6%, Uptake 10% • 40-50 age group: Eligible 60%, Uptake 52% • 51-60 age group: Eligible 28%, Uptake 37% • 61+ age group: Eligible 12%, Uptake 11% This demonstrates the opportunity to pick up risk factors at an earlier stage and to start prevention early. • Female: Eligible 43%, Uptake 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 second year would focus on the PCNs 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 has impacted the transition phase of the newly commissioned model and will likely impact time scales of refining and embedding the associated new ways of working ahead of any future recommissioning exercise. The above notwithstanding, Commissioners continue to work with the PCNs on recovering the core offer and engaging on future commissioning models.

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?	A steady increase in referrals during Q4 which continued into April, shows continued demand and need for social prescribing. The main purpose of social prescribing is to connect individuals with their community, so high referrals suggests people are accessing support and maintaining connections with their communities. However, referrals are often for more complex reasons, beyond the scope of social prescribing and it's difficult to identity support in the community due to funding difficulties. There are also repeat referrals into the service which could suggest those that are re-referred into the service are not maintaining good health. Whilst the percentage of residents financially coping have reduced, the percentage of residents in crisis, at risk or struggling has not increased and, instead, the percentage of residents who were coping and have now left the dataset have increased. This is likely to indicate that residents' financial situations have improved to the point where they are no longer in receipt of benefits, as well as reflecting the move from localised benefits to Universal Credit. At present, we do not have the Universal Credit data to include in this reporting but this is currently being built into our reporting by the council's data teams. However, there has been an increase in the percentage of residents categorised as "in crisis" or "at risk". The team are currently working to identify trends with these residents and put interventions in place, both to reduce the impact on these residents as well as the likelihood of residents with the same characteristics falling further into poverty in the future. As the changes have been recent, the team are currently exploring the demographics of impacted residents to confirm the impact on inequalities in the borough.
Does the data/intelligence identify any health inequalities and whether they are reducing?	To counter some of the issues discussed above and ensure health inequalities are addressed and reduced, AUKL social prescribers continue to explore opportunities to support Lambeth residents connect with communities and North Lambeth PCN LWs were recently successful in a funding grant to continue delivering yoga/ chair based yoga classes and peer support to residents.
What are the challenges hindering any progress and are there actions which can be taken to address these?	On S Prescribing, the complexity of referrals doesn't always meet the social prescribing remit and there's a lack of services and support to signpost Lambeth residents onwards. The financial wellbeing of residents continues to be challenged due to wider economic factors linked primarily to austerity, continuing high inflation for food and energy and the welfare benefits system not keeping pace with the costs of essentials (e.g. Universal Credit (allowances and two-child policy), Healthy Start Vouchers being insufficient to meet the cost of infant formula). The council continues to provide reactive responses to poverty and increases in the cost of living whilst also developing longer-term responses to reducing the instance and impact of poverty in the borough through a Tackling Poverty action plan, with a delayed launch date of June 2025 due to political changes, with health as a key area of focus, recognising the impact of poverty on health outcomes.
Additional Comments	This report is based on anecdotal reports from AUKL SPs only- with no centralised system we are unable to report on the social prescribing service across the borough.

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?	For the childhood vaccination programme, National data is currently unavailable. We understand that data cleansing is in progress and will continue to monitor for publication, providing updates as they become available. For flu vaccinations for over 65, although seasonal flu vaccinations are commissioned and provided by the NHS, we committed to contributing to a 2% increase on uptake in 2023/24 season through targeted outreach and engagement activities.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Unfortunately, we have observed a decline in uptake for the 2024/25 season, with a recorded flu vaccination rate of 54.4% among the over 65s group. This mirrors trends observed in some other SEL boroughs, based on the data we have been able to access and compare. The challenges in improving uptake arise from a complex combination of factors, including individual barriers such as vaccine fatigue, mistrust, hesitancy, and differing health beliefs, alongside systemic issues. We intend to build on the insights gained from last season to shape our approach for this year.

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) began helping 143 new people in March, more than in February (131). This makes 1,673 new people supported in 2024/25, 144 more than 2023/24. The number of people Focused Support (FS) started supporting in March fell to 27 from 36 in February, which makes 452 new people in 2024/25, 102 more than the year before. In March, Lambeth Single Point of Access referred 103 people to STS, just under the average of 109 for 2024-25, but more than expected. People attending a second STS appointment in March had waited an average of 27.3 days. This is 1.3 days longer than the average wait in 2023/24. This increase of 5% roughly matches the 4% increase in the number of people working with STS over the same period (499 in March and 480 on average for 2023/24). Lambeth SPA is still working to ensure that SPA first appointments are correctly recorded so that STS second appointment wait times are as accurate as possible.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Past data has highlighted that Black services users are under-represented in accessing the less intensive forms of support (like short-term support) and have a greater need to access intensive support (such a focused support and acute care). Data for the last two quarters shows a significant improvement in Black service users' access to short term support, and their use of focused support becoming more representative of the make up of the borough (Black people being 21.7% of the Lambeth adult population). In the quarter, January to March, Black services users made up 29.7% of those accessing short-term support (up 6.3% points) and 42.0% of those for focused support (down 7.3% points). The latest data on waiting times for a second appointment with STS shows no significant difference between Black and White service users.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	We believe that social and economic factors that disproportionately affect Black communities lie behind their need for more intensive services. We use the PCREF framework to engage with our local communities and build trust to improve access, experience and outcomes. Greater access to services for Black people in the early stages of their illness will reduce their 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?***	In Q4 there were 803 LARC appointments used in GPs and the LARC Hub. Activity has remained fairly stable over the year. As the new LARC Hub service mobilises and more clinicians are trained, we hope to see an increase in LARC activity in PCNs where provision is lower. TOPs data is updated for 2024/25. This shows 2,194 terminations for the year. This is 5% less than the previous year. There is a slight increase in repeat terminations from the previous year - from 41% to 43%.
Does the data/intelligence identify any ***health inequalities and whether they are reducing?***	This week UKSHA circulated a supplementary report to the Summary Profile of Local Authority Sexual Health Profiles (SPLASH) to local authorities. This report gives a more detailed breakdown of STIs and HIV data by demographics. The report covers 2023 and showed: • In 2023, 20.9% of diagnoses of new STIs made in Sexual Health Services (SHS) in Lambeth residents were in young people aged 15 to 24 years old. This compares to 41.5% in England. • Overall, of those Lambeth residents diagnosed with a new STI in 2023, 76.3% were men and 23.7% were women (in SHSs and non-specialist SHSs; excluding diagnoses with no patient gender recorded). • In people where sexual orientation was known, 57.6% of new STIs in Lambeth residents in 2023 were among GBMSM. This compares to 27.5% in England. • In Lambeth residents, an estimated 7.3% of women and 24.5% of men diagnosed with gonorrhoea at a SHS between 2019 and 2023 became reinfected with gonorrhoea within 12 months. Nationally, an estimated 5.2% of women and 15.5% of men became reinfected with gonorrhoea within 12 months. • In Lambeth residents, an estimated 21.6% of 15 to 19 year old women and 21.5% of 15 to 19 year old men presenting with a new STI at a SHS during the five year period from 2019 to 2023 became re-infected with a new STI within 12 months. • The proportion of new STI's by ethnic group in Lambeth is White, 58.6%, Black 17.65,Asian, 4.9%, Mixed 9.5%, other 4.2%, not specified 5.1% • Where recorded, 36.2% of new STIs diagnosed in Lambeth residents in 2023 were in people born overseas. We continue to see inequalities in sexual health outcomes with a larger proportion of STIs diagnosed in GBMSM and those aged between 20-29.
What are the ***challenges hindering any progress*** *and* ***are there actions which can be taken*** *to address these?*	The refreshed Sexual Health Strategy for Lambeth, Southwark, Lewisham , Bexley and Bromley (LSLBB) will be live for consultation by mid May and the LSLBB commissioning team are currently developing an action plan to direct the work over the next 5 years. Improved reporting and updated KPIs are now in place with all the NHS Trusts within SEL. The Outreach services targeting Health Inclusion Groups is now live and developing its clinical capacity to enable interventions to take place outside of clinical environments. The digital service tool 'Find Sexual Health' has launched an improved and comprehensive offer to both residents and professionals. Commissioners are working with London Colleagues to progress the re-procurement of the London online service, which will have an expanded offer across STI testing and contraception and will also include access to PrEP. In the meantime, the Lambeth team is procuring a digital PrEP pilot to enable early access to online PrEP for Lambeth residents.

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 61.8% screened (July 2024) compared to 50% in December 2019. Above national target of 60% screened.
2. Cervical Cancer screening aged 25-64-shows levels are quite stable but not increasing with 62.7% screening in June 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 56% screened in July 2024 which is an increase from 55% in July 2023. 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

At the end of Q4 993 Residents had started PrEP and there had been 4,702 individuals with a continuing PrEP record. There is a reduction of PrEP starts over time and an increase in PrEP continuing, which indicates that current users are converting to continuing and starters are plateauing.

The 2024/25 target was met for both SMI and LD. Performance was down on last year which was, in large part, due to issues accessing blood testing labs.

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 (69.8%), then white (67.0%) and then significantly lower for mixed (62.3%), Asian (55.2%) and other (51.4%). Significantly lower for those with LD (46.1%) compared to non-LD (63.6). Rates have not improved in past 2 years.
3. Breast cancer screening aged 50-70-1st deprivation quintile have lowest rates. White (60.5%) and black (60.2%) ethnicity have similar rates, lower in Asian (56.0%), mixed (54.4%) and “other” (51.1%) ethnicities, Significantly lower in LD (44.5%) compared to non-LD (58.5) and SMI (45.6%) compared to non-SMI (58.7%). Compared to 2 years ago SMI rate has improved but LD has declined.

On PrEP within these activity numbers 28 continuers where female and 40 starters were women, this number is slightly up on last year but remains very low and we would like to increase the number of women accessing PrEP.

Local audits identified that males with SMI were more likely not to engage in health checks, and of that group, African and Caribbean males were a significant proportion. Local audits identified that black females, white males and black people under 30 with LD were less likely to have a health check. Plans have been developed that tailor communication and engagement to these groups.

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. Firstly as mentioned above there is a lag in the data so we are 10 months behind with official data to see local rates which can lead to delays in identifying evolving issues. Due to primary care it is difficult for primary care to take on additional screening promotion work. The breast screening incentive has also been removed from the local PMS contract. We are working to try and arrange alternative financial incentives. 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. We are still waiting on the updated clinical guidelines for providing PrEP within clinical settings. In the meantime, Commissioners and HIV Clinical Champions have started a community pilot to develop, training and promotional materials for PrEP across clinicians and residents, with the aim to support community services to enable access to residents that don't generally access sexual health clinics. Commissioners are currently working with procurement colleagues to commission a digital PrEP pilot, we are hopeful this will be in place by the end of Q1. On SMI Annual Health Checks programme changes to the requirement to maintain disease registers in general practice may affect the ability to validate data. Lambeth actual SMI prevalence will be monitored against expected prevalence. The 6 core checks are no longer incentivised under QOF 2025/6. 10% of the MH element of the Lambeth Offer will be used to encourage practices to perform the screenings.

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 2025. Improvement of blood pressure control has continued whilst hypertension detection and diagnosis has increased. Improvements have been made year on year. Continued work over the year is required to improve to the Health and Care Plan outcome of 77% blood pressure control (140mmHg/90mmHg) in people aged 79 years and under by end of FY 2024-25. The Lambeth ambition for the proportion of people with Type 2 diabetes, who meet all 8 Care Process metrics, is to reach a minimum of 77% or improve from baseline (National Diabetes Audit 22-23 percentage) by 10 percentage points. The measuring period aligns to the National Diabetes Audit 15 month measuring period January 2024 to March 2025 and is cumulative over this period. At the end of March 2025 76.1% of patients had their 8 Care Processes measured and recorded to support diabetes treatment and care, alongside the total number of people with a diagnosis of Type 2 diabetes increasing through 24-25 compared to April 2024. Problematic polypharmacy (prescribing of 10 or more concurrent medicines) increases the risk of drug interactions and adverse drug reactions (ADR), impairing medication adherence and impacting on a patient's quality of life, this risk increases with the number of prescribed medicines a patient is on and when specific therapeutic combinations are concurrently prescribed. In conjunction with the patient, SMRs provide a holistic medication review to ensure prescribed medicines are safe, effective and personalised to patients' current needs. SMRs improve outcomes, reduce unnecessary or inappropriate prescribing and polypharmacy, reduce harm and improve patient outcomes. The number of coded Structured Medication Reviews (SMR) in Lambeth for patients who are 65 years or over and prescribed 10 or more medicines is being tracked to indicate progress. There is an increasing trend of people over the age of 65 who are taking 10 or more medicines received a structured medication review since 01 April 2024. At the end of March 2025, a total of 1518 of the 3209 (47.3%, previously 37%) 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 March 2024 to March 2025 data; 23770 and 24872 respectively and within these cohorts, blood pressure control has remained consistent with higher absolute numbers in comparison to the previous year; 15,815 and 16,548 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. Polypharmacy 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?	The number of people waiting for Lambeth SPA at the end of March 2025 was 480 (up 32% from February). People are getting support sooner than they were in May 2024, when more than 900 people were waiting, but waiting times are still too long. More introductions are being processed within 3 days (up to 34.0% in March from 22.4% in February) and the average wait for people in March fell to 12.9 days, from 16.1 days in February. SPA is working to a target of no-one waiting longer than 14.0 days, but in March this was achieved for only 66% of people. 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 97% of target in March, finishing 2024/25 at 98% of the annual target, with 6,608 people having completed treatment.
*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 the year 2024/25, Black service users were given onward referrals to Community Mental Health Services to their White counterparts (24% and 25% respectively). In 2024/25 Black and White service users also waited for about the same length for time, on average, for a referral decision from Lambeth SPA (31.1 and 32.2 days respectively). Access to Lambeth Talking Therapies Recovery for Black service users has been steadily improving. In Q3 Oct-Dec 2024 (the latest period for which data is available), 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?*	Changes to the way Lambeth SPA works and additional support helped to reduce both the number of people waiting and how long they wait. But as of March 2025, this trend has reversed, and both figures are steadily increasing again. An LWNA management case for change gained approval from LWNA leadership and the service is currently being remodelling to meet the needs of the community within the available budget. Lambeth Talking Therapies continues to focus on having more new clients access the service who are then assessed 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 bus team are hitting their target of 50 or more average interactions numbers per day. The outreach is seeing good numbers. There is a slight seasonal dip in the amount of interactions in Q4 – owing to weather and less community events.
Does the data/intelligence identify any ***health inequalities and whether they are reducing?***	The data captured is unable to track that. We are working towards implementing a new service with the bus (Vital 5), and there are some delays in us being able to have an EMIS template for the Vital 5 programme.
What are the ***challenges hindering any progress*** *and* ***are there actions which can be taken*** *to address these?*	EMIS template for Vital 5. Working closely with Vital 5 programme team, Southwark and Ardens to resolve. Implementing an interim data capture in the meantime.
Additional Comments	Team have had training on Vital 5 and Women and Girls health – further addressing health inequalities by adding to their knowledge and ability to signpost and share information with residents.

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 increased to **257 beds** by the end of March 2025 following the bed consolidation process. KCH IRT continue to have mobilisation delays – escalation discussions in progress with KCH to understand the delay.

The steering group formally agreed to a further year funding allocation to support Remote Monitoring and extend the Doccla contract for 12 months from April 2025 to provide extra time to development of Lambeth and Southwark model aligned to Out of Hospital strategy development review against current technology in place and wider consideration.

The Health Innovations Network, on behalf of SEL ICS, published a paper titled Learning from the Implementation of Remote Monitoring Tech in April, based on the outputs from a workshop in March 2025, showed variable successes and challenges across the SEL boroughs with the implementation of Remote Monitoring technology, but there remained considerable opportunity with changes to the operational approach, building staff confidence and improved identification and case finding for appropriate referral.

An ICB cost improvement initiative has introduced a challenge to the recurrent funding available to Hospital @home. The Steering Group organised a stock take session for the April, planning for 25/26, which included discussion on:

- What should be taken forward for H@H that represents activity (against 80% target) and best value?
- Mainstreaming governance to include UEC/UCR/H@H/SDEC under Improving the Health of Our Population committee – review of membership/partners

There has been agreement in principle to mainstream the governance from a standalone programme structure to BAU under the emerging Improving the Health of our Population committee structure. 25/26 planning discussions will be ongoing.

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 2795 consultations between March 2023 and March 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 March 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?***	Limited capacity to support a population analytics approach to data analysis has meant that it has been challenging to take forward any work to define and understand (potential) demand for hospital @home services so that we can measure if our current capacity is appropriate or if there's a requirement for expansion. It is also difficult to outline and 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. Provider Business Informatics teams are working to support the virtual wards minimum dataset ensuring teams are able to meet the data specification and perform the submission process. On the Lambeth Pharmacy First Plus Service, data from March 2025 shows most interventions (2078) 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, 57% of patients would have visited general practice to request the medication on prescription, 42% would have gone without medication and 1% would have contacted Out of Hours service. 42% 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, patient aged under 16 years or are aged 16, 17 or 18 years old are the top social vulnerability eligibility groups accessing Lambeth Pharmacy First Plus Service in March 2025. General Practice feedback has been that the service has a had a positive impact for patients and reduced GP appointments for minor conditions.
*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.

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?*	One of the identified barriers has been about awareness, communicating and engaging the system and the public by providing an understand of Hospital @home, how it benefits patients, and the system, and how the system can refer to either prevent avoidable admissions to hospital or enable an earlier supported discharge from a hospital bed. A comms/engagement plan remains a work in progress including high-level engagements, alignment with the NHS and local NHS acute Trust priorities, such as patient flow in hospital where Hospital @home can provide an alternative, following the Darzi report and communications with system partners remains ongoing. 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	250
Jul-23	151
Aug-23	105
Sep-23	106
Oct-23	114
Nov-23	84
Dec-23	105
Jan-24	110
Feb-24	131
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
Feb-25	106
Mar-25	97
Total – 2795	

	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	28 Feb 2025	31 Mar 2025	TOTAL
Total Pharmacy First consultations (includes referrals to the 7 Clinical Pathways, Minor Illness and Urgent Medicine Supply service)	1,308	1,604	1,626	1,709	1,589	1,704	1,667	1,820	1,647	2,175	2,441	2,534	2,472	2,500	**26,796**

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

1. Universal credit (46%)
2. Income Support (29%)
3. Young people aged 16, 17 or 18 years old (7%)

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 from 53 in February 2025 to 63 in March 2025.
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. 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 (43% 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).

Data for Q3 and Q4 2024/25 is currently showing an increase of 0.4% for identification on practice registers (K3) and a reduction of 0.4% in conversion to PCSP (K4), but these figures are subject to change following confirmation of missing data for The Vauxhall Surgery.

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.
What are the challenges hindering any progress and are there actions which can be taken to address these?	The Discharge Operational Delivery Group (DODG) has a dedicated workstream looking at the reablement pathway from the ward to the internal flow hub and then on to the service to 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. 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. Key challenges include varying levels of capacity and professional confidence within Primary Care to initiate PCSP conversations. A recent survey of Lambeth GPs showed that GPs recognize Advance Care Planning (PCSP) as a primary care commitment, but that confidence in initiating and holding these conversations is not consistently high. Other challenges include variable data capture across PCNs, partly to different coding practice occurring in different practices within PCNs. SEL Ageing Well Funding (£64k non-recurrent for 1 year) project is underway to help address these barriers project resource to help address these barriers, 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 lead champions to increase completion and quality of UCP / ACP in Lambeth, including addressing data capture.
Additional Comments	Palliative and End of Life Care 2024-25 Data caveat: please note that primary care data for the 12 month period April 2024 to March 2025 has been affected by a data quality issue meaning that data is missing in parts for The Vauxhall Surgery and two other SEL GP practices (outside of Lambeth). The data will be updated in May with the corrected figures; in the meantime, please note that the figures currently reported for 2024/25 may not reflect all Advance Care Plan and end of life register records.

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 last quarter of 2024/25, January to March, CLaSS started working with 47 new people, slightly fewer than the 50 new clients in the third quarter, October to December. LWNA's Individual Placement and Support (IPS) helps people with a serious mental illness find and sustain paid employment. The IPS service helped 8 people find work in the last quarter, January to March, falling from 15 in the previous quarter. Both results fall short of the original target for the service of 36 placements per quarter, but the team did achieve a significant improvement in results for job retention, supporting 11 people to sustain employment for at least 13 weeks and 5 for 26 weeks or more, Restrictive incidents and seclusions for inpatients in March rose to 31, just 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, fell to 68.6% from 83.1% in February.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	The CLaSS service accepted in the third quarter, October to December, 43% were for Black services users, down from the 47% seen in the previous quarter and the 47% average for the year. The relatively low numbers involved mean that small improvements may not be statistically significant, but this does coincide with a lower proportion of Black people seeking support from another intensive support service, focused support, which fell to 42% in the most recent quarter of 2024/25 when it typically averages around 50%. Both figures remain much higher than might be expected, given that the Black population of Lambeth is around 22%. CLaSS supports people moving on from inpatient care without appropriate accommodation, and so this inequality will reflect the higher proportion of Black service users in this situation. Of the 436 restrictive incidents and seclusions reported for Lambeth acute inpatients with a stated ethnicity in 2024/25 (April to March), 258 (59%) were for Black patients who, in the same period made up 296 (46%) of the 638 admitted inpatients. The number of incidents and seclusions involving Black patients fell sharply in the last quarter (January to March) to 47% from 61% in the prior three months (October to December). 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 accessing LWNA's less intensive services is only a little higher than expected given that 22% of Lambeth adult population identifies as Black. Over the whole year 2024/25, April to March, Black people made up 28% of those accessing short-term support. However, Black people are over-represented among those accessing more intensive services. Over the same period, Black people made up 49% of those accessing focused support. LWNA uses the PCREF framework to engage with local communities and build trust to improve access, experience and outcomes. Improved access to early forms of support, as seen in the last quarter January to March, 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

Alliance and Programmes	**Homeless Health (Owner) with contributions from LWNA and Substance Misuse**
Update Month	**May 2025**

*What does the data/intelligence indicate around **progress against the outcome?***	Recommissioning of the Vulnerable Adults Pathway is due to commence at the end of May 2025, this includes changes to contract monitoring frameworks and KPI's including health outcomes. A continued focus will be 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 in the VAP who are registered with GP's continues to be at its highest level (98%). This has been achieved through contract monitoring and consistent messaging to Providers to ensure each resident is being supported to register. The number of residents in the VAP who are engaging with mental health services has also increased in Q4 and over the year, there is a continued focus on ensuring all residents who have a mental health need identified are receiving support in this area. Move on to independent accommodation (longer term accommodation) has also increased in Q4. This is predominately attributable to moves to the Lambeth's SHAP Housing First scheme (social housing with intensive, flexible support) The challenges with move on to the private rented sector continue for our client group but providers across the VAP continue to work with Single Homeless Project (SHP) and other providers where appropriate to move residents onto their own accommodation. The number of rough sleepers being brought into accommodation has also increased in the quarter and over the year, this is partly due to the Severe Weather Emergency Protocol (SWEP) activations and the "in for good principle" which focuses on ensuring everyone who was placed in emergency accommodation during the cold weather has an assessment and an offer of accommodation, so that they do not return to rough sleeping. Lambeth successfully moved on 57 people out of a total of 78 individuals who were in SWEP emergency accommodation during the winter months, our highest achievement.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Access to GP's and mental health services has increased which would indicate that residents across the VAP are addressing health needs/inequalities are reducing in these areas. Rough sleepers accessing accommodation is increasing and therefore individuals will be supported to engage in addressing health needs.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	The ongoing issues with the private rented sector more broadly, and then the added issue of residents with a history of homelessnessbeing discriminated against when viewing properties. 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.