LAMBETH TOGETHER CARE PARTNERSHIP (FORMERLY LAMBETH TOGETHER STRATEGIC BOARD)

Date: Thursday 4 September 2025
Time: 1.00 pm
Venue: Microsoft Teams

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Members of the Committee

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

Cllr Nanda Manley-Browne	Lambeth Together Care Partnership Board Co-Chair / Cabinet Member for Healthier Communities (job-share), Lambeth Council
Raj Mitra	Children and Young People's Alliance Clinical and Care Professional Lead, GP
Ade Odunlade	Chief Operating Officer, South London and Maudsley NHS Foundation Trust
Folake Segun	Chief Executive, Healthwatch Lambeth
George Verghese	Co-Chair of the Lambeth Primary Care Clinical Cabinet, GP

Further Information

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

Access for Members of the Committee
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Access for elected Members of the Council
Councillors who are not members of the Committee but wish to attend must inform Democratic Services by 12pm on the weekday before the meeting. Upon doing so they will be invited to attend.

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AGENDA

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Lambeth Together

Integrated Assurance Report

15 July 2025

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Our Health, Our Lambeth

Lambeth Together health and care plan 2023-28

At the last Lambeth Together Partnership Board, members approved the proposed changes to the Health and Care Plan impact measures for 25/26 and the forward view presentation timetable for 25/26.

The following two slides show a diagram noting Health and Care plan high level aspirations and breakdown of impact measures per outcome.

These metrics will be summarised in the usual scorecard in further detail

Aspiration	Outcome	Impact Measures 25/26
People lead healthy lives and have good physical and emotional health and wellbeing for as long as possible	A	Smoking prevalence reduction; Uptake of the NHS Health Check for all eligible adults; Number of adults insubstance misuse (opiate, non-opiate and alcohol clients in treatment) treatment
	B	Percentage of low-income residents coping financially, two measures TBD
	C	Proportion of Lambeth registered children by age 2 that have received one dose of MMR; Proportion of Lambeth registered population who are over the age of 65 receiving immunisation for Flu; Proportion of Lambeth registered population who are within the 'at risk cohort' receiving immunisation for Flu
	D	Number of community organisations and volunteers undertaking mental health awareness and suicide prevention training; Number of Entering treatment with Short-Term Support with Living Well Centres; Number of Entering treatment with Focused Support with Living Well Centres; LWNA Short Term Waiting Time
	E	Rates of STI testing; Rates of STI diagnoses; Number of LARC uptake in primary care
Physical and mental health conditions are detected early and people are supported and empowered to manage these conditions and avoid complications	F	Uptake of SMI health checks; Uptake of LD/AHC health checks; Proportion of Bowel Cancer screening for those aged 60-74; Proportion of cervical Cancer Screening aged 25-64; Proportion of breast cancer screening for women aged 50-70; Number of new PrEP users (and continuers) resident in Lambeth
	G	Proportion of people with Type 2 diabetes who have all 8 care processes measured and recorded on an annual basis; Proportion of people aged 79 or under with hypertension who achieve a blood pressure measure less than or equal to 140/90mmHg this FY; Proportion of people aged 80 or over with hypertension who achieve a blood pressure measure less than or equal to 150/90mmHg this FY; Proportion of people over age of 75 who are taking 10 or more medicines, having a medication review
	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; Access to Lambeth Talking Therapies for Black African and Caribbean residents to ensure they are as least as good as those of White residents; 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; Number of children and young people waiting longer than 52 weeks for an assessment and commencing treatment with Child and Adolescent Mental Health Services

Aspiration	Outcome	Impact Measures 25/26
People have access to and positive experiences of health and care services that they trust and meet their needs	I	Health and Wellbeing Bus - No of interactions - Welfare Advice and Mental Health session; Beacons service - No of interactions (brief opportunistic exchange), Hi 5 and BP check; Vital 5 & Women and Girls community interactions
	J	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; Patients to be admitted, transferred, or discharged within 4 hours of arrival to A&E - GSTT sites; Patients to be admitted, transferred, or discharged within 4 hours of arrival to A&E - KCH sites; Percentage of General practice appointments seen within two weeks
	K	No of community referrals to reablement; No of people who require no service or a reduced service following reablement; Proportion of carers of the users of Adult Social Care Services are offered a carers assessment; Number of people identified as being in their last year of life on practice registers; Proportion of people with Personalised Care and Support Plan(PCSP)/UCP
	L	Continuity of maternity care for women; Patient experience indicators on maternity care; The benefits of continuity of care in maternity include improved maternal and foetal outcomes, increased satisfaction with care, reduced healthcare costs, and better communication and trust between the healthcare provider and the patient; Infant and maternal mortality
	M	Number of supported employment and supported internships we create through our health and care partners; Proportion of people with LDA who are known to ASC services and are in work; Waiting times for an ASD diagnosis for children and young people; Number of children and adults with learning disabilities and/or autism currently cared for in specialist inpatient units
	N	Number of people per quarter supported by the Living Well Network Alliance to stay in their own homes (ClaSS); Number of people per quarter supported by the Living Well Network Alliance into paid employment (IPS); 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); Number of service users reporting a positive experience of using mental health services, feeling they have benefited from support and are more independent and in control of their lives; Seclusions and restrictive interventions on inpatient setting
	O	Number of rough sleepers brought into accommodation; Proportion of people living in our supported housing that are registered with a GP; Number of rough sleepers who have returned to the streets after being in settled accommodation; Number of Rough Sleepers and residents within the Vulnerable Adults' Pathway engaged with the Integrated Health Network (Multi-disciplinary health team with focus on supporting people into substance use treatment and addressing physical and mental health needs)

Health and Care Plan: Key headlines (1)

	Outcome	Key Headlines
A	***People maintain positive behaviours that keep them healthy***	Planned deep dive, see enclosed presentation along with highlight report updates
B	***People are connected to communities which enable them to maintain good health***	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 due to political changes, with health as a key area of focus, recognising the impact of poverty on health outcomes.
C	***People are immunised against vaccine preventable diseases***	National (COVER) reporting lacks insights on vaccination inequalities. UKHSA's national health equity audit revealed the presence of avoidable inequalities within the UK vaccination system. A local health equity audit was also completed. It took a systematic approach to examining the areas and extent of inequalities in Lambeth's vaccination service to enable a data driven targeted engagement programme to be designed for those most need it. Inequalities in vaccination coverage and timeliness were found in Lambeth's childhood vaccination system.
D	***People have healthy mental and emotional wellbeing***	Planned deep dive, see enclosed presentation along with highlight report updates

Health and Care Plan: Key headlines (2)

	Outcome	Key Headlines
E	***People have healthy and fulfilling sexual relationships and good reproductive health***	A dashboard is being developed by the PH Health Intelligence team which will allow us to more easily view STI testing and diagnosis numbers by age, ethnicity, sexual orientation and STI type. This will allow us to better understand need and whether targeted work with communities is having the desired effect on outcomes. The aim is that the dashboard will be completed by the end of Q2
F	***People receive early diagnosis and support on physical health conditions***	On cancer screening, there are numerous ongoing challenges. 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 pressures it is difficult for primary care to take on additional screening promotion work. The breast screening incentive has been removed from the local PMS contract so there is now no local primary care incentives for cancer screening. Due to staffing changes within the NWDA there is now less capacity for focus on cancer projects. 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 along with a PCN community engagement event which took place at the end of February. The NWDA have also funded multiple successful PCN engagement events. The local breast screening service are also working to increase appointments outside of normal working hours to aim to increase screening rates.
G	***People who have developed long term health conditions have help to manage their condition and prevent complications***	Blood pressure control measures for both age groups are cumulative measures starting from April 2025. Improvement of blood pressure contr has continued whilst hypertension detection and diagnosis has increased. Improvements have been made year on year. 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 prior year baseline by 10 percentage points. The measure is cumulative from April 2025. Challenges include General Practice capacity. 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.
H	***When emotional and mental health issues are identified; the right help and support is offered early and in a timely way***	Lambeth SPA has consistently found it difficult to maintain necessary staffing levels and financial restrictions affecting the use of agency staff worsened this problem in recent months. However, remodelling of the core SPA team started in June, including closer co-operation with the Crisis Outreach Service (COS) and, in time, with primary care services. 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. Lambeth CAMHS referrals remain high, with a gap between referrals received and accepted. No reasons or themes for rejected referrals are captured in the data. Caseload has grown, largely due to neurodevelopmental cases (e.g. ADHD), which typically stay under CAMHS care longer. First contact within 28 days is generally being achieved, with Lambeth performing well on this measure. This is important, as it introduces those referred to service to additional support and advice available to them whilst waiting for further assessment or therapeutic intervention.

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***	HWBus activity clearly indicates that we are reaching a large number of residents as per the total interactions captured. This total comes from both approaches; using the H&W Bus on high streets and at community spaces as well as Health Champion outreach without the bus at various centres and spaces. It also demonstrates that we are consistently offering a variety of services to residents and in tandem, giving them access to information on these health topics. On Beacons service, the data demonstrates the outreach attracts strong numbers and there is demand at neighbourhood level.
J	***People know where to go to get the right help, and are treated at the right time, in the right place, for their needs***	Community Pharmacy have undertaken 1184 consultations between May 2024 and April 2025 with Lambeth residents/registered patients to provide advice and guidance on self-care and supply of medicines where appropriate. The 2025-26 SEL Medicines Optimisation Plan includes a measure to increase use of the NHS app capability of ordering repeat prescriptions so that patients may more easily be equipped to take greater control over their health and care and to access care at the right time and place.
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***	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. We will be monitoring the outcome of these cases in the future and can report on this next time.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. On End of Life Care, 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.
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 LDA care in specialist inpatient units, we note a steady decrease since 2022/23. From a position of 16 patients cared in inpatients setting in 22/23, we can report that in July 25 there are 10 patients cared on inpatient setting. The proportion of inpatients who are Black/Black British has fallen from 50% (22/23) to 27% (July 25) indicating there is no longer an over-representation of people from Black backgrounds in the most restrictive settings. This demonstrates the hard work of the whole Lambeth Together network and partners to achieve this result.
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***	Of the new people supported by CLaSS in the first quarter of 2025/26, April to June, 50% were for Black services users, down from the 54% seen in the previous financial year. However, there are too few people involved to be sure that this small difference is statistically significant. More intensive LWNA services presents a mixed picture in the first quarter, April to June, with the proportion of Black people newly accepted into inpatient care rising by 4%, but the equivalent figure for more intensive community support (focused support and home treatment) falling by 4%. Both figures remain much higher than might be expected though, given that the Black adult population of Lambeth is 21.7%.
O	***People who are homeless, or at risk of becoming homeless, (including rough sleepers and refugees) have improved health***	Following the review process for 25/26 the team agreed to monitor four impact measures in 25/26. A continued focus will be on GP registration across the Vulnerable Adults Pathway (maintaining 90% or above) and number of rough sleepers brought into accommodation. We introduced two new measures for 25/26 focussing on number of rough sleepers who have returned to the streets after being in settled accommodation and number of rough sleepers and residents within the Vulnerable Adults' Pathway engaged with the Integrated Health Network (Multi-disciplinary health team with focus on supporting people into substance use treatment and addressing physical and mental health needs).

Finance

Finance: South East London ICB: Lambeth

Overall Finance Position (2025/26 M02)

Service Area	Year to date Budget £'000s	Year to date Actual £'000s	Year to date Variance £'000s	Annual Budget £'000s	Forecast Outturn £'000s	Forecast Variance £'000s
Acute Services	81	81	0	488	488	0
Community Health Services	4,978	4,978	0	29,867	29,867	0
Mental Health Services	3,956	4,048	(92)	23,639	23,976	(337)
Continuing Care Services	5,985	5,985	0	35,911	35,574	337
Prescribing	7,069	7,069	0	43,998	43,998	0
Other Primary Care Services	659	659	0	3,957	3,957	0
Delegated Primary Care Services	15,900	15,900	0	95,399	95,399	0
Corporate Budgets	758	743	15	4,545	4,545	0
Total	**39,386**	**39,464**	**(78)**	**237,803**	**237,803**	**0**

- The borough is reporting an overall £78k year to date overspend position and a forecast breakeven position at Month 02 (May 2025). The reported forecast position includes £337k overspend on Mental Health Services (including Learning Disabilities) and £337k underspend on Continuing Health Care (CHC) Services.
- The underlying key risks within the 2025-26 Lambeth's finance position remain associated with demand driven budgets (Audiology, Interpreting Service, Cardiovascular Diagnostic Service, Mental Health including Learning Disability Services, Continuing Health Care Services and Prescribing).
- Mental Health budget year to date and forecast overspend is driven by increased ADHD spend, Mental Health and Learning Disabilities (LD) placement expenditure, and mitigated by constraining investments. Borough Commissioners leading on efficiency and productivity schemes including right sizing projects with providers to enable service users to live more independently though either stepping down restrictive levels of care or moving to more independent settings.
- Delegated Primary Care Services is reporting a breakeven position against in year budget at month 2, noting previous year (2024-25) overspend position is driven by locum reimbursements, retainer scheme and list size growth.
- The Continuing Healthcare budget is forecasting £337k underspend as the CHC team continues to deliver on reviewing high-cost packages and out of area placements. Work is ongoing to establish better value costs. The number of active CHC and FNC clients at M02 is 532.
- Prescribing actual data is provided two months in arrears and the borough is reporting a breakeven position against in year budget at month 2.
- The borough 2025-26 minimum (5%) efficiency and productivity target is £11.3m and has a savings plan of £12.6m. In addition to the embedded efficiency (£5.6m) as part of the budget setting process, the borough has saving plans for Continuing Healthcare (£1.9m), Prescribing (£1.1m) and Mental Health Services Learning Disability Services (1.2m). The borough efficiency and productivity target is forecast to deliver in full.

Lambeth Council M2 Updates

Integrated Health& Care:

PHG forecast risks:

- Inflationary increase on NHS contracts not known and will need to hold contingency to fund contractual uplifts
- Current forecast excludes pay award increases.

Adult Social Care:

- **Current** projection of £7.8m overspend, a £5.1m increase compared to 2024/25 outturn. Outturn position included reserve and nonrecurrent funding which mitigated the overall position.
- Largest pressure areas remain in LD and OP, in particular LD Residential and Supported Living and OP Nursing, from ongoing increase in acuity, cost and demand

Management Actions to improve position:

- **Care Package Reviews:** Improving performance in reviews & target areas to manage demand
- **Transitions Management:** Joint work with Children's through 0-25 service
- **Preventative intervention focus:** Enhanced focus on initial contact with social care services; increasing reablement referrals from the community
- **Intermediate care and support after hospital discharge**: increasing the number of step-down beds
- **Oversight and Scrutiny:** Weekly and fortnightly panels review all new care packages and placements

Division	Budget £'000	Forecast £'000	Variance £'000
INTEGRATED COMMISSIONING			
TOTAL INCOME	(12,299)	(12,349)	(50)
TOTAL EXPENDITURE	12,432	12,482	50
TOTAL NET EXPENDITURE	**133**	**133**	**0**
SENIOR MANAGEMENT - INTEGRATED HEALTH & CARE			
TOTAL INCOME	(198)	(322)	(124)
TOTAL EXPENDITURE	1,775	1,899	124
TOTAL NET EXPENDITURE	**1,577**	**1,577**	**0**
PUBLIC HEALTH			
TOTAL INCOME	(42,052)	(41,388)	(664)
TOTAL EXPENDITURE	42,052	41,388	664
TOTAL NET EXPENDITURE	**0**	**0**	**0**

ADULT SOCIAL CARE	Budget £'000	M2 Variance £'000
ADULTS WITH LEARNING DISSABILITIES	41,025	10,573
ADULTS WITH MENTAL HEALTH NEEDS	11,124	921
OLDER PEOPLE	29,011	8,029
OTHER - ADULTS	13,855	(13,091)
SUPPORTING PEOPLE	4,503	391
ADULTS WITH PHYSICAL DISABILITIES	14,899	903
SUPPORTED HOUSING	780	7
QUALITY ASSURANCE AND SAFEGUARDING	2,562	86
Grand Total	**117,759**	**7,820**

Quality

Quality update will be presented at September's LTAG, where the team will share local intelligence from Q1 report

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.

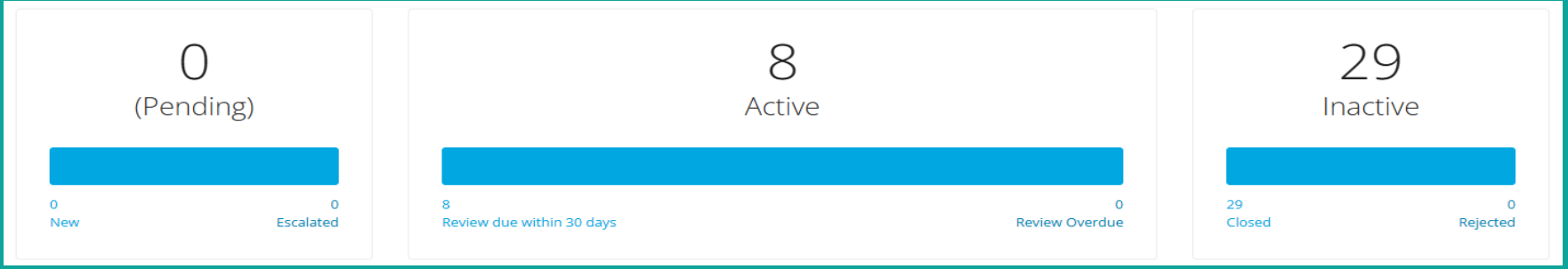
Lambeth Risk Register

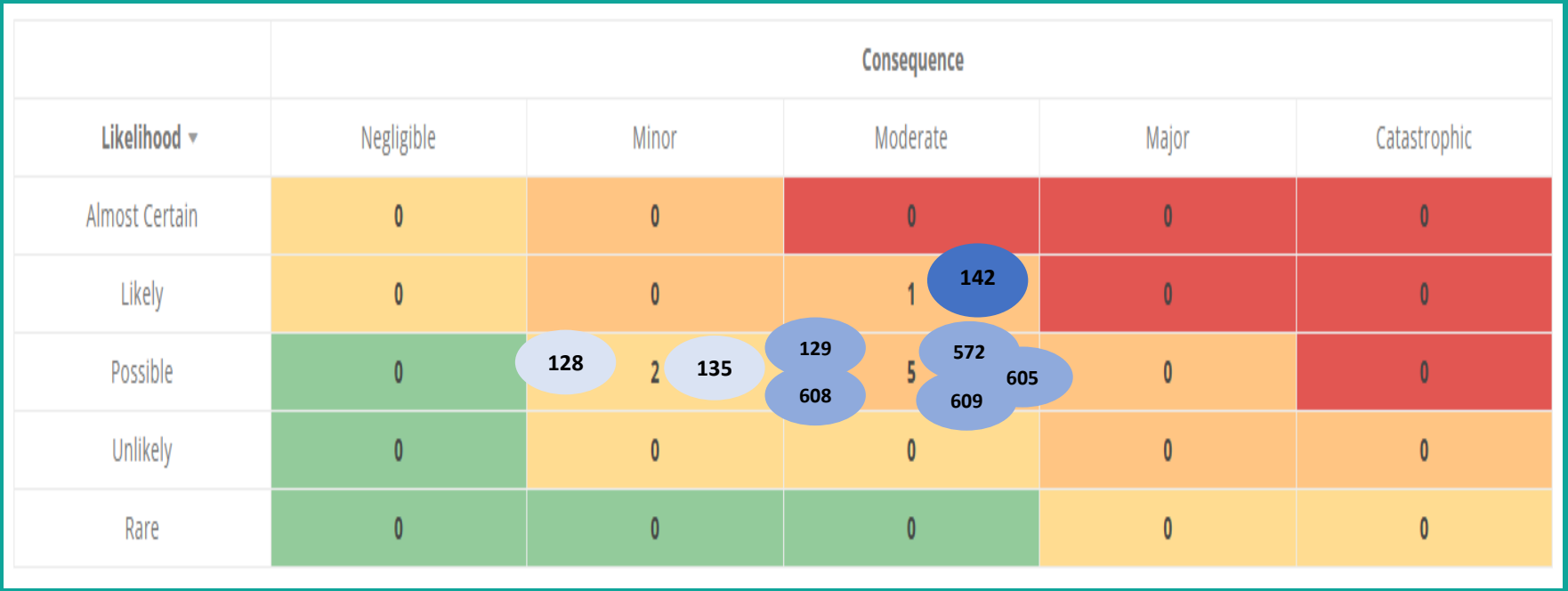
- LCP leads were asked to complete a “check and challenge” for all risks, supporting risk owners and sponsors to ensure all risks remain up-to-date and relevant. This exercise took place in May/ June to ensure 24/25 risks that are no longer relevant for 25/26 cycle are closed. This work was completed, and this information was shared with SEL lead to inform SEL board of 25/26 risk across LCPs.

- As of June, there were 8 active risks on the South East London Risk register for Lambeth.

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
605	Finance
608	Finance
609	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 neurodiversity assessments - children and young people	9
135	Failure to safeguard adults	6
142	Immunisation Rates protect Children, including vulnerable groups from communicable diseases.	12
572	Increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population - Seasonal Flu Vaccination	9
605	Delivery of overall Place/borough productivity & efficiency requirement and achievement of financial balance for 2025-26.	9
608	Delivery of Delegated Primary Care productivity & efficiency requirement and managing expenditure within allocated financial resources for 2025-26	9
609	Delivery of productivity & efficiency requirement and achievement of financial balance for Mental Health for 2025-26 financial year	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	May-25	National standard	67%	75.3%	71.0%	Above	1
IAPT discharge	Apr-25	Operating plan		500	N/A	N/A	-
IAPT reliable improvement	Apr-25	Operating plan	67%	75%	69%	Above	1
IAPT reliable recovery	Feb-25	National standard	48%	55%	48%	Above	1
SMI Healthchecks	Q4 24/25	Local trajectory	66%	63.6%	6.6%	Above	2
LD and Autism - Annual health checks	Ape 25	Local trajectory	68	62	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	May-25	Corporate Objective	73.3%	67%	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	Apr-25	Operating plan	90.0%	90.6%	86.9%	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 25/26

Objective Title	Action Title
Adults Transformation	Cancer - Work collaboratively with primary care to increase the uptake of cancer screening.
Adults with Learning Disabilities	Focus on LDA Health Inequalities.
Adults with Learning Disabilities	NHSE Learning Disability and Autism Programme.
Children and Young People	Pull together a comprehensive dataset for Lambeth women using maternity services.
Children and Young People	CYP - Mental Health Support
Long Term Conditions Optimisation	Deliver Long Term Conditions Optimisation Priorities
Medicines Optimisation	Deliver Medicines Optimisation Priorities
Primary Care	Improve Access to Primary Care
Primary Care	Shift to Neighbourhoods by working collaboratively with Integrated Health & Care providers
Public Health	Lambeth HEART
Public Health	Health Intelligence
Public Health	Sexual Health
Public Health	Age-Friendly Lambeth
Public Health	Infection Prevention and Control of Communicable Diseases
Public Health	Staying Healthy
Public Health	Substance Misuse

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

The table provides a summary of 25/26 business plan actions for the Integrated Health and Care (IHC) directorate. We are now completing responses for Q1 and will update the group at September's meeting on directorate position across these actions.

Appendix:
Health and Care Plan Outcomes:
Detailed assurance narrative

Impact measures performance trend (1)

Outcome	Impact measure	Target/Plan	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year to Date	Comments
A	Smoking prevalence reduction	Actual	12.3%			12.2%											Data source - SEL Vital 5 dashboard (as of June 25) - Of those with a smoking status, 30,039 (12.2%) are recorded as smoking in the past 5 years.
		Plan							12.6%			12.5%			12.3%		
		Variance															
	Number of adults insubstance misuse opiate clients in treatment	Actual	Currently working with SMS commissioners to report the data														
		Plan															
		Variance															
	Number of adults insubstance misuse non-opiate clients in treatment	Actual															
		Plan															
		Variance															
	Number of adults insubstance misuse alcohol clients in treatment	Actual															
		Plan															
		Variance															
	Uptake of the NHS Health Check for all eligible adults	Actual		0.92%	1.24%	1.73%											
		Plan		0.22%	0.51%	0.60%	0.60%	1.00%	1.25%	2.00%	2.48%	3.18%	4.00%	4.56%	5.25%		
		Variance		0.7%	0.7%	1.1%											
B	Percentage of low-income residents coping financially	Actual	77.7%			79.3%											
		Plan	78.2%			77.7%			79.8%			80.3%			80.8%		Target of increasing by 0.5% each quarter vs previous quarter
		Variance	-1%			2%											
C	Proportion of Lambeth registered children by age 2 that have received one dose of MMR	Actual	82.6%														
		Plan	83.5%			79.5%			80.9%			79.9%			82.6%		Plan = against previous year position
		Variance	-0.9%														
	Proportion of Lambeth registered population who are over the age of 65 receiving immunisation for Flu	Actual															
		Plan								41.2%	49.3%	52.6%	54.0%	54.4%	54.7%		Flu uptake in 24/25 (data source EZA)
		Variance															
	Proportion of Lambeth registered population who are within the 'at risk cohort' receiving immunisation for Flu	Actual															
		Plan								24.6%	30.2%	32.8%	34.0%	34.4%	34.6%		Flu uptake "At Risk" cohort (SEL COVID & FLU Vaccinations Dashboard)
		Variance															

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

Impact measures performance trend (2)

Outcome	Impact measure	Target/Plan	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year to Date	Comments
D	Number of community organisations and volunteers undertaking mental health awareness and suicide prevention training	Actual	Target - 16 suicide prevention training sessions booked for the next 12 months. STORM 5 suicide prevention Level 1 training sessions booked for the next 12 months. MHA 6 half-day sessions over the next 12 months														Target - 16 suicide prevention training sessions booked for the next 12 months. STORM 5 suicide prevention Level 1 training sessions booked for the next 12 months. MHA 6 half-day sessions over the next 12 months
		Plan															
		Variance															
	Number of Entering treatment with Short-Term Support with Living Well Centres.	Actual	143	125	150	151											
		Plan															
		Variance	12	-18	25	1											Against previous month's position
	Number of Entering treatment with Focused Support with Living Well Centres.	Actual	27	37	39	32											
		Plan															
		Variance	27	10	2	-7											Against previous month's position
	LWNA Short Term Waiting Time	Actual	27.3	25.6	30.4	26.5											
		Plan	26.0	26.0	26.0	26.0											Average time from introduction received by SLaM to 2nd contact by a Short-Term Support team
		Variance	-1.3	0.4	-4.4	-0.5											
E	Rates of STI testing	Actual	Currently working with Sexual health commissioners to report the data														
		Plan															
		Variance															
	Rates of STI diagnoses	Actual															
		Plan															
		Variance															
	Number of LARC uptake in primary care	Actual															
		Plan				319			272			276			299		24/25 Out turn
		Variance															
F	Uptake of SMI health checks	Actual	64%	2.80%	7.6%	14.3%											
		Plan	5%	5.0%	10%	15%	20%	25%	30%	35%	40%	45%	50%	55%	60%		Year end target 60%
		Variance	58.7%	-2.2%	-2.4%	-0.7%											
	Uptake of LD/AHC health checks	Actual	83%	3.9%	8.0%	13.2%											Year end target 75%
		Plan	75%	6.3%	13%	19%	25%	31%	38%	44%	50%	57%	63%	69%	76%		
		Variance	7.6%	-2.4%	-4.6%	-5.6%											
	Proportion of Bowel Cancer screening for those aged 60-74	Actual	Bowel cancer screening – 2.5 year coverage (ages 60-74) Sept 24 - 61.8%. 25/26 ambition of 64.6% Cervical cancer screening – 3.5/5.5 year coverage (ages 25-64) May 24 - 62.7%. 25/26 ambition of 64.6% Breast cancer screening – 36-month coverage (ages 50-70) Sept 24 - 56.4%. 25/26 ambition of 60.2%.														Bowel cancer screening – 2.5 year coverage (ages 60-74) Sept 24 - 61.8%. **25/26 ambition of 64.6%**
		Plan															
		Variance															
	Proportion of cervical Cancer Screening aged 25-64	Actual															Cervical cancer screening – 3.5/5.5 year coverage (ages 25-64) May 24 - 62.7%. **25/26 ambition of 64.6%**
		Plan															
		Variance															
	Proportion of breast cancer screening for women aged 50-70	Actual															Breast cancer screening – 36-month coverage (ages 50-70) Sept 24 - 56.4%. **25/26 ambition of 60.2%.**
		Plan															
		Variance															
	Number of new PrEP users (and continuers) resident in Lambeth	Actual															
		Plan															
		Variance															

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Impact measures performance trend (3)

Outcome	Impact measure	Target/Plan	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year to Date	Comments
G	Proportion of people with Type 2 diabetes who have all 8 care processes measured and recorded on an annual basis	Actual	76%	13.8%	21.5%	30.7%											
		Plan	77%	6.4%	12.8%	19.3%	25.7%	32.1%	38.5%	44.9%	51.3%	57.8%	64.2%	70.6%	77%		Year end target of 77%
		Variance	-1%	7.3%	8.7%	11.5%											
	Proportion of people aged 79 or under with hypertension who achieve a blood pressure measure less than or equal to 140/90mmHg this FY	Actual	70%	12.3%	21.9%	31.3%											
		Plan	77%	7%	13%	20%	27%	33%	40%	47%	54%	60%	67%	74%	80%		Year end target of 80%
		Variance	-7%	5.7%	8.5%	11.2%											
	Proportion of people aged 80 or over with hypertension who achieve a blood pressure measure less than or equal to 150/90mmHg this FY	Actual	81%	14.7%	27.1%	38.4%											Year end target of 80%
		Plan	77%	7%	13%	20%	27%	33%	40%	47%	54%	60%	67%	74%	80%		
		Variance	4.1%	8.0%	13.7%	18.4%											
	Proportion of people over age of 75 who are taking 10 or more medicines, having a medication review	Actual	47.3%	1.8%	3.7%	6.1%											
		Plan															
		Variance															
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	34%	34.0%	36.0%	28.8%	27.4%										
		Plan															
		Variance															
	Access to Lambeth Talking Therapies for Black African and Caribbean residents to ensure they are as least as good as those of White residents	Actual	24.2%														
		Plan	21.7%														
		Variance	2.5%														
	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	50.3%														
		Plan	48.0%														
		Variance	2.3%														
	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			17												
		Plan															
		Variance															
I	Health and Wellebing Bus - No of interactions -	Actual				3,670											More than 3000 interactions in the first quarter
		Plan															
		Variance															
	Beacons service - No of interactions Interactions (brief opportunistic exchange), Hi 5 and BP check	Actual				3,228											878 Hi 5 intereactions and 982 opportunistic BP checks
		Plan															
		Variance															
	Vital 5 & Women and Girls community interactions	Actual				237											58 1-1 Vital 5 checks delivered; 10% advised to see GP within 3 weeks, 85 showed high irsk or possibly dependency after Audit C questionnaires.
		Plan															
		Variance															

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Impact measures performance trend (4)

Outcome	Impact measure	Target/Plan	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year to Date	Comments
J	Percentage of General practice appointments seen within two weeks	Actual	90%	89%	89%												
		Plan	90.0%	90.0%	90.0%												
		Variance	0.0%	-1.0%	-1.0%												
	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	2,500														
		Plan															
		Variance															
	Patients to be admitted, transferred, or discharged within 4 hours of arrival to A&E - GSTT sites	Actual	74%			77.70%											
		Plan															
		Variance															
	Patients to be admitted, transferred, or discharged within 4 hours of arrival to A&E - KCH sites	Actual	71.9%			71.6%											
		Plan															
		Variance															
K	No of community referrals to reablement	Actual	Currently working with ASC team to source the data														
		Plan															
		Variance															
	No of people who require no service or a reduced service following reablement	Actual															
		Plan															
		Variance															
	Proportion of carers of the users of Adult Social Care Services are offered a carers assessment	Actual	100%														
		Plan	100%														
		Variance	0%														
	Number of people identified as being in their last year of life on practice registers	Actual	2054														
		Plan	1988														
		Variance	66														
	Proportion of people with Personalised Care and Support Plan(PCSP)/UCP	Actual	49%														
		Plan	48%														
		Variance	1%														
L	Continuity of maternity care for women	Actual	Work is undeway to source the data														
		Plan															
		Variance															
	Patient experience indicators on maternity care The benefits of continuity of care in maternity include improved maternal and foetal outcomes, increased satisfaction with care, reduced healthcare costs, and better communication and trust between the healthcare provider and the patient.	Actual															
		Plan															
		Variance															
	Infant and maternal mortality	Actual															
		Plan															
		Variance															

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Impact measures performance trend (5)

Outcome	Impact measure	Target/Plan	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year to Date	Comments
M	Number of supported employment and supported internships we create through our health and care partners.	Actual															
		Plan															
		Variance															
	Proportion of people with LDA who are known to ASC services and are in work	Actual															
		Plan															
		Variance															
	Number of children and adults with learning disabilities and/or autism currently cared for in specialist inpatient units	Actual	14			10											At the end of Q1, there were 9 adults and one children in specialist settting
		Plan															
		Variance															
	Waiting times for an ASD diagnosis for children and young people	Actual															
		Plan															
		Variance															
N	Number of people per quarter supported by the Living Well Network Alliance to stay in their own homes (ClaSS)	Actual	8			14											Number of service users starting paid employmenet during each quarter
		Plan	36			36											IPS Performance Target
		Variance	-28			-22											Variance from Target
	Number of people per quarter supported by the Living Well Network Alliance into paid employment (IPS)	Actual	47			34											Number of service users (unique Trust IDs) from referrals accepted during each quarter
		Plan															CLaSS does not work to a fixed quarterly target.
		Variance	47			-13											Variance from previous quarter
	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	492			415											Count of Lambeth SPA "signpost to other agency" + relevant events for all other Lambeth teams
		Plan															
		Variance	492			415											
	Number of service users reporting a positive experience of using mental health services, feeling they have benefited from support and are more independent and in control of their lives,	Actual	68.6%														From PEDIC
		Plan	78.4%														Mean value Sep-23 to Sep-24
		Variance	-9.8%														
	Seclusions and restrictive interventions on inpatient setting	Actual	31			31											Restrictive incidents + seclusions
		Plan	32			32											Median value Apr-23 to Dec-24
		Variance	1			1											
O	Number of rough sleepers brought into accommodation	Actual	62														
		Plan	52														
		Variance	10														
	Proportion of people living in our supported housing that are registered with a GP	Actual	98%														
		Plan	92%														
		Variance	6%														
	Number of rough sleepers who have returned to the streets after being in settled accommodation	Actual															
		Plan															
		Variance															
	Number of Rough Sleepers and residents within the Vulnerable Adults' Pathway engaged with the Integrated Health Network (Multi-disciplinary health team with focus on supporting people into substance use treatment and addressing physical and mental health needs)	Actual															
		Plan															
		Variance															

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A. People maintain positive behaviours that keep them healthy

Tracks Smoking prevalence reduction, number of Substance Misuse in 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?	A newly commissioned NHS Health service came into effect in 24-25 where PH commissioned directly with practices organised into PCN's The model came about from prior service evaluation and best practice learnings aims to improve accessibility and outcomes in line with key elements of the NHS Long Term Plan. The main objectives for the re-designed service were to: • Provide equitable access by implementing a more consistent service model across the whole of the borough. • Intervene earlier by increasing invites and uptake – with an emphasis on prevention, early detection, and management e.g., reducing avoidable presentations in GP or Acute care. • Move to a population health focus by developing an at-scale model that targets health inequalities for groups who experience poorer health outcomes. Activity was down in 24-25 with 5355 Healthchecks performed as opposed to 6893 performed in 23-24 but when accounting for transitioning to a new model and the critical incident experienced in the early part of 24-25 that effectively rendered the service inoperable for a quarter of the year, the 24-25 activity compares quite well to the preceding year. Incomplete Healthchecks accounted for 2449 for 24-25 which further burnishes the point. Key outcomes for 24-25 include: • 16% of patients who had a health check in 24-25 were referred to lifestyle services or prescribed medication. This includes 250 patients prescribed statins, 84 prescribed antihypertensives, 352 referred to the National Diabetes Prevention Programme (NDPP), 19 referred to smoking cessation services, 3 referred to alcohol services, and 142 referred to weight management. • 11%of patients were diagnosed with a health condition and added to appropriate registers. This includes 131 patients with hypertension, 41 with diabetes, 7 with chronic kidney disease (CKD), and 408 with non-diabetic hyperglycaemia. • 86% of patients were identified with low 10-year cardiovascular disease (CVD) risk, 12% with moderate risk, and 2% with high risk. All patients received appropriate advice and support.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	The Lambeth population that are eligible for an NHS Health Check is around 90,000 people. Data at the end of 24-25 showed 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%

A. People maintain positive behaviours that keep them healthy

Tracks Smoking prevalence reduction, number of Substance Misuse in 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 are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*

Challenges

- Legacy issues of the critical incident highlighted at the end of Q1 24-25.
- Service was recommissioned in Spring 24 on a 1+1-year basis with the intention that the 2nd year would focus on the PCN's and Lambeth commissioners agreeing and developing an at scale model to deliver the service in the most optimal way, focussing on our key priorities. The on-going impact of the situation highlighted above 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.
- On-going issues with GP capacity/ priorities
- The above notwithstanding, Commissioners continue to work with the PCNs on recovering the core offer and engaging on future commissioning models.
- GP Infrastructure limitations that may hinder roll out of at scale model ambitions.

Actions

- Continue NHS Healthcheck Steering Group Strategy and steering Group with LMC representation
- Intention to Direct Award NHS Healthchecks to GPs/ PCNS for 26-27 to build on recently recommissioned model
- Agreeing and refine targeted invite approach with GPs to increase key demographic uptake.
- Evaluating the effectiveness of DHSC Healthcheck at work and Healthchecks online pilots

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

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

Alliance and Programmes	NWDA (owner) with contributions from CYP and Staying Healthy

What does the data/intelligence indicate around progress against the outcome?	There has been an increase in percentage of residents financially coping since the beginning of the financial year to 79.3%.
Does the data/intelligence identify any health inequalities and whether they are reducing?	Support for financial and housing remain high, with the majority of referrals for one of these needs. So although a demand on the service demonstrates engagement with the community there is a risk that wider determinants such as the cost of living crisis, lack of housing provision etc. is having a detrimental impact on individuals and health inequalities cannot always be addressed via social prescribing alone. Improving financial resilience is an important social determinant of health.
What are the challenges hindering any progress and are there actions which can be taken to address these?	Wider financial implications within Lambeth and Nationally is seeing the VCSO and other supporting organisations reduce in size, service offer or ceasing all together. This impacts the work of social prescribing as there are limited resources to signpost/ refer clients on. Social Prescribers are having to take on more work that was originally anticipated within the role. However, it does bring positive challenges too, providing opportunities to explore alternative ways of delivering social prescribing and investing more time in community development. Ongoing challenge of no centralised CRM/database for social prescribing in Lambeth. 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 due to political changes, with health as a key area of focus, recognising the impact of poverty on health outcomes.
Additional Comments	

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?***	Ongoing data quality issues have impacted vaccination figures. Inaccuracies included over- or under-reported coverage, and some children with incomplete records counted as fully vaccinated. The 5-year-old cohort, especially for multi-dose vaccines (e.g. DTaP, MMR2), was most affected. Actions Taken: • The NHS is now using the correct system (CarePlus) • Revised 2024/25 data is being published; previous years will not be republished to avoid further inaccuracies • Enhanced checks and audits are being implemented • Findings are being shared nationally to support future improvements These changes should be considered when reviewing or comparing vaccination data over time. Flu vaccinations for over-65s will begin in October, following the national campaign launch in September for children and pregnant women. ImmForm remains the national reporting platform, with data collection starting alongside the flu season. As the 2% uptake increase target (based on 2023/24 levels) was not achieved in 2024/25, it will be maintained for this season. We remain committed to contributing towards this ambition for 2025/26 through targeted outreach and engagement.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	National (COVER) reporting lacks insights on vaccination inequalities. UKHSA's national health equity audit revealed the presence of avoidable inequalities within the UK vaccination system. A local health equity audit was also completed. It took a systematic approach to examining the areas and extent of inequalities in Lambeth's vaccination service to enable a data driven targeted engagement programme to be designed for those most need it. Inequalities in vaccination coverage and timeliness were found in Lambeth's childhood vaccination system.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Data quality issues, including over- or under-reporting of coverage for 5-year-olds and multi-dose vaccines, have affected figures. NHS has updated systems and audits; revised 2024/25 data will now published. For the 2024/25 season, flu vaccination uptake among the over-65s declined to 54.4%, reflecting similar trends in some other SEL boroughs. Challenges include vaccine fatigue, mistrust, hesitancy, and systemic barriers. We are using insights from last season to inform this year's strategy.
Additional Comments	

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 151 new people in June, little changed from the150 in May and slightly less than the monthly average of 156 for 2024/25. This makes 426 new people supported so far in 2025/26. The number of people Focused Support (FS) started supporting in June fell to 32 from 39 in May, which makes 108 new people supported so far in 2025/26. In June, Lambeth Single Point of Access referred 118 people to STS, a little more than the average of 110 for 2024-25. People attending a second STS appointment in March had waited an average of 26.3 days. This is 1.5 days longer than the average wait of 24.8 days in 2024/25. This increase of 6% is perhaps lower than might be expected, given the that the 583 people working with STS in June is 11% higher than the 524 average for 2024/25).
*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 shows that the improvement in Black service users' access to short term support seen during the last quarter of 2024/25 has largely beer sustained. In the first quarter of 2025/26, April to June, Black services users made up 28.7% of those accessing short-term support (down 1.0% points on the previous quarter) but much higher than past quarters and higher than the 21.7% of the Lambeth adult population that identifies as Black. 46.5% of people new to focused support in the first quarter were Black (up 4.5% points) on the previous quarter, but still much lower than the 2024/25 average of 53.1%. Demand for intensive services for Black Service users then appears to be falling as access to less-intensive services improves. The latest data on waiting times for a second appointment with STS shows only as mall difference between Black and White service users, who waited on average 29 and 27 days respectively.
*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 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?***	Reproductive Health: Total LARC in primary care for Q4 was 485 (correction from previously reported figure of 803). This is including GP LARC activity and Hub activity from both the new and previous hub service. Q4 reported the highest activity across both services, which is in line with seasonal trends. Compared to 23.24, there has been a 26% decrease in LARC appointments taken up in primary care in 24.25. This could be due to the ending of the MSI standalone LARC Clinic in March 2024, setting up of new LARC GP arrangements, changes to Mirena Coil license (extended from 5 years to 8 years) and or change in demand. Data is not yet available for Q1. Within termination services, as previously reported, there was an overall decrease of abortions in 24.25 by 5% compared to 23.24. And a slight increase of subsequent abortions from 41% to 43%. Sexual Health: The latest available data on number of STI tests and number of STI diagnosis is up to Q3 24/25. There was a slight uptick in tests in Q2 24/25 to 17,179 which dropped back down to 16,218 in Q3 24/25. This is more in line with previous quarters. There were 2,406 new STI diagnosis in Q3 24/25. This is a slight decrease from the previous quarter (2,688). The annual release of STI diagnosis rates have recently been published and show a decrease in STI diagnosis rates from 2024 compared to 2023 in Lambeth (3,257 per 100,000 vs 3,598 pper 100,000). Testing rates also saw a slight decrease from 2024 compared to 2023 (20,964 per 100,000 vs 21,645 per 100,000).
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Demographic data within termination services shows that certain demographics are over-presented within the service compared to the population percentage. 25% of service users were aged 20-24 years old, this age groups accounts for 8% of the Lambeth population. 18% of service users identified as Black African women compared to 11% of the Lambeth population. This could represent an unmet contraceptive need within these demographics.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Sexual Health A dashboard is being developed by the PH Health Intelligence team which will allow us to more easily view STI testing and diagnosis numbers by age, ethnicity, sexual orientation and STI type. This will allow us to better understand need and whether targeted work with communities is having the desired effect on outcomes. The aim is that the dashboard will be completed by the end of Q2. The Sexual health team are undertaking a piece of work looking across all our data all our sources to enable us to target our services and interventions, with the launch of the updated strategy. STI Prioritisation Framework.

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

Tracks rate of STI testing & diagnoses 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

Additional Comments	The online consultation for the refreshed Sexual Health Strategy for Lambeth, Southwark, Lewisham , Bexley and Bromley (LSLBB) has now closed and the results being analysed, on quick view we have a good spread across ages, gender and ethnicity although we only had a total of 133 responses, although 30 percent do represent organisations. To enable further engagement to take place and ensure that we are reaching out to communities that might not respond to an on-line engagement process, commissioners and partners will spend the next month going out to conduct face to face feedback with key resident groups and forums. Public Health leads reported to Lambeth Adult Health and Social Care Board scrutiny Sub committee on this work 10/7/25 The LSLBB commissioning team are currently inputting aims, objectives and actions in relation to the action plan that will direct the underlying work towards the Strategies objectives, this online tool will allow for 'live' monitoring of our work and enable the strategy oversight group to assess our progress quarterly. The oversight group will be made up of, commissioners, clinicians and our community partners. The re-procurement of the London online service has now gone live. The Lambeth team has procured a digital PrEP pilot to enable early access to online PrEP for Lambeth residents; this is ready to go-live once the governance has completed and our lead Councilors have been informed of this pilot work.

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 (September '24) compared to 50% in December 2019. Note for the financial year of 25/26 the national target has increased to 62% but this data is from when the target was 60%. 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%. **No update to data since last report in May** 3. Breast cancer screening aged 50-70-Upward trend in the past year. Most recent data shows 56.4% screened in September 2024 which is an increase from 55% in September 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. Health checks have been taking place during the first 2 months of the year. Whilst figures are low, as expected at this time of the year, the number of checks completed doubled in the 2 months.
*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 annual health checks, local audits of people who had not attended for a check over the last 3 years identified inequalities. Plans have been developed that tailor communication and engagement to these groups and are being implemented. Below are the main actions from the plan. The audits may be repeated to detect any changes.

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. 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 pressures it is difficult for primary care to take on additional screening promotion work. The breast screening incentive has been removed from the local PMS contract so there is now no local primary care incentives for cancer screening. Due to staffing changes within the NWDA there is now less capacity for focus on cancer projects. 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 along with a PCN community engagement event which took place at the end of February. The NWDA have also funded multiple successful PCN engagement events. The local breast screening service are also working to increase appointments outside of normal working hours to aim to increase screening rates. Widely share information about health checks with people with learning disabilities and their family/carers ensuring it is Easy Read and includes information about eligibility for being on the register. Distribute information and resources to GPs that support engagement in the health check. Share best practice and national guidance updates with practices. Joint working with Lambeth Carers' Hub and Social Services to run health and social Q&A sessions for individuals with LDA and their carers Link with schools, including special schools, and colleges and SENCOs and Children's Commissioning Establishing joint clinics between the paediatric team and GSTT and GPs for complex patients transitioning from children to adult services Close joined-up working with SLaM's Health Check Liaison Team for SMI health checks Work collaboratively with voluntary organisations who are supporting people on the ground to raise awareness of the health check and encourage people to take them up

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 80% blood pressure control (140mmHg/90mmHg) in people aged 79 years and under by end of FY 2025-26. 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 prior year baseline by 10 percentage points. The measure is cumulative from April 2025. At the beginning of June 2025 75.5% 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 (denominator) increasing from April 2025. 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 continues to be tracked to indicate progress. There has been 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 2025. On 15 June 2025, a total of 175 of the 3335 (5.25%) 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 June 2024 to June 2025 data; 6147 and 6426 respectively and within these cohorts, blood pressure control has remained consistent with higher absolute numbers in comparison to the previous year; 24,059 and 25,030 respectively. 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 measurement and recording of the 8 care processes for Black, Asian and multi ethnic groups continues to trend upwards. 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 previously inclusion in the 2024/25 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. 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?	At the end of June 2025, the number of people waiting for a referral from Lambeth SPA was 595 (down 3% from the end of May) and these people have been waiting, on average, 13.4 days for urgent introductions and 53.6 days where introductions are categorised as being routine. Despite this small improvement, both the waiting list and waiting times for onward referral have roughly doubled since the end of January 2025. 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 85% of target in May (the latest available data), unchanged from April. So far in this financial year, 995 people have completed their LTT treatment.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Data for Lambeth SPA shows no particular inequalities within the SPA process. 21% of Black Service users introduced to SPA received onward referrals to Community Mental Health Services, the same percentage as for White service users. Average waiting times for introductions processed in June also show no meaningful difference, being 35.0 days and 33.8 days for Black and White service users respectively. Access to Lambeth Talking Therapies Recovery for Black service users continues to improve. In Q4 Jan-Mar 2024 (the latest period for which data is available), 24.2% 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?*	Lambeth SPA has consistently found it difficult to maintain necessary staffing levels and financial restrictions affecting the use of agency staff worsened this problem in recent months. However, remodelling of the core SPA team started in June, including closer co-operation with the Crisis Outreach Service (COS) and, in time, with primary care services. A special team of additional clinicians has also been formed to focus on the large number of long waiting introductions. This team has been tasked with eliminating this backlog by the beginning of September, while the core SPA team has been tasked with reducing waiting times for all new introductions. 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.

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

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Alliance and Programmes	LWNA and CYPA (owners)

What does the data/intelligence indicate around progress against the outcome?	Lambeth CAMHS referrals remain high, with a gap between referrals received and accepted (see Table 1 on next slide). No reasons or themes for rejected referrals are captured in the data. Caseload has grown, largely due to neurodevelopmental cases (e.g. ADHD), which typically stay under CAMHS care longer (see Table 2 on next slides). First contact within 28 days is generally being achieved, with Lambeth performing well on this measure (see Table 3 see Table 2 on next slides). This is important, as it introduces those referred to service to additional support and advice available to them whilst waiting for further assessment or therapeutic intervention. Around 25% of cases are still waiting over 52 weeks, reflecting ongoing pressure (see Table 4 see Table 2 on next slides).
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Long waits are concentrated in the neurodevelopmental pathway. The data does not provide breakdowns by ethnicity, deprivation, or other characteristics for those waiting the longest, so no inequalities can be confirmed or tracked from this data.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Increased referrals (significant rise since the pandemic) alongside stable acceptance rates have raised caseloads and pressure on services. Neurodevelopmental cases drive long waits due to their complexity and duration on caseload. Targeted action includes additional ADHD capacity, but demand continues to exceed capacity in this pathway.

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)**

Table 1 – Referrals

Referrals Received

Borough	Jun-2024/25	Jul-2024/25	Aug-2024/25	Sep-2024/25	Oct-2024/25	Nov-2024/25	Dec-2024/25	Jan-2024/25	Feb-2024/25	Mar-2024/25	Apr-2025/26	May-2025/26	Total
CAMHS NAT. & SPEC. OUTPATIENTS	13	22	32	33	29	31	31	32	31	20	21	24	319
CROYDON CAMHS	7	4	0	2	7	4	6	5	10	7	3	1	56
LAMBETH CAMHS	149	165	88	127	164	150	123	130	127	169	130	213	1735
LEWISHAM CAMHS	201	194	79	122	168	212	162	191	212	239	171	178	2129
SOUTHWARK CAMHS	185	222	133	171	198	187	171	168	188	202	138	176	2139
Total	**555**	**607**	**332**	**455**	**566**	**584**	**493**	**526**	**568**	**637**	**463**	**592**	**6378**

Referrals Accepted

Borough	Jun-2024/25	Jul-2024/25	Aug-2024/25	Sep-2024/25	Oct-2024/25	Nov-2024/25	Dec-2024/25	Jan-2024/25	Feb-2024/25	Mar-2024/25	Apr-2025/26	May-2025/26	Total
CAMHS NAT. & SPEC. OUTPATIENTS	11	16	18	30	25	25	26	27	26	17	18	15	254
CROYDON CAMHS	1	2	0	1	1	0	3	1	0	2	1	0	12
LAMBETH CAMHS	97	123	59	67	110	98	76	103	108	112	94	144	1191
LEWISHAM CAMHS	172	189	68	110	160	168	174	164	196	189	190	171	1951
SOUTHWARK CAMHS	152	216	136	180	209	181	169	139	119	167	110	96	1874
Total	**433**	**546**	**281**	**388**	**505**	**472**	**448**	**434**	**449**	**487**	**413**	**426**	**5282**

Table 2 - Caseload

Caseload EOM

Borough	Jun-2024/25	Jul-2024/25	Aug-2024/25	Sep-2024/25	Oct-2024/25	Nov-2024/25	Dec-2024/25	Jan-2024/25	Feb-2024/25	Mar-2024/25	Apr-2025/26	May-2025/26
CAMHS NAT. & SPEC. OUTPATIENTS	524	523	519	530	509	510	483	494	508	500	491	476
CROYDON CAMHS	10	12	9	14	14	13	12	11	11	11	11	10
LAMBETH CAMHS	2379	2424	2407	2425	2480	2517	2554	2581	2620	2676	2708	2766
LEWISHAM CAMHS	3215	3246	3169	3159	3187	3248	3327	3408	3490	3640	3687	3782
SOUTHWARK CAMHS	3172	3259	3234	3258	3312	3267	3338	3355	3374	3448	3426	3405
Total	**9300**	**9464**	**9338**	**9386**	**9502**	**9555**	**9714**	**9849**	**10003**	**10275**	**10323**	**10439**

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)**

Table 3 – First Contact Within 28-Days

FY 25/26	Apr-25			May-25		
SEL	No. of first contacts	No. first contacts within 28 days	% contacts within 28 days	No. of first contacts	No. first contacts within 28 days	% contacts within 28 days
Intake Team Lewisham CAMHS	188	4	2%	171	21	**12%**
Lambeth CAMHS Lighthouse Team	121	114	94%	97	96	**99%**
Southwark CAMHS Referrals Team	106	52	49%	65	34	**52%**
Grand total	**415**	**170**	**41.0%**	**333**	**151**	**45.3%**

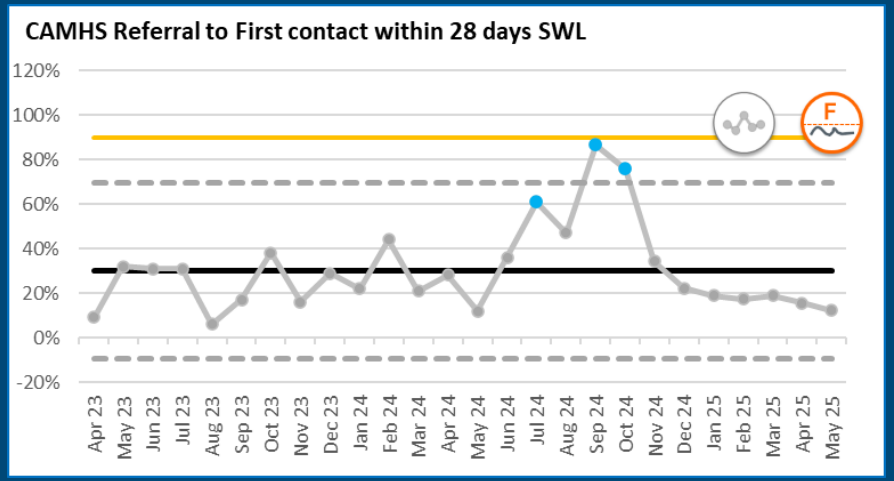

Table 4 – Waiting Times

Sub Service Line	Sum of waiting < 4 weeks	Sum of waiting 5 to 10 weeks	Sum of waiting 11 to 25 weeks	Sum of waiting 26 to 52 weeks	Sum of waiting >52 weeks	Total Waits
CAMHS Nat.& SPEC. OUTPATIENTS	52	59	96	39	5	251
LAMBETH CAMHS	20	15	12	3	17	67
LEWISHAM CAMHS	72	63	22	8	8	173
SOUTHWARK CAMHS	66	128	16	15	12	237
Grand total	**210**	**265**	**146**	**65**	**42**	**728**

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?***	HWBus - The data clearly indicates that we are reaching a large number of residents as per the total interactions captured. This total comes from both approaches; using the H&W Bus on high streets and at community spaces as well as Health Champion outreach without the bus at various centres and spaces. It also demonstrates that we are consistently offering a variety of services to residents and in tandem, giving them access to information on these health topics. Beacon – The data demonstrates the outreach attracts strong numbers and there is demand at neighbourhood level.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	HWBus - By introducing the Vital 5 health check we are specifically targeting our Core20plus5 population and offering an intervention based on prevention in order to reduce health inequalities. Beacon – The data shows 65% of people they support are from black population.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	HWBus - We have a challenge joining up to EMIS. The workaround solution is a pathway created with GP Fed in order that people seen through the bus who are advised to see their GP urgently - can opt in for us to notify their GP's of this. Beacon – challenges over funding for the programme causing risk to service. Beacon in talks with ICB.
Additional Comments	

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

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?

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 1184 consultations between May 2024 and April 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 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 the last 12-months rolling data from 31 May 2024 to 30 April 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.

The 2025-26 SEL Medicines Optimisation Plan includes a measure to increase use of the NHS app capability of ordering repeat prescriptions so that patients may more easily be equipped to take greater control over their health and care and to access care at the right time and place.

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?***	Data from April 2025 shows most interventions (973) 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, 64% of patients would have visited general practice to request the medication on prescription, 36% 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 receive income support are the top social vulnerability eligibility groups accessing Lambeth Pharmacy First Plus Service in April 2025. General Practice feedback has been that the service has a had a positive impact for patients and reduced GP appointments for minor conditions. Data from May 2025 shows a 2.6% increase (16,961 in May 2025 vs 16,528 in April 2025) in repeat prescriptions being ordered via the NHS app.
*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. The NHS App is available for use by anyone aged 13 or over who is registered with an NHS GP practice in England. As with any technology, there will be unequal access to these services across different socio-economic groups, which, can lead to worsening healthcare inequalities. Households with lower incomes, for example, may have limited internet access and lack the digital skills needed to make use of it. Disability may also contribute to difficulties accessing digital tools and inclusivity must be at the heart of their design. Practice staff should support patients with access needs, for example those with learning disabilities, autism, visual impairment, and hearing loss. A more traditional, non-digital, solution should remain available for those patients who simply cannot or will not engage digitally.

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	
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
Apr-25	106
Total – 1184	

Total Pharmacy First consultations (includes referrals to 7 Clinical Pathways, Minor Illness and Urgent Medicine Supply Service)	
May-24	2304
June-24	2224
Jul-24	2374
Aug-24	2336
Sept-24	2655
Oct-24	2310
Nov-24	3207
Dec-24	3596
Jan-25	3687
Feb-25	3641
Mar-25	3721
Apr-25	3073
Total – 35,128	

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

1. Universal credit (38%)
2. Patients aged under 16 years (35%)
3. Income Support (10%)

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

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

Alliance and Programmes	NWDA (Owner)

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

The number of accepted referrals to Reablement has remained steady at 55 in April and May 2025.

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The number of people who have a reduced or no 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 or no need for care at the end of Reablement continues to improve and is currently 89%.

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. We will be monitoring the outcome of these cases in the future and can report on this next time.

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

The overall trend for Lambeth end of life data outcomes K3 and K4 (palliative and end of life care improvement measures) is progress towards increased identification and uptake of advance care planning. This is across both the identified outcome measures for people identified as being in their last year of life on practice registers (45% increase from Q1 22-23 to Q4 24-25) and Proportion of people with Personalised Care and Support Plan(PCSP)/UCP (21.1% 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 1% in conversion to PCSP (K4), following data cleansing at the start of Q1 25/26 (Vauxhall Surgery data previously missing from May report to LTAG).

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 are made via the hospital discharge route. However we are increasing the number of people who are offered a reablement service via our front door team in Adult Social Care. This extends the reablement offer to people living in the community at home. Community Referrals to Reablement are now at 20% which is an increase from 17% 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. A number of the community referrals to Reablement are declined. We are introducing a weekly meeting to look at the reasons why community referrals are declined to improve the referral acceptance rate.
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	Data caveat: Q1 data will be available in the second week of July, therefore this update is substantively consistent with the May report to LTAG. Key change is the inclusion of update Q4 data following corrected data capture for the Vauxhall Surgery).

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?***

Since the last Assurance meeting, the Children and Young People Alliance has not been able to secure any maternity reporting data. This has been escalated, and the Alliance is working closely with data and reporting colleagues at provider trusts and within the Local Maternity and Neonatal System to address this long-standing challenge.

Any potential risks around reporting challenges have been, and continue to be, mitigated through individual quality and governance audits at both system and local level, as well as through regular collaboration and attendance at the Local Maternity and Neonatal System Quality and Safety Forum.

The Alliance will continue to keep Assurance colleagues updated on developments in this space.

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, 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?***	In July 2025 the number of people cared for in specialist inpatient units was 10 (9 adults and 1 YP). This indicates a steady decrease since 22/23 which evidences the effective work to facilitate discharge to the community and prevent admission.
Does the data/intelligence identify any ***health inequalities and whether they are reducing?***	Ethnic background of those supported in inpatient settings is monitored. The proportion of inpatients who are Black/Black British has fallen from 50% (22/23) to 27% (July 25) indicating there is no longer an over-representation of people from Black backgrounds in the most restrictive settings. This demonstrates the hard work of the whole Lambeth Together network and partners to achieve this result.
What are the ***challenges hindering any progress*** *and* ***are there actions which can be taken*** *to address these?*	On LDA employment opportunities, it is a challenge to present updated data that evidences the work to support people with LD into paid work. The data for 2024/25 is not available yet, and will need to be delivered through the ASCOF data measurement process.
Additional Comments	

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, April to June, CLaSS started working with 34 new people, fewer than the 47 new clients in the last quarter, January to March. LWNA's Individual Placement and Support (IPS) helps people with a serious mental illness find and sustain paid employment. The IPS service helped 14 people find work in the last quarter, April to June, a significant improvement on the 8 people supported in the previous quarter. This is less than the original placement target of 36 per quarter, but the team also helped 9 people to sustain employment for at least 13 weeks and 2 for 26 weeks or more, There were 31 restrictive incidents and seclusions for inpatients in June, just below the average of 35 for financial year 2024/25, April to March. Positive friends and family survey responses for LWNA services were at 77.8% in May-25 (the latest month for which data is available). This is just short of the 79.5% average for the previous financial year.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Of the new people supported by CLaSS in the first quarter of 2025/26, April to June, 50% were for Black services users, down from the 54% seen in the previous financial year. However, there are too few people involved to be sure that this small difference is statistically significant. More intensive LWNA services presents a mixed picture in the first quarter, April to June, with the proportion of Black people newly accepted into inpatient care rising by 4%, but the equivalent figure for more intensive community support (focused support and home treatment) falling by 4%. Both figures remain much higher than might be expected though, given that the Black adult population of Lambeth is 21.7%. Of the 81 restrictive incidents and seclusions reported for Lambeth acute inpatients with a stated ethnicity in the first quarter of 2025/26, April to June, 45 (56%) were for Black patients who, in the same period made up 89 (53%) of the 168 newly admitted inpatients with a recorded ethnicity. However, the number involved are not large enough to draw firm conclusions. The figures are also 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?*	Black service users remain more likely to need intensive forms of support, such as inpatient care or home treatment and focused support in the community, than White services users, who typically access less intensive forms of support earlier in the development of their illness. LWNA is using the PCREF framework to engage with local communities and build trust to improve access, experience and outcomes. Improved access to early forms of support, will reduce the level of inequality seen in the more intensive services.

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

Tracks Resettlements, rough sleepers brought to accommodation, GP registration, rate of engagement with Multidisciplinary services within the Vulnerable Adults pathway- recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

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

*What does the data/intelligence indicate around **progress against the outcome?***	Following the review process for 25/26 the team agreed to monitor four impact measures in 25/26. A continued focus will be on GP registration across the Vulnerable Adults Pathway (maintaining 90% or above) and number of rough sleepers brought into accommodation. We introduced two new measures for 25/26 focussing on number of rough sleepers who have returned to the streets after being in settled accommodation and number of rough sleepers and residents within the Vulnerable Adults' Pathway engaged with the Integrated Health Network (Multi-disciplinary health team with focus on supporting people into substance use treatment and addressing physical and mental health needs).
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Access to GP's and mental health services has increased last year 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 homelessness being 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.
Additional Comments	