

Lambeth Together Care Partnership Board

21st March 2024

Title	Lambeth Together Assurance Sub-Group
Meeting Date	21 st March 2024
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Lead	Sue Gallagher – Lay Member

This item is for:

<input checked="" type="checkbox"/>	Information	<input type="checkbox"/>	Discussion	<input type="checkbox"/>	Decision	<input type="checkbox"/>	Ratification
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Recommendations:

The Lambeth Together Care Partnership Board is asked to:

1. Note the report from the Lambeth Together Assurance Sub-Group and the associated Integrated Assurance Report presented on 30th January 2024

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

None

Summary and Impact on Inequalities

Purpose:

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

Lambeth Together Health and Care Plan Focus Points:

At the 30th January 24 meeting the Lambeth Together Assurance Group (LTAG) meeting agenda centred around two of the outcomes which the partnership is aiming to achieve through delivery of the 'Our Health, Our Lambeth, As Lambeth Together's health and care plan'. These were

- Outcome 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*
- Outcome A: *People maintain positive behaviours that keep them healthy: with a specific focus on smoking*
- Outcome O: *People who are homeless, or at risk of becoming homeless, (including rough sleepers and refugees) have improved health*

Integrated Assurance Report

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

- 21 out of 38 metrics tracked in scorecard format are green, exceeding baseline/national targets or last year's cumulative position. This represents a reduction of 7 from the last report in November 2023, although the reduction is down in part to adjustments made to the metrics following the mid-year review.

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

- **Outcome G (Long Term Health Conditions):** There has been good around increasing the number of our residents know to be suffering from chronic pain as well as those receiving a review from their GP.
- **Outcome E (Sexual Health):** The report shared details around inequity in sexual health and the work being undertaken to understand and reduce this.
- **Outcome B (Connected Communities):** Indicated that whilst there had been an increase in social prescribing referrals since the last reporting period, that referrals are now lower than what they were when compared to the cumulative position last year.
- **Outcome D (Mental Health Access):** access rates for Black communities have improved year on year for IAPT with a higher proportion of clients accessing the service than the population proportion. However, challenges continue around triage and assessments rates and long waits due to increase demands on the neuro pathway further compounded by the industrial action.
- **Quality Alerts in General Practice:** There was a conversation around the primary care quality alters data and its implications.
- **Risk register:** None risks on the risk register were rated as server or critical and were all within the ICB tolerance threshold with no new risks being reported. The risk around business continuity for Waterloo Health centre has largely been addressed due to the move to temporary premises however, the risk still remained a Lambeth Walk site as temporary alternative site was some distance away from the current practice. It was recognised that in focusing solely on Lambeth risks that the wider system risks might be missed, and the group should consider how we ensure that the wider risks are not lost – for example, wider financial risks.

Lambeth Together Integrated Assurance Report

30 January 2024



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Foreword



Progressing 'Our Health, Our Lambeth'

As we usher in the new year, January provides a moment for reflection and renewed commitment to the objectives outlined in 'Our Health Our Lambeth'. The last months have seen significant developments in tracking and reporting of our Health and Care Plan, coupled with dynamic challenges that test our resilience as a Health and Care Partnership.

Navigating System Pressures and Industrial Action

The period saw additional strain on our health and care services with industrial action by junior doctors with a mandate until 29th February 2024. Our collaborative efforts with system partners aim to minimise disruption and adverse impacts on services and patients. Urgent Emergency Care (UEC) touchpoint meetings facilitated crucial communication and action coordination among Lambeth and Southwark leads.

Management Cost Reduction (MCR)

The Integrated Care Board (ICB) initiated a 45-day staff consultation in October to achieve a necessary 30% management cost reduction. Valuable feedback highlighted themes such as capacity, ways of working, structural variations, partner readiness, and potential missed opportunities. Post-consultation, the process of filling posts in the new structure is underway, incorporating stages focused on staff affected by changes, suitable alternative employment, and open competition.

In Lambeth, efforts to achieve savings targets have been managed with less disruption due to our well-developed integrated structures. Collaboration across Lambeth and the wider SEL system will be pivotal in addressing the impact of reduced resources. While acknowledging the challenges, we extend support to staff and aim to maintain high service levels to our residents.

Looking Ahead

As we move forward, we remain committed to the principles of 'Our Health, Our Lambeth'. The upcoming months will see continued evaluations, learnings, and adaptations as we approach our one year review in May 2024. Challenges, be they in industrial actions or management cost reductions, reinforce our collective resolve to deliver quality healthcare services to Lambeth residents.

In closing, our gratitude extends to all partners, stakeholders, and the Lambeth community for their unwavering support. Together, we navigate complexities, learn from experiences, and work collaboratively towards a healthier Lambeth.

Our Health, Our Lambeth

Lambeth Together health and care plan 2023-28



Introducing a Scorecard

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

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

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

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

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

Lambeth Together Health and Care Plan Scorecard – January 2024

ID	Outcome	January 24			November 23			Jan 24 vs Nov 23
		Measures Reported	Above/in line with Baseline	% measures above/in line with baseline	Measures Reported	Above/in line with Baseline	% measures above/in line with baseline	
A	People maintain positive behaviours that keep them healthy	1	0	0%	2	1	50%	-1
B	People are connected to communities which enable them to maintain good health	3	2	67%	3	3	100%	-1
C	People are immunised against vaccine preventable diseases	1	1	100%	1	1	100%	0
D	People have healthy mental and emotional wellbeing	2	1	50%	2	2	100%	-1
E	People have healthy and fulfilling sexual relationships and good reproductive health	1	1	100%	1	1	100%	0
F	People receive early diagnosis and support on physical health conditions	6	3	50%	5	4	80%	-1
G	People who have developed long term health conditions have help to manage their condition and prevent complications	4	3	75%	4	3	75%	0
H	When emotional and mental health issues are identified; the right help and support is offered early and in a timely way	5	2	40%	5	3	60%	-1
I	People have access to joined-up and holistic health and care delivered in their neighbourhoods	1	0	0%	1	0	0%	0
J	People know where to go to get the right help, and are treated at the right time, in the right place, for their needs	3	1	33%	3	2	67%	-1
K	Older adults are provided with the right health and care support at the right time, live healthy and active later lives and are supported to age well	5	3	60%	5	3	60%	0
L	Women have positive experiences of maternal healthcare and do not experience a disproportionate maternal mortality rate	0	0	-	1	0	0%	0
M	People with learning disabilities and/or autism achieve equal life chances, live as independently as possible and have the right support from health and care services	1	1	100%	1	1	100%	0
N	People using mental health support services can recover and stay well, with the right support, and can participate on an equal footing in daily life	1	0	0%	1	1	100%	-1
O	People who are homeless, or at risk of becoming homeless, (including rough sleepers and refugees) have improved health	4	3	75%	4	3	75%	0
Total		38	21	55%	39	28	72%	-7

A. People maintain positive behaviours that keep them healthy



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

Update Month January 2024

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

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

DrinkCoach is a digital brief advice and intervention platform. Lambeth has in the past had a good level of interaction with the platform, however this has been lower than previously in 203/24 despite promoting Drink Coach across multiple platforms and in partnership with the PCN's, Health and Wellbeing Bus and other community-based providers to support promotion of Drink Coach and its use. Negotiations with Drink Coach are ongoing to determine a more effective and targeted campaign of comms and promotion across Lambeth communities.

Interim one year review of Thriving Stockwell Community Living Room programme has seen good uptake of the preventative offer with 1,984 attendances during the year across a range of activities including Latin-American Dance & Movement, Rumba class, Creative Sewing Group and Chair Yoga Wellbeing group. A full one-year review is due to be completed, as part of the ongoing programme evaluation.

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

Drink Coach is one part of a raft of plans and initiatives that are being developed to help target those who are engaged in harmful drinking. A further needs assessment is going to be completed that will enable commissioners to more fully understand need within the local community alongside assets and what we can utilise to enable work towards reducing health inequalities and enabling more people to seek support.

Lambeth has the largest LGBTQ+ population in London and national data shows higher rates of smoking amongst the LGBTQ+ community.

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

Awareness of Drink Coach and potential digital exclusion – commissioners are continuing to work with local partners to develop a range of support that can be accessed across communities.

A pilot LGBTQ+ creative smoking group was run in partnership with GSTT, Lambeth Links and Art 4 Space, achieving good outcomes but low uptake. Partners are currently planning co-design and engagement work with the LGBTQ+ community to improve the offer for the next cohort and inform the social marketing approach.



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

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

indicator ID	Measure	Lastest period	Lastest period position	Previous period Position*	vs previous Period*	Lastest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
B1	number of social prescribing unique contacts	Dec-23	475	396	79	4,497	5,648	-1151	Baseline = cumulative position at same point in 22/23	Increase
B2	Residents' wellbeing, use of community assets and social cohesion	Q2 23/24	82%	81%	1%	82%	82%	0%		Increase
B3	percentage of low-income residents coping financially	23/24 Q3 (Oct)	80.3%	78.8%	1.5%	80.3%	76.2%	4.1%	Baseline = 22/23 Q4	Increase

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

B1 Number of social prescribing unique contacts - There has been a 20% increase of social prescribing unique contacts from the latest period to the current period. This demonstrates residents continue to accessing and be supported via the social prescribing offer, linking them into community groups, services and activities.
B3 Percentage of low-income residents coping financially - Both the percentage and the whole number of people within the council's Low Income Family Tracker identified as 'coping' financially has increased in the last period.

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

B1 Number of social prescribing unique contacts - Although lower than the baseline, data suggests a shift in how social prescribing is being accessed with more group and peer support available and delivered now. For example in North Lambeth yoga classes and exercise classes are being run and organised by Social Prescribers with high attendance. So the wider health inequalities are being addressed in more innovative approaches than the traditional social prescribing model.
B3 Percentage of low-income residents coping financially - 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?

B1 Number of social prescribing unique contacts - We no longer have a central CRM system to monitor and record data. Across the borough Social Prescribers are now using Emis to record case notes and referrals. This has made it difficult to monitor the Lambeth social prescribing service, cross-borough and record the group social prescribing offers and groups that are now being run.
B3 Percentage of low-income residents coping financially - The financial wellbeing of residents continues to be challenged due to wider economic factors linked primarily to austerity, inflation and the welfare benefits system not keeping pace with the costs of essentials (e.g. Universal Credit (allowances and two-child policy), the freezing of Local Housing Allowance, Healthy Start Vouchers being insufficient to meet the cost of infant formula). The council has in place a comprehensive evidence-informed cost of living response plan to mitigate the impact of the crisis for our most vulnerable residents in 2023/24. All elements of that programme are in delivery. Since the last reporting period the council has successfully implemented an approach to auto-awarding free school meals to eligible Lambeth households with children in Lambeth schools and started a pilot project targeting cost of living support at residents with health conditions worsened by the cold during the winter focussing on residents with sickle-cell disease.

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



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

indicator ID	Measure	Lastest period	Lastest period position	Previous period Position*	vs previous Period*	Lastest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
B1	number of social prescribing unique contacts	Dec-23	475	396	79	4,497	5,648	-1151	Baseline = cumulative position at same point in 22/23	Increase
B2	Residents' wellbeing, use of community assets and social cohesion	Q2 23/24	82%	81%	1%	82%	82%	0%		Increase
B3	percentage of low-income residents coping financially	23/24 Q3 (Oct)	80.3%	78.8%	1.5%	80.3%	76.2%	4.1%	Baseline = 22/23 Q4	Increase

Additional Comments

B1 Number of social prescribing unique contacts - A Housing and Health Forum, comprising of Social Prescribers, charities, Lambeth Housing, local Housing Associations, primary care staff and Councillors was set up to bridge the gap between housing and social prescribing. The forum has worked together to provide reciprocal training to upskill knowledge on social prescribing and housing to enable us to better support Lambeth residents. Following this success the forum is building on the reciprocal training idea to work with other teams in the wider Lambeth ecosystem, to increase awareness of social prescribing and increase access to support, to empower local workers and volunteers to know where to signpost and referral onto and encourage further engagement to local community groups to address health inequalities.

C. People are immunised against vaccine preventable diseases



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

Update Month January 2024

indicator ID	Measure	Latest period	Latest period position	Previous period Position*	vs previous Period*	Latest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
C1	Proportion of Lambeth registered children by age 2 that have received all primary immunisations and 1 dose of MMR	23/24 Q1	85.3%	84.3%	1.0%	85.3%	84.0%	1.3%	Baseline = same period last Year	Increase

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

C1 Proportion of Lambeth registered children by age 2 that have received all primary immunisations and 1 dose of MMR: 23/24 Q1 data indicates MMR vaccination uptake in Lambeth at 85.3%, below the WHO-recommended 95% for herd immunity. The risk of measles outbreaks persists. Prioritizing the local goal of 90% is crucial for community protection. Strategic interventions and community engagement are key to closing the gap, requiring continued collaboration, streamlined communication, and concerted efforts to achieve the desired vaccination coverage for robust public health outcomes.

C3 Proportion of school-age vaccination consent forms returned to the vaccination provider : Suboptimal return of consent forms for in-school vaccinations hinders achieving national targets, risking preventable infections which impact school attendance. Crucial measures are needed to address this challenge, improve consent form return rates, and ensure the success of school-age vaccination initiatives for enhanced public health outcomes and broader community immunity.

As at 9th January 2024 . **Over 65's:** Lambeth has successfully vaccinated 549 more patients compared to the same period last year. However, it's important to note that the current cohort includes approximately 1,700 more individuals, resulting in a lower overall percentage uptake. Achieving last year's outcome appears feasible with concerted efforts and a significant push in vaccinations between now and the end of February.

Pregnant Women: While Lambeth has vaccinated slightly fewer patients compared to the same period last year, our percentage uptake has increased by 2.3%. We have already surpassed last year's seasonal percentage uptake.

2-3 year olds: Lambeth has successfully vaccinated 63 more patients compared to the same period last year, representing an additional 1.7% of this cohort.

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

National reporting, including COVER lacks insights on vaccination inequalities. Learning from UKHSA's national health equity audit revealed the presence of avoidable inequalities within the UK vaccination system.

Recent analysis indicates that deprivation doesn't appear to be a factor as there doesn't appear to be a high correlation with unvaccinated Measles and our most deprived areas.

There are higher populations of Asian/Asian British in North Lambeth and in Streatham. That population also has a low uptake % compared to other groups.

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

Vaccination challenges stem from complex and interacting factors, including intrapersonal (such as vaccine fatigue and hesitancy, health beliefs and health literacy), community (such as religious, cultural and gender norms), and institutional elements (such as access & registration, culturally specific services, vaccination funding and delivery). To address these issues, we're piloting education sessions in trusted sites like children's centres, emphasizing the importance of vaccination for child health. Lambeth also played a key role in the SEL Immunisations Webinar on July 12, equipping frontline staff with communication tools. A local health equity audit is underway, systematically identifying barriers and facilitators for vaccination uptake in specific population groups, guiding targeted interventions

D. People have healthy mental and emotional wellbeing



Alliance and Programmes

LWNA and CYPA (owners)

Update Month

January 24

indicator ID	Measure	Lastest period	Lastest period position	Previous period Position*	vs previous Period*	Lastest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
D2	number of community organisations and volunteers undertaking mental health awareness and suicide prevention training.	Q2 23/24	31	91	-60	122	85	37	In 22/23 there were 169 attendances at Lambeth Suicide Prevention Training, Suicide Prevention Level 1 (Adults - V4), Raising Awareness of Mental Health. Assume that half of those were undertaken in H2 hence baseline of 85	Increase
D3	Number of People Entering into Treatment for Integrated Talking Therapies	Dec-23	659	1001	-342	8,540	8,757	-217	Target for Dec 23 was 973. Cumulative Target Apr-Dec 23 = 8757.	Increase
D3	proportion of people referred starting treatment within 6 weeks	Dec-23	98%	98%	0%	N/A	N/A	N/A	Target for 23/24 is 75%	Increase
D3	proportion of people who complete treatment and recover	Dec-23	55%	51%	4%	N/A	N/A	N/A	Target for 23/24 is 50%	Increase

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

More up to date data on the delivery of suicide prevention training is not yet available. IAPT access rates are typically depressed in December due to the holiday period, and the expected pattern for the service will see higher access numbers in the first half of the financial year. However, Dec-23 numbers are lower than those for Dec-22 which may indicate a lack of progress on this outcome. The proportion of people starting treatment within 6 weeks continues to be well above target and the quarterly average has improved against last quarter. The proportion of those completing treatment and recovered continues to improve steadily and has now been over target, on average, for two consecutive quarters.

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

Further data is needed to comment on any inequalities in relation to suicide prevention training. Access rates for Black service users has improve significantly in this financial year however the recovery rate for the Black community, despite some improvement, continue to be a cause for concern. Dropout rates have improved thanks to actions taken under an ongoing quality improvement project.

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

The primary challenge continues to be that Black service users tend to come to the service with more significant problems than the all service average. Increased admissions from the Black community has increased the proportion of those for whom the service will not provide enough support. Lambeth Talking Therapies has conducted interviews with everyone completing treatment and increased training for therapists. This focuses on the reasons why Black Service users may leave treatment before it is completed or otherwise not report themselves as recovered on completion.

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



Alliance and Programmes

Sexual Health

Update Month

January 2024

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

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

STI rates in Lambeth have increased in recent years, as with London and England. STI rates need to be interpreted alongside testing rates - further data shows that testing rates have also increased in Lambeth. High testing is necessary to identify and treat STIs to prevent further cases. It is likely that the roll out of the new IT systems within the Local Trusts will affect in-clinic capacity levels for a period of time.

Take up of LARC in primary care has generally been increasing since Q2 22/23. Lambeth has a higher LARC prescribing rate than London but lower than England.

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

Nationally available data and evidence shows some groups have a higher need for sexual and reproductive health and persistent inequalities exist. Strong links exist between deprivation and STIs, teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM), trans and non-binary people, young people, and people from Black, Asian and Multi-Ethnic groups.

Regarding LARC uptake, currently this data does not allow us to demonstrate changes in inequalities. Improving ethnicity coding and recording in future will facilitate this. Being able to view the data across PCNs will help to identify whether there are inequalities in access to LARC for different locations and gaps in service provision. Changes to the commissioning of these services and data collection arrangements may give opportunities to improve ethnicity coding and reporting in 2024. Other data sources (an audit of online contraception) demonstrate inequalities in access to contraception by ethnic group. Repeat EHC use is proportionally higher in people of Mixed and Black African ethnicities.

In 2023 analysis of our E-service data was undertaken by a Master's research student and supervised by a PH Consultant. There is further work to be done but initial findings show different usage by different communities and across ages. We will consider these initial findings with our planned promotional campaign to raise awareness on the online service and sexual health service access more generally and use planned engagement opportunities to understand this further.

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

High STI rates are a reflection of a wide range of factors including population characteristics, uptake of testing services, knowledge of good sexual and reproductive health and health promotion. A range of services play a role in improving sexual health.

Challenges: SRH clinics are seeing residents with increasing complexity, partly a consequence of simple cases being redirected to the e-service (as intended) but also our soft intelligence indicates that some individuals are presenting with increased complexity of needs due to multiple factors and a lack of resource or capacity elsewhere within the health and social care system. Activity is also lower due to staffing / capacity issues and the impact of strikes.

Actions: We have developed a dashboard to better enable analysis of activity at Trusts. We are also undertaking analysis of inequalities in e-service use to inform actions to reduce inequalities. A new contract for the integrated sexual health service at KCH, to be in place from April 2024 (GSTT's to go live later in 2024), will seek to reduce STIs and inequalities in STIs. A model for outreach and health promotion services is being developed to provide further targeted services to those with the greatest need and/or barriers to access.

Data and engagement with residents point to an unmet need in terms of contraception availability and access. Availability and ease of accessing appointments, choice of contraceptive method and awareness and education on contraception services are some of the drivers for this.

Actions: Increasing appointment availability and funded training to increase LARC fitters through LARC and ISHS re-procurements; development of the Find Sexual Health website booking system to make it easier to find/book contraceptive appointments including LARC; increasing awareness and education of available services and different contraceptive methods; further engagement with underrepresented cohorts to inform all services, including targeted outreach services.

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



Alliance and Programmes

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

Update Month

January 2024

indicator ID	Measure	Latest period	Latest period position	Previous period Position*	vs previous Period*	Latest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
F1	Uptake of the NHS Health Check for all eligible adults	Dec-23	711	591	120	5.8%	6.2%	-0.4%	Baseline = cumulative % uptake of those eligible vs position at same point in 22/23	Increase
F1	uptake of SMI health checks	Dec-23	324	270	54	39.6%	34.6%	5.0%	Baseline = cumulative % uptake of those eligible vs position at same point in 22/23	Increase
F1	Uptake of LD/AHC health checks	Dec-23	152	122	30	55.2%	53.2%	2.0%	Baseline = cumulative % uptake of those eligible vs position at same point in 22/23	Increase
F2	proportion of Bowel Cancer screening for those aged 60-74	Apr-23	60.5%	60.6%	-0.1%	60.5%	60%	0.5%	Baseline = National Target	Increase
F2	proportion of Cervical Cancer Screening aged 25-64	Aug-23	62.7%	62.9%	-0.2%	62.7%	80%	-17.3%	Baseline = National Target	Increase
F2	proportion of breast cancer screening for women aged 50-70	Apr-23	52.6%	51.6%	1.0%	52.6%	80%	-27%	Baseline = National Target	Increase

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

F1.2 Uptake of SMI health checks & F1.3 Uptake of LD/AHC health checks- Since the last report no new outcomes data on diagnosis and support for conditions is available for NHS Health Checks. Quarter 3 outcomes data is due end January 2024. Overall activity remains on track and in line with baseline. According to the data Lambeth is reporting to NHSE, the rate of uptake of health checks is increasing and it is anticipated that targets will be achieved by March 2024.

F2 Cancer Screening programme: We will contribute to meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred for suspected cancer receive a timely diagnosis and increase the % of cancers diagnosed at stages 1 and 2 by 2028. We will improve rates of all cancer screening programmes thus improving early Bowel, Breast and Cervical cancer diagnosis for our Lambeth residents:

Bowel Cancer Screening:

- Lambeth have achieved above the National standard of 60%.
- The Catch 22 non-responder calling project will further support the uptake of bowel cancer screening. The Catch 22 multi-lingual facilitators have contacted over 7,000 Lambeth residents who have not participated in bowel screening. The project has been extended to support all 41 Lambeth practices and should see the full impact of this, with a further increase in uptake by Feb/March 2024.

Breast Cancer Screening:

- Uptake figure indicates a 1% increase since the last reporting period.
- Continued work is underway to improve coding of activity and data quality issues, and increase the uptake of Breast screening.
- Breast Screening PMS preparatory year, focused on understanding how practices can be supported with improving their coding and contacting non-responders, imbedding breast screening Arden templates and training provision is being delivered.
- Breast screening awareness campaigns targeting Lambeth communities to raise awareness of the breast screening programme.

Cervical Cancer Screening:

- Uptake figure indicates we are lower than the national standard
- Ongoing activity to increase uptake is underway, this consists of working closely with Southwark Place to produce Cervical screening social media campaigns which will target specific groups known to have less participation in cervical screening.
- Lambeth Healthwatch will be undergoing research to support the campaigns, identifying barriers to uptake, looking at specific groups who have the lowest uptake.
- Targeted work with refugee and asylum seeker population, faith and community groups and with Portuguese /Spanish speaking groups

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



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

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

F1.2 Uptake of SMI health checks & F1.3 Uptake of LD/AHC health checks- Since the last report no new demographic or inequalities data is available for NHS Health Checks. Local data show that access to health checks is about even between broad ethnicity categories. The table below shows the percentage of each ethnicity having completed health checks:

There are opportunities to review equalities in other areas such as outcomes.
Please note the data in the table was extracted in a different point in time from the scorecard data.

Population	Asian	Black	White	Other
LDA	52%	56%	52%	49%
SMI	50%	48%	46%	45%

F2 Cancer Screening programme - There is no available breakdown of population health data to clearly identify populations in need, work is ongoing to capture this data across all screening programmes.

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

F2 Cancer Screening programme:
Workforce capacity- Unable to commence some projects due to lack of workforce and funding to take on extra projects

- EZ analytics cancer screening data show variances and inaccuracies in comparison to SEL dashboard. Therefore, opted to use Cancer Screening Data (sharepoint.com) for better accuracy .
- There are differences between EZA data and Cancer Population Insights Dashboard (sharepoint.com) data for the 3 screening programmes due to different business rules being used, which is outside of our control.

Next steps:

- To understand variation in data, identify where data reconciles and determine acceptable marginal tolerances to ensure consistency when reporting on this information.
- To capture inequalities data from current and future projects and work with analytics teams across the system on reporting

Additional Comments

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



Alliance and Programmes

NWDA (Owner)

Update Month

January 2024

Indicator ID	Measure	Latest period	Latest period position	Previous period Position*	vs previous Period*	Latest overall position	Baseline	Overall position vs Baseline	Comments	What does good look like
G1	proportion of people with Type 2 diabetes who receive 8 checks on an annual basis	Dec-23	66.5%	60.8%	5.7%	66.5%	58%	8.7%	Latest position = cumulative position year to date. Previous Period = same position for same period last year. Baseline = Position as of Dec 23 57.8%	Increase
G3	Cardiovascular dashboard, HYP aged 79 or under and last BP is less than or equal to 140/90 this FY	Dec-23	56.5%	52.9%	3.6%	56.5%	58%	-1.3%	Latest position = cumulative position year to date. Previous Period = same position for same period last year. Baseline = Position as of Dec 23 57.8%	Increase
G3	Cardiovascular dashboard, HYP aged 80 or over and last BP is less than or equal to 150/90 this FY	Dec-23	69.8%	67.0%	2.8%	69.8%	58%	12.0%	Latest position = cumulative position year to date. Previous Period = same position for same period last year. Baseline = Position as of Dec 23 57.8%	Increase
G4	proportion of people over age of 75 who are taking 10 or more medicines, having a medication review	Nov-23	405	319	86	23.7%	1.4%	22%	Baseline = April 2023 position Latest position = number of cumulative reviews completed in year	Increase

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

- Blood pressure control measures for both age groups are cumulative measures starting from April 2023. Improvement is seen towards the 77% year-end target with more people in Lambeth having BP control than at the same time last year. At the end of 2022-23, Lambeth met the ambition for patients aged 80 or over, but more work is needed for those aged 79 or under. Focussed work continues in prioritising those cohorts who are not controlled and who are from the Black and Ethnic Minority population. Health Equity Champions have been recruited to support hypertension work as per PCN focus. Lambeth Together joined the national 'Know Your Numbers Week public campaign' in September where 117 staff took up the opportunity in Brixton Civic Centre to measure BPs. Promotion of the EZ analytics measure for reducing health inequality in hypertension, was discussed and promoted at LTC Update Webinar. 75% of community pharmacies have signed up to offer the national hypertension check service and service activity continues to grow. Focussed hypertension training events for primary care staff at non clinical PLT and at nurse forum completed in December. CESEL will be providing support to targeted practices in Q4.
- The Lambeth ambition for the proportion of people with Type 2 diabetes, who meet all 8 Care Process metrics, is to reach a minimum of 77% or improve from baseline (National Diabetes Audit 22-23 percentage) by 10 percentage points. The measuring period aligns to the National Diabetes Audit 15 month measuring period January 2023 to March 2024 and is cumulative over this period. Year on year performance has increased.
- The number of Structured Medication Reviews (SMR) in Lambeth patients who are 75 years or over and prescribed 10 or more medicines is progressively increasing. 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, with this risk increasing with the number of prescribed medicines and for specific therapeutic combinations. In conjunction with the patient, SMRs provide a holistic medication review to ensure prescribed medicines are safe, effective and personalised to patients' current needs. SMRs undertaken as part of a patient-centred, holistic approach to healthcare have been shown to improve outcomes, reduce unnecessary or inappropriate prescribing and polypharmacy, reduce harm and improve patient outcomes.

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



Alliance and Programmes

NWDA (Owner)

Update Month

January 2024

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

The Chronic Pain register is the total number of patients coded as having chronic pain in Lambeth General Practices. The work to create and maintain the register is relatively new and started in April 2022-23. For this financial year 2023-24, practices are being asked to maintain the list, and also begin a programme of clinical chronic pain reviews in order to implement the NICE guidance. This work began in July and in 15th September 2023, there were **28918 patients** on the register and **72 reviews** had taken place. 1st January 2024, there were **29111 patients** on the register and a total of **165 reviews** have now taken place.

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

- The Cardiovascular app within EZ analytics has been updated for 23-24 to provide more detailed ethnicity data. Current data shows that hypertension control in the Black African, Black Caribbean, Mixed White and Asian, Unknown or not stated ethnic groups is improving, with comparable rates of target blood pressures being reached across all ethnicities. Year on year performance across target ethnicities and all ethnicities has increased also.
- The Diabetes app within EZ Analytics has been updated for 23-24 to capture ethnicity data. Currently data shows that the proportion of people from Black, Asian or other ethnicity groups who have had their 8 Care Processes measured and completed is increasing as more annual reviews are undertaken. Year on year performance across the measured groups has also increased.
- Overprescribing can lead to increased harm from unnecessary or inappropriate prescribing. By ensuring medicines are being used appropriately, we can reduce adverse effects, hospitalisation and improve outcomes, which may impact on those with greater health inequalities. The data shows a continual increase in SMRs conducted since inclusion in the 2023/24 Medicines Optimisation Section (of the Lambeth GP Improvement Scheme), and we continue to work with colleagues across SEL on reducing inappropriate prescribing and polypharmacy as further evidence emerges.

We now need data on who is receiving the chronic pain reviews, and some further thought on how to increase the number at a faster rate which addresses any inequity. Healthcare usage data may assist this, as will further education and training for clinicians. We will consult with the Social Prescribing Link Workers for their insights and opinions.

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



Alliance and Programmes

NWDA (Owner)

Update Month

January 2024

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

Challenges include General Practice capacity, access, patient awareness and engagement. General Practice is being supported to focus on improvements in these outcomes through the Lambeth General Practice Improvement Scheme – LTC section and Premium Specification KPIs focussing 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. 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. The Neighbourhood Wellbeing Delivery Alliance project in hypertension supports our drive to reach the BAME populations through targeted interventions such as community research and reflecting the patient voice in our local pathways.

On Chronic Pain,

1. We were waiting for searches so that all practices can identify the long-term frequent attenders who also have chronic pain. The provider has not delivered, and so alternatives are now being sought.
2. Another challenge is the lack of a consistent community-based pathway for patients who have chronic pain, particularly complex chronic pain. Early discussions are underway with ICB & Trust colleagues on developing an MDT service to discuss complex cases.
3. Our Social Prescribing Link Workers have been working with people on the Chronic Pain Register to assist with developing a personalised care plan, and we need to collate this activity.
4. We are also awaiting the evaluation of some of the pilot projects, for example PEACS (Pain: Equality of Care and Support in the community) project. This is a new care pathway being developed for people living with chronic pain in Lambeth and has been piloted in Stockwell.

Additional Comments



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

Alliance and Programmes **LWNA and CYPA (owners)**

Update Month **January 2024**

indicator ID	Measure	Lastest period	Lastest period position	Previous period Position*	vs previous Period*	Lastest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
H1	average wait times for triage and initial assessment following a referral to the Living Well network Alliance Single Point of Access to be under 72 hours by 2024	Dec-23	19.2	10.3	8.9	19.2	36.1	-16.9	Baseline = April 23. Reporting average waiting time (in days) for urgent introductions only	Decrease
H2	access to Lambeth Talking Therapies for Black African and Caribbean residents	Q2 23/24				1638	1184	455	Baseline = New Black or Black British clients in 22/23 divided by 4 x 2 (for Q2)	Increase
H2	Recovery rates access to Lambeth Talking Therapies for Black African and Caribbean residents	Q2 23/24				44%	45%	-1%	Baseline = 22/23 recovery rate for Black or Black British clients	Increase
H5	Proportion of children and young people with eating disorders are seen by a clinician within 1 week for urgent appointments and 4 weeks for routine support	Oct-23	100.0%	100.0%	0.0%	100.0%	83.0%	17.0%	Baseline = National Target Lastest position = cumulative % within target vs position at same point in 22/23	Increase
H5	Number of children and young people waiting longer than 44 weeks for an assessment and commencing treatment with	Oct-23	17.0%	17.0%	0.0%	17.0%	12.3%	4.7%	Baseline = March 22/23 position	Decrease

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

Data on wait times for triage and initial assessment show that recent improvements have not been sustained, with measures after the holiday period almost returning to their unacceptably high levels seen in mid-2023. A business plan for significant change to address this issue will shortly be considered by Alliance management. Given budgeting arrangements, IAPT access is expected to be higher in the first half of the year and lower in the second, however results for the third quarter were both under target and below the trend established in the corresponding quarter of 2022-23. Overall IAPT recovery rate continues to improve, however the rate for Black service users continues to fall behind the all service average.

H.5.1 Proportion of children and young people with eating disorders are seen by a clinician within 1 week for urgent appointments and 4 weeks for routine support –The analysis indicates a trend of consistent adherence to established benchmarks, with a note of low figure occurrences. It has been suggested that the separation of routine and urgent referrals in reporting may offer additional insights.

H.5.2 Number of children and young people waiting longer than 44 weeks for an assessment and commencing treatment with Child and Adolescent Mental Health Services – There has been a noted increase in the instances of 44+ WW. This trend can be attributed to the increased demands on the neurodevelopmental pathway and the services for assessing attention deficit hyperactivity disorder (ADHD), compounded by the repercussions of industrial actions.

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

H.5.1 Proportion of children and young people with eating disorders are seen by a clinician within 1 week for urgent appointments and 4 weeks for routine support – The data does not highlight any inequalities. Information obtained from the Child and Adolescent Mental Health Services (CAMHS) 4-Borough pack currently does not include ethnicity breakdown, or pathway compliance/drop-off data.

H.5.2 Number of children and young people waiting longer than 44 weeks for an assessment and commencing treatment with Child and Adolescent Mental Health Services – The data does not suggest any inequalities. Figures from the 4-borough pack demonstrate a congruence with the data from neighbouring boroughs.



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

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

<p><i>Does the data/intelligence identify any health inequalities and whether they are reducing?</i></p>	<p>The data on wait times does not indicate any significant disparity in waiting times between service users based on their ethnicity. Access to Lambeth Talking Therapy for Black residents has historically been lower than expected given Lambeth demographics. The most recent data shows that efforts to address this are being effective, with Black access rates now being 2 full percentage points higher than expected. Despite focused efforts to address the issue, the recovery rate for Black service users remains slightly under the baseline from the previous financial year and 6 points below the overall average in the corresponding period.</p>
<p><i>What are the challenges hindering any progress and are there actions which can be taken to address these?</i></p>	<p>Reducing SPA wait times is highly sensitive to both staff numbers and team productivity, both of which were significantly reduced over the holiday period. A business case for change to address both concerns is being made to Alliance Leadership.</p> <p>IAPT has made significant progress in advancing access for Black services users, but recovery rates remain a challenge, with Black service users starting with more serious problems than the all service average. The service has increased ethnicity awareness and trauma sensitivity training for therapists and has undertaken exit interview with service users not deemed recovered, to understand any specific issues that they encountered.</p> <p>H.5.1 Proportion of children and young people with eating disorders are seen by a clinician within 1 week for urgent appointments and 4 weeks for routine support –The current dataset from the Child and Adolescent Mental Health Services does not include an ethnicity breakdown or details on pathway compliance and continuity. Although, given this is a specialised national service, and local numbers are low, having this breakdown may only be meaningful when viewed at a national level or locally over a bigger date-range.</p> <p>H.5.2 Number of children and young people waiting longer than 44 weeks for an assessment and commencing treatment with Child and Adolescent Mental Health Services – Within the neurodevelopmental pathway, patients receiving medical treatment for ADHD are supported by CAMHS up to the age of 18, which necessitates substantial ongoing care. Currently, the patients who have been waiting the longest for service are those awaiting ADHD assessments. The assessments are conducted by a dedicated, specialised team, which is a process presently being evaluated for enhancement.</p> <p>Enhanced patient-reported outcome measures (increased paired CGAS), segmented by demographic categories such as age, gender, and ethnicity, would enhance the monitoring of progress towards Outcome H.</p>
<p><i>Additional Comments</i></p>	<p>For all referrals to CAMHS, a 28-day national standard across all services and pathways will be instituted, guaranteeing that a plan, signposting, advice, or initial intervention is offered in a timely manner. Discussions are in progress to define precise metrics to accurately monitor performance against this standard, which will be outlined in the subsequent slide. It is anticipated that this approach will have a beneficial effect on the management of waiting lists.</p> <p>Furthermore, there are specific ADHD quality improvement plans currently in the discussion phase. The goal is to reduce waiting times and enhance triage efficiency (for instance, issuing outcome questionnaires sooner to facilitate quicker assessments).</p>



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

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

indicator ID	Measure	Latest period	Latest period position	Previous period Position*	vs previous Period*	Latest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
11	usage of consultant connect by primary care	Oct-23	613	554	59	4,232	4,689	-457	Baseline = cumulative calls this financial year vs position at same point in 22/23	Increase

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

Consultant connect allows GPs real-time specialist advice and so allows the patient to receive their care in the community rather than in hospital. The latest data shows that consultant connect utilisation is around between April and October 2023 is around 10% lower than the same period in the previous year.

However, Lambeth continues to have the highest utilisation of the service when compared to the other 5 boroughs in South East London having a consultant connect activity rate of 9.1 per 1,000 population. (Southwark 5.0, Lewisham 4.0)

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

Data/Intelligence as it stands does not identify any indication health inequalities are reducing. Further work is required to capture ethnicity data/intelligence across the various services provided at neighbourhood level.

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

There is perceived variation between practices because data/intelligence is not consistently captured across all 41 practices. Pre-Pandemic Service Improvement Facilitators (SIF) were commissioned to support practices/PCNs record data/intelligence effectively. Resource should be identified to reinstate this important work going forward.

Additional Comments

- Important actions to support progress:
- Reinstate SIF support
 - Consultant Connect standardised template adopted to record patient outcome
 - Relevant searches set up to identify reduction in health inequalities



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

Alliance and Programmes

NWDA (Owner) with contribution from Substance Misuse

Update Month

January 2024

indicator ID	Measure	Lastest period	Lastest period position	Previous period Position*	vs previous Period*	Lastest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
J1	proportion getting an appointment with their GP practice within two weeks and this includes all populations and those who contact their practice urgently are assessed the same or next day according to clinical need	Oct-23	90.5%	89.2%	1.3%	90.5%	85.0%	5.5%	Previous Period = Year end position 22/23 Baseline = national target (85%)	Increase
J8	capacity of virtual wards	Nov-23	148	148	0	148	161	-13	Baseline = Target capacity for that period	Increase
J8	proportion of virtual wards being used	Nov-23	74%	80%	-6%	74%	80%	-6%	Baseline = Target occupancy for that period Previous position = Target capacity for that period	Increase

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

J4 Number of people accessing healthcare professionals through increased use of community pharmacies & J5 Number of people using the community

- The Lambeth Pharmacy First Plus Pilot was launched in March 2023 to address and support the health inequalities in Lambeth in relation to the impact of the cost-of-living crisis on the ability of the local population to self-care and buy medicines available over the counter for minor and self-limiting conditions in line with NHS England guidance. Community Pharmacy have undertaken 1216 consultations between March – November 2023 with Lambeth residents/registered patients to provide advice and guidance on self-care and supply of medicines where appropriate.
- The GP-Community Pharmacy Consultation Service increases GP capacity through triaging of low-acuity conditions to community pharmacy. GP referrals to GP-CPCS, whilst no longer incentivised via the national contract, supports the national approach to increasing GP access. The Pharmacy First service additionally 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.

J8 Capacity of virtual wards - Recruitment to teams expanding current capacity i.e. Palliative Care and IRT, remains ongoing, as well as therapy posts to the @Home service. @Home implemented their additional beds from late November and a negotiation with the Palliative Care team agreed to increase their reported capacity – Lambeth and Southwark are now providing 201 beds.

Doccla utilisation remains challenging. IRT went live with their pathway towards the end of October, beginning of November, which saw a brief increase in referrals to Doccla, however IRT quickly discovered that there was a need to find a solution to manage clinical escalation and support weekend working and so they paused their referrals until this could be organised. Discussions planned with the @Home service to help support these issues with the expectation that IRT will pick up referrals again in the New Year.

Discussions with the heart failure team to develop a Doccla pathway have been organised and a plan in place to implement in early January. A mid-point reflection session took place in late November with key stakeholders and a number of issues highlighted and resolved. This group will continue and support the Doccla evaluation which is scheduled between February and April 2024.



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

Alliance and Programmes

NWDA (Owner) with contribution from Substance Misuse

Update Month

January 2024

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

J4. Number of people accessing healthcare professionals through increased use of community pharmacies & J5. Number of people using the community

- Data from March to November 2023 shows most interventions (931) 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, 55% of patients would have gone without medication and 44% would have visited general practice to request the medication on prescription, as they are unable to buy the medicines over the counter to deal with minor conditions due to the current cost of living crisis. People who are receiving support through universal credit, income support, the NHS Low income Scheme or are under the age of 16 years old, are the top social vulnerability eligibility groups accessing Lambeth Pharmacy First Plus Service in November 2023.

J8 Capacity of virtual wards - e disparity of service provision for Integrated Respiratory services continues to remain an issue for the south of the Boroughs. KCH colleagues are fully engaged and seeking to find a solution with a proposal for consideration by the VW Programme Steering Group for funding with reference to affordability and feasibility.

A similar issue has been highlighted for palliative care services where St Christophers provide community palliative care. Discussions are organised to resolve the issue and ensure an equitable provision for residents in the north and south of the boroughs.

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

J4. Number of people accessing healthcare professionals through increased use of community pharmacies & J5. Number of people using the community

- Increased promotion of both the Lambeth Pharmacy First Plus service and the Community Pharmacy Consultation Service is needed amongst local GP practices. The Medicines Optimisation Team has linked in with the Local Authority Cost of Living Programme Lead to discuss continual and increased promotion of the service to local residents. The Medicines and LTC Team is continually promoting the services via local bulletins to GP practices, has increased direct local communications to GP practices in areas of low engagement and with GP practices who support the IAC (Initial Accommodation Centre)/ Asylum Seekers Contingency and bridging hotels.
- General Practice feedback has been that the pilot has had a positive impact for patients and reduced GP appointments for minor conditions however access across all Lambeth Pharmacies is needed to improve equity of access.
- Community Pharmacy neighbourhood leads (CPNLs) are being given additional hours to engage with general practice and their peers to provide clinical leadership and support the national access priority.
- The Community pharmacy dashboard launched in October, providing CPNLs with up to date data to inform pharmacies and GP practices of referral, uptake and benchmarking rates of Community Pharmacy services, such as the GP-CPCS service.

Additional Comments

J4. Number of people accessing healthcare professionals through increased use of community pharmacies & J5. Number of people using the community - There will be a national rebranding of the GP-CPCS and other clinical services provided through community pharmacy to 'Pharmacy First'. This will now include a further 7 conditions which can be assessed and treated through pharmacies, including provision of antibiotics and other treatments. This is not to be confused with the local Pharmacy First Plus pilot, which addresses inequalities in access to medicines over the counter for a different range of conditions. The local pilot has been rebranded to Lambeth Pharmacy First Plus.



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

Alliance and Programmes	NWDA (Owner)
Update Month	January 2024

Indicator ID	Measure	Latest period	Latest period position	Previous period Position*	vs previous Period*	Latest overall position	Baseline	Overall position vs Baseline	Comments	What does good look like
K1	number of people with an intermediate care offer	Nov-23	61	62	-1	453	515	-62	Baseline = cumulative accepted referrals to reablement this financial year vs position at same point in 22/23	Increase
K1	number of people who have a reduced need for care at the end of this service.	Sep-23	80%	84%	-4.0%	84%	78%	6.0%	Baseline = March 23/24 position	Increase
K2	proportion of carers of the users of Adult Social Care Services are offered a carers assessment.	Sep-23	97%	98%	-1.0%	97%	98%	-1.0%	Baseline = March 23/24 position	Increase
K3	Proportion of people identified as being in their last year of life on practice registers	Q2 23/24	1,954	1,937	17	1,954	1,651	303	End of Life Register. Baseline = register as at Q4 22/23	Increase
K3	Proportion of people with Personalised Care and Support Plan(PCSP)/UCP	Q2 23/24	47%	46%	1%	47%	42%	5%	Baseline = % of those on the End of Life Register at at Q4 22/23	Increase

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

The number of accepted referrals to Reablement has decreased. This is because the Reablement service have an improved triage. The result is that a number of people are reporting they no longer require therapy and they have been removed from the waiting list. This is a temporary measure to reduce the number of people waiting. There is also some work happening in the Discharge Operational Delivery Group working with therapists on the acute wards about the criteria for referring to reablement. This will help to reduce the number of people being referred to the service who are not appropriate.

The number of people who have a reduced need for care at the end of a period of Reablement has increased and this is positive. Following the mock inspection in ASC are now including those people referred for therapy only (no care needs). By including therapy only referrals we have improved the number of people who have a reduced need for care at the end of the service.

We have a high performance rate for the proportion of carers of service users who were offered a carer's assessment. The baseline is 98% and this has decreased slightly to 97%. We are planning some practice sessions with staff to maintain our performance in this area. We will be using staff members identified as Carer's Champions to help deliver this training.

The data attached within this report shows the uptake of flu vaccinations for carers as at 28th November 2023. Latest figures from EZ Analytics dated 9th January shows an overall uptake of 26.5% (990 vaccinations) and is showing a small increase week on week. This is in line with previous year's uptake for carers in Lambeth. The updated Carers Strategy has recently been published and looks to encourage more Carers to notify their GP Practices of their role. The data activity is shared at practice level to ensure there is an 100% offer to all Carers. Carers can access their vaccinations at their GP Practice or at their local pharmacy.

- Residents survey -
- There wasn't really any difference between groups part from those living with a disability were more likely to say they were not receiving the support they need. No difference for those 65-74 and 75+
 - We will be working with health and care colleagues to develop an actions as part of the Age Friendly action plan



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

Alliance and Programmes	NWDA (Owner)
Update Month	January 2024

<p><i>What does the data/intelligence indicate around progress against the outcome?</i></p>	<p>K3.1 Proportion of people identified as being in their last year of life on practice registers and K3.2 Proportion of people with Personalised Care and Support Plan(PCSP)/UCP outcome measure indicates positive progress against the outcome, based on improved identification of patients in their last year of life and increased proportion of people with PSCP / UCP. Both measures increased (improved) in Q2 23/24 and previously increased throughout 2022/23.</p>
<p><i>Does the data/intelligence identify any health inequalities and whether they are reducing?</i></p>	<p>The majority of reablement referrals come via the hospital discharge route. We are increasing the number of people who are offered a reablement service via our front door team in Adult Social Care in order to offer reablement to people living in the community at home.</p>
<p><i>What are the challenges hindering any progress and are there actions which can be taken to address these?</i></p>	<p>Recruitment has been a challenge particularly recruitment of therapists for the reablement service.</p> <p>The Discharge Operational Delivery Group has a dedicated workstream looking at the reablement pathway from the ward to the internal flow hub and then on to the service to try and improve the process and ensure referrals to the service are appropriate. The calls to people on the waiting list has been described above.</p> <p>For end-of-life identification and conversion to PSCP / UCP (K3.1 and K3.2) further discussion between end of life and Primary Care leads required to identify specific challenges and potential actions – agenda item for 17 January Lambeth and Southwark End of Life Group. Further coordination between Commissioning and Primary Care planned to review the measure descriptors and identify if these can be improved.</p>
<p><i>Additional Comments</i></p>	



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

Alliance and Programmes

CYPA (Owner)

Update Month

January 2024

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

We are currently enhancing the process for updating activity data from maternity providers in Lambeth, which has delayed the latest updates to the South East London Local Maternity & Neonatal System (SEL LMNS) dashboard. Lambeth maternity providers and SEL LMNS are aware of the need for timely data and are diligently working to address this. The ultimate aim of SEL LMNS is to introduce a maternity dashboard that will offer a detailed overview of local activity and enable effective monitoring of outcomes. In collaboration with the Lambeth Early Action Partnership (LEAP), the Children & Young Person Alliance (CYPA) is evaluating the LEAP data platform. This evaluation aims to align with the "Our Lambeth, Our Health" strategic plan, identifying how the platform can support current and future tracking of health outcomes. CYPA is exploring additional data-linkage tools to enhance our understanding of maternal health and its determinants. A collaborative effort with King's College Hospital, Guy's & St Thomas' Hospital, LEAP, and SEL LMNS has produced a report on Lambeth Maternity Services for review by the Adult Social Care & Health Scrutiny Sub-Committee. This allows for a review of current initiatives, assessment of maternity care disparities, and provision of recommendations for improvements, ensuring a comprehensive oversight.

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

The CYPA and Lambeth Intelligence lead recently met with colleagues leading the ELIXIR The 'Born in South London' project. The project is aiming to build up a cohort of patients from conception to birth and beyond to study their 'life-course health' as well as understand how ethnicity and deprivation impact upon early years health. Another aim is to identify and act upon the facts that cause the current disproportionately high rate of maternal and infant for South London's Black population.

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

Challenges around data flow has impacted the ability of the CYPA to track impact measures under this Outcome. Data flows have now been re-established which will allow work to recommence of development of the South East London Maternity dashboard. The dashboard is currently being tested LMNS colleagues with ongoing discussion taking place regarding a standard dataset for each of the south east London boroughs

Additional Comments

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



Alliance and Programmes	LDA (Owner)
Update Month	January 24

indicator ID	Measure	Latest period	Latest period position	Previous period Position*	vs previous Period*	Latest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
M3	rate of uptake for an Annual Health Check and Health Action Plan for those with LDA	Oct-23	34.2%	28.1%	6.1%			-	Baseline = cumulative position to date vs same period last year	Increase

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

For all outcomes measure see the Deep Dive to LTAG given on 19/09/2023 for a detailed description of progress up till end Aug 23.

Update since last report:
 M1. number of children and adults discharged from specialist inpatient units - Two discharges to the community from inpatient Assessment and Treatment Units
 M3. rate of uptake for an Annual Health Check and Health Action Plan for those with LDA - Uptake of AHCs continues to track ahead of progress this time last year. As at 31/12 49.2% of those on the GP Register have had the check. The number of people on the register has increased to 1,619 which means that more people will have access to the benefits of the AHC and care plan.

M2. measures on Number of people with LDA in work and Education, and number of supported employment and supported internships we create through our health and care partners – no updates since the last report. M4. Waiting times at for an ASD diagnosis for children and young people – due to EPIC implementation reporting functions are still being validated to ensure data quality and integrity. Once these verification processes are completed and ratified, we will be able to report on this impact measure.

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

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

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



Alliance and Programmes: **LWNA (Owner)**
 Update Month: **January 24**

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

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

30 day readmission data shows no change on average over the last two quarters, however these are a significant improvement in performance against the first quarter, which was the worst performing quarter under the Alliance. This indicates that efforts to review discharge protocols were and are being successful. However, the current numbers remain broadly higher, on average, than in previous years and the latest position remains over the baseline set for the year.

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

Analysis of 30 day readmissions measure does not include a breakdown by ethnicity, but it is very unlikely that any such analysis would be meaningful given the relatively low numbers involved.

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

Demand for inpatient beds increases year on year and, while capacity remains constant, there is inevitably pressure to discharge as soon as appropriate community support can be arranged and any risks can be assessed and managed. The need for multi-agency coordination around discharges is fully recognised. A process involving daily multi-agency meetings to review discharge plans is in place to ensure that discharged patients are both medically ready and have appropriate on-going support in place.

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



Alliance and Programmes

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

Update Month

January 2024

indicator ID	Measure	Latest period	Latest period position	Previous period Position*	vs previous Period*	Latest overall position	Baseline	Overall position vs Baseline	comments	What does good look like
Q1	number of people resettled into longer-term accommodation	Q2 23/24	3%	3%	0%	3%	5%	-2.0%	Baseline = Q4 22/23 position	TBA
Q1	number of rough sleepers brought into accommodation	Q2 23/24	58	71	-13	58	38	20	Baseline = Q4 22/23 position	TBA
Q3	proportion of people living in our supported housing that are registered with a GP	Q2 23/24	79%	75%	4%	79%	74%	5%	Baseline = Q4 22/23 position	TBA
Q4	rate of residents in supported housing engaged with mental health support services.	Q2 23/24	14%	12%	2%	14%	12%	2%	Baseline = Q4 22/23 position	TBA

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

Last year 2022/23 saw a steep rise in rough sleeping numbers with 623 people seen compared to 438 the year before. The increase was mainly driven by people who were new to rough sleeping which accounted for just over two thirds of the total (417) compared to 260 the previous year.

Up until the end of December this year we have already seen over 600 rough sleepers with three months still remaining towards the overall yearly total. Intelligence so far shows us that this is again being driven by new rough sleepers mainly from Lambeth. The main reasons being given for rough sleeping are loss of private rented accommodation or being asked to leave by friends or family. The cost of living crisis is thought to be the main factor behind this alongside an unaffordable private rental market. The next highest number is people losing supported accommodation although these are not necessarily Lambeth services

The severe weather protocol (SWEP) has been enacted twice in the last two months with very high take up of accommodation offers. During the January SWEP Lambeth stood up 28 SWEP places across the Vulnerable Adults Pathway (more than twice the usual amount) which were taken up in the first two days. As a result of this we opened an Emergency Rest Centre in the Assembly Room at Lambeth Town Hall offering 10 overnight bed spaces over a 4 night period which was used by 9 individuals over the period.

The make up of the new rough sleeping cohort is mainly people with no to low support needs who are just seeking support to get back into accommodation and do not require supported housing. The move on option for these people is private rented sector accommodation which is increasingly hard to access both in terms of cost and supply. Across London there has been a sharp increase in former asylum seekers sleeping rough but the numbers in Lambeth, for now, are very low

The increase in rough sleepers has driven the numbers of people classed as Living On The Street to between 40-50 people at any given time since July this year compared to the average of 20-25 previously. The clear and obvious implication of this is that peoples physical and mental health needs will increase the longer they remain on the street. The Lambeth Vulnerable Adults Pathway is running at capacity and the emergency hotel accommodation funded by the Rough Sleeping Initiative (RSI) grant are also full with waiting lists. We are meeting with DLUHC to agree the repurposing of some parts of the RSI grant to fund extra hotel accommodation although it is unlikely this will meet the total demand.

Finance



Finance: South East London ICB: Lambeth



Overall Finance Position (M9)

	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	900	356	544	1,200	810	390
Community Health Services	19,241	17,600	1,641	25,654	23,845	1,809
Mental Health Services	15,811	15,851	(40)	21,055	21,055	(0)
Continuing Care Services	23,971	24,841	(870)	31,961	33,108	(1,147)
Prescribing	29,049	31,948	(2,900)	38,664	42,497	(3,833)
Prescribing Reserves	405		405	607		607
Other Primary Care Services	2,579	2,455	124	3,439	3,274	165
Other Programme Services	1,986	192	1,794	2,648	256	2,392
Delegated Primary Care Services	60,028	60,028	0	80,040	80,040	0
Corporate Budgets	4,358	3,693	665	5,811	4,873	938
Total	158,327	156,965	1,363	211,079	209,758	1,321

Overall Savings Position

	Year to date Plan £'000s	Year to date Delivery £'000s	Year to date Variance £'000s	Annual Plan £'000s	Forecast Delivery £'000s	Forecast Variance £'000s
Efficiencies embedded within 2023-24 starting budgets	(1,744)	(1,744)	0	(2,325)	(2,325)	0
Additional Vacancy Factor	0	(600)	600	0	(600)	600
Continuing Care Services	(1,312)	(1,299)	(13)	(1,834)	(1,809)	(25)
Prescribing	(1,159)	(1,059)	(100)	(1,611)	(1,493)	(118)
Total	(4,215)	(4,702)	487	(5,770)	(6,228)	458

- The borough is reporting an overall £1.4m year to date underspend position and a forecast year-end position of £1.3m favourable variance at Month 9 (December 2023). The reported year to date position includes £0.9m overspend on Continuing Healthcare and £2.5m overspend on Prescribing (inclusive of reserve), offset by underspends in some budget lines and includes the impact of recovery action (£2.9m) and implementing freeze on new financial commitments.
- The underlying key risks within the reported position relate to the Prescribing and Continuing Healthcare budgets and further risk against the Integrated Community Equipment Service Contract (Health and Social Care) with NRS. In addition to the reported position there are risks against implementation of self-referral for the Community Adult Audiology Service, increasing demand/significant waiting times of ADHD service and cost of Primary Care Estate projects.
- The CHC team continues to deliver on reducing packages for high-cost cases including for 1:1 care, LD clients and transitions cases. The team is also working locally with Adult Social Care commissioning colleagues to develop provision particularly in context of place-based needs. Lambeth has been subject to disproportionate rates for some services but work at place is ongoing to establish better value costs. The number of active CHC/FNC clients in M09 is 602.
- Prescribing month 9 position is based on M07 2023/24 actual data as the PPA information is provided two months in arrears. The year to date overspend of £2.5m is driven by increase in demand, price/supply pressures due to Cat M/ NCSO and Long-Term Condition drug prescribing. All ICBs are experiencing similar impact. The borough Medicines Optimisation team are working on saving initiatives via local improvement schemes including undertaking visits to outlier and selected practices to identify further opportunities around prescribing efficiencies, working with community pharmacy to reduce waste and over-ordering, etc. The team is delivering the savings plan as practices progress with local improvement plans in-year.
- The 2023/24 borough minimum savings requirement is £4.7m and has a savings plan of £5.8m. In addition to the embedded efficiency (£2.3m) as part of the budget setting process, the borough has saving plans for both Continuing Healthcare (£1.8m) and Prescribing (£1.6m) budgets. Year to date delivery at M09 is £0.5m above plan mainly due to additional vacancy factor. All existing and future expenditure/investment is being scrutinised to ensure key priorities are delivered within confirmed budgets.

Finance: Lambeth Council – Adults & Health M6 position



	OUTTURN 22/23 (£000)	FULL YEAR BUDGET 23/24 (£000)	FULL YEAR FORECAST 23/24 (£000)	VARIANCE (£000)
ADULT SOCIAL CARE	100,759	111,206	116,374	5,168
INTEGRATED COMMISSIONING	223	133	133	-
SENIOR MGMT – A&H	1,481	1,464	1,464	-
PUBLIC HEALTH	1,266	-	-	-

ASC Service Groups	Full Year Budget (£000)	Full Year Forecast (£000)	Variance (£000)
ADULTS WITH LEARNING DIFFICULTIES	42,567	46,441	3,874
ADULTS WITH MENTAL HEALTH NEEDS	13,196	13,388	192
OLDER PEOPLE	29,926	32,352	2,426
OTHER – ADULTS	6,408	4,102	(2,306)
ADULTS WITH PHYSICAL DISABILITIES	13,086	14,247	1,161
SUPPORTED HOUSING	1,170	1,170	-
SUPPORTING PEOPLE	4,853	4,673	(180)

£5.1m forecast overspend, with budget pressures relating almost solely to third party expenditure on packages of care

Main pressure areas:

- £3.8m overspend in Learning Disabilities with key issue of high acuity of new clients resulting in increasing costs of community-based care.
- £2.4m overspend in Older People with home care and nursing care being key issues with higher acuity and greater numbers.
- Inflationary increase in new placement costs in all areas with particular impact in OP nursing care.

Main mitigations:

- Systematic review of high-cost placements to ensure these are appropriate and whether lower care cost options can be developed or further increases can be limited
- Reducing residential placement referrals where possible and increasing support at home.
- Alternatives to supported living being sought in some high acuity cases.
- Overspend can be met in year by reserves and other short-term funding will also be utilised.

Quality



Insight from the South East London People's Panel



SEL ICB put in a successful application to NHS England for funding to establish a People's Panel which was match funded by the ICB. The ICB appointed Jungle Green, an independent agency, to recruit members via face-to-face recruitment methods on the street and at community events. The panel is currently made up of 1,050 members of the public broadly representative of the SEL population according to the 2021 Census according to age, gender, ethnicity and borough. The panel enables the ICS to understand the views and experiences of a broadly representative sample of local residents to inform and shape services, so they meet the needs of local people.

The first survey was carried out as part of the recruitment process during January – March 2023 and May to August 2023. The second survey was carried out for two weeks during September and October 2023.

For the first survey, 18% of the total number of people surveyed were from Lambeth (n=194/1083).

The second survey had a response rate of 23% (n=233) across SEL. This number is much smaller than the first survey.

Please note that the second survey results were not broken down by place probably due to the small numbers.

The link below provides more information on the two surveys

[South East London People's Panel | Let's Talk Health and Care South East London \(letstalkhealthandcareselondon.org\)](https://letstalkhealthandcareselondon.org)

Key highlights for Lambeth from the first survey is as below:

- 85% of Lambeth panellists rated feeling healthy which is the highest compared to other SEL boroughs
- 33% of Lambeth residents reported feeling lonely which is above the SEL average of 31%
- The following issues were reported as being at the top of Lambeth panellists' minds:
 - 28% - cost of living
 - 18% - my health and wellbeing
 - 6% - environment – compared with 3% for SEL overall
- For the top single most effective action that people can take to keep themselves healthy and well, Lambeth panellists highlighted:
 - better living conditions/improved housing - notably 13% Lambeth compared with 11% in SEL overall.
 - eat more healthily – notably 11% Lambeth compared with 6% for SEL overall

These key findings in Lambeth and other places in SEL, along with feedback from other engagement activities (focus groups, listening sessions, outreach, etc.) will help inform the work the SEL ICB is doing in partnership with Citizens UK to understand what actions different institutions such as: NHS, local councils, universities, etc. can take to support people and communities to thrive.

This insight will inform the ICB year-round campaign to help people navigate the NHS. This will be centred around the needs of the public and the benefit to the individual when using different services.

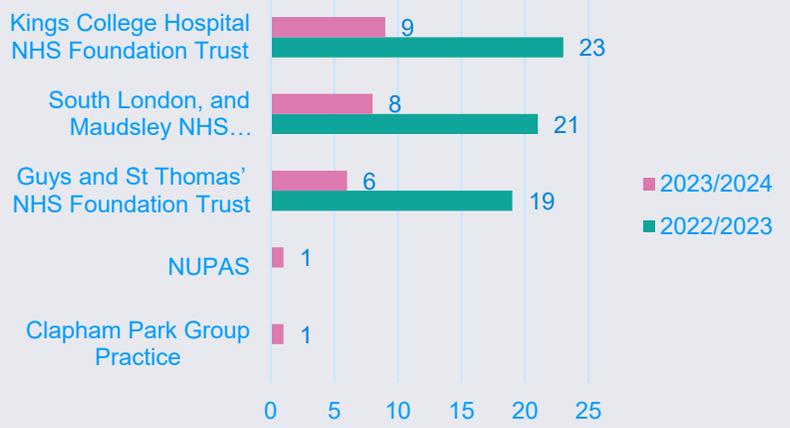


Serious Incidents Involving Lambeth Patients

Serious Incidents Reported Per Month April 2021 - To Date

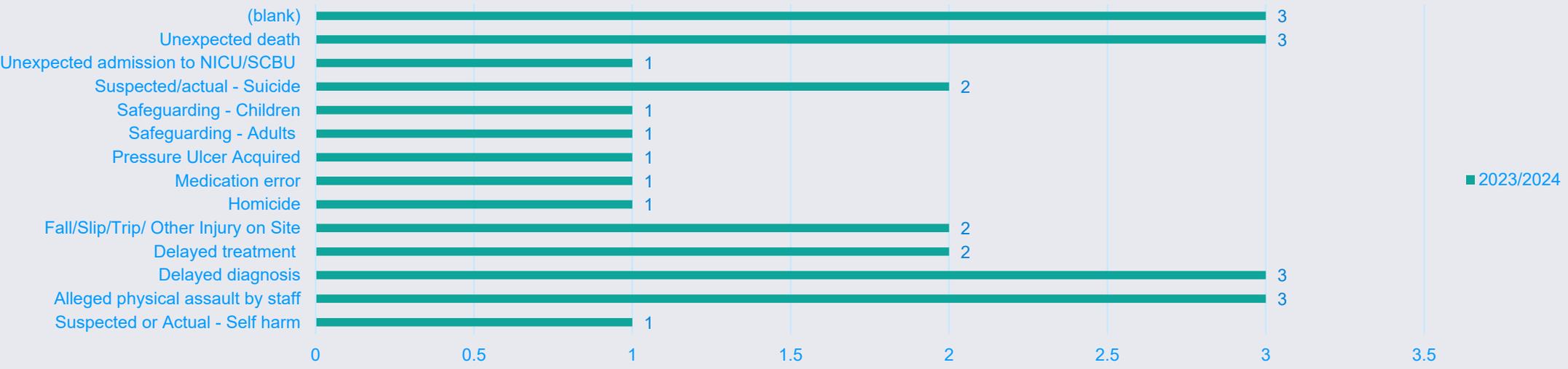


Serious Incident Reported by Trust



It is important to mention that the implementation of the new Patient Safety Incident Response Framework (PSIRF) by the SEL major providers has impacted the level of serious incidents reporting in 2023. With the new framework, the focus is now more on improvement and sharing learning.

Serious Incident Reported By ICB Theme



Patient Safety Update



- Following the death of a 14-year-old with a severe pancreatic injury at KCH, a new pancreatic injury pathway had been developed which has been adopted nationally. In addition, they have extended their simulation training to include the recognition of sepsis and human factors. The trust has invested in the procurement of a high-fidelity mannequin to support simulation training. They have also introduced an iMobile team to support staff across the trust. The team sits independently of ITU and provides a 24/7 service.
- Given the rise in violence and aggression incidents across all providers, SEL ICB is working to co-design a strategy to improve staff and patient safety. Discussions were held at the System Quality Group on the underlying causes for the increase and there was agreement that there were two populations types which present the highest risk: Alcohol and drug users and those presenting in mental health crisis; It was agreed that there is a need to ensure patients are seen at the right time, right place and by the right service. To explore these issues, a clinical huddle for clinical directors is being convened to review these types of incidents, boost the Violence & Aggression Network, consolidate information and develop an SEL strategy.
- A serious incident involving a patient's access to insulin has led to a SEL review which will include the Medicines Optimisation Team, Primary Care and Safeguarding. The patient had tried on a number of occasions to obtain a prescription from their GP and pharmacist. However, the brand was out of stock. The patient was admitted to

the ICU with Diabetic Ketone Acidosis, hyperkalaemia and acute kidney injury.

- Two stakeholder events have been held with Mental Health and Acute Providers. All of whom are in the process of embedding and various stages of transition to the new Patient Safety Incident Response Framework (PSIRF).
- One stakeholder event has been held with Independent Service Providers; some of whom are beginning their PSIRF journey whilst others, are in the process of transition.
- SEL has begun to review providers' PSIR Plans for final sign off between January and March 2024 by the ICB Quality & Performance Committee.
- SEL have begun the transition to the Learning from Patient Safety Events database (LFPSE). However, due to current limitations of the system NHSE will continue to use STEIS for reporting of Patient Safety Investigations until October 2024.
- Board Oversight Training around PSIRF is being sought for SEL.
- 3 Patient Safety Partners have been recruited. Currently they attend System Quality Group, Learning from Death Group and Themes & Concerns Group.

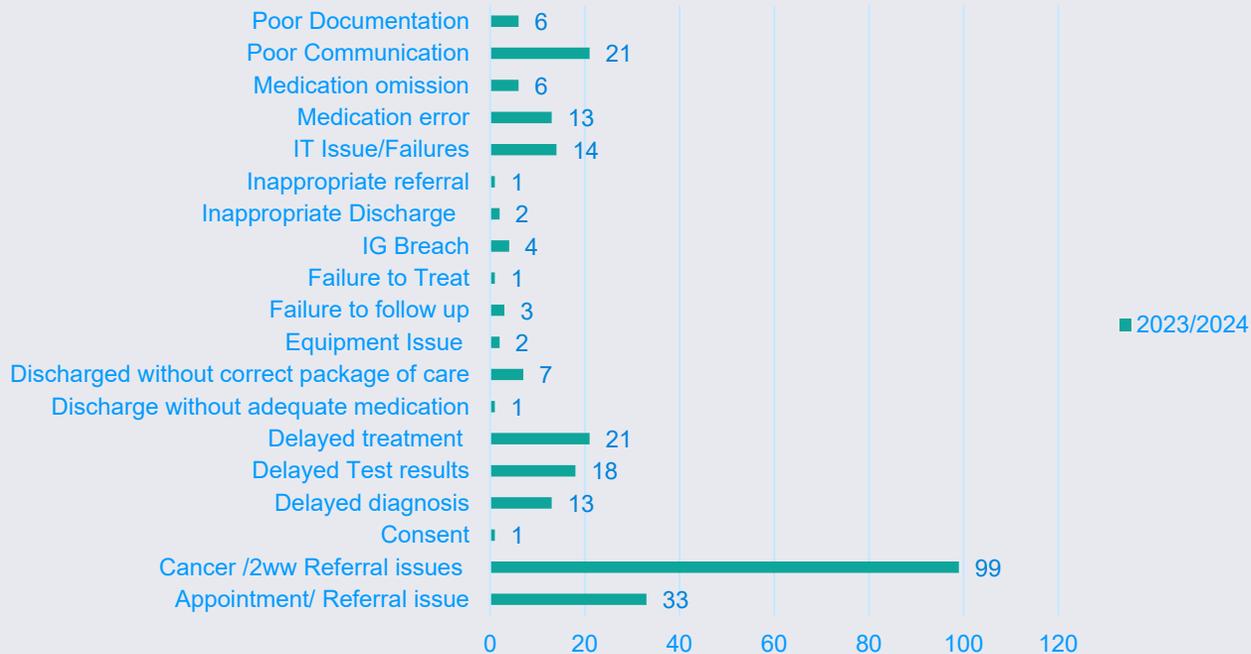
Lambeth Quality Alerts



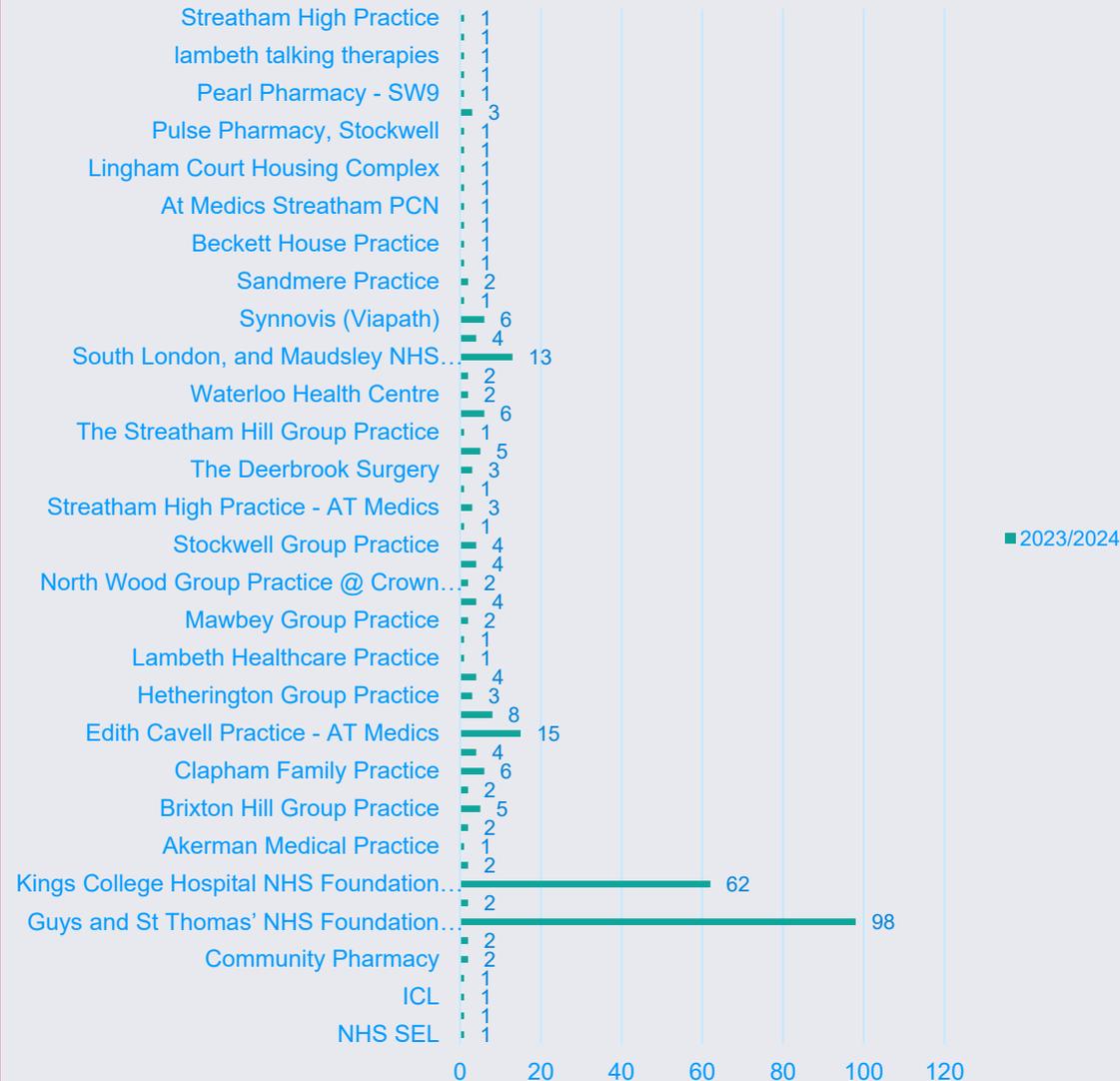
Quality Alerts Reported Per Month April 2021 - Date



Themes from Quality Alerts Raised



Quality Alerts Raised Against Organisation



Emerging Concerns and Themes from EPIC Related Quality Alerts



Emerging Concerns

- Hospital Discharge Summaries – summaries are challenging to read and actions for GPs are not usually clear.
- Appointment / Clinic Letters - Patients not consistently receiving appointment / clinic letters
- Delays in secondary care outpatient appointments.
- Laboratory Reports – incorrect test requests, reports coming unmatched, etc

ICB Actions and Next Steps

- The ICB has organised regular sessions that bring together all the various stakeholders to discuss these concerns. These include GSTT, KCH, Synnovis, GP Partners, etc
- Synnovis is putting significant effort/resource into the investigation and the number of issues is reducing.
- Practices are encouraged to continue to raise quality alerts relating to EPIC and other issues.

Update from GSTT and KCH Re: Defer to provider

King's College Hospital and Guy's and St Thomas' are aware that more services than usual have required patients to be referred as 'deferred to provider' rather than directly bookable since early October. 2023.

The vast majority of services are now re-open and available for direct booking; where the referral needs to be 'deferred to provider', the trusts are managing subsequent appointment booking manually. GPs should continue to refer directly where possible, and 'deferred to provider' where required.

All remaining clinics which have previously been directly bookable are now back to normal since mid-December, as the trusts continue to update booking systems.

Where the above has led to delays in confirming appointment dates for patients, compared to direct booking processes, the trusts have apologised and are working rapidly to complete the final work.

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.

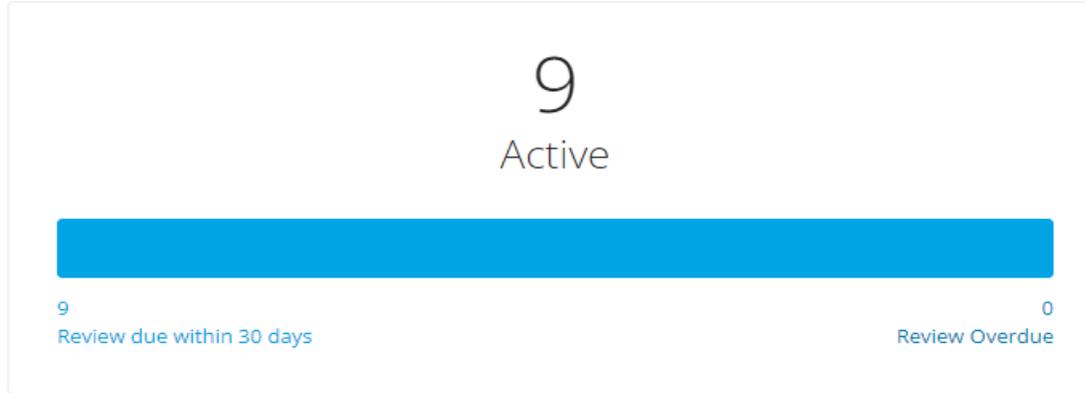
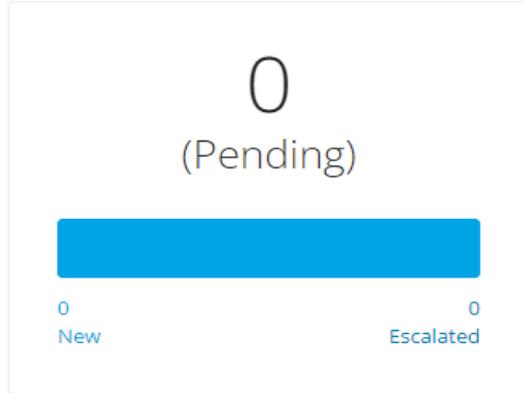
Lambeth Risk Register

- 9 active risks currently held on the Lambeth Together risk register.
- All 9 risks have been reviewed and are up to date, with no changes to risk scores. These slides represent the position as of 16th January 2024.
- No further risk identified for addition to the risk register. And no risk closed in December and so far in January.
- CHC overspend risk subsiding and budget recovery plan is working and providing the required level of mitigation.
- Safeguarding Children risk fully mitigated by the local authority partner. A review is underway to confirm this position.
- All risks are within the appetite threshold prescribed by the ICB. No escalation was required following the latest review.
- GP healthcare services at the Waterloo Health Centre and the Lambeth Walk Surgeries are secured and ongoing with minimal threat to local healthcare provision and the local health economy. The initial risk of loss of premises due to expiring leases have been fully mitigated through the acquisition of a temporary accommodation and extension of a lease agreement. Further work is ongoing for a long-term permanent solution.

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.



Likelihood ▾	Consequence				
	Negligible	Minor	Moderate	Major	Catastrophic
Almost Certain	0	0	0	0	0
Likely	0	2	1	0	0
Possible	0	3	2	1	0
Unlikely	0	0	0	0	0
Rare	0	0	0	0	0

Risk highlights



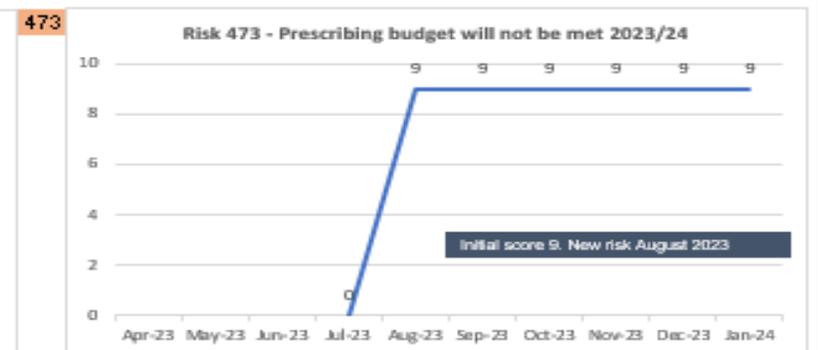
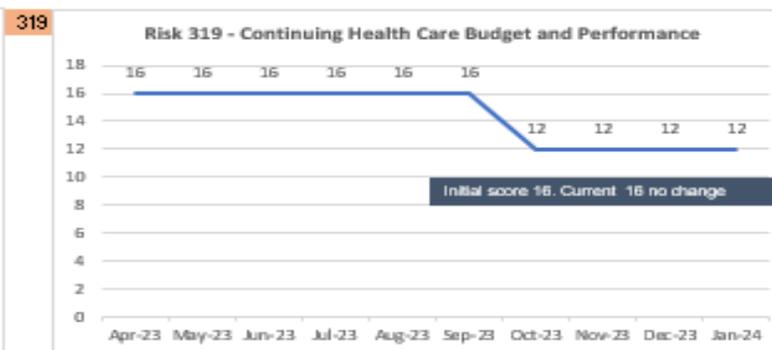
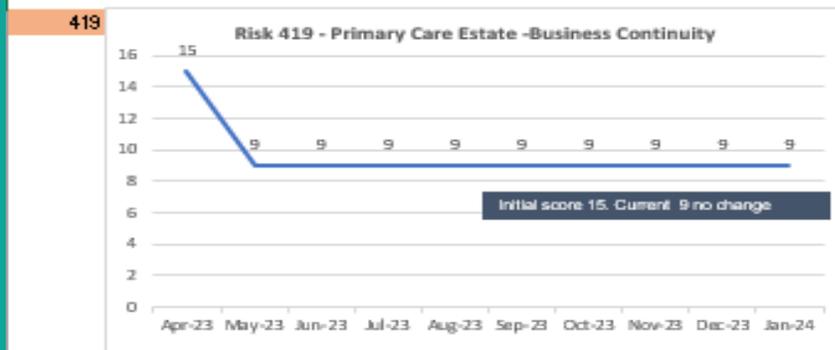
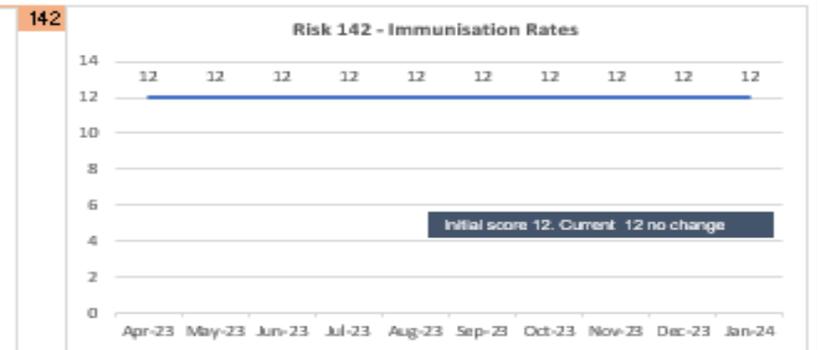
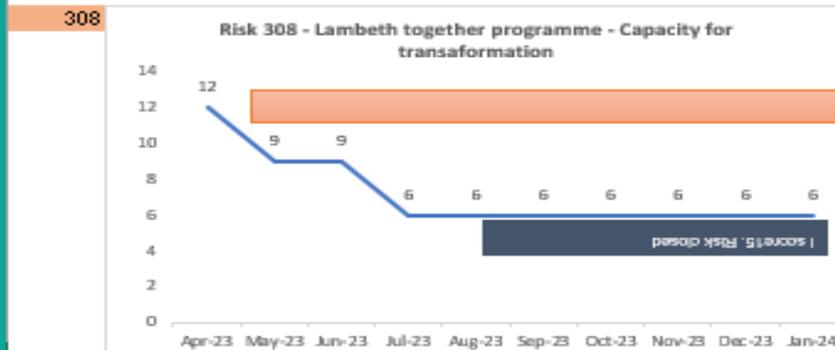
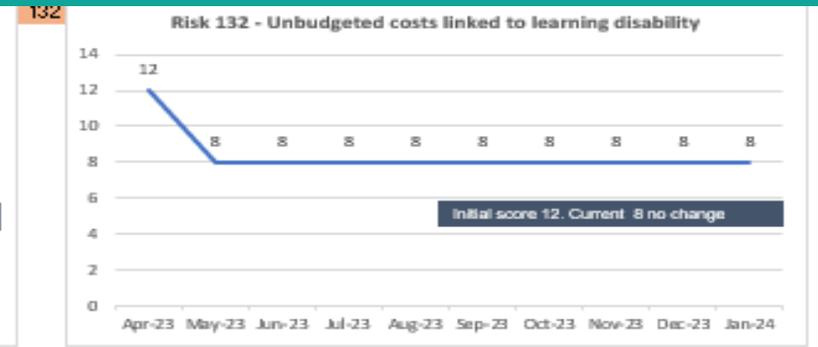
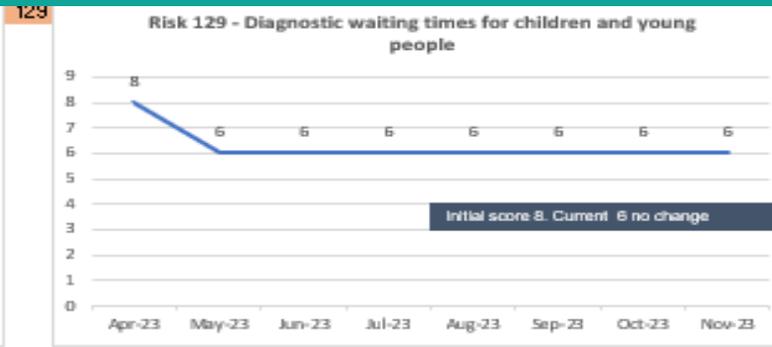
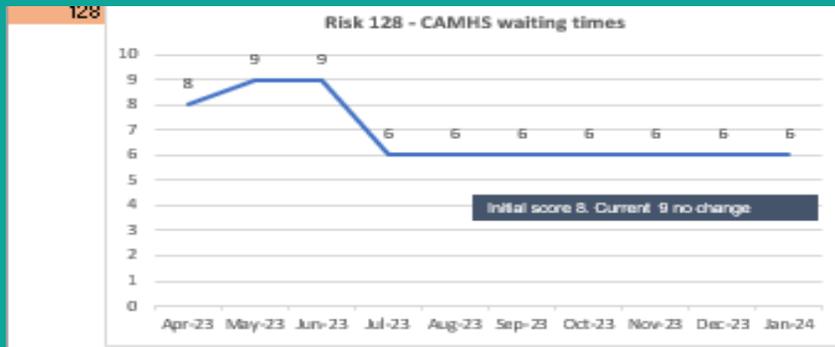
Director / lead	leads for the 7 priority areas, lead commissioners
Management Lead	Andrew Eyres, each of the leads for the 7 priority areas, lead commissioners
Data source / period	SEL BAF, Highlight reports x 7 / Enabler reports.

Risk #	Title	Risk Category	Current Rating	Target Rating	Risk Threshold	Next Review
127	CAMHS waiting times	Strategic	6	3	12	31/01/2024
128	Diagnostic waiting times for children and young people	Strategic	6	4	12	31/01/2024
132	Unbudgeted costs linked to learning disability	Finance	8	6	12	31/01/2024
135	Safeguarding of Adults	Clinical, Quality and Safety	8	6	9	31/01/2024
142	Immunisation Rates	Strategic	12	3	12	31/01/2024
308	Lambeth Together, Capacity for Transformation	Operations	6	4	15	31/01/2024
318	Continuing Healthcare Budget and Performance	Finance	12	8	12	31/01/2024
418	PCC and Premises [Business Continuity]: - Waterloo Health Centre - Lambeth Walk Group Practice	Clinical, Quality and Safety	9	9	9	31/01/2024
472	Prescribing Budget and Performance	Finance	9	6	12	31/01/2024

Risk highlights



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



Lambeth Integrated Health and Care Directorate Business Plan Update



Integrated Health and Care Business Plan Q3 23/24



Inphase Business Plan Q3	Percentage Complete.	Status
Adult Mental Health Good health & wellbeing with an improved healthy life expectancy for those with the poorest outcomes		
Access: Reduce wait times for initial assessment through monitoring and reviews.	75%	Green
Health Inequalities: Increase performance of SMI health checks.	75%	Green
Adults Commissioning Good health & wellbeing with an improved healthy life expectancy for those with the poorest outcomes		
Quality and safety: Improve standards and oversight through PAMMS	75%	Amber
Adults Social Care Good health & wellbeing with an improved healthy life expectancy for those with the poorest outcomes		
Continue to encourage and lead cross departmental working.	75%	Green
Ensuring equality, diversity and inclusion is championed: embed EDI strategy.	75%	Green
Prevention: Develop and continue approach to helping population to remain as independent as possible	75%	Green
Work continues to align business processes to deliver the Adult Social Care Reform agenda.	75%	Green
Adults Transformation Good health & wellbeing with an improved healthy life expectancy for those with the poorest outcomes		
Cancer - Work collaboratively with primary care to increase the uptake of cancer screening	75%	Green
Adults with Learning Disabilities Good health & wellbeing with an improved healthy life expectancy for those with the poorest outcomes		
Focus on LDA Health Inequalities	75%	Green
NHSE Learning Disability and Autism Programme	75%	Green
Children and Young People Good health & wellbeing with an improved healthy life expectancy for those with the poorest outcomes		
Design and deliver a Single Point of Access (SPA) for Children and Young People	50%	Amber
Pull together a comprehensive dataset for Lambeth women using maternity services.	50%	Amber
Recommission Domiciliary Care and CHC framework.	50%	Green
Support Special Educational Needs and/or Disabilities (SEND) inspection preparation.	75%	Green
Good health & wellbeing with an improved healthy life expectancy for those with the poorest outcomes Long Term Conditions Optimisation		
Long Term Conditions optimisation: Reducing health inequalities and improving access.	75%	Green
Good health & wellbeing with an improved healthy life expectancy for those with the poorest outcomes Medicines Optimisation		
Medicines value: Identify high-value, quality initiatives for medicines optimisation	75%	Green
Good health & wellbeing with an improved healthy life expectancy for those with the poorest outcomes Primary Care and Transformation		
Deliver a Primary Care Commissioning programme	50%	Green
Ensure the continuation of high quality access to general practice.	50%	Green
Good health & wellbeing with an improved healthy life expectancy for those with the poorest outcomes Public Health		
Health Determinant Research Collaboration - Staff training and development	85%	Green
Health Protection - Redesign childhood Immunisations to meet challenge of low uptake	90%	Green
Sexual Health - Re-modelling South East London Sexual Health Trust Contracts	75%	Green
Staying Healthy - Develop and implement approaches to improve access to health improvement Services	75%	Green
Staying Healthy - To make Lambeth an Age Friendly Borough	75%	Green
Substance Misuse - Further development and embedding of the Combatting Drugs Partnership	75%	Green

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

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

The table provides a summary of the areas of focus within the 23/24 plan. In Q3, we can report majority actions have recorded a green status which shows progress towards year end objectives.

There were three actions where amber status was recorded, one on Adults commissioning and two on Children and Young People service lines. The reasons behind this score relate to programme delays due to the complexity with delivery of some deliverables, particularly on SPA design and impact on reporting structures due to EPIC implementation.

South East London ICB Corporate Objectives & delegated assurance metrics



South East London ICB Corporate Objectives & delegated assurance metrics



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.

Future reports will include narrative around metrics listed which are not already covered elsewhere within the report

Further clarification has been sought from the SEL ICB Assurance team on how a number of the benchmark positions have been derived

Standard	Period covered in report	Comparator	Benchmark	Lambeth current performance	Previous period performance	SEL Average	Above/below SEL average?	SEL Borough rank	SEL Corporate Objective?
Dementia diagnosis rate	Nov-23	National standard	67%	75%	64.3%	69.8%	Above	2	No
IAPT access	Oct-23	Operating plan	1118	970	940	N/A	N/A	-	No
IAPT recovery rate	Oct-23	National standard	50%	50%	48%	50.0%	Equal	3	No
SMI Healthchecks	Q2 - 23/24	Local trajectory	2773	2713	N/A	N/A	N/A	-	Yes
PHBs	Q2 - 23/24	Local trajectory	544	280	N/A	N/A	N/A	-	No
NHS CHC assessments in acute	Q2 - 23/24	National standard	0%	0%	N/A	0%	N/A	-	No
CHC - Percentage assessments completed in 28 days	Q2 - 23/24	Local trajectory	60%	35%	N/A	65.0%	below	6	No
CHC - Incomplete referrals over 12 weeks	Q2 - 23/24	Local trajectory	1	2	N/A	N/A	N/A	6	No
Children receiving MMR1 at 24 months	Q2 - 23/24	England average	89%	83%	N/A	86.7%	below	5	No
Children receiving MMR1 at 5 years	Q2 - 23/24	England average	92%	88%	N/A	88.6%	below	6	No
Children receiving MMR2 at 5 years	Q2 - 23/24	England average	84%	79%	N/A	79.8%	below	6	No
Children receiving DTaP/IPV/Hib % at 12 months	Q2 - 23/24	England average	91%	88%	N/A	88.1%	below	6	No
Children receiving DTaP/IPV/Hib % at 24 months	Q2 - 23/24	England average	93%	88%	N/A	90.3%	below	3	No
Children receiving pre-school booster (DTaPIPv%) % at 5 years	Q2 - 23/24	England average	83%	77%	N/A	76.8%	below	6	No
Children receiving DTaP/IPV/Hib % at 5 years	Q2 - 23/24	England average	93%	88%	88.3%	90.1%	below	6	No
LD and Autism - Annual health checks	Oct-23	Local trajectory	518	718	490	N/A	N/A	-	Yes
Bowel Cancer Coverage (60-74)	Apr-23	Corporate Objective	67%	61%	N/A	65.8%	below	6	Yes
Cervical Cancer Coverage (25-64 combined)	Jul-23	Corporate Objective	69%	63%	N/A	66.5%	below	6	Yes
Breast Cancer Coverage (50-70)	Apr-23	Corporate Objective	57%	53%	N/A	58.1%	below	5	Yes
Percentage of patients with hypertension treated to NICE guidance	Q1 - 22/23	Corporate Objective	70%	64%	63.7%	64.1%	below	5	Yes
Flu vaccination rate over 65s	31/12/2023	Previous year	56.8%	56.4%	N/A	65.7%	below	6	Yes
Flu vaccination rate under 65s at risk	31/12/2023	Previous year	33.0%	29.2%	N/A	33.0%	below	5	Yes
Flu vaccination rate – children aged 2 and 3	31/12/2023	Previous year	34.3%	37.4%	N/A	39%	below	3	No