Lambeth together

OUR HEALTH, OUR LAMBETH

Lambeth Together health and care plan 2023-28

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Foreword

This is Our Health, Our Lambeth. As Lambeth Together's health and care plan, it sets out how health and care services in Lambeth will work together, and with residents and communities, to improve health and wellbeing outcomes for people of all ages and from all our communities, over the next five years.

We recognise that we are not an equal borough. We have faced exceptionally challenging times in recent years - significant cuts to public services, Brexit, the Covid-19 pandemic, and the ongoing cost of living crisis. The impacts are not felt equally, and poverty, racism and inequality have worsened health outcomes for many in our community. Together, we must rise to these challenges and be bold in our actions to overcome them – not be afraid to do things differently to support our residents, patients, partners, carers and staff.

We can do better by working together in partnership to transform how we support our patients, carers, and residents. Through Lambeth Together, and our innovative Delivery Alliances, we will work to improve health and care outcomes by building on our already strong relationships, developing programmes of work to address all health and care activity in Lambeth, and prioritising fairness and equity in all we do.

Our focus as a health and care system will be on tackling unfair and avoidable differences in health between different groups of people. To do this, we must support people to lead healthier lives. We must do more to prevent ill health, and provide support earlier if people become unwell. People must have access to a positive experience of health and care services that they trust and that meet their needs.

We are committed to improving the lives of every Lambeth resident, without leaving anyone behind. The key to this will be supporting a range of positive and action-focused approaches that seek to remove unfair and avoidable differences experienced by people with characteristics protected by the Equality Act. In Lambeth, this includes taking an anti-racist approach to build our communities' trust and confidence in our services.

Our plan responds to the priorities, developed by residents and communities, set out in the Lambeth Health and Wellbeing Strategy and the Lambeth Borough Plan, and is aligned with the South East London Integrated Care System's Strategic Priorities. We have developed our plan from the intelligence presented in the Lambeth Health and Wellbeing Strategy, the learned experience of our partners and the lived experience of residents from across our diverse communities. We have set out the changes we want to make, what we need to do to achieve them and what help we need, over the next five years. Our plan is ambitious. We also recognise that we will need to learn from our experiences and adapt to changing circumstances as we go, using research and evidence to continue to understand and act on the causes of health inequity in Lambeth.

Lambeth Together Care Partnership Board Co-chairs

Cllr Jim Dickson

Cabinet Member for Healthier Communities, Lambeth Council

Dr Dianne Aitken

Lambeth GP

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About this document

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

Purpose: To set out how health and care services in Lambeth will work together to improve health and wellbeing outcomes over the next five years

Approved by: Lambeth Together Care Partnership Board

Date: 18 May 2023

Lambeth Together

Lambeth Together is a partnership of the voluntary and community sector, the NHS, Lambeth Council, and others, focused on improving health and wellbeing and reducing inequalities for people in Lambeth through an integrated health and care system.

Our partnership was established in 2017 to improve ways of working across our organisations and with our communities to meet health and care needs across our borough and to plan and coordinate services focused on our local population. In the summer of 2022, we formally became part of the South East London Integrated Care System (ICS), which has been formed in response to the Government's Health and Social Care Act 2022. This was an important milestone in our evolution as a partnership, as we continue to work together to plan and manage the services for which we are responsible.

Working together, we coordinate care across our borough to remove unhelpful divides between hospital and community-based services, physical and mental health, and health and social care. Making services more joined-up, easier to access and better suited to people's needs will help people get the right care and support in the right place, as early as possible and help our population achieve better health in the decades to come.

Why Lambeth Together?

In the past, divisions between hospitals and family doctors, between physical and mental health and between NHS and Council services have meant that too many people experience disjointed care. By joining together locally, we can better support people's health and wellbeing and their experience of care.

Integrating care also makes sense for services that are facing growing pressures. We are all living longer, so people are more likely to need help for illness, or several illnesses, over their lifetime. Lambeth also has a growing population, so it's likely that more people will need to use health services in future.

Helping people with their own health and wellbeing, so they stay well for longer, is better for everyone. Ensuring people have easy access to care when they need it, benefits patients, staff and carers. Having teams that work together across organisations to understand what matters most to people also transforms our staff's experience, enabling them to focus on each individual in a unique way.

Lambeth Together – who we are

There are many different organisations involved. These include:

- community voices, like Healthwatch Lambeth, Black Thrive Lambeth and Patient and Public Voice Members of our Board
- voluntary and community services such as Age UK Lambeth, Thames Reach and Certitude
- and public bodies like Lambeth Council, NHS South East London Integrated Care Board, South London and Maudsley NHS Foundation Trust, Guy's and St Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust, and Lambeth GP practices.

You can read more about our partners and our leadership, including our Board members, here.

As we come from a diverse range of organisations, with different systems and workplace cultures, we recognise it's important to work in a similar way as much as possible. We've developed a vision and a commitment to working together, which includes behaviours that we call the 'Lambeth Together Way'. To find out more about our commitment to working together, read or watch a video of our pledge.

We have prioritised eight population groups and health issues where we will work together to improve health and wellbeing and the way that we plan and manage services. We call these our 'Delivery Alliances' and our Programmes.

Lambeth Together Delivery Alliances and Programmes focus on population groups and health issues where we will work together to improve health and wellbeing. They are responsible for bringing together our partners and people with lived experience to plan and manage initiatives that will join-up services, improve outcomes and address inequalities.

Children and Young People Delivery Alliance

Supporting children and young people in Lambeth to grow up healthy and happy.

Children and Young People Alliance

Staying Healthy Programme

Promoting the health of the Lambeth population and supporting communities to maintain good health and wellbeing.

Homeless Health Programme

Improving health outcomes for people who are homeless or at risk of becoming homeless, (including rough sleepers and refugees).

Neighbourhood and Wellbeing Delivery Alliance

Improving the health and wellbeing of adults by working together in local neighbourhoods.

Neighbourhood and Wellbeing Alliance

Living Well Network Delivery Alliance

Supporting adults in Lambeth who are experiencing mental illness or distress.

Living Well Network Alliance

Learning Disabilities and Autism Programme

Improving outcomes and support for people who are autistic or have a learning disability.

Sexual Health Programme

Improving people's sexual and reproductive health and enabling people with HIV to live and age well, across Lambeth, Southwark and Lewisham.

Substance Misuse Programme

Reducing the harms caused by substance misuse and supporting those using substances to access the right help to meet their needs.

Our Plan

Our plan sets out how health and care services in Lambeth will work together to improve health and wellbeing outcomes over the next five years.

- focuses on supporting people to lead healthy lives, improving prevention and early intervention, and making sure that people have access to and positive experiences of health and care services that they trust and meet their needs. We know that the key to this will be delivering in different ways, supported by a positive and action-focused approach to equity for all protected characteristics including taking an anti-racist approach, to build trust and confidence with our communities
- is ambitious; we know we can do better by working together to transform how we work, to deliver for our patients and residents
- supports developing our ability to become more research active and embed a culture of evidence-based decision making, led by our communities, through the Lambeth HEART programme, to use research and evidence to understand and act on the causes of health inequalities in Lambeth
- responds to the priorities developed by residents and communities as set out in the Lambeth Health and Wellbeing Strategy and the Lambeth Borough Plan and is aligned with the South East London Integrated Care System Strategic Priorities
- sets out our **aspirations** for the borough, our residents, and patients and those who care for them, including what we want to happen, change or improve (our **outcomes**), the **principles** of how we will work, **what we need to deliver the plan** and **how we will know if we are making a difference**.

This is a five year plan with an annual action plan.

This is just the start, and we intend to evaluate, learn, reflect, and refine as we go. As a partnership, we will report on our progress against our action plan at every meeting in public of the Lambeth Together Care Partnership Board (every two months). We will review our plan every year, by reflecting on our activities and impact, and asking ourselves:

- Is this working? Can we do more? Do we need to change course?
- We have delivered what we said we would, what's next?
- We have met that target, should we aim higher?
- We have different data now so should we review this measure or target?
- What are patients and residents telling us?
- What lessons have we learned?
- What is research evidence telling us about the causes of health inequalities in Lambeth and how can we impact these?

We will have a transparent process for agreeing change and we will publish an annual review that will share our progress and plans for the coming year. We will make sure that this is accessible and easy to understand.

To achieve our outcomes, our Delivery Alliances and Programmes will work together to deliver priority actions against them. Delivery Alliances and Programmes will work together to achieve actions, which are collectively owned across our partnership and all our work will focus on those groups and communities that have the poorest health outcomes.

VITAL 5

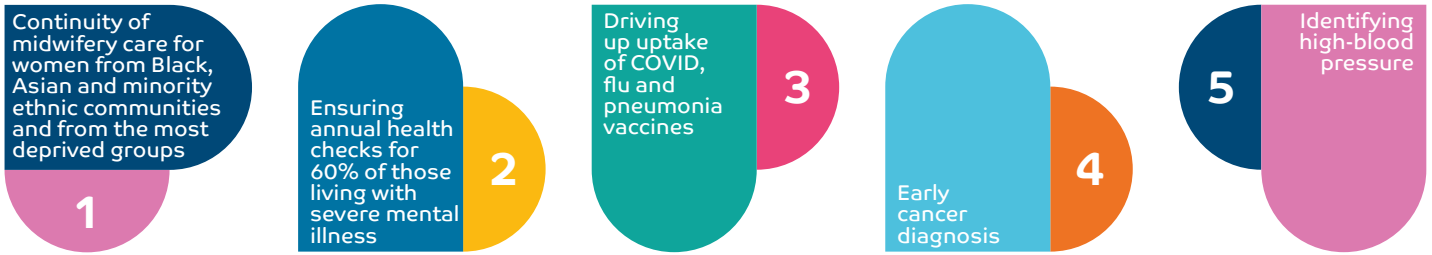
The Vital 5 are five factors that have a major impact on health at an individual and population level. These are blood pressure, obesity, mental health, smoking status and alcohol intake.

We know that focusing on prevention and early detection in these five areas is an effective way of improving outcomes for our population. Our plan has included the Vital 5 throughout as we know that identifying, recording, and sharing the Vital 5 data between all health partners and our patients, and acting on the results across our population, would make the biggest difference to people's health and to the sustainability of health and social care.

(Credit King's Health Partners
https://www.kingshealthpartners.org/our-work/value/vital-5)

THE SEVEN

NHS England has set out five clinical areas that need rapid improvement, in order to tackle health inequalities. These are:



In Lambeth, we have identified two further clinical areas that need rapid improvement in order to tackle health inequalities, based on our local population. These are:

Our aspirations and outcomes

The priorities that we aim to achieve over the next five years are outlined in our Health and Wellbeing Strategy 2023-28; ensuring the best start in life, supporting people to lead healthy lives and have good physical and mental wellbeing and supporting communities to flourish and build their resilience. Lambeth Together has committed to contribute to delivering on these priorities and Our Health, Our Lambeth sets out how we will do that.

Aspiration:

People lead healthy lives and have good physical and emotional health and wellbeing for as long as possible

Outcomes:

- People maintain positive **behaviours** that keep them healthy
- People are connected to **communities** that enable them to maintain good health
- People are **immunised** against vaccine preventable diseases
- People have **healthy mental and emotional wellbeing**
- People have healthy and fulfilling **sexual relationships** and good reproductive health

Aspiration:

Physical and mental health conditions are detected early and people are supported and empowered to manage these conditions and avoid complications

Outcomes:

- People receive **early diagnosis and support** for physical health conditions
- People who have developed **long term health conditions** have help to manage their condition and prevent complications
- When **emotional and mental health issues** are identified, the right help, support and diagnosis is offered early and in a timely way

Aspiration:

People have access to and positive experiences of health and care services that they trust and meet their needs

Outcomes:

- People have access to joined-up and holistic health and care delivered in their **neighbourhoods**
- People know where to go to get the **right help**, and are treated at the **right time**, in the **right place**, for their needs
- **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
- Women have positive experiences of maternal healthcare and there are no disproportionate **maternal mortality rates** among women
- 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
- People using **mental health** support services can **recover and stay well**, with the right support, and can participate on equal terms in daily life
- People who are **homeless**, or at risk of becoming homeless, (including rough sleepers and refugees) have improved health

What will help us deliver our Plan

In developing our plan, we have reflected on and agreed the ways we need to work and what our staff, Partners and residents need, to help us meet our outcomes.

Our principles:

To deliver these outcomes, we need to operate differently. By working together and reflecting on our ongoing engagement with patients and service users, we have developed a set of principles which will guide our work in delivering this plan.

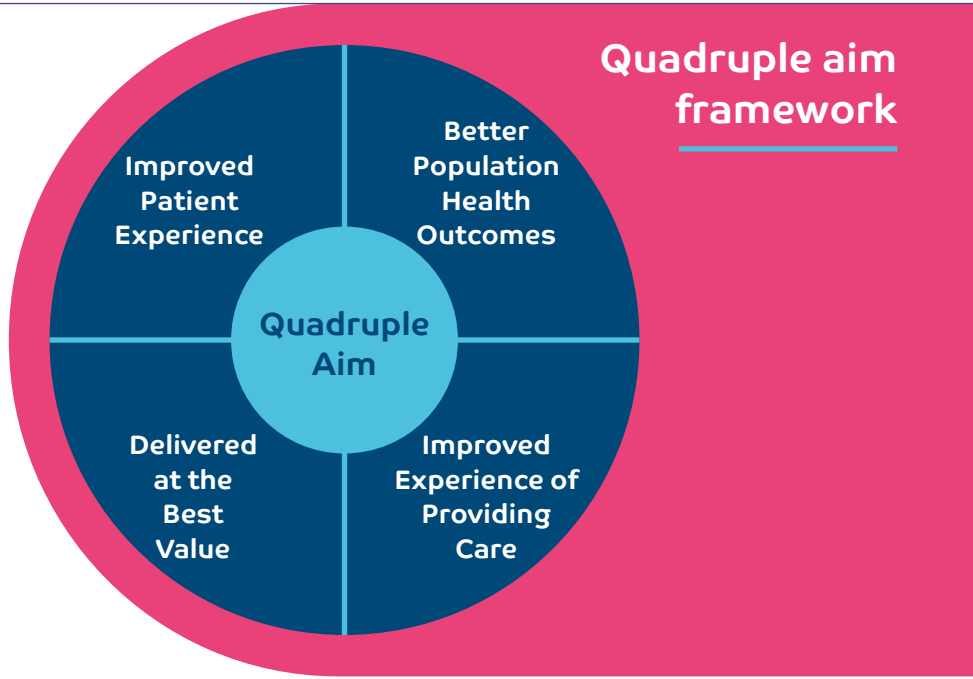
Without these principles being brought to life, it is unlikely we will be able to fulfil the ambition we have outlined. We will pay attention not only to what we want to achieve, but also to what we do and how we change to genuinely live these principles.

We commit to:

- a positive and action orientated approach to equity for all protected characteristics including taking an anti-racist approach, seeking to build trust and confidence with our communities
- an asset-based approach, building and amplifying what is already in the community, starting with the assumption of strengths and trust in Lambeth's communities
- a determined and dynamic approach to integration, which understands that no one organisation has the answers to these complex issues we are attempting to tackle, and that collaboration is essential
- an approach which enables and supports the concept of 'health and wellbeing in all policies', building on what has been achieved since 2016
- undertaking open and participative research, where local people are involved in collecting data and building evidence to inform our decisions.

Our ways of working

- Measure and understand the experience of people accessing our services and use this information to reduce inequalities.
- Commit to and embed equality, diversity and inclusion across all levels of our system with a focus on reducing health inequalities throughout all our work.
- Work together as an effective, well-governed, and transparent Local Care Partnership within an Integrated Care System and in collaboration with other Local Care Partnerships.
- Deliver through our Delivery Alliances and Programmes, with strategic oversight, effective assurance and risk management functions.
- Maintain a whole system approach to providing health and care by focusing on our quadruple aims: improved patient experience; better population health outcomes; improved experience of providing care; and care delivered at best value.



Our workforce

- Support our workforce and their wellbeing, including developing and retaining our staff, and supporting fair pay for care staff as part of Lambeth's Ethical Care Charter.
- Have a workforce that, at all levels, can relate to people's lived experience, is representative of and supports our diverse and intersectional communities.
- Have a workforce that has capacity, is trusted and supported so communities receive a consistent and reliable service.
- Enable our workforce to work together, across organisational boundaries, in an integrated way, including through our Clinical and Care Professional Network.

Digital

- Make sure residents have access to digitally enabled care across health and care settings that are easily accessed, consistent and ensures the right service for their needs.
- Make sure those residents who do not wish to use digital tools and/or are digitally excluded, can still access health and care services at the same level and standard.
- Work with partners across South East London Integrated Care System and beyond to enable sharing of information to support planning and care delivery.

Our communities

- Communicate and engage with our patients and residents using a range of methods, ensuring information is accessible and easy to understand, and listen to patients, residents and community voices, ensuring those voices actively influence improvement.
- Work collaboratively to reduce health inequalities and support healthy neighbourhoods, recognising and supporting our assets in the community including residents, carers, grassroots organisations, volunteers, voluntary and community sector (VCS) organisations and community groups.
- Have 'anchor institutions' that serve the wellbeing of our population by strategically and intentionally managing their resources to help address local social, economic, and environmental priorities to reduce health inequalities.

Buildings

- Encourage all health and care partners to work together in the same buildings to transform service delivery and improve access to care, delivered from high quality premises.

Intelligence

- Develop a culture and infrastructure that prioritises data-driven decision-making and approaches to understanding the unique needs of Lambeth residents, especially those who are facing health inequalities. Our goal is to make a positive impact on specific populations within our community, such as those from different ethnic backgrounds, sexual orientations, and those living in deprived areas.
- Identify opportunities to improve services, provide proactive care, and understand the impact of what we do on our populations. This will involve improving how we collect and analyse information and learn from best practice, research, and quality reviews to continuously improve our efforts.

Finances

- Provide a stable financial environment that supports continued improvement in health and care services and outcomes for people, to ensure a robust and effective delivery of core responsibilities, by using approaches that improve productivity, efficiency and value through making the best possible use of the money we have.

Two examples of our data-driven approach are **Lambeth HEART** and **Lambeth DataNet**.

Lambeth HEART is a research and evaluation network developed by Lambeth Council's Public Health Team in collaboration with local stakeholders, including Black Thrive, King's College London, and Applied Research Collaboration South London.

Lambeth DataNet is a data resource that links anonymised information to enable us to plan and provide better health care to everyone in the area.

To learn more, visit LINK https://lambethtogether.net/our-ways-of-working/.

How we will know if we are making a difference

We will use a range of ways to understand the impact we are making in Lambeth.

We have collectively committed to achieving these outcomes and will monitor our progress through regularly reporting to the Lambeth Together Care Partnership Board. The Board will consider how well we are doing at meeting our outcomes and review our activity if we are not delivering as planned.

We recognise that over the course of this five year plan things will change. National health and care directives will evolve, and the amount and quality of data, intelligence and insights will improve. To be able to adapt to these changes, we are building a governance process to regularly review the measures we use to monitor success and to adjust, improve, and refine them as necessary so that they continue to be fit for purpose.

Where things are working well, we may increase our ambition and build upon the success. Where our work is not having the results we expected, we will learn from this and adjust our approach so that we get back on track.

We will ensure that the measures we use to report progress are inclusive. We will focus on reducing the unfair and avoidable differences in health between different groups of people; and by focusing on these health inequalities, we will ultimately achieve better outcomes for everyone in Lambeth.

Our reporting will also allow for detailed investigation and consideration of other relevant measures by our Delivery Alliances and Programmes about the success of their work.

Lambeth Health Determinants Research & Evaluation Network (HEART) will create local government research infrastructure which seeks to understand and act on the causes of health inequalities and improve health and wellbeing outcomes in Lambeth. Developing an open and participative research collaboration involving local people will help inform our decisions as an integrated health and care system and bring opportunities to measure impact using integrated data and a race equity lens.

We will have a transparent process for agreeing change and we will publish an annual review that will share our progress and plans for the coming year. We will make sure that this is accessible and easy to understand.

We know that data and numbers won't tell us all the facts and that patients, carers and residents' feedback is vital. So, alongside our targets and impact measures, we have built listening routes into many parts of our system, so that we are continuously hearing and learning.

Our Public Forum supports service users, providers, and representatives to speak directly to the Board, online and in person. Our Delivery Alliances, Programmes and partners encourage and support diverse local voices to be heard through a great variety of engagement channels including reference and focus groups, local partnership events, and our Health Champions on our Health & Wellbeing Bus.

There is also Alliance-supported 'voice' activity that feeds directly to the Board such as the Youth Council and youth advisors, the Parents' Forum and Parent champions, and the Lambeth Mental Health Collaborative.

We fully recognise our statutory involvement responsibilities and seek to go further. Our formal consultations, surveys, and questionnaires are designed to ensure that our service stakeholders can influence the design and delivery of our services.

We will continue to work with a wide range of resident and patient groups including partners such as Healthwatch Lambeth, Black Thrive, Age UK Lambeth and others to provide us with qualitative insights into our performance. By working with these groups, we will gain a deeper understanding of how our services are affecting the lives of our residents and identify areas where we can improve.

How can I get involved?

We are committed to working with communities to make sure the services we are responsible for work for the people they are created for. If you're a Lambeth resident who cares about health and care in your community and would like to shape how we work, we'd love to hear from you. Find out more about the ways you can get involved in the work we do or email us on hello@lambethtogether.net.

How we developed Our Health, Our Lambeth

Our plan has been created by our Lambeth Together partner organisations, our Delivery Alliances and Programmes, and informed by wider consultation and engagement, both in our ongoing programmes of work and during the development of Lambeth's Health and Wellbeing Strategy. In developing our Health and Wellbeing Strategy, we consulted with the public, and with a range of voluntary, community, faith and social enterprise organisations, on what is important in Lambeth in regard to health and wellbeing.

Our Delivery Alliances and Programmes engage with patients and residents throughout their work and have used their understanding of the populations they serve, to inform their commitments in this Plan. As a partnership we will continue to listen to patients and residents and community voices and to work with people and communities in how we plan, deliver, and monitor the success of our work at all levels.

Appendix 1 – Activities and impact measures

Aspiration: People lead healthy lives and have good physical and emotional health and wellbeing for as long as possible

People maintain positive behaviours that keep them healthy

People and communities have access to information about and the right support around substance misuse, the impacts of smoking and alcohol use, and how to manage their weight, in ways that are accessible and meaningful to them. There is a decrease in the number of people smoking, and an increase in the number of people achieving a healthy weight and drinking less alcohol.

Programme:

Staying Healthy Programme - with contributions from: Living Well Network Alliance, Substance Misuse and Learning Disabilities and Autism Programmes.

Activity	Impact measures
• Work with local communities, voluntary sector, Primary Care Networks (PCNs) and other partners to ensure residents have access to advice and support in community settings to stay well, which is tailored and culturally appropriate.	Increase the percentage of patients with long term conditions and recorded as current smokers, who have a record of an offer of support and treatment, within the preceding 12 months.
• Use a combination of 'Vital 5' and NHS Health Check approach to improve routine identification of smokers and those at greatest risk of obesity, providing brief advice and referral to the stop smoking service and to weight management support.	Increase the percentage of patients with long term conditions having their body mass index (BMI) recorded, within the last 12 months.
• Deliver stop smoking services and support including specialist services and community pharmacy provision and strengthen links with hospital and pharmacy stop smoking pathways.	Improved appropriate referrals from primary care to the range of weight management support programmes available (NHS Digital, locally commissioned services, National Diabetes Prevention Programme).
• Set up a new weight management service with better links into communities that have the highest need and are likely to benefit most.	Increase the number of respondents completing DrinkCoach survey and monitor the proportion of people flagged as having a 'possible dependence'.
• Work across the Council and NHS South East London Integrated Care Board to support a holistic needs-led approach across the whole weight management care pathway to increase access to the most appropriate weight management support for residents.	Increase the number of substance misusing people from vulnerable and priority groups engaged by multi-disciplinary outreach team.

- Enhanced outreach and engagement, (including outreach for people with disabilities and for new parents) including targeted street outreach for: people experiencing rough sleeping and homelessness (aligned with and complementing rough sleeping grant initiatives where relevant), targeted vulnerable/priority groups including sex workers, crack and heroin users and alcohol users who are not in contact with treatment, and young people not accessing services
- Additional treatment places for people dependent on alcohol.
- Capacity to support collaboration, information sharing and joint working arrangements between drug and alcohol treatment and other key local agencies, to better understand and meet the needs of vulnerable/priority groups.
- Complete a Health Profile of Substance Misuse in Lambeth using different data sources to better understand our population, collaboratively working with partners and local communities to investigate and identify the current and future health and service needs of our population.
- Develop a comprehensive prevention programme for substance misuse.
- Improve identification of those with high risk drinking through use of the 'Vital 5' tool and implementing brief intervention and onward referral.
- Develop our outreach and early prevention initiatives such as our Assertive Outreach Team in partnership with Police and Community Safety and access to early and brief interventions on alcohol and drugs use.
- Strengthen referral pathways for risky and dependent alcohol drinkers from primary care and acute trust-embedded addiction care teams to treatment services.
- Deliver the Healthier You diabetes prevention programme, improving uptake particularly in our most deprived populations.
- Promoting uptake of the community pharmacy stop smoking and blood pressure check service, and the health and wellbeing champion in pharmacy service.

Increase the number of people accessing and engaging in structured treatment programmes.

All patients accessing inpatient support through alcohol support teams are supported into local services on discharge for follow-up support.

People are connected to communities that enable them to maintain good health

Communities are well-connected, engaged and thriving, with the environment, infrastructure, tools and support needed to have good health and wellbeing. The wider determinants of poor health that impact infant and adolescent mortality, are addressed.

Programme:

Neighbourhood and Wellbeing Delivery Alliance - with contribution from the Staying Healthy Programme and Children and Young People's Alliance.

Activity	Impact measures
• Age UK Lambeth, Lambeth Training Hub and Lambeth GP practices to support recruitment and retention of social prescribing link workers. • Developing stronger links between Primary Care Networks and local communities through PCN Equity Champions, the Thriving Communities project and Health and Wellbeing Hubs. • Evaluating the impact of the Thriving Communities project. • Providing capacity building support to community and voluntary organisations to further assist their promotion of health and wellbeing and to continue to develop trust and confidence in the health and care system among our Black and diverse communities. • Using an outreach approach to providing health and wellbeing information and advice in community settings with a focus on reaching those with higher risk of poor health. • Support residents through targeted interventions to maximise their incomes, reduce costs and build financial resilience. • Engage communities through Lambeth Health Determinants Research & Evaluation Network (HEART) to develop research priorities. • Develop an evidence-based programme of work that responds to wider determinants of infant mortality, that focuses on how to bring neighbourhood resources and strengthen communities to support parents, families and their children. • Targeted support to access self-care medicines available from community pharmacies in the borough to support people affected by deprivation. • We will review cases of infant deaths and identify common wider determinants of infant mortality in Lambeth. We will use these findings to create a clear programme of work to address this, using community and neighbourhood resources.	Social prescribing connects people to activities, groups, and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing. We will ensure the availability of services for social prescribing and increase the number of social prescribing unique contacts. Lambeth Residents survey continues to measure residents' wellbeing, use of community assets and social cohesion and shows year-on-year improvement. Impact of the rising cost of living on Lambeth's low-income residents is reduced. Measured by an improvement in the financial resilience of our low-income residents as an indication of the support provided (increase in % of low-income residents coping financially). Proportion of people with long term physical or mental health conditions who are economically inactive will reduce.

People are immunised against vaccine preventable diseases

Uptake of childhood immunisations increases and uptake of Covid-19, flu and pneumonia vaccines increase for eligible adults.

Programme:

Staying Healthy Programme and Children and Young People's Alliance - with contributions from: Neighbourhood and Wellbeing Delivery Alliance.

Activity	Impact measures
• Complete a Joint Strategic Needs Assessment Health Profile of Childhood Immunisations in Lambeth using different data sources to better understand our population, collaboratively working with partners and local communities to investigate and identify the current and future health and service needs of our population. • Review local incentivisation schemes for General Practices (GPs) and explore how they are routinely inviting residents for vaccinations, with the aim to improve vaccination uptake in specific cohorts (such as high-risk groups, over 65s, and children), focusing on those who have previously not responded or declined a vaccination appointment. • Work with Primary Care Networks to improve invitation and reminder arrangements and consider alternative delivery sites to improve access for childhood immunisations and seasonal vaccination programmes with a focus on people aged over 65 and those with long term conditions. • Acute settings within hospital trusts to routinely enquire about seasonal vaccinations when patients in high-risk cohorts attend sites, and co-administer vaccinations where possible. • Health Visitors to continue to actively check immunisation status of newborns' and infants during routine health reviews and refer parents to GPs for vaccination where required. • Professionals working with children and families, such as those within nurseries, children centres, schools and children's social care to be familiar with the UK Universal Immunisation Schedule and promote vaccination to parents, encouraging them to check with their GPs when unsure about children's immunisation history. • Midwifery teams to promote the UK vaccination programme at antenatal appointments with expectant mothers to increase awareness of the programme and encourage uptake when baby is born. • Schools to continue to support promotion of school-age vaccination programmes by working in partnership with the school-aged immunisation provider to ensure timely sharing of class lists.	By age two, 90% of Lambeth children will have received all primary immunisations and one dose of MMR. Of those children who have missed an immunisation (non-responders), follow up by healthcare providers will increase uptake by a further 50%. 100% of school-age vaccination consent forms returned to the vaccination provider. Increase the number of Lambeth registered population who are over the age of 65 receiving immunisation for flu.

• Schools to be encouraged to identify vaccination champions to support school-based vaccination programmes - champions can include safeguarding leads, teachers and school nurses and should include supporting the return of consent forms with parents (particularly those who have not responded). • Redesign delivery of the childhood vaccination programme, and consider Making Every Contact Count, to pilot new and innovative ways to ensure equitable access and achieve a high-quality vaccination programme. • Out of hours and weekend provision is available across the borough for vaccination appointments. • Co-administration of Covid-19 and flu is normal practice for those over 65 and with multiple long term conditions. • Immunisation records of families with under 5-year-olds are routinely checked by health visitors, with referrals made to GPs as required. • Vaccinations are opportunistically discussed with all families of children who have missing immunisations.	

People have healthy mental and emotional wellbeing

Lambeth's communities co-produce and co-deliver better and faster support for people to improve and maintain their emotional wellbeing. Our support is targeted at those individuals and communities most in need and is based on feedback from people about what works best. Children and young people can access Community Child and Adolescent Mental Health Service (CAMHs) support in a timely manner and more children and young people are able to use a wider range of emotional health and wellbeing provision. Children and young people report improved emotional health and wellbeing following contact with commissioned provision.

VITAL 5

Programme:

Living Well Network Alliance and Children and Young People's Alliance.

Activity

- Offer mental health awareness training and promote new Lambeth signposting tool to community and voluntary organisations particularly those that work with vulnerable communities.
- Actively promote suicide prevention training to reach groups identified in the Lambeth Suicide Prevention Strategy as being at greater risk.
- Working as part of South London Listens, increase the number of Wellbeing Hubs and Community Mental Health Champions.
- South London and Maudsley Hospital (SLaM) mental health promotion team to develop and implement more needs-led mental health promotion initiatives.
- Living Well Network Alliance to develop service user representation in decision-making groups.
- Develop and expand Living Well Network Alliance's Culturally Appropriate Peer Support and Advocacy Service (CAPSA) - this service employs people from Lambeth's Black communities with lived experience of mental health issues to work with and advocate (speak up) for those we support. They work and train with staff in our Living Well Centres and other Alliance teams to improve our support for people from Black communities. Improving our cultural awareness also helps to improve our support to all those from minority communities.
- Undertake regular outreach sessions at community events within Lambeth to promote the Lambeth Talking Therapies service, audit service user experience to feedback into service development and the pilot model of culturally appropriate group therapy with Black Thrive.

Impact measures

Lambeth's communities can co-deliver support for people to improve and maintain their emotional wellbeing.

Increase in the number of community organisations and volunteers undertaking mental health awareness and suicide prevention training.

25% of those that need the Lambeth Talking Therapies service (called access rate) should be able to access the service, 75% of people referred should start treatment within 6 weeks and at least 50% of people who complete treatment should recover, in line with national targets.

Children and young people that access emotional wellbeing support, report being more emotionally healthy because of that support. To do this we will standardise our approach to measuring outcomes from our full range of providers, allowing us to set a target for our ambition.

- Review Joint Strategic Needs Assessment Health Profile of Mental Health in Lambeth using different data sources to better understand our population, collaboratively working with partners and local communities to investigate and identify the current and future health and service needs of our population.
- Living Well Network Alliance to develop, refresh and embed engagement with those we support and their carers, including increased co-production and regular feedback from service users on their experience.
- Roll out Dialog tool during 23-24, including training and support to staff, to ensure a robust and consistent process to capture treatment satisfaction and feedback.
- Implement changes as part of the Patient and Carer Race Equality Framework (PCREF) programme to improve the access, experience and outcomes of the people we support from our Black, LGBTQ+ and other minority communities - the South London and Maudsley NHS Trust, a core member of the Living Well Network Alliance, is one of four national pilots for PCREF which aims to eliminate differences in access, experience and outcomes in mental health for those from Black and Minority Ethnic communities.
- In line with the Children and Young People's Mental Health and Emotional Wellbeing Plan, design and deliver a multi-agency Single Point of Access (SPA) to mental health support, drawing together a range of services seeking to support children and young people and their families.
- Offer varied emotional wellbeing provision for children and young people that is a cohesive and joined-up offer, that is well-communicated and enables improved access - develop a standardised approach to measuring outcomes across providers.
- As part of the Suicide Prevention Action Plan and feeding into the Autism strategy work with mental health services to improve the experience of people with autism - relevant recommendations from the evidence review on autism and suicide are considered and adopted.
- Work collectively to improve experiences and recovery outcomes for black service users and carers through access to the right culturally appropriate care and support that meets people's needs.
- Ensure that early access to emotional and psychological support for people experiencing mental distress can prevent a more severe mental health crisis and help people stay in their homes and work, which has positive benefits for them, their families and wider community.

People have healthy and fulfilling sexual relationships and good reproductive health

People have informed access to contraception, high quality Sexually Transmitted Infections (STI) treatment and testing and there is zero HIV-related stigma and zero HIV transmissions.

Programme:

Sexual Health Programme.

Activity	Impact measures
Sexually Transmitted Infections • Open access Sexually Transmitted Infections clinical services will have a refreshed service offer. • Work with the London Sexual Health Programme to plan for the future of the London e-service. • Increase accuracy of partner notification and reporting. • Increase and improve outreach and education to underserved groups. • Work with pharmacies to consolidate a sexual and reproductive health service offer. • Promote condom distribution services and benefits of condom use.	Whilst a high Sexually Transmitted Infections rate can reflect a high incidence of infection in the population, it can also suggest good access to and uptake of services that enable people to be tested and infections identified. We want to see a reduction in STI diagnoses while maintaining high rates of testing.
Abortion and reproductive health services • Work with the NHS and providers to refresh the service offer. • Analyse what our services are delivering and who is accessing them. • Monitor contraception access at separate clinical, online, GP and other service providers. • Pilot models of Long-Acting Reversible Contraception (LARC) training and delivery. • Continue to use the e-service for contraception. • Continue to develop online booking across providers to support access and gain 'live' system oversight of capacity. • Continue participation with London and national partners to support a sustainable and accessible system.	Monitor the gap in use of contraception from Sexual Health London (SHL) online among different ethnic groups and the number of abortions to Lambeth residents to address barriers to access. Long-Acting Reversible Contraception (LARC) such as implants, or intra-uterine devices or intra-uterine systems (sometimes called "the coil") are highly effective forms of contraception. Lambeth residents can access these in a wide range of settings including in primary care. We will increase the number of LARC uptake in primary care. This indicator can also be used as a proxy measure for the overall aim of offering a range of contraception types in a range of settings.

Access to contraception	
• Continue commissioning the e-service. • Work with pharmacies to consolidate a sexual and reproductive health service offer. • Increase education and promotional activities for residents.	
Long-Acting Reversible Contraception (LARC)	
• Pilot models of LARC training and delivery. • Continue to develop the digital tool/online booking across providers to support access and gain 'live' system oversight of capacity. • Commission additional training opportunities for primary care staff, Sexual Health in Practice (SHIP) and LARC. • Promotional and educational activities for residents.	
Other sexual and reproductive health and HIV work	
• Redesign outreach pathways for vulnerable adults and young people across services. • Look to design and include alternative pre-exposure prophylaxis (PrEP) access models. • Maximise opportunities to co-create improved HIV pathways.	

Aspiration: Physical and mental health conditions are detected early and people are supported and empowered to manage these conditions and avoid complications

People receive early diagnosis and support for physical health conditions

All people eligible for an annual health check have access and there is an increase in uptake; with a specific increases/focus in uptake for people with learning disabilities and those living with severe mental illness. Increase the number of cancer cases diagnosed at stage 1 or 2. People living with HIV know their status, the virus is undetectable, they live and age well and there are zero HIV related deaths.

THE SEVEN

Programme:

Neighbourhood and Wellbeing Delivery Alliance - with contributions from: Living Well Network Alliance, Sexual Health, Staying Healthy, Learning Disabilities and Autism Programmes.

Activity	Impact measures
The NHS Health Check • Redesign the NHS Health Checks programme in Lambeth to ensure a focus on improving uptake for those at most risk, by focusing on outreach and delivery in community settings. • Target health inequalities by increasing invites and uptake of NHS Health Checks and improving referral/diagnosis rates for those with highest risk. • Embed population health management approaches making better use of data. • Align to the Vital 5 prevention work in community settings. • Evaluate and review new programme delivery. VITAL 5 **Serious Mental Illness (SMI) Annual Health Checks/Health Action Plans** • Primary care to implement a quality improvement plan with Living Well Network Alliance support to ensure delivery of SMI Healthcheck in line with national targets and quality metrics. • Undertake targeted promotion of SMI Healthchecks to patients and carers particularly those from black and minority ethnic communities.	The NHS Health Check is a health check-up for adults in England aged 40 to 74. It is designed to spot early signs and lower the risk of stroke, kidney disease, heart disease, type 2 diabetes or dementia. Our aim is for increased uptake of the NHS Health Check for all eligible adults, and increased uptake of health checks to more than 60% of adults with severe mental illness and more than 75% of adults with a learning disability or autism. Additionally, we want to see an increase in the percentage of patients who have severe mental illness, with health risks linked to smoking, alcohol use and their weight, given appropriate advice.

Learning Disabilities and Autism Annual Health Checks (AHC)/Health Action Plans	
• Work with health and care partners to ensure access to and delivery of AHC's in line with national line targets and quality metrics. • Personalised care - improve % of people with an agreed Health Action Plan following identified risk as result of AHC. • Promotion of AHC amongst target population especially those from Black communities i.e., Big Health Week.	
Cancer screening	
• Increase the uptake of all cancer screening across our diverse communities particularly for those whom English is not their first language including the local Portuguese and Spanish speaking community. • Deliver the Catch 22 Bowel Cancer Screening initiative, involving targeted work to increase the uptake of bowel cancer screening in Lambeth where 26 General Practices identified with the lowest uptake have been invited to take part in the bowel cancer screening calling initiative and non-responders will be contacted by Catch 22 multilingual facilitators. • Public educational and promotional event(s) to include raising awareness of the national cancer screening programmes (Breast, Bowel and Cervical) and Prostate Cancer. • Improvements in Severe Mental Illness (SMI) and Learning Disability (LD) yearly health checks to include discussions and encouragement to take up cancer screening opportunities.	We will contribute to meeting the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days and increase the percentage 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.

HIV testing and pre-exposure prophylaxis (PrEP)	
• Development of data dashboard of HIV testing and diagnoses across the system. • A new HIV care and support and peer support network will be in place. • Educational and promotional stakeholder events will raise awareness of HIV programme ambitions. • A GP Champion for HIV is in place. • Sexual Health and HIV training commissioned for primary care staff. • Collect real time and demographic data on PrEP usage. • Increase access to PrEP for all service users.	Lambeth has an ambition to reach the Fast Track Cities goal of zero HIV stigma, transmissions and deaths. To achieve this, all those living with HIV need to know their status to be able to receive treatment and support. Testing all those who require bloods to be taken whilst in Emergency Departments helps to identify those who do not know their status and link them to HIV care and treatment, and to re-engage those in treatment who may have become disengaged. It can also help to normalise testing for HIV and contribute to reducing stigma. We will increase the percentage of eligible people receiving an HIV test whilst attending Emergency Departments and increase the number of Lambeth residents who are new and continuing PrEP users.

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

Diabetes is identified early and managed well. Those with chronic pain have consistent, high quality support, are not over medicalised, have community support and streamlined pathways. High blood pressure is prevented and identified through the use of blood pressure checks. Personalised care approaches and structured medicines reviews are utilised to ensure that people are prescribed the right medicines for them and know how to take them.

VITAL 5 THE SEVEN

Programme:

Neighbourhood and Wellbeing Delivery Alliance.

Activity	Impact measures
Diabetes • The Lambeth Community Diabetes Service will work very closely in partnership with General Practices, Primary Care Networks, Guy's and St Thomas' Hospital (GSTT), King's College Hospital (KCH), The South London and Maudsley Hospital (SLaM), Community Pharmacies and other partners, to improve population health and reduce inequalities. • The Community Diabetes Service will do this through several approaches. This includes working with GP practices to deliver teaching and multi-professional identification and review of priority people. • We will also use local Quality Improvement methods to support GPs in delivering diabetes reviews including training, guidelines and other resources developed with colleagues across South East London. • Healthcare professional learning events. • Implement recommendations from patient feedback via Centric community researchers. • Supporting people with diabetes with holistic and personalised care will be part of the care planning approach from General Practice, social prescribers and community pharmacy.	For diabetes to be well-managed a series of annual checks are available to monitor and improve the overall health of people with diabetes. These checks will help reduce the risk of complications associated with the condition. We will increase the proportion of people with Type 2 diabetes who receive these checks on an annual basis.

Chronic Pain • Improve the information that the GP has to advise those with chronic pain to access treatment. • Work with a group of patients who have chronic pain to improve the provision and information to access pain services in the community and from their GP.	Local research shows that chronic pain, along with anxiety, is the most prevalent long term condition in Lambeth. A greater proportion of women, Black and Asian populations in our most deprived communities live with chronic pain. To improve outcomes for people with chronic pain, we know people need reviews to help them set and achieve their quality-of-life goals. GPs and their linked staff will ensure they have processes in place to ensure that people suffering from chronic pain are known to them. We will increase the level of support provided by offering education on living well with pain, reviews to set goals and improvements, and review of medication.
High blood pressure (hypertension) • Hypertension workstream to coordinate all Lambeth hypertension activity with a focus on reducing health inequalities. • We will support General Practice to meet national targets to reduce hypertension. • We will support a new community pharmacy hypertension check service to reduce demand in General Practice. • We will use a local Quality Improvement methods to support GPs in delivering training and support around hypertension care including access to training, guidelines and other resources developed with colleagues across South East London. • The local Community Hypertension Service will provide support to General Practice in managing more complex disease. • We have implemented a community diagnostics service for cardiovascular disease, which helps us identify hypertension.	Increase the number of people with known hypertension whose target blood pressure is achieved.

Medicines Optimisation	
• We will work with our GPs and pharmacies to support more people to access medication reviews. • Priorities include supporting review of people taking multiple medicines who may be suffering from adverse effects or not benefitting from medication to ensure they receive appropriate medicines to support their goals through shared decision-making approaches. • We will develop our Medicines and Prescribing network for multi-professional clinical staff in General Practice to support training and sharing of best practice. • Reducing medicines waste through engaging with our public and net zero targets for medicines.	Multiple medicines can cause multiple adverse effects without any additional benefit. We will increase the number of people over age of 65 who are taking 10 or more medicines, having a medication review. Evidence tells us that reducing the number of inappropriate medicines in older people reduces harm.

When emotional and mental health issues are identified, the right help, support and diagnosis is offered early and in a timely way

Mental health support is available in the community and schools and is a timely and a positive experience. We reduce the number of people reaching a mental health crisis point and give prompt and appropriate support to people in crisis.

VITAL 5

Programme:

Living Well Network Alliance and Children and Young People's Alliance.

Activity	Impact measures
• Monitor and review Living Well Network Alliance Single Point of Access capacity and performance to agree service model. • Implement NHSE Community Mental Health Framework, including recruitment of staff to provide enhanced capacity to deliver community based mental health treatment, care and crisis intervention. • Undertake regular outreach sessions at community events within Lambeth to promote the Lambeth Talking Therapies service, audit service user experience to feedback into service development and pilot model of culturally appropriate group therapy with Black Thrive. • Roll out Dialog tool during 2023 to 2024, including training and support to staff, to ensure a robust and consistent process to capture service user self-reported wellbeing. • Roll out mental health training offer to GPs to increase capacity and capability to identify, assess, and address mental health needs of patients, and refer onwards. • Expand community reablement support to help people with practical issues that can help prevent crisis that lead to loss of accommodation and/or admission to hospital and care settings. • Extend capacity of Home Treatment Team and further VCS community based out of hour crisis options such as the Evening Sanctuary to assist more people to improve service user experience and contribute toward unplanned admission avoidance, and monitor impact including numaber of users of these services who would say they would otherwise have attended A&E.	Reduce average wait times for triage and initial assessment following a referral to the Living Well Network Alliance Single Point of Access to under 72 hours by 2024. Increase access to and recovery rates for Lambeth Talking Therapies for Black African and Caribbean residents to ensure they are as least as good as those of White residents. Monitor Living Well Network Alliance service user self-reported wellbeing. Increase the percentage of patients in secondary care due to a mental health crisis, who are discharged and are not re-admitted within 30 days. Improve access to mental health support for children and young people, lensuring that 95% 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 and that no child or young person waits longer than 44 weeks for an assessment and commencing treatment with Child and Adolescent Mental Health Services. We will ensure we meet the national access target, which for Lambeth is ensuring 2,112 CYP have access to Child and Adolescent Mental Health Services across a 12-month period.

- Recruitment of Mental Health Practitioners to ensure coverage across PCNs in Lambeth, to provide early identification, assessment and intervention to people with a range of emotional, phycological and mental health conditions in primary care i.e. anxiety, depression, sleep disorders, so that people can access or be signposted/referred to the right support in the community quickly, improving prospects for resolution or improvement and reducing risk of deterioration that may lead to crisis or negative impacts on relationship, work, housing and overall wellbeing.
- Roll out Living Well Network Alliance's Staying Well offer across Lambeth, which will involve mental health support staff working more closely with GPs, Social Prescribers and local communities as part of neighbourhood teams to ensure more convenient and better joined-up care between General Practice and community mental health services.
- Develop specialist eating disorder and complex psychological and behavioural needs pathway to enable more people to be supported in the community and reduce unplanned admission due to crisis.
- Improve the diversity in ethnicity of children and young people accessing Mental Health School Teams - agree baseline from 22/23 annual report, set target for 23/24 with regular monitoring and establish task and finish group to consider how this can be improved.
- We will continue to develop and deliver our Mental Health School Teams in Lambeth schools and improve the diversity in ethnicity of children and young people accessing this support - we will roll out of MHSTs to another 14 schools in early 2023/24, enabling us to ensure we have widespread cover across 28 schools.
- Working with a voluntary sector provider to consult with children and young people in schools, to better understand emotional health and wellbeing needs relating to our LGBTQ+ community.
- Delivering a pilot with SLAM and community organisations (The Well Centre, Coram and Place 2 Be) to better understand how we can join up our response to CYP emotional health and wellbeing need, bringing services, data and statutory provision together.

Aspiration: People have access to and positive experiences of health and care services that they trust and meet their needs

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

People are supported by integrated working by GPs, mental health services, community health, social care staff and others. Children and young people remain supported by health and care services when they transition to adulthood where appropriate.

Programme:

Neighbourhood and Wellbeing Delivery Alliance - with contributions from: Living Well Network Alliance and Children and Young People's Alliance

Activity	Impact measures
• Lambeth Together Delivery Alliances support the development of equitable provision of integrated care in the borough - the Neighbourhood and Wellbeing Delivery Alliance (NWDA) supports the creation of health and care community networks (called Thriving communities) to inform neighbourhood service development with a particular focus on providing an equitable offer of health and social care and development of localised health solutions for all our residents. • NWDA partner organisations (PCNs, secondary care, social care, community care, VCS etc) recognise that to develop integrated working across the borough and in neighbourhoods requires an iterative, partnership approach that acknowledge the complexity of the system and allows new approaches to be tested, developed and implemented at scale. • Primary Care Networks (PCN) and community-based partners will explore opportunities to evolve integrated neighbourhood provision and models using insight from residents and service users to inform localised provision such as neighbourhood teams for mental health and workforce development to support flexible multi-disciplinary teams. • Use our wide range of existing estates for the delivery of integrated services from a range of partners including community groups. • Each PCN to have a social prescribing team which is expanding and recruiting to specialist posts in recognition of local need, including dedicated children and young people posts and mental health.	Increase usage of consultant connect by primary care. All young people aged 17.5 years old, open to CAMHs will have a clear transition pathway to ensure they remain supported by health and care services when they transition to adulthood. Patients understand the services they can directly access and we see an increase in the numbers of self-referrals to those services, rather than referrals from GPs.

- Re-launch and monitoring of Consultant Connect as first line for advice and guidance for primary care clinicians and encouragement of uptake in use - working with SEL team to identify any actions which may lead to increase in successful answer rates - Consultant connect allows GPs real-time specialist advice and so allows the patient to receive their care in the community rather than in hospital.
- Adults' and children's mental health teams will work more closely together to improve planning, communications, and the transition of young people to adult mental health services - upon transition to Adult Mental Health Services, we aim to have in place an improved transitions pathway between CAMJHS and Adult Mental Health.
- Refine and develop the approach to Population Health Management around the Core20.
- Roll out Living Well Network Alliance's Staying Well offer across Lambeth, which will involve mental health support staff working more closely with GPs, Social Prescribers and local communities as part of neighbourhood teams to ensure more convenient and better joined-up care between General Practice and community mental health services.
- A programme of communication with Lambeth's population to allow a greater understanding of the differing healthcare roles, services available, and how they can have direct access to the right service for their need.
- Development of the London Care Record that supports the delivery of holistic care to patients and can be used from across health and care services.
- Ensure there are tailored ways to support groups who often find it difficult to access healthcare, such as asylum seekers and traveller communities.
- Ensure that continuing healthcare (CHC) provides and effective and efficient service and provides valuable support to those within our community with complex needs.

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

People can access the right support in the right place at the right time, utilising the most appropriate help including primary care, community pharmacy, 111, urgent treatment centres and emergency departments. More people attending hospital, are treated and go home on the 'same day' and people admitted to hospital are discharged in an appropriate timeframe with a reduction in preventable delays. People needing scheduled treatment are suitably prioritised and any unnecessary waits are reduced. People in need of support due to the harms caused by drug or alcohol misuse, are offered it at the persons point of need and support services can work together to counter these harms with the individual and wider communities. 'Virtual wards' allow patients to get the care they need at home safely and conveniently, rather than being in hospital.

VITAL 5

Programme:

Neighbourhood and Wellbeing Delivery Alliance - with contribution from: Substance Misuse Programme.

Activity	Impact measures
Urgent and Emergency Care transformation and access • Review of communication, engagement and behavioural activities including analysis of options to improve local public messaging on sites and in communities. • Demand management including review of access routes and alternative appointment slots in community/primary care and access to these and the potential benefits of digital access in emergency departments to support direct appointment bookings. • Review and implement best practice standards for Same Day Emergency Care including opening times, access routes and ring-fencing use of capacity. • Ensuring that the population receive access to a primary care professional that is appropriate to their clinical need. • Deliver a programme of communication with Lambeth's population to allow a greater understanding of the differing healthcare roles, services available, and how they can have direct access to the right service for their need. • Increase the use of digital tools including the NHS app so that patients may more easily be equipped to take greater control over their health and care and to access care at the right time and place.	Everyone who needs an appointment with their GP practice gets one within two weeks and this includes all populations. Those who contact their practice urgently are assessed the same or next day according to clinical need. Increase the volume of appointments provided by General Practice in line with our SEL system trajectory. Increase referrals into urgent community response (UCR) from all key routes, with a focus on maximising referrals from 111 and 999 and creating a single point of access where not already in place - consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard. Improve access to healthcare professionals through increased use of community pharmacies; GPs and NHS 111 direct people to pharmacies to support people with minor ailments and advice around self-care. Increase the number of people using the community pharmacy consultation service for support and help with common ailments.

• Continue to ensure that patients are not excluded from accessing health care through digital poverty by evaluating our pilot which involves members of our population teaching others to access technology practically and sharing lived experiences. • Use digital software (Apex) to support GP practices to understand their population needs and provide and redeploy workforce accordingly across Primary Care Networks. • People experience culturally appropriate translation services for our diverse population so consultations can be supported by in person translators or virtually as appropriate. • Development of the London Care Record that supports the delivery of holistic care to patients and can be used from across health and care services. • Evaluate the benefits of basing GPs and Social Prescribing Link workers in Emergency Departments in meeting the needs of patients whose needs can be better met elsewhere. • Increase referrals by primary care via consultant connect into Same-Day Emergency Care, increase communications and engagement with primary care to raise awareness of Same-Day Emergency Care and access criteria - monitor activity, demand and any unmet demands for Same-Day Emergency Care at both GSTT and Kings. • Enhance direct access for diagnostics using local Community Diagnostic Hubs. • Working with providers on High Intensity Use services to support demand management in Urgent and Emergency Care (UEC). • Continue triage service for urgent and elective eye consultations, as well as direct referral pathways from community optometrists to Minor Eye Condition Service across Lambeth and SEL. • People with mental ill-health have the right support at the right time to avoid unnecessary periods in ED including by being discharged appropriately and in a timely way from ED and inpatient beds. • Engage in the development and deployment of a London Care Record that supports Advanced Care Planning.	An increase in the numbers of self-referrals to direct access services, rather than referrals from GPs.

Substance Misuse • Support collaboration, information sharing and joint working arrangements between drug and alcohol treatment and other key local agencies, to better understand and meet the needs of vulnerable/priority groups. • Complete a Joint Strategic Needs Assessment Health Profile of Substance Misuse in Lambeth using different data sources to better understand our population, collaboratively working with partners and local communities to investigate and identify the current and future health and service needs of our population. • Improve identification of those with high risk drinking through use of the Vital 5' tool and implementing brief intervention and onward referral and increase the uptake of training amongst primary care staff on Information Brief Advice on alcohol.	Reduce the number of drug and alcohol related A&E attendances.
'Virtual wards' • Lambeth Together and Partnership Southwark develops the model for 'Virtual Wards', bringing benefits to multi-disciplinary working across the borough and building on the 'At Home' model in operation.	Our aim is to help keep people treated at home or within the community, by increasing the provision and utilisation of 'virtual wards'. In doing so, it will ensure patients receive high-quality care that is tailored to their individual needs, while also helping to reduce the burden on hospital services, prevent unnecessary hospital admissions, and ensure that patients receive the right care, in the right place, at the right time. We will create capacity in Lambeth for 140-150 'virtual ward' beds and work towards their utilisation.

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

Older adults, with a focus on maximising their independence, have access to good quality care services which range from support to remain at home to support to live in care homes. Lambeth is an age-friendly and dementia friendly borough and supports people in ageing well and continuing to tackle the challenges that lead to poorer outcomes in older age. Adults have personalised care and support by health and care services during the end of their lives.

Programme:

Neighbourhood and Wellbeing Delivery Alliance.

Activity

- Review Joint Strategic Needs Assessment Health Profile of Older People in Lambeth using different data sources to better understand our population, collaboratively working with partners and local communities to investigate and identify the current and future health and service needs of our population, to inform our future service planning.
- Make Lambeth an Age Friendly Borough where people can live healthy and active later lives. To achieve this, we will work with older people and charities like Age UK Lambeth to make Lambeth a better place to grow older - this will include a focus on supporting people in ageing well and continuing to tackle thechallenges that lead to poor outcomes in older age.
- Review delivery model of reablement across the partnership; integrating clinicians, ensuring access to the service is equitable in general and between the community pathway and the discharge pathway.
- Review of pilot on Adult Social Care 'front door' with Age UK Lambeth and design future model of delivery, ensuring an inclusive and equitable service, with an interface with community health and primary care.
- Work collaboratively within SEL ICS to implement and embed a 'core offer' for community Specialist Palliative Care providers.
- Prioritise integration of Palliative and End of Life Care into frailty pathways and 'virtual wards' models.

Impact measures

Intermediate Care including Reablement helps people live independently, and/or recover from an episode of ill health. It is therapy-led and provided in the person's own home with care arranged by an integrated team of mainly Health & Social Care professionals. We will monitor the number of people with an intermediate care offer. The service is non-chargeable for up to six weeks and we will monitor the number of people who have a reduced need for care at the end of this service.

We have commissioned Lambeth Carers Service to ensure carers are supported in their caring role, have access to the information and resources they need, and feel recognised locally for their contribution. We will work collaboratively with the Carers Service to ensure its effectiveness and Adult Social Care will ensure 90% of carers of the users of Adult Social Care Services are offered a carers assessment.

We will target improvements in end of life care linked to the National Palliative and End of Life Care 22-25 strategic priorities of accessibility, quality and sustainability. We will work towards an increased % of people identified as being in their last year of life on practice registers and increase number of people with Personalised Care and Support Plan (PCSP).

- Work collaboratively with the Lambeth Carers Service to ensure carers are supported in their caring role, have access to the information and resources they need, and feel recognised locally for their contribution.
- Review, launch and implement new Carer's Strategy and review the support and information available for carers.
- Carers to receive health and wellbeing interventions, including vaccinations, from the right workforce in their general practice Primary Care Network.
- Carers can access support through their practice Personalised Care team including Social Prescribing Link Workers.
- Enable primary care providers to develop Advanced Care Planning in their practices and around them - linking with local system providers to share ideas and collaborate.
- Falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, e.g. being a major precipitant of people moving from their own home to long term nursing or residential care. To reduce emergency admissions due to falls in people aged 65 and over we will carry out a falls prevention campaign which will include Lambeth based falls prevention leaflets, e-training to non-health care staff and increased provision of strength and balancing classes.
- We will make dementia friendly training available to help ensure that people with dementia feel understood, valued and able to contribute to their community.
- Development of the London Care Record that supports the delivery of holistic care to patients and can be used from across health and care services.
- We will work to ensure we use best practice procurement and commissioning models that deliver inclusive services, working with partners such as Age UK Lambeth and Opening Doors to provide care that is accessible across our diverse communities including Black and LGBTQ+ residents.
- We will continue to work with providers to make sure services are person-centred, that are able to meet people's needs and operate safely.

Increase the percentage of Lambeth Residents' Survey respondents aged 65 and over that describe their health as good.

Increase in uptake of flu/pneumococcal and Covid-19 vaccinations in people known to be Carers.

Women have positive experiences of maternal healthcare and there are no disproportionate maternal mortality rates among women

Maternal outcomes improve for all, and the disparity of maternal outcomes for Black women is eradicated.

Programme:

Children and Young People's Alliance.

Activity	Impact measures
• Work with colleagues across the system to pull together a comprehensive dataset for Lambeth women using maternity services to counter significant inequalities in experience. This includes partnership working through Local Maternity and Neonatal Systems (LMNS) consolidating maternity metrics across providers and utilisation of analytic resources produced by SEL BI team, such as, Core20PLUS5. This will allow us to create a localised action plan to meet the specific needs of Lambeth women. • Continue to deliver the actions from the final Ockenden report as set out in the April 2022 letter as well as those that will be set out in the single delivery plan for maternity and neonatal services. • Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury. • Ensure all women have personalised and safe care through every woman receiving a personalised care plan and being supported to make informed choices, including increased use of continuity of midwifery care. • Improve access to perinatal mental health services. • Women are asked by midwifery and health visiting services about domestic abuse and substance use throughout pregnancy, to be offered the right support, and supported around their contraception needs postnatally.	Continuity of care in maternity refers to the provision of care throughout the pregnancy, birth, and postnatal period by the same healthcare provider or team. The benefits of continuity of care in maternity include improved maternal and foetal outcomes, increased satisfaction with care, reduced healthcare costs, and better communication and trust between the healthcare provider and the patient. Continuity of care also allows for the early detection and management of potential complications and can lead to a more personalized and individualized approach to care. Continuity of maternity care is delivered for at least 75% of women from Black, Asian and minority ethnic communities. We will monitor the rates of maternal mortality during labour, neonatal deaths and pre-term birth and expect to see them reducing.

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

People with learning disabilities and/or autism are discharged from inpatient settings and supported to live in the community with appropriate accommodation and care. Health and social wellbeing across the life course for all people of all ages, with learning disabilities and autism, improves.

Programme:

Learning Disabilities and Autism Programme - with contributions from: Children and Young People's Alliance.

Activity	Impact measures
Specialist inpatient units discharge • Review crisis intervention/admission prevention services to agree improved borough offer. • ALD Placement Transformation Strategy - Ensure accommodation-based placements maximise lifelong independence underpinned by clear systematic contractual framework to ensure best value. • Commission bespoke option for group of named individuals that are most complex and at highest risk.	It is vital we reduce reliance on inpatient care for patients with learning disabilities and/or autism (LDA), while improving the quality of inpatient care. We will increase the number of children and adults discharged from specialist inpatient units, with a particular focus on reducing the rates of Black patients placed in overly restrictive settings.
Employment • People with learning disabilities are less likely to be in employment than the overall population. We will monitor and report on how many people are with learning disabilities are in work and how many opportunities for supported employment we are able to create. • Developing new supported employment and internship opportunities through our health and care partners.	People with learning disabilities are less likely to be in employment than the overall population. To achieve our outcome, we will increase the proportion of people with LDA in work or education, aiming for an increase to 5%, by increasing the number of supported employment and supported internships we create through our health and care partners. People with a learning disability often have poorer physical and mental health than other people. It is important that everyone over the age of 14 who is on their GP's learning disability register has an annual health check; we will improve the rate of uptake for an Annual Health Check and Health Action Plan, for those with LDA, and ensure that there is no disparity in uptake between ethnic groups.

CYP ASD Diagnosis • Develop the Lambeth All-Age Autism Strategy with users, carers and partners. • Engagement piece working with Lambeth Council's Communication Team. • Understand local population of people with autism and mapping exercise using local and national data, PH data - Pathway and diagnosis in Lambeth Council, Employment and Children, Young people and SEND. • Work with partner organisations in developing the LBL strategy.	We will reduce the waiting times for an Autism Spectrum Disorder (ASD) diagnosis for children and young people.
General • Working with SEL ICB and health partners to ensure accurate capture of information for patients with learning disability and autism to ensure they get the right access to health provision; support performance and quality monitoring, and underpin effective population health planning. • Contribute to the South East London Integrated Care Board Learning Disability and Autism Programme and support the development of integrated, workforce plans for the learning disability and autism workforce. • As part of the Suicide Prevention Action Plan and feeding into the Autism strategy work with mental health services to improve the experience of people with autism - relevant recommendations from the evidence review on autism and suicide are considered and adopted.	

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

People with mental health needs are able to recover, live independently, live in stable and appropriate accommodation, and in education, training, volunteering or employment.

Programme:

Living Well Network Alliance.

Activity	Impact measures
• Expand community reablement support to help people with practical issues that can help prevent crisis that leads to loss of accommodation and/or admission to hospital and care settings whilst helping people maintain or regain skills that promote independence and beneficial quality of life, reduce dependence on use of institutional care. • Extend capacity for Living Well Network Alliance Home Treatment Team to support more people experiencing mental health crisis in the community. • Develop specialist eating disorder and complex psychological and behavioural needs pathway to enable more people to be supported in the community and reduce unplanned admission due to crisis. • Work with statutory partners to ensure work opportunities for people with Severe Mental Illness (SMI) and other Long term conditions and ensure full mobilisation and monitoring of the L Living Well Network Alliance Individual Placement Support Service (IPS) to enable more people with SMI to achieve their goal of sustainable paid work with a fair wage whilst accessing support to help find and maintain employment and monitor the service against intended goals. • Work with Black Thrive and partners including Lambeth Council Employment and Skills as part of the 'No Wrong Door' initiative to enable people who are vulnerable including people with SMI or other conditions can access a range of specialist and mainstream information, education and vocational support to so that people have meaningful, learning and occupation opportunities that provide structure and builds confidence and skills. • Deliver on the reprovision of the Lambeth Hospital together with SLaM, including the mobilisation of a redesigned inpatient care model to provide better quality and more culturally appropriate clinical service. • Roll out Dialog tool during 23-24, including training and support to staff, to ensure a robust and consistent process to capture service user self-reported wellbeing.	Increased numbers of people with Severe Mental Illness (SMI) are supported to live in their own home and 200 people per year are supported by the Living Well Network Alliance into paid employment. We will monitor the number of referrals Living Well Network Alliance teams make for service users to additional support routes (such as education, training and employment support, Community Support, Alcohol Advice, Smoking, Benefits advice, Dietician, Family Support) and the number of service users reporting a positive experience of using mental health services, feeling they have benefited from support and are more independent and in control of their lives, particularly those from Black and other minority ethnic communities. We will monitor repeated A&E attendance and acute mental health inpatient readmissions as part of performance and quality monitoring to assess effectiveness and as part of reflective learning to ensure recovery and/or other agreed goals are met.

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

In supported housing, residents have access to a GP and holistic support with their mental health and substance use. Homeless vulnerable adults and rough sleepers receive tailored support to manage physical and mental health conditions to prevent serious illness and the overall number of entrenched rough sleepers is reduced.

VITAL 5

Programme:

Homeless Health Programme - with contributions from: Living Well Network Alliance and Substance Misuse Programme.

Activity	Impact measures
• A specialist team will support single households in Temporary Accommodation to secure offers of long term settled accommodation. • Improve the quality of temporary accommodation through closer contract monitoring and improved technology. • The Lambeth Rough Sleeping Outreach Team will continue to target all rough sleepers found in Lambeth to ensure everyone is offered a route off the streets. Long term entrenched rough sleepers will continue being case worked by specialist roles within the team such as a Living On The Streets worker, and embedded roles such as a Public Protection Officer and an Approved Mental Health Professional. • Through contract monitoring and audit visits we will identify the numbers of people in supported housing who are not yet registered with a GP. We will work with service providers and health colleagues to target those individuals and identify any potential barriers. • Develop model to allow cross referencing GP registration for those in supported housing, with engagement with GP. • Develop intelligence to review how long rough sleepers brought into accommodation, have sustained tenancy. • Enhanced outreach and engagement, (including outreach for people with disabilities and new parents) including targeted street outreach for: people experiencing rough sleeping and homelessness (aligned with and complementing rough sleeping grant initiatives where relevant), targeted vulnerable/priority groups including sex workers, crack, heroin users and alcohol users who are not in contact with treatment, young people not accessing services.	To improve the health outcomes of those who are homeless or at risk of becoming homeless, we first want to reduce homelessness overall. We will therefore work to increase the number of people resettled into longer term accommodation by preventing or relieving homelessness and increase the number of rough sleepers brought into accommodation. Increase the number of households that move on from temporary accommodation into settled housing. Increase the proportion of people living in our supported housing that are registered with a GP. Monitor our rate of residents in supported housing engaged with mental health support services. As substance use is a significant cause of poor health outcomes for our street homeless population in Lambeth, we will also monitor how effectively we refer people to drug treatment services upon their release from prison, and what proportion then complete their treatment.

- Expansion of treatment provision for substance misuse and alcohol dependence.
- Improve identification of those with high risk drinking through use of the 'Vital 5' tool and implementing brief intervention and onward referral.
- Increase referrals to substance misuse services from the police (custody), probation and criminal justice system.
- Develop comprehensive prevention programme for substance misuse.
- Increase number of people accessing and completing treatment for substance misuse.

Appendix 2 - Managing risks

The matrix below represents the possible combined risk scores based on a measurement of both the likelihood (probability) and severity (impact) of risk issues. A combination of likelihood and severity score provides the combine risk score. Risk score is from 1-25 (1= rare and negligible severity and 25 = Almost certain and catastrophic).

Risk	Risk Description	Current Risk Rating	Target Risk Rating	Risk Mitigation
Data and intelligence	Insufficient or poor-quality data results in an inability to track the progress and evaluate our interventions and impact. Incomplete, outdated, or inaccurate data hinders the effectiveness of our decision-making and analysis.	8	6	Continue to invest in how we collect and record data to improve the richness of our data, making information more timely, accurate and complete, building on existing relationships between the analytical teams across the partnership.
				Develop an assurance mechanism through the assurance group to review monitor and evaluate progress and to enable scrutiny of the validity of data and intelligence.
				Build into our governance process the mechanism to periodically review the plan and to adjust, improve, and refine how we monitor delivery and adjust performance indicators as data quality improves.
Financial savings/ pressures	Lambeth Together partner organisations need to make financial savings and/or face significant budget pressures.	16	8	Partner organisations continue to provide a stable financial environment that supports improvement and investment in healthcare and outcomes. The commitment to financial sustainability will be vital to ensuring a robust and effective delivering of core responsibilities, secured through approaches that demonstrably improve productivity, efficiency, and value through making the best possible use of funding available.

Risk	Risk Description	Current Risk Rating	Target Risk Rating	Risk Mitigation
Wider economic impact on inequalities	We know that our focus as a health and care system must be on tackling unfair and avoidable differences in health between different groups of people, that were exacerbated through the Covid-19 pandemic. A national cost of living crisis, high inflation and rising costs, threatens to worsen living standards and increase poverty, which could lead to a widening of inequalities.	12	9	Work in partnership with Lambeth Council's Cost of Living programme to provide extra support for residents most impacted by the cost of living crisis, including ensuring offers of support for residents are communicated throughout the health and care system.
Rise of infectious disease(s)	Future pandemic or epidemic of an infectious disease such as flu or Covid-19. Managing a pandemic may inhibit our collective ability to deliver this plan.	12	6	Infectious disease prevention measures to remain in place and promoted to the public. Public Health pandemic planning to be in place.
Workforce	Reduced ability to recruit, retain and support staff.	9	6	Software ("Apex") rolled out to support General Practices to effectively plan their workforce requirements, based on healthcare needs in the borough.
				The Lambeth Together & Development Hub to develop Peer support groups for the workforce to encourage resilience and personal development.
				The Lambeth Together & Development Hub is working with practices to develop apprenticeships for healthcare workers in Lambeth.

Risk	Risk Description	Current Risk Rating	Target Risk Rating	Risk Mitigation
				Lambeth will pilot the Automation of Patient Registration to facilitate administration function in General Practice, which will benefit both the patient and General Practice Workforce.
				Commit to supporting the workforce to relate to our communities' lived experience, is representative of and supports our diverse and intersectional communities.
				Support carers pay, as part of Lambeth's Ethical Care Charter.
				Engage with, and across, our workforce including through our Clinical and Care Professional Network.
Immunisations Fatigue	Vaccine hesitancy, fatigue and reluctance in the population following the Covid-19 pandemic.	12	3	As part of our childhood immunisation strategy for 2023-2025, regular engagement activities will be held at trusted community sites to develop a greater understanding of underserved and marginalised communities. These sessions will be held in person, and online, and provide a forum where residents can ask questions related to vaccine preventable diseases, along with other common childhood illnesses. In addition to this, a targeted communication strategy will be co-developed with key stakeholders and be carried out in community languages on various platforms. A robust training package is also being developed for clinical and non-clinical staff working with children and their families to strengthen Making Every Contact Count and ensure a consistent approach to building vaccine confidence within Lambeth.
				Each general practice will produce and implement their protocol and systems to promote uptake of vaccinations and immunisations including a robust process to invite people to be vaccinated in accordance with the national schedule. This should include routine monthly searches on the clinical system to identify outstanding eligible cohorts and look ahead reports where appropriate.

Risk	Risk Description	Current Risk Rating	Target Risk Rating	Risk Mitigation
System-wide demand	Demand on the health and care system impacts Lambeth Together to the extent that it constrains partner ability to prioritise transformation.	16	12	Executive group to review system pressures regularly and consistently, alongside transformation work, and encourage operational information sharing and solution-focused partnership working.
Changes to national priorities	Legislative changes or changes in national priorities impacts upon local priorities.	8	4	Ensure Our Health, Our Lambeth remains flexible and adaptable by building into our governance a process to periodically review the plan and to adjust, improve, and refine as necessary so that the plan continues to be fit for purpose. Formally review the plan annually and propose changes to be agreed by the Lambeth Together Care Partnership Board.
Enablers are not present	In developing our plan, we have reflected on and agreed the ways we need to work and what conditions we need to succeed. If these enabling factors are not present, this will impact our ability to meet our outcomes.	12	6	Ensure existing working groups are aligned to and delivering on our Enablers. Where our Enablers need dedicated improvement, we will bring together the right people to do this. We will pay attention to the Enablers in the same way we do our outcomes and build oversight of these enablers into our governance and ways of working.

Appendix 3 - Financial Context

The economy and public sector funding is expected to be constrained over the next five years as we recover from the pandemic and other factors. Most of our resources are allocated through the NHS and local government and our budget the assumptions we are making in the short-term are set out below.

Within the NHS, we will need to be realistic in our resource assumptions and combine the need to deliver improved effectiveness and outcomes through transformation and prevention. We will seek to prioritise those interventions that address inequality in outcomes. Our commitment to financial sustainability will be vital to ensure robust and effective delivery of our ambitions and responsibilities.

The Government is investing an additional £3.3 billion in the next two years to support the NHS, enabling actions that will improve hospital and community healthcare performance towards pre-pandemic levels. They will also make available up to £2.8 billion in 2023-2024 and £4.7 billion in 2024-2025 to help support adult social care and hospital discharge.

- Inflation – NHS South East London published funding growth is 5.32% in 2023/24 and 3.22% in 2024/25. This reduces to 2.64% in 2023/24 and 1.99% in 2024/25 after the application of required adjustments. Net inflation uplift of 1.8% applied across all budgets.
- Efficiency - We will be more rigorous in the tests we apply to both existing and additional investment with a specific focus on return on investment and benefits realisation. A minimum 4% efficiency savings will be required.
- Transformation - Additional funding received to implement transformation programmes in Mental Health, Health Inequalities and Virtual Wards. Our investment approach will result in a shift in total share of spend from hospital-based care towards community, mental health, primary care, and health inequalities & prevention.
- Integrated Care Board (ICB) running costs – Pay award/increase is unfunded and 30% real terms reduction on Running Cost required by 2025/26.
- Cost Pressures - Pressures will be monitored and mitigations developed on an ongoing basis to ensure expenditure is within the available resources.

SouthEast London Integrated Care Board Budget - Lambeth	Total Budget £000
Hospital Services	321,108
Community Health Services	84,070
Mental Health Services	106,124
NHS Continuing Care Services	31,652
Prescribing	38,288
Other Primary Care Services	2,977
Primary Care Services Delegated from NHS England	77,993
Corporate Cost	5,619
Total	**667,831**

The Lambeth Council Financial Strategy covers the four years from 2023-2027. The aim of the Financial Strategy is to have a balanced financial position with sufficient funding to support statutory duties and deliver manifesto commitments, recognising the funding uncertainties that exist.

In developing the Financial Strategy, the Council has estimated the amount of funding available over the planning period with the main sources of income being government funding, business rates and Council Tax receipts. There is greater uncertainty in the year 2025/26 onwards where national funding for social care reduces and increased costs may occur relating to social care reform.

The Council has also estimated expenditure over the planning period and included extra costs, for example for inflation for internal staffing and contracts. There is a high chance that actual expenditure increases will be higher than the estimates in the current environment, making planning difficult and it could be difficult to manage expenditure within budgets due to this.

The main driver of cost growth in social care in recent years has been increased acuity of clients coming into social care, increased numbers of clients from hospital discharges and price pressure from limited market capacity. Added to these, there are now increases in the costs that providers must pay to deliver services. Expected future costs are estimated from recent experience but there could be much larger cost increases.

The Council has responsibility to find ways to meet any funding shortfall so that it has a balanced budget and has sought to address this through income generation (changes to charges or new grants), procurement (opportunities through contracts) and transformation to deliver better value for money.

The Council has a balanced position in 2023/24 and will continue to identify further savings throughout the planning period.

2023/24 Council Revenue Budgets (compared to 2022/23)		
Directorate	**2022/23 Net Budget £'000**	**2023/24 Net Budget £'000**
Adults & Health	96,391	107,414
Children's Services	78,136	96,739
No Recourse to Public Funds	2,734	2,762
Resident Services	47,627	51,888
Housing Services	19,246	19,237
Sustainable Growth & Opportunity	2,868	3,345
Finance & Investment	13,903	20,444
Chief Executive Office	8,048	7,454
Corporate Items	81,255	81,743
Total	**350,208**	**391,026**

Adults & Health 2023/24 Budget	
Adult Social Care	**£'000**
Adults with learning difficulties	39,187
Adults with mental health needs	12,472
Adults with physical disabilities	11,501
Older people	28,678
Other - Adults	8,413
Supported housing	868
Supporting people	4,696
Adult Social Care Total	**105,815**
Public Health (100% Grant Funded)	**0**
Commissioning	**1,599**
Total	**107,414**