Lambeth Together

Integrated Assurance Report

16 September 2025

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Our Health, Our Lambeth

Lambeth Together health and care plan 2023-28

Lambeth Together Health and Care Plan Scorecard – September 2025

			Sep-25				Jul-25	
ID	Outcome	Measures tracked	Measures Reported with a target	On plan/ target	% measures on track (where have a target)	Vs previous update	% measures on track (where have a target)2	Comments
A	*People maintain positive behaviours that keep them healthy*	5	1	1	100%	–	100%	
B	*People are connected to communities which enable them to maintain good health*	1	1	1	100%	–	100%	
C	*People are immunised against vaccine preventable diseases*	3	3	0	0%	–	0%	Flu indicators will be validated at year end positon.
D	*People have healthy mental and emotional wellbeing*	3	3	1	33%	↓	67%	Average waiting time for LWNA Short term support as at August 25 is 1.3 weeks above plan.
E	*People have healthy and fulfilling sexual relationships and good reproductive health*	3	1	1	100%	–	100%	LARC activity is monitored via EZ and SH team maintain a log, commentary support progress against plan. STI testing and diagnoses rate is monitored via quarterly GumCAD reports.
F	*People receive early diagnosis and support on physical health conditions*	5	5	3	60%	–	60%	One Cancer screening programme tracking above national target. SMI & LD Annual Health checks on a trajectory to meet year-end targets
G	*People who have developed long term health conditions have help to manage their condition and prevent complications*	4	3	3	100%	–	100%	Cardiovascular and Diabetes measures above previous year trajectory.
H	*When emotional and mental health issues are identified; the right help and support is offered early and in a timely way*	4	2	1	50%	↓	100%	
I	*People have access to joined-up and holistic health and care delivered in their neighbourhoods*	3	2	2	100%	–	100%	
J	*People know where to go to get the right help, and are treated at the right time, in the right place, for their needs*	4	1	1	100%	–	100%	
K	*Older adults are provided with the right health and care support at the right time, live healthy and active later lives and are supported to age well*	4	2	2	100%	↑	100%	
L	*Women have positive experiences of maternal healthcare and do not experience a disproportionate maternal mortality rate*	0	0	0	-		-	See planned deep dive report (Sept 25)
M	*People with learning disabilities and/or autism achieve equal life chances, live as independently as possible and have the right support from health and care services*	3	1	1	100%	–	100%	
N	*People using mental health support services can recover and stay well, with the right support, and can participate on an equal footing in daily life*	4	3	1	33%	–	33%	Measures tracked against previous year activity
O	*People who are homeless, or at risk of becoming homeless, (including rough sleepers and refugees) have improved health*	4	4	4	100%	–	100%	Measures tracked against previous year activity
	Total	50	32	22	69%	↓	75%	

Health and Care Plan: Key headlines (1)

	Outcome	Key Headlines
A	***People maintain positive behaviours that keep them healthy***	Q1 2025-2026, saw a total of 1,677 Health checks completed. This compares favorably to the same period last year where 1,105 health checks were completed indicating that the practices continue to acclimate to the new ways of working under the new model despite the issues experienced in the early part of 24/25.
B	***People are connected to communities which enable them to maintain good health***	The need for social prescribing continues, with high demand on the service. Comparison of one surgery Age UK Lambeth provides the Social Prescribing Link Worker saw monthly referrals increase significantly. A yearly comparison from July 2024 with 8 referrals to 39 referrals in July 2025.
C	***People are immunised against vaccine preventable diseases***	The national flu campaign began on 1 September with the children's and pregnant women's programme; other eligible groups, including over-65s, will follow from 1 October. ImmForm remains the national monitoring platform. Co-administration of flu with other vaccines (COVID, RSV, etc.) where possible, is being encouraged in Lambeth. As the 2% uptake increase target was missed in 2024/25, the same goal will be carried forward into this season, with renewed focus on outreach and engagement.
D	***People have healthy mental and emotional wellbeing***	The Lambeth Living Well Centres' Short-Term Support service (STS) began helping 183 new people in August, fewer than the 208 seen in July but still many more than the monthly average of 156 for 2024/25. This makes 817 new people supported so far in 2025/26. The number of people Focused Support (FS) started supporting in August fell to 26 from 39 in July, which makes 173 new people supported so far in 2025/26. The Lambeth Single Point of Access (SPA) referred 167 people to STS in July, and 89 in August, following concerted efforts in July to reduce the number of people open to SPA.

Health and Care Plan: Key headlines (2)

	Outcome	Key Headlines
E	***People have healthy and fulfilling sexual relationships and good reproductive health***	Planned deep dive, see enclosed presentation along with highlight report updates
F	***People receive early diagnosis and support on physical health conditions***	Bowel Cancer screening aged 60-74- The most recent data shows upward trend with 61.8% screened (January 2025). Note for the financial year of 25/26 SEL ambition is 64.6% but this data is from when the target was 60%. Cervical Cancer screening aged 25-64-shows levels are quite stable but not increasing with 62.7% screening in June 2024 compared to 62.8% in April 2023. National target is 80%. Note for the financial year of 25/26 SEL ambition is 64.6% Breast cancer screening aged 50-70-Upward trend in the past year. Most recent data shows 57.9% screened in January 2025 which is a significant increase from 54.8% in December 2023. Not returned to pre-covid levels which were 61% in November 2019. Below national target of 80%. Note for the financial year of 25/26 SEL ambition is 60.2%
G	***People who have developed long term health conditions have help to manage their condition and prevent complications***	More black and minority ethnic people have been identified with hypertension when comparing August 2024 to August 2025 data; 9141 and 9817 respectively and within these cohorts, blood pressure control has remained consistent with higher absolute numbers in comparison to the previous year; 24,242 and 25,162 respectively. Current data from the EZ Analytics Cardiovascular app shows that hypertension control in the Black African, Black Caribbean, Mixed White and Asian, Unknown or not stated ethnic groups is improving, with comparable rates of target blood pressures being reached across all ethnicities. In addition, year on year performance across target ethnicities and all ethnicities has increased. The measurement and recording of the 8 care processes for Black, Asian and multi ethnic groups continues to trend upwards.
H	***When emotional and mental health issues are identified; the right help and support is offered early and in a timely way***	Data for Lambeth SPA in July and August showed no inequalities in the SPA process. 26% of Black Service users introduced to SPA received onward referrals to Community Mental Health Services or the Trust, the same percentage as for White service users. Average waiting times for urgent introductions processed in August also show no meaningful difference, being 7.3 days and 7.7 days for Black and White service users respectively. Access to Lambeth Talking Therapies (LTT) Recovery for Black service users continues to improve. In April to June 2025 (the latest period for which data is available), 25.2% of new clients identified themselves as Black, better than the 24.2% seen in the previous quarter, and the 21.7% Black population of Lambeth. Session attendance and treatment completion continues to be roughly equal across groups. On CAMHS activity, caseload pressure is significantly driven by the neurodevelopmental pathway. The data does not provide breakdowns by ethnicity, deprivation, or other characteristics for those referred or waiting, so limited health inequalities can be confirmed or tracked from this data. The report is, however, being developed and updated constantly.

Health and Care Plan: Key Headlines (3)

	Outcome	Key Headlines
I	***People have access to joined-up and holistic health and care delivered in their neighbourhoods***	On the Health and Wellbeing Bus ,the data indicates consistent reach into communities and delivery of health and wellbeing services to residents. A consistent challenge has been identifying result of service user after interaction with H&W bus and team and if person went on to making progress. We have been using a follow up form that ties with directly with GP records which holds potential to address this challenge.
J	***People know where to go to get the right help, and are treated at the right time, in the right place, for their needs***	Lambeth Pharmacy First Plus Service data shows from May 2024 to July 2025 most interventions (1,195) have taken place for people whose registered post code district falls within IMD decile 1 to 3, which shows the service is accessed by the target population - those with the highest deprivation. Data to date, demonstrates that if people did not have access to the Lambeth Pharmacy First Plus Service, 71% of patients would have visited general practice to request the medication on prescription and 29% would have gone without medication as they are unable to buy the medicines over the counter to deal with minor conditions due to the current cost of living crisis. People who are receiving support through universal credit, patient aged under 16 years or receive income support are the top social vulnerability eligibility groups accessing Lambeth Pharmacy First Plus Service in July 2025. General Practice feedback has been that the service has a had a positive impact for patients and reduced GP appointments for minor conditions.
K	***Older adults are provided with the right health and care support at the right time, live healthy and active later lives and are supported to age well***	On Adult Social Care updates, we can note operationally we continue to achieve a high performance rate for the proportion of carers of service users who were offered a carer's assessment. The baseline is 98% and the latest overall position is 100%. We have also identified a member of staff in each team to be Carer's Champions and this will help to raise awareness of carers in the teams. Further detail is included on highlight slide.
L	***Women have positive experiences of maternal healthcare and do not experience a disproportionate maternal mortality rate***	Planned deep dive, see enclosed presentation along with highlight report updates

Health and Care Plan: Key Headlines (4)

	Outcome	Key Headlines
M	***People with learning disabilities and/or autism achieve equal life chances, live as independently as possible and have the right support from health and care services***	Ethnic background of those supported in inpatient settings is monitored and we can note the proportion of inpatients who are Black/Black British has fallen from 50% (22/23) to 27% (July 25) indicating there is no longer an over-representation of people from Black backgrounds in the most restrictive settings. This demonstrates the hard work of the whole Lambeth Together network and partners to achieve this result.
N	***People using mental health support services can recover and stay well, with the right support, and can participate on an equal footing in daily life***	There were 43 restrictive incidents and seclusions for inpatients in August 2025, well over both the 37 seen in July and the average of 35 for financial year 2024/25. Of the 79 restrictive incidents and seclusions reported for Lambeth acute inpatients with a stated ethnicity in July and August 2025, 40 (51%) were for Black compared 56% in the preceding 3 months Apr-Jun. However, the numbers involved are too small, highly variable and linked to the same people involved multiple times to draw any firm conclusions. On Patient Reported Experience Measures, we can note Positive friends and family survey responses for LWNA services were at 82.4% in August, an improvement of 2.9% points on the 79.5% average for the previous financial year.
O	***People who are homeless, or at risk of becoming homeless, (including rough sleepers and refugees) have improved health***	Planned deep dive, see enclosed presentation along with highlight report updates

Finance

Finance: South East London ICB: Lambeth

Overall Finance Position (2025/26 M04)

Service Area	Year to date Budget £'000s	Year to date Actual £'000s	Year to date Variance £'000s	Annual Budget £'000s	Forecast Outturn £'000s	Forecast Variance £'000s
Acute Services	163	163	0	488	488	0
Community Health Services	9,993	9,993	0	29,978	29,978	0
Mental Health Services	8,075	8,660	(585)	24,128	25,296	(1,168)
Continuing Care Services	11,970	11,970	0	35,911	35,177	734
Prescribing	14,570	14,570	0	43,998	43,998	0
Programme Wide Projects			0		(436)	436
Other Primary Care Services	1,319	1,319	0	3,957	3,957	0
Delegated Primary Care Services	32,085	32,205	(119)	96,256	96,613	(357)
Corporate Budgets	1,515	1,474	41	4,545	4,545	0
Total	79,690	80,352	(663)	239,259	239,615	(356)
Equalisation of Ring Fence Delegated Primary Care						356
Revised Full Year Forecast Variance						**0**

- The borough is reporting an overall **£663k year to date overspend position** and a forecast breakeven position at Month 04 (July 2025) after the "equalisation" of the ring fenced delegated primary care budgets. The reported forecast position includes **£1,168k overspend on Mental Health Services** (including Learning Disabilities) offset by 734k underspend on Continuing Health Care (CHC) Services and the finding of additional savings.

- The key risks within the 2025-26 Lambeth's finance position are **exponential growth in referrals to independent sector providers for ADHD & ASD assessments and Integrated Community Equipment Contract Provider contract**. Further risks remain associated with demand driven budgets (Mental Health and Learning Disability Services, Audiology, Interpreting Service, Cardiovascular Diagnostic Service, Prescribing and Continuing Health Care Services).

- Mental Health budget year to date and forecast overspend is mainly driven by increased ADHD and ASD assessments under the Right to Choose process (**the forecast expenditure at M04 for this specific budget is £2.0m overspend**), Mental Health and Learning Disabilities (LD) placement expenditure, and mitigated by constraining investments. Borough Commissioners leading on efficiency and productivity schemes including right sizing projects with providers to enable service users to live more independently though either stepping down restrictive levels of care or moving to more independent settings.

- Delegated Primary Care Services is reporting a forecasted breakeven position after the "equalisation" of the ring fenced delegated primary care budgets at month 4, noting previous year (2024-25) overspend position was driven by locum reimbursements, retainer scheme and list size growth.

- The Continuing Healthcare budget is forecasting £734k underspend as the CHC team continues to deliver on reviewing high-cost packages and out of area placements. Work is ongoing to establish better value costs. The number of active CHC and FNC clients at M04 is 559.

- Prescribing actual data is available two months in arrears and the borough is reporting a breakeven position against in year budget at month 4 based two months actual data.

- The borough 2025-26 minimum (5%) efficiency and productivity target is £11.3m and has a savings plan of £12.6m. In addition to the embedded efficiency (£5.6m) as part of the budget setting process, the borough has saving plans for Continuing Healthcare (£1.9m), Prescribing (£1.1m) and Mental Health Services Learning Disability Services (1.2m). The borough efficiency and productivity target is forecast to deliver in full.

Lambeth Council M3 Updates

Division	Budget	Forecast	Variance
	£'000	£'000	£'000
INTEGRATED COMMISSIONING	133	133	0
SENIOR MANAGEMENT - INTEGRATED HEALTH & CARE	1,577	1,677	100
PUBLIC HEALTH	0	0	0
INTEGRATED HEALTH & CARE TOTAL	1,710	1,810	100

	Annual Budget	Full Year Forecast	Forecast Variance
	£000	£000	£000
ADULTS WITH LEARNING DISSABILITIES	41,025	52,699	11,674
ADULTS WITH PHYSICAL DISABILITIES	14,899	16,378	1,479
ADULTS WITH MENTAL HEALTH NEEDS	11,124	12,477	1,353
SUPPORTED HOUSING	780	780	0
OLDER PEOPLE	28,941	40,626	11,685
OTHER – ADULTS	13,855	(4,633)	(18,488)
SUPPORTING PEOPLE	4,503	4,559	56
ADULT SOCIAL CARE	**117,689**	**125,689**	**8,000**

Integrated Health & Care:

- Breakeven position in Public Health and Integrated Commissioning
- Overspend in Senior Management of £100k, subject to confirmation of reserve funding for additional fixed-term commissioning capacity.
- Public Health grant allocation of £39.160m for this financial year, inflationary uplifts on NHS contracts and pay awards to be confirmed later in the year.

Adult Social Care:

Forecasting an overspend of £8m. Long-term support placements remain the primary driver of the overspend, especially in **Older People (OP)** and **Adults with Learning Disabilities (ALD)**.

Significant increases in spend over recent years has been driven by inflation in placement costs and increased acuity.

Growth funding of £4.1m and government grant income is currently held within the ASC senior management cost centre and will need to be allocated across the service groups to meet emerging pressures.

Mitigations & Actions:

- **Care package reviews**, **transitions management**, and **preventative interventions** in place.
- **Weekly scrutiny panels** reviewing all new placements.

Lambeth together

Quality

Quality update enclosed with LTAG pack

Risk Summary

Risk highlights

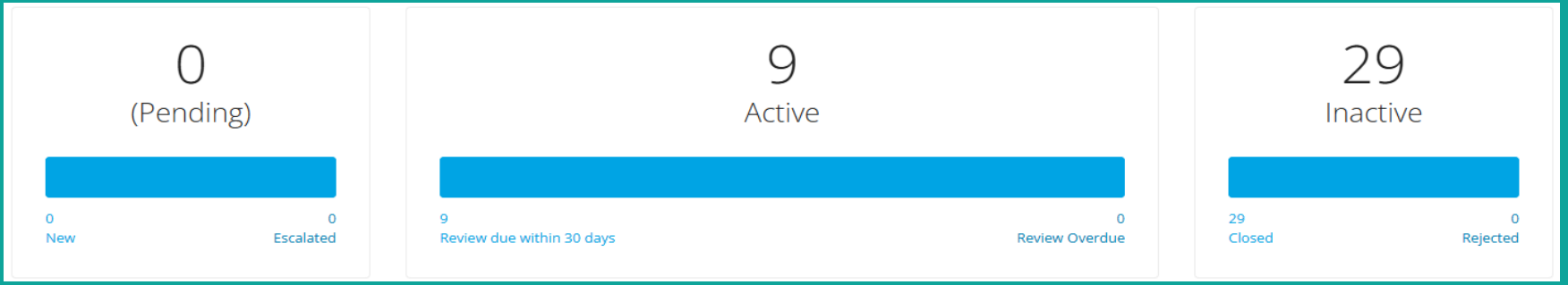
Director / lead	leads for the 7 priority areas, lead commissioners
Management Lead	Andrew Eyres, each of the leads for the 7 priority areas, lead commissioners
Data source / period	SEL BAF, Highlight reports x 7 / Enabler reports.

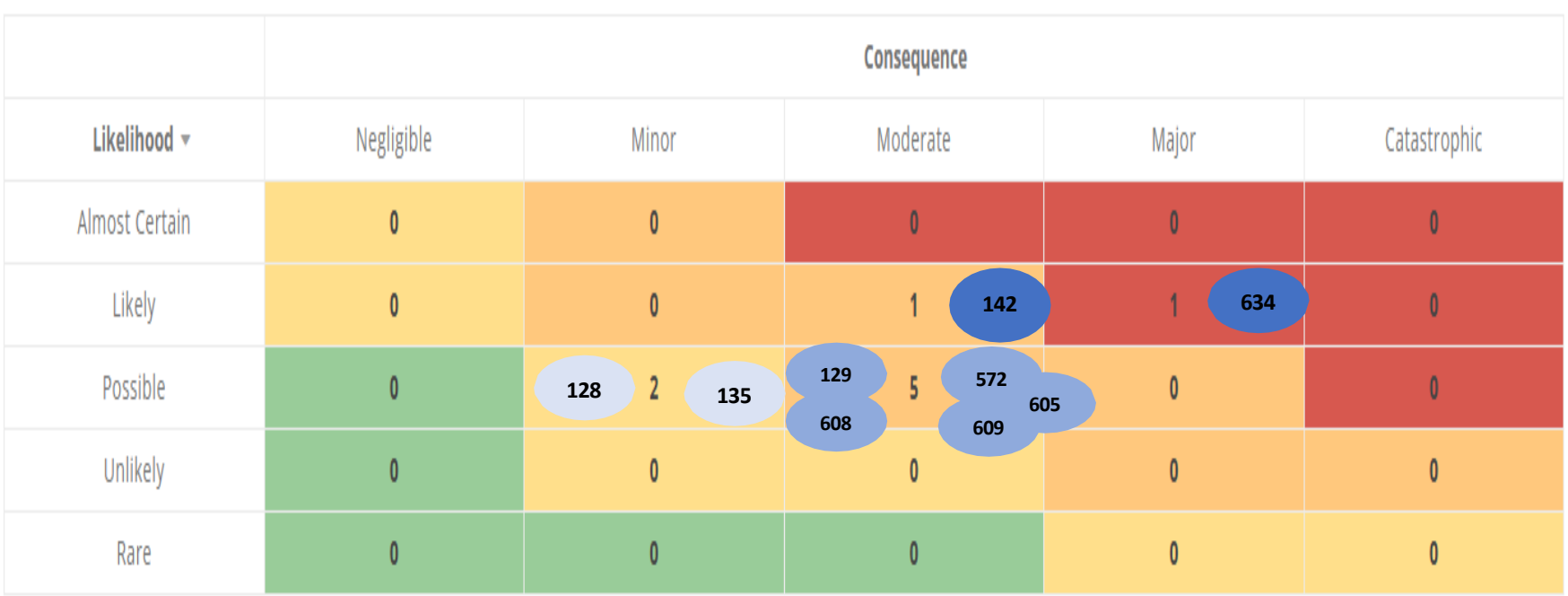
Lambeth Risk Register

- As of August, there were 9 active risks on the South East London Risk register for Lambeth.
- Since the last update to this group the following risk was opened,
  - Integrated Community Equipment Service - Under S75 agreement, there have been issues with current provider which have been impacting on hospital discharges and ensuring residents receive the right equipment at the right time to support their recovery. There have been significant financial risks related to the provider, ending with the provider going into liquidation in July affecting the delivery and continuity of the service.
- SEL Risk forum took place in July and risk leads met to discuss risks across SEL, receive updates from risk leads and review Local Care Partnership comparative report, we were asked to consider the following points,
  - SEL Risk lead asked LCP partners to consider and add risks in relation to non-standard contracts currently in place for CHC and MH placements.
  - INT estate and digital risks added by Lewisham check if applicable for Lambeth
  - Lambeth's risk exposure in relation to delivery of Joint Forward Plans
- The above points were discussed on 12th August at SMT meeting and partners noted there's no exposure to the above risks in relation to Lambeth LCP.

Risk highlights

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





Lighter low risk score, darker higher risk score

ID	Type
128	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities
129	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities
135	Clinical, Quality and Safety
142	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities
605	Finance
608	Finance
609	Finance
572	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities
634	Clinical, Quality and Safety

Risk highlights

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

Risk ID	Risk Title	Current Rating
128	CAMHS waiting times	6
129	Diagnostic waiting times for neurodiversity assessments - children and young people	9
135	Failure to safeguard adults	6
142	Immunisation Rates protect Children, including vulnerable groups from communicable diseases.	12
572	Increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population - Seasonal Flu Vaccination	9
605	Delivery of overall Place/borough productivity & efficiency requirement and achievement of financial balance for 2025-26.	9
608	Delivery of Delegated Primary Care productivity & efficiency requirement and managing expenditure within allocated financial resources for 2025-26	9
609	Delivery of productivity & efficiency requirement and achievement of financial balance for Mental Health for 2025-26 financial year	9
634	Integrated Community Equipment Service	16

South East London ICB Corporate Objectives & delegated assurance metrics

South East London ICB Corporate Objectives & delegated assurance metrics

Standard	Period covered in report	Comparator	Benchmark/ Trajectory	Current performance	SEL Average	Above/below SEL average?	SEL Borough rank
Dementia diagnosis rate	Jul-25	National standard	67%	76.2%	71.2%	Above	1
IAPT discharge	Jun-25	Operating plan	533	515	N/A	N/A	-
IAPT reliable improvement	Jun-25	Operating plan	67%	67%	67%	Above	2
IAPT reliable recovery	Feb-25	National standard	48%	51%	48%	Above	1
SMI Healthchecks	Q4 24/25	Local trajectory	55%	57.0%	53.6%	Above	1
LD and Autism - Annual health checks	Ape 25	Local trajectory	178	228	N/A	N/A	-
Bowel Cancer Coverage (60-74)	Jan-25	Corporate Objective	63.3%	61.8%	67.9%	Below	6
Cervical Cancer Coverage (25-64 combined)	Jun-24	Corporate Objective	63.3%	62.7%	66.9%	Below	6
Breast Cancer Coverage (50-70)	Jan-25	Corporate Objective	59.2%	57.9%	63.1%	Below	6
Percentage of patients with hypertension treated to NICE guidance	Jul-25	Corporate Objective	74.6%	66%	67.0%	Above	3
Appointments seen within two weeks	Apr-25	Operating plan	-	91.9%	88.2%	Above	1

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

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

Lambeth Integrated Health and Care Directorate Business Plan Update

Integrated Health and Care Business Plan 25/26

Parent Object	Action Title	Sum of Percentage Complete
Adults Transformation	Work collaboratively with primary care to increase the uptake of cancer screening	25%
Adults with Learning Disabilities	Focus on LDA Health Inequalities	25%
	NHSE Learning Disability and Autism Programme	25%
Children & Young People	CYP - Mental Health Support	75%
	Pull together a comprehensive dataset for Lambeth women using maternity services	75%
Long Term Conditions Optimisation	Deliver Long Term Conditions Optimisation Priorities	25%
Medicines Optimisation	Deliver Medicines Optimisation Priorities	25%
Primary Care	Improve Access to Primary Care	25%
	Shift to Neighbourhoods by working collaboratively with Integrated Health and Care providers	25%
Public Health	Age-Friendly Lambeth	25%
	Health Intelligence	25%
	Infection Prevention and Control of Communicable Diseases	25%
	Sexual Health	25%
	Staying Healthy	25%
	Substance Misuse	25%
Public HealthCPC: People Focussed Services	Future early intervention and prevention offer	10%
	Lambeth HEART	25%

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

The table provides a summary of Q1 position across the areas of focus within the 25/26 plan. Most actions have been listed as Green and none of the actions was escalated for support, trajectories are on target to meet year-end objectives.

Appendix:
Health and Care Plan Outcomes:
Detailed assurance narrative

Impact measures performance trend (1)

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

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

Impact measures performance trend (2)

Outcome	Impact measure	Target/Plan	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year to Date	Comments
D	Number of community organisations and volunteers undertaking mental health awareness and suicide prevention training	Actual	Target - 16 suicide prevention training sessions booked for the next 12 months. STORM 5 suicide prevention Level 1 training sessions booked for the next 12 months. MHA 6 half-day sessions over the next 12 months														Target - 16 suicide prevention training sessions booked for the next 12 months. STORM 5 suicide prevention Level 1 training sessions booked for the next 12 months. MHA 6 half-day sessions over the next 12 months
		Plan															
		Variance															
	Number of Entering treatment with Short-Term Support with Living Well Centres.	Actual	143	125	150	151	208	183									
		Plan															
		Variance	12	-18	25	1	57	-25									Against previous month's position
	Number of Entering treatment with Focused Support with Living Well Centres.	Actual	27	37	39	32	39	26									
		Plan															
		Variance	27	10	2	-7	7	-13									Against previous month's position
	LWNA Short Term Waiting Time	Actual	27.3	25.6	30.4	26.5	26.6	24.7									
		Plan	26.0	26.0	26.0	26.0	25.96	25.96									Average time from introduction received by SLaM to 2nd contact by a Short-Term Support team
		Variance	-1.3	0.4	-4.4	-0.5	-0.6	1.3									
E	Rates of STI testing	Actual	Currently working with Sexual health commissioners to report the data														
		Plan															
		Variance															
	Rates of STI diagnoses	Actual															
		Plan															
		Variance															
	Number of LARC uptake in primary care	Actual															
		Plan				319			272			276			299		24/25 Out turn
		Variance															
F	Uptake of SMI health checks	Actual	64%	2.80%	7.6%	14.3%	21.4%	25.9%									
		Plan	5%	5.0%	10%	15%	20%	25%	30%	35%	40%	45%	50%	55%	60%		Year end target 60%
		Variance	58.7%	-2.2%	-2.4%	-0.7%	1.4%	0.9%									
	Uptake of LD/AHC health checks	Actual	83%	3.9%	8.0%	13.2%	20.2%	25.6%									Year end target 75%
		Plan	75%	6.3%	13%	19%	25%	31%	38%	44%	50%	57%	63%	69%	76%		
		Variance	7.6%	-2.4%	-4.6%	-5.6%	-4.9%	-5.8%									
	Proportion of Bowel Cancer screening for those aged 60-74	Actual															Bowel cancer screening – 2.5 year coverage (ages 60-74) Jan 25 - 61.8%. **25/26 ambition of 64.6%**
		Plan															
		Variance															
	Proportion of cervical Cancer Screening aged 25-64	Actual															Cervical cancer screening – 3.5/5.5 year coverage (ages 25-64) June 24 - 62.7%. **25/26 ambition of 64.6%**
		Plan	Bowel cancer screening – 2.5 year coverage (ages 60-74) Jan 25 - 61.8%. **25/26 ambition of 64.6%**														
		Variance	Cervical cancer screening – 3.5/5.5 year coverage (ages 25-64) June 24 - 62.7%. **25/26 ambition of 64.6%**														
	Proportion of breast cancer screening for women aged 50-70	Actual	Breast cancer screening – 36-month coverage (ages 50-70) Jan 25 - 57.9% - 56.4%. **25/26 ambition of 60.2%**														Breast cancer screening – 36-month coverage (ages 50-70) Jan 25 - 57.9% - 56.4%. **25/26 ambition of 60.2%.**
		Plan															
		Variance															
	Number of new PrEP users (and continuers) resident in Lambeth	Actual															
		Plan															
		Variance															

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

Impact measures performance trend (3)

Outcome	Impact measure	Target/Plan	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year to Date	Comments
G	Proportion of people with Type 2 diabetes who have all 8 care processes measured and recorded on an annual basis	Actual	76%	13.8%	21.5%	30.7%	40.0%	47.1%									
		Plan	77%	6.4%	12.8%	19.3%	25.7%	32.1%	38.5%	44.9%	51.3%	57.8%	64.2%	70.6%	77%		Year end target of 77%
		Variance	-1%	7.3%	8.7%	11.5%	14.3%	15.0%									
	Proportion of people aged 79 or under with hypertension who achieve a blood pressure measure less than or equal to 140/90mmHg this FY	Actual	70%	12.3%	21.9%	31.3%	39.9%	45.7%									
		Plan	77%	7%	13%	20%	27%	33%	40%	47%	54%	60%	67%	74%	80%		Year end target of 80%
		Variance	-7%	5.7%	8.5%	11.2%	13.1%	12.2%									
	Proportion of people aged 80 or over with hypertension who achieve a blood pressure measure less than or equal to 150/90mmHg this FY	Actual	81%	14.7%	27.1%	38.4%	48.3%	55.9%									Year end target of 80%
		Plan	77%	7%	13%	20%	27%	33%	40%	47%	54%	60%	67%	74%	80%		
		Variance	4.1%	8.0%	13.7%	18.4%	21.5%	22.4%									
	Proportion of people over age of 75 who are taking 10 or more medicines, having a medication review	Actual	47.3%	1.8%	3.7%	6.1%	8.6%	8.6%									
		Plan															
		Variance															
H	Proportion of referrals to the Living Well Network Alliance Single Point of Access, which were processed during the month (i.e. triaged, referred onwards or otherwise responded to) within 72 hours.	Actual	34%	34.0%	36.0%	28.8%	27.4%	22.3%	37.7%								
		Plan															
		Variance															
	Access to Lambeth Talking Therapies for Black African and Caribbean residents to ensure they are as least as good as those of White residents	Actual	24.2%			25.2%											
		Plan	21.7%			21.7%											
		Variance	2.5%			3.5%											
	Recovery rates for Lambeth Talking Therapies for Black African and Caribbean residents to ensure they are as least as good as those of White residents	Actual	50.3%			47.8%											
		Plan	48.0%			48.0%											
		Variance	2.3%			-0.2%											
	Number of children and young people waiting longer than 52 weeks for an assessment and commencing treatment with Child and Adolescent Mental Health Services	Actual			17												
		Plan															
		Variance															
I	Health and Wellebing Bus - No of interactions -	Actual				3,670											More than 3000 interactions in the first quarter
		Plan															
		Variance															
	Beacons service - No of interactions Interactions (brief opportunistic exchange), Hi 5 and BP check	Actual				3,228											878 Hi 5 intereactions and 982 opportunistic BP checks
		Plan															
		Variance															
	Vital 5 & Women and Girls community interactions	Actual				237											58 1-1 Vital 5 checks delivered; 10% advised to see GP within 3 weeks, 85 showed high irsk or possibly dependency after Audit C questionnaires.
		Plan															
		Variance															

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Impact measures performance trend (4)

Outcome	Impact measure	Target/Plan	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year to Date	Comments
J	Percentage of General practice appointments seen within two weeks	Actual	90%	89%	89%	90%	90%										
		Plan	90.0%	90.0%	90.0%	90.0%	90.0%										
		Variance	0.0%	-1.0%	-1.0%	-0.3%	0.2%										
	Improve access to healthcare professionals through increased use of community pharmacies - GPs and NHS 111 direct people to pharmacies to support people with minor ailments and advice around self-care and common clinical conditions	Actual	2,500														
		Plan															
		Variance															
	Patients to be admitted, transferred, or discharged within 4 hours of arrival to A&E - GSTT sites	Actual	74%			77.70%											
	Patients to be admitted, transferred, or discharged within 4 hours of arrival to A&E - KCH sites	Actual	71.9%			71.6%											
K	No of community referrals to reablement	**Actual**		7	15	12	6										
		Plan															
		Variance															
	No of people who require no service or a reduced service following reablement	**Actual**		47	38	36	36										
		Plan															
		Variance															
	Proportion of carers of the users of Adult Social Care Services are offered a carers assessment	**Actual**	100%	100%	100%	100%	100%										
		Plan	100%	100%	100%	100%	100%										
		Variance	0%	0%	0%	0%	0%										
	Number of people identified as being in their last year of life on practice registers	**Actual**	2087			2111											
		Plan	1988			2013											
		Variance	99			98											
	Proportion of people with Personalised Care and Support Plan(PCSP)/UCP	**Actual**	46%			46%											
		Plan	48%			49.4%											
		Variance	-2%			-3%											
L	Continuity of maternity care for women	Actual	Work is undeway to source the data														
		Plan															
		Variance															
	Patient experience indicators on maternity care The benefits of continuity of care in maternity include improved maternal and foetal outcomes, increased satisfaction with care, reduced healthcare costs, and better communication and trust between the healthcare provider and the patient.	Actual															
		Plan															
		Variance															
	Infant and maternal mortality	Actual															
		Plan															
		Variance															

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Impact measures performance trend (5)

Outcome	Impact measure	Target/Plan	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year to Date	Comments
M	Number of children and adults with learning disabilities and/or autism currently cared for in specialist inpatient units	Actual	14			10											At the end of Q1, there were 9 adults and one children in specialist inpatient settting
		Plan															
		Variance															
N	Number of people per quarter supported by the Living Well Network Alliance to stay in their own homes (ClaSS)	Actual	8			14											Number of service users starting paid employmenet during each quarter
		Plan	36			36											IPS Performance Target
		Variance	-28			-22											Variance from Target
	Number of people per quarter supported by the Living Well Network Alliance into paid employment (IPS)	Actual	47			34											Number of service users (unique Trust IDs) from referrals accepted during each quarter
		Plan															CLaSS does not work to a fixed quarterly target.
		Variance	47			-13											Variance from previous quarter
	Number of referrals Living Well Network Alliance teams make for service users to additional support routes (such as education, training and employment support, Community Support, Alcohol Advice, Smoking, Benefits advice, Dietician, Family Support)	Actual	492			415											Count of Lambeth SPA "signpost to other agency" + relevant events for all other Lambeth teams
		Plan															
		Variance	492			415											
	Number of service users reporting a positive experience of using mental health services, feeling they have benefited from support and are more independent and in control of their lives,	Actual	68.6%	67.7%	77.8%	76.5%	81.8%	82.4%									From PEDIC
		Plan	78.4%	78.4%	78.4%	78.4%	78.4%	78.4%									Mean value Sep-23 to Sep-24
		Variance	-9.8%	-10.7%	-0.6%	-1.9%	3.4%	4.0%									
	Seclusions and restrictive interventions on inpatient setting	Actual	31	25	28	31	37	43									Restrictive incidents + seclusions
		Plan	32	32	32	32	32	32									Median value Apr-23 to Dec-24
		Variance	1	7	4	1	-5	-11									
O	Number of rough sleepers brought into accommodation	Actual	62			64											
		Plan	52			44											Plan = against previous year position
		Variance	10			20											
	Proportion of people living in our supported housing that are registered with a GP	Actual	98%			98%											
		Plan	92%			90.0%											Plan = against previous year position
		Variance	6%			8%											
	Number of rough sleepers who have returned to the streets after being in settled accommodation	Actual	1			2											
		Plan				1											Plan = against previous year position
		Variance				1											
	Number of Rough Sleepers and residents within the Vulnerable Adults' Pathway engaged with the Integrated Health Network (Multi-disciplinary health team with focus on supporting people into substance use treatment and addressing physical and mental health needs)	Actual	116			85											
		Plan				28											Plan = against previous year position
		Variance				57											

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A. People maintain positive behaviours that keep them healthy

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

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

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

A newly commissioned NHS Health service came into effect in 24-25 where PH commissioned directly with practices organised into PCN's. The model came about from prior service evaluation and best practice learnings aims to improve accessibility and outcomes in line with key elements of the NHS Long Term Plan. The contract is now entering its second contractual year. Q1 2025-2026, saw a total of 1677 Health checks completed. This compares favourably to the same period last year where 1105 health checks were completed indicating that the practices continue to acclimate to the new ways of working under the new model despite the issues experienced in the early part of 24/25

Key outcomes for those who had a Health check this quarter were as follows:
12% of patients who had a health check were referred to lifestyle services or prescribed medication. This includes:

- 29% patients prescribed statins,
- 2% prescribed antihypertensives,
- 31% referred to the National Diabetes Prevention Programme (NDPP),
- 4% referred to smoking cessation services,
- 2% referred to alcohol services,
- 32% referred to weight management.

7%of patients were diagnosed with a health condition and added to appropriate registers. This includes:

- 21% diagnosed with hypertension,
- 3% diagnosed with diabetes,
- 1% with chronic kidney disease (CKD),
- 1% with Familial Hypercholesterolaemia
- 74% with non-diabetic hyperglycaemia.

84% of patients were identified with low 10-year cardiovascular disease (CVD) risk,
14% with moderate risk, and
2% with high risk.

All patients received appropriate advice and support.

A. People maintain positive behaviours that keep them healthy

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

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

Does the data/intelligence identify any health inequalities and whether they are reducing?	The Lambeth population that are eligible for an NHS Health Check is around 90,000 people. Current data shows uptake is largely in line with the demographics of that eligible cohort: • White: Eligible 51% (incl. White British 22% and White Other 29%), Uptake 52% (incl. White British 29% and White Other 23%) • Black: Eligible 17%, Uptake 20% • Asian: Eligible 6%, Uptake 7% • Other: Eligible 8%, Uptake 9% • 40-50 age group: Eligible 60%, Uptake 55% • 51-60 age group: Eligible 28%, Uptake 32% • 61+ age group: Eligible 12%, Uptake 13% This demonstrates the opportunity to pick up risk factors at an earlier stage and to start prevention early. • Female: Eligible 42%, Uptake 51% • Male: Eligible 58%, Uptake 49%
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	<u>Challenges</u> • Ongoing capacity of primary care • Improving uptake of the service especially amongst key demographics • Recommissioning of the service for 26-27 • Infrastructure limitations impacting Incorporating/ embedding At scale model/ Neighbourhood model <u>Actions</u> • Continue regular NHS Healthcheck Steering Group meeting focussing on implementing Strategy and Action plan with LMC representation • Steering Group to address scope and shape Neighbourhood working model • Intention to Direct Award NHS Healthchecks to GPs/ PCNS for 26-27 to build on recently recommissioned model • Agreeing and refining targeted invite approach with GPs to increase key demographic uptake. • Evaluating the effectiveness of DHSC Healthcheck at work and Healthchecks online pilots. • To continue to seek out other proof of concept initiatives to enhance uptake and impact of Healthchecks

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

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

Alliance and Programmes	NWDA (owner) with contributions from CYP and Staying Healthy
What does the data/intelligence indicate around progress against the outcome?	The need for social prescribing continues, with high demand on the service. Comparison of one surgery Age UK Lambeth provides the Social Prescribing Link Worker saw monthly referrals increase significantly. A yearly comparison from July 2024 with 8 referrals to 39 referrals in July 2025.
Does the data/intelligence identify any health inequalities and whether they are reducing?	As always support for financial and housing remains high, with the majority of referrals for one of these needs. So although a demand on the service demonstrates engagement with the community there is a risk that wider determinants such as the cost of living crisis, lack of housing provision etc. is having a detrimental impact on individuals and health inequalities cannot always be addressed via social prescribing alone.
What are the challenges hindering any progress and are there actions which can be taken to address these?	Wider economical, political and social factors impact the social prescribing landscape. There are financial restraints across the borough and nationally which impacts the delivery of statutory, Council and VCSO services. Limited services reduces where Social Prescribing Link Workers can signpost/ refer clients onto. The abolition of NHS England could have an impact on the delivery of social prescribing. It remains unknown if there will be any significant impact or not. Ongoing challenge of no centralised CRM/database for social prescribing in Lambeth.
Additional Comments	

C. People are immunised against vaccine preventable diseases

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

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

What does the data/intelligence indicate around ***progress against the outcome?***	Previous data quality issues—such as inaccurate coverage figures and incomplete child records being counted as fully vaccinated – have now been resolved. Revised 2024/25 data has been published, and enhanced checks and audits are in place. While these measures address the technical problems, the impact on trust and partner motivation is still being felt. **Flu Campaign 2025/26** The national flu campaign began on 1 September with the children's and pregnant women's programme; other eligible groups, including over-65s, will follow from 1 October. ImmForm remains the national monitoring platform. Co-administration of flu with other vaccines (COVID, RSV, etc.) where possible, is being encouraged in Lambeth. As the 2% uptake increase target was missed in 2024/25, the same goal will be carried forward into this season, with renewed focus on outreach and engagement.
Does the data/intelligence identify any ***health inequalities and whether they are reducing?***	National (COVER and ImmForm) reporting do not capture inequalities, but they do show variation in performance across GP practices and vaccination programmes. To tackle gaps and inequalities, work is underway with the Pharmacy Federation to deliver MECC interventions through community pharmacies, encouraging flu-eligible adults (mainly those who are in clinical at-risk groups and those aged over 65 years) to take up offers when collecting prescriptions. For childhood vaccinations, the Vaccination in New Space initiative complements GP delivery by providing one-to-one sessions at children's centres – supporting parents and carers to understand the benefits of immunisation – and home visits for families not reached through GP call-and-recall. A draft dashboard is being developed to track uptake and target engagement in low-uptake areas, while evaluation of the flu campaign with the HEART team will guide improvements for 2026–27.
What are the ***challenges hindering any progress*** *and* ***are there actions which can be taken*** *to address these?*	**Childhood Vaccination**: Previous data quality issues - such as misreporting coverage for five-year-olds and multi-dose vaccines - have now been addressed through updated NHS systems and strengthened audits, with revised 2024/25 data now published. Flu vaccination uptake among over-65s fell to 54.4% in 2024/25, consistent with declines in other SEL boroughs. This reflects ongoing challenges including vaccine fatigue, mistrust, hesitancy, and systemic barriers. These insights are informing a revised strategy for the current season, with greater focus on tackling barriers and rebuilding confidence.

D. People have healthy mental and emotional wellbeing

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

Alliance and Programmes	LWNA and CYPA (owners)
What does the data/intelligence indicate around progress against the outcome?	The Lambeth Living Well Centres' Short-Term Support service (STS) began helping 183 new people in August, fewer than the 208 seen in July but still many more than the monthly average of 156 for 2024/25. This makes 817 new people supported so far in 2025/26. The number of people Focused Support (FS) started supporting in August fell to 26 from 39 in July, which makes 173 new people supported so far in 2025/26. The Lambeth Single Point of Access (SPA) referred 167 people to STS in July, and 89 in August, following concerted efforts in July to reduce the number of people open to SPA. People attending a second STS appointment in August had waited an average of 24.7 days. This is 0.1 days less than the average wait of 24.8 days in 2024/25. This reduction has been achieved despite there being 669 people working with STS at the end of August, 28% higher than the 524 average for 2024/25).
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Past data has highlighted that Black services users are under-represented in accessing the less intensive forms of support (like short-term support) and have a greater need to access intensive support (such a focused support and acute care). Data shows that the improvement in Black service users' access to short term support seen during the last quarter of 2024/25 was sustained July and August, with Black services users making up 35.0% of those accessing short-term support (up 6.3% points on Q1 2025/56). This is also much higher that the 21.7% of the Lambeth adult population that identifies as Black. However the proportion of those new to focused support in July and August that were from the Black community rose to 65.0%. This is a 18.4% rise from the previous quarter and considerably higher than the 2024/25 average of 53.1%. This could be a result of people flowing quickly through Short-Term Support into Focused Support but given the relatively low numbers involved work and time is needed to whether this is significant and if so, what might be the cause.. The latest data on waiting times for a second appointment with STS shows only as small difference between Black and White service users, who waited on average 27 and 25 days respectively.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	We believe that social and economic factors that disproportionately affect Black communities lie behind their need for more intensive services. We use the PCREF framework to engage with our local communities and build trust to improve access, experience and outcomes. Greater access to services for Black people in the early stages of their illness will reduce their need for more intensive forms of support.

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

Tracks rate of STI testing & diagnoses and Primary care LARC uptake- recognising that these aren't the only data items we collectively should be looking at the track delivery of the outcome.

Alliance and Programmes | **Sexual Health**

*What does the data/intelligence indicate around **progress against the outcome?***	Total LARC activity in primary care for Q1 was 915 – total LARC fittings were 510. This included activity within GPs and Hub activity from the new LARC Hub. This is an increase from Q4 where there was 485 total LARC activity including 141 LARC fittings. The GP LARC training programme has commended with one GP receiving training through August and 4 others booked to complete training. There were 509 abortions in Lambeth in Q1. This compares to 574 in Q1 in the previous year. Data from GUMCAD on STI testing and diagnosis number have not been updated since the last report. In July 2025 4,834 kits were requested from the E-service, 3,505 were returned which is 72.5% return rate, 93 residents received treatment. In Q1 there were 3953 residents seen within our 3 Local Trusts in SEL compared to 4,176 last quarter, activity remains stable
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Current Trust in-clinic data shows a good spread across ages, ethnicity and gender in relation to our Borough demographics Higher take-up of LARC among women over 25 compared to population percentage. Reflective of national trend of low LARC take-up in under 25s. Total LARC prescribing rate is significantly higher in Lambeth compared to London (42 per 1000 vs 34 per 1000, 2023)
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Challenges around IT limitations preventing practices from facilitating inter-practice referrals, are currently reducing flexibility for increasing capacity in primary care Alternative to enable inter-practice referrals within PCNs/neighborhoods. New service model of GSTT will offer more appointments for residents through online bookable appointments. Inclusion of EHC in National Pharmacy Contraception Service – will likely increase take-up of EHC via pharmacies. Commissioners will still have access to service data.
Additional Comments	A summary of the recent consultation on the refreshed sexual health strategy will shortly be available on-line. Feedback and suggestions has been collated and will be incorporated into the final publication. In addition to this engagement we have also recently consulted on the proposal to make the temporary move from Streatham Hill Clinic to Minnie Kidd House permanent, if this approach is supported it will mean additional capacity being made available within Lambeth, by opening further clinical spaces, ensuring evening clinics are made available as well as specific young people specific sessions.

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

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

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

What does the data/intelligence indicate around progress against the outcome?	Bowel Cancer screening aged 60-74-Upward trend. Most recent data shows upward trend with 61.8% screened (January 2025) compared to 50% in December 2019. Note for the financial year of 25/26 SEL ambition is 64.6% but this data is from when the target was 60%. Cervical Cancer screening aged 25-64-shows levels are quite stable but not increasing with 62.7% screening in June 2024 compared to 62.8% in April 2023 but down from 66.7% in April 2019. National target is 80%. Note for the financial year of 25/26 SEL ambition is 64.6% **No update to data since last report in July** Breast cancer screening aged 50-70-Upward trend in the past year. Most recent data shows 57.9% screened in January 2025 which is a significant increase from 54.8% in December 2023. Not returned to pre-covid levels which were 61% in November 2019. Below national target of 80%. Note for the financial year of 25/26 SEL ambition is 60.2% Source for all of above is the SEL screening dashboard. There are other sources but this is most accurate and comes from Open Exeter directly. On PrEP activity, data is only available to July 2025. Looking at the data over the years of routine commissioning this is the first year that we are seeing a reduction in numbers accessing PreP, although those that are accessing PrEP as part of continuing prevention pathway rather than starting it, remain higher. The slowing of the growth seen since October 2020 could also be because prescription length has increased to 6 mths, there are also some providers trialling longer acting PrEP methods.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Bowel Cancer screening aged 60-74-Data shows lower screening rates for those with learning disability, severe mental illness and from lower deprivation quintiles. It also shows lower screening rates for those of black, mixed, Asian and ”other” ethnicity compared to white population. Comparing most recent data with 2 years ago shows increased screening rates for black ethnicities and those with SMI Cervical Cancer screening aged 25-64-Current data shows highest screening in those with black ethnicity (70.3%), then white (67.8%) and then significantly lower for mixed (62.8%), Asian (55.0%) and other (52.7%). Significantly lower for those with LD (44%) compared to non-LD (64.7). Rates have not improved in past 2 years. Breast cancer screening aged 50-70-1st deprivation quintile have lowest rates. White (62.3%) and black (62.5%) ethnicity have similar rates, lower in Asian (58.1%), mixed (56.7%) and “other” (53.5%) ethnicities, Significantly lower in LD (45.6%) compared to non-LD (60.4%) and SMI (47.1%) compared to non-SMI (60.7%). Rates overall are improving. Woman accessing PrEP are still very low, below 2% of activity but it is encouraging to see the activity figures slowly increasing indicating that for those women who have been identified, it is an acceptable preventative option. Males between the ages 20 – 60 are preferring to access PrEP within Central London, with the younger ages accessing more locally. Activity within our local Trusts is increasing overtime.

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

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

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

*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	There are numerous ongoing challenges. There is a lag in the data so we are 9-14 months behind with official data to see local rates which can lead to delays in identifying evolving issues. Due to primary care pressures it is difficult for primary care to take on additional screening promotion work. The breast screening incentive has been removed from the local PMS contract so there is now no local primary care incentives for cancer screening. Due to staffing changes within the NWDA there is now less capacity for focus on cancer projects. There are however numerous ongoing projects locally. SELCA have funded projects with IRMO (Latin American community) and LAMSOM (Somali community) which will be coming to an end soon They have also funded a PCN project to increase breast and cervical screening. The NWDA have also funded multiple successful PCN engagement events. The local breast screening service are also working to increase appointments outside of normal working hours to aim to increase screening rates. On PrEP, we need to target our outreach activities to those that are not accessing clinics, we will be doing this via our PrEP in our communities pilot work, working with our outreach providers, GP Champions and Trust clinicians and pharmacists. A recent pilot that has gone live in Lewisham has highlighted the considerable challenges currently faced when wanting to dispense PrEP outside of a specialist clinic. However clinicans working on the communities' access pilot are feeding the learning back to professional bodies to support updating guidance and planning. In the meantime, clinicians will be working with our outreach providers to ensure there are opportunities to widen access where possible. Now that this pilot has dedicated staff, education and training sessions and materials will be developed to improve awareness and knowledge across our communities. Local Trusts have started offering remote/online opportunities to access PrEP, and further to the contract award for GSTT in October, they will be offering dedicated access to residents who are willing to use the shared EPIC hospital record, through evening and weekend access.
Additional Comments	An online digital PrEP pathway is now available for those that are assessed as appropriate to access PrEP remotely. This is a temporary solution until the new Pan London online service is reprocured.

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

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

Alliance and Programmes | **NWDA (Owner)**

What does the data/intelligence indicate around progress against the outcome?	Blood pressure control measures for both age groups are cumulative measures starting from April 2025. Improvement of blood pressure control has continued whilst hypertension detection and diagnosis has increased. Improvements have been made year on year. Ongoing work throughout the year is required to achieve the Health and Care Plan target of 80% blood pressure control by the end of FY 2025–26: ≤140/90 mmHg in people aged 79 years and under, and ≤150/90 mmHg in those aged 80 years and over. As of 1 August 2025, among patients with hypertension, 15,757 of 39,483 aged 79 years and under (39.9%) have blood pressure ≤140/90 mmHg, while 2,901 of 6,007 aged 80 years and over (48.9%) have blood pressure ≤150/90 mmHg indicating there is still work to do to meet the national target. This year's Know Your Numbers Week, led by Blood Pressure UK, runs from 8 to 14 September. The theme is "Looking for the Missing Millions", highlighting the estimated 5 million UK adults living with undiagnosed high blood pressure. To support the campaign locally, Lambeth Health and Wellbeing Bus will offer free blood pressure checks Wednesday 10th – Civic Centre (for staff) and Thursday 11th – Rushcroft Road, outside Brixton Library (for the public).Campaignmaterials for waiting areas and consultation rooms have also been shared with GP practices and community pharmacies. The Lambeth ambition for the proportion of people with Type 2 diabetes, who meet all 8 Care Process metrics, is to reach a minimum of 77% or improve from prior year baseline by 10 percentage points. The measure is cumulative from April 2025. At the beginning of August 2025 29.3% of patients had their 8 Care Processes measured and recorded to support diabetes treatment and care, alongside the total number of people with a diagnosis of Type 2 diabetes (denominator) increasing from April 2025. We undertook a webinar in collaboration with our NHS Diabetes Prevention Programme provider, Thrive Tribe, in June to promote the benefits of referring patients for this support programme and increase referrals. This was well attended by GPs and practice pharmacists. Problematic polypharmacy (prescribing of 10 or more concurrent medicines) increases the risk of drug interactions and adverse drug reactions (ADR), impairing medication adherence and impacting on a patient's quality of life, this risk increases with the number of prescribed medicines a patient is on and when specific therapeutic combinations are concurrently prescribed. In conjunction with the patient, SMRs provide a holistic medication review to ensure prescribed medicines are safe, effective and personalised to patients' current needs. SMRs improve outcomes, reduce unnecessary or inappropriate prescribing and polypharmacy, reduce harm and improve patient outcomes. The number of coded Structured Medication Reviews (SMR) in Lambeth for patients who are 65 years or over and prescribed 10 or more medicines continues to be tracked to indicate progress. There has been an increasing trend of people over the age of 65 who are taking 10 or more medicines received a structured medication review since 01 April 2025. On 1 August 2025, a total of 291 of the 3390 (8.58%, previously 5.25%) patients have had a SMR.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	More black and minority ethnic people have been identified with hypertension when comparing August 2024 to August 2025 data; 9141 and 9817 respectively and within these cohorts, blood pressure control has remained consistent with higher absolute numbers in comparison to the previous year; 24,242 and 25,162 respectively. Current data from the EZA Cardiovascular app shows that hypertension control in the Black African, Black Caribbean, Mixed White and Asian, Unknown or not stated ethnic groups is improving, with comparable rates of target blood pressures being reached across all ethnicities. In addition, year on year performance across target ethnicities and all ethnicities has increased. The measurement and recording of the 8 care processes for Black, Asian and multi ethnic groups continues to trend upwards. Polypharmacy can lead to increased harm from unnecessary or inappropriate prescribing. By ensuring medicines are being used appropriately, we can reduce adverse effects, hospitalisation and improve outcomes, which may impact on those with greater health inequalities. The data shows a continual increase in SMRs conducted since previously inclusion in the 2024/25 Medicines Optimisation Section (of the Lambeth GP Improvement Scheme), and we continue to work with colleagues across SEL on reducing inappropriate prescribing and polypharmacy as further evidence emerges.

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

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

Alliance and Programmes	NWDA (Owner)

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

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

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

Alliance and Programmes	LWNA and CYPA (owners)

What does the data/intelligence indicate around progress against the outcome?	As at the end of August 2025, the number of people open to Lambeth Single Point of Access (SPA) was 144, down 26% from the 194 open at the end of July and 76% from the 595 open at the end of June. This improvement follows a concerted effort to reduce the number of people open and waiting for their referral to be processed by the SPA team. A special team of additional staff members focused on dealing with the oldest referrals. Those people still open to SPA at the end of August, had been open to SPA, on average, for 6.6 days in the case of urgent referrals and 15.3 days for routine referrals, respectively a 51% and 71% reduction from the end of June. Lambeth Talking Therapies (LTT) is now measuring access by the number of people completing treatment rather than attending a first appointment. By that measure, the service was at 109% of target at the end of July (the latest available data), up from 96% at the end of June. 2,089 people have completed their LTT treatment so far in this financial year. Lambeth CAMHS referrals remain high (c114 / month). Demographic breakdown of referral data is not provided in the SLaM report, nor is information on referral rejection. Caseload has grown (from 2424 active cases to 2821 in a 12-month period), largely due to neurodevelopmental cases (e.g. ADHD) which typically stay under CAMHS care longer. First contact within 28 days is being achieved, with Lambeth performing well on this measure (ave. 96% Q1 2025). This is important, as it introduces those referred to service to additional support and advice available to them whilst waiting for assessment or therapeutic intervention. 52-week waiters have reduced markedly (from 26 in April ‘25 to 7 in June ‘25), and this is due to targeted waiting-list work.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Data for Lambeth SPA in July and August showed no inequalities in the SPA process. 26% of Black Service users introduced to SPA received onward referrals to Community Mental Health Services or the Trust, the same percentage as for White service users. Average waiting times for urgent introductions processed in August also show no meaningful difference, being 7.3 days and 7.7 days for Black and White service users respectively. Access to Lambeth Talking Therapies (LTT) Recovery for Black service users continues to improve. In April to June 2025 (the latest period for which data is available), 25.2% of new clients identified themselves as Black, better than the 24.2% seen in the previous quarter, and the 21.7% Black population of Lambeth. Session attendance and treatment completion continues to be roughly equal across groups. Reliable recovery rates for Black service users have been steadily improving but were disappointing in July at 45.8% (2.2% points below the 48.0% target and 6.0% points below the whole service average). The LTT team noted that starting severities were higher for members of the global majority. On CAMHS activity, caseload pressure is significantly driven by the neurodevelopmental pathway. The data does not provide breakdowns by ethnicity, deprivation, or other characteristics for those referred or waiting, so limited health inequalities can be confirmed or tracked from this data. The report is, however, being developed and updated constantly.

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

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

Alliance and Programmes	LWNA and CYPA (owners)

*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Efforts to remodel the Lambeth Single Point of Access that begun in June have been overtaken by the need to widen the scope of change and urgently reduce the backlog of referrals. Rapid progress is now being made on a new clinically led project that is working to propose a new model more closely aligned with Lambeth's strategy for more neighbourhood-based care. Lambeth Talking Therapies continues to focus on having more new clients access the service who are then assessed as being recovered and showing significant improvement in their symptoms when they complete treatment (i.e. are in "Reliable Recovery"). The LTT service is also working to increase session numbers for Black clients and ensure that reliable recovery rates are consistently over 48% for all ethnic groups. Neurodevelopmental cases contribute to long waits and increasing caseload due to their complexity and treatment duration. Targeted action includes additional ADHD capacity, but demand continues to exceed capacity in this pathway.

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

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

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

What does the data/intelligence indicate around ***progress against the outcome?***	HWBus ,the data indicates consistent reach into communities and delivery of health and wellbeing services to residents.
Does the data/intelligence identify any ***health inequalities and whether they are reducing?***	HWBus, the data shows that people with health inequalities are being identified, many of whom may not be linked in with/connected to other health services such as alcohol use interventions.
What are the ***challenges hindering any progress*** *and* ***are there actions which can be taken*** *to address these?*	HWBus, a consistent challenge has been identifying result of service user after interaction with H&W bus and team and if person went on to making progress. We have been using a follow up form that ties with directly with GP records which holds potential to address this challenge.
Additional Comments	

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

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

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

What does the data/intelligence indicate around progress against the outcome?	The Lambeth Pharmacy First Plus Service addresses and supports the health inequalities in Lambeth in relation to the impact of the cost-of-living crisis on the ability of the local population to self-care and buy medicines available over the counter for minor and self-limiting conditions in line with NHS England guidance. Community Pharmacy have undertaken 1473 consultations between May 2024 and July 2025 with Lambeth residents/registered patients to provide advice and guidance on self-care and supply of medicines where appropriate. The NHS Pharmacy First Service increases GP capacity through triaging of low-acuity conditions to community pharmacy. GP referrals to NHS Pharmacy First supports the national approach to increasing GP access. Data from the last 12-months rolling data from 30 June 2024 to 30 May 2025 shows a positive increase in use. The National Pharmacy First service and local Pharmacy First Plus Service increases access to general practice, through provision of self-care advice and any necessary treatments directly via pharmacies for people at higher risk of health inequalities or higher deprivation. The 2025-26 SEL Medicines Optimisation Plan includes a measure to increase use of the NHS app capability of ordering repeat prescriptions so that patients may more easily be equipped to take greater control over their health and care and to access care at the right time and place.
Does the data/intelligence identify any health inequalities and whether they are reducing?	Data from May 2024 to July 2025 shows most interventions (1195) have taken place for people whose registered post code district falls within IMD decile 1 to 3 which shows the service is accessed by the target population - those with the highest deprivation. Data to date, demonstrates that if people did not have access to the Lambeth Pharmacy First Plus Service, 71% of patients would have visited general practice to request the medication on prescription and 29% would have gone without medication as they are unable to buy the medicines over the counter to deal with minor conditions due to the current cost of living crisis. People who are receiving support through universal credit, patient aged under 16 years or receive income support are the top social vulnerability eligibility groups accessing Lambeth Pharmacy First Plus Service in July 2025. General Practice feedback has been that the service has a had a positive impact for patients and reduced GP appointments for minor conditions. Data from July 2025 shows a 11.2% increase (18,387 in July 2025 vs 16,528 in April 2025) in repeat prescriptions being ordered via the NHS app.
What are the challenges hindering any progress and are there actions which can be taken to address these?	Initial usage of the NHS Pharmacy First Service was slow due to IT issues and training needs. Increased promotion of both the Lambeth Pharmacy First Plus service and the NHS Pharmacy First through local bulletins, practice visits and webinars has helped to increase understanding and usage of the Services. The Medicines Optimisation Team has collaborated with the Local Authority Cost of Living Programme Lead to discuss continual and increased promotion of the Lambeth Pharmacy First Plus service to residents. The NHS App is available for use by anyone aged 13 or over who is registered with an NHS GP practice in England. As with any technology, there will be unequal access to these services across different socio-economic groups, which, can lead to worsening healthcare inequalities. Households with lower incomes, for example, may have limited internet access and lack the digital skills needed to make use of it. Disability may also contribute to difficulties accessing digital tools and inclusivity must be at the heart of their design. Practice staff should support patients with access needs, for example those with learning disabilities, autism, visual impairment, and hearing loss. A more traditional, non-digital, solution should remain available for those patients who simply cannot or will not engage digitally.

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

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

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

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

Lambeth Pharmacy First Plus Service Total number of patient interventions	
May-24	87
Jun-24	112
Jul-24	83
Aug-24	65
Sept-24	96
Oct-24	95
Nov-24	138
Dec-24	111
Jan-25	88
Feb-25	106
Mar-25	97
Apr-25	106
May-25	84
Jun-25	97
Jul-25	108
Total – 1473	

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

1. Universal credit (44%)
2. Patients aged under 16 years (33%)
3. Income Support (9%)

Total Pharmacy First consultations (includes referrals to 7 Clinical Pathways, Minor Illness and Urgent Medicine Supply Service)	
June-24	2224
Jul-24	2374
Aug-24	2336
Sept-24	2655
Oct-24	2310
Nov-24	3161
Dec-24	3442
Jan-25	3496
Feb-25	3471
Mar-25	3575
Apr-25	3294
May-25	3528
Total – 35,886	

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

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

Alliance and Programmes	NWDA (Owner)

*What does the data/intelligence indicate around **progress against the outcome?***	The number of accepted referrals to Reablement has decreased slightly to an average of 45 per month for June and July. For this financial year 17% of referrals to Reablement have come from the community. . The number of people who have a reduced or no need for care at the end of a period of Reablement has remained high and this is positive. The percentage for people with a reduced or no need for care at the end of Reablement remains steady at 86%. There has been a change in the way we deliver Reablement. The Rehab Support Workers (RSW's) in Intermediate Care Lambeth are now delivering personal care as well as exercise programmes. We will be monitoring the outcome of these cases. We continue to achieve a high performance rate for the proportion of carers of service users who were offered a carer's assessment. The baseline is 98% and the latest overall position is 100%. We have also identified a member of staff in each team to be Carer's Champions and this will help to raise awareness of carers in the teams.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	The majority of reablement referrals are made via the hospital discharge route. However we are increasing the number of people who are offered a reablement service via our front door team in Adult Social Care. This extends the reablement offer to people living in the community at home. Community Referrals to Reablement are now at 17%. This will help to offer a more equitable service for those residents living at home who may benefit from reablement care. There is a named linked physiotherapist from GSTT Rehab and Reablement Team working closely with the ASC front door managers to help identify appropriate referrals to reablement.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	The Discharge Operational Delivery Group (DODG) has a dedicated workstream looking at the reablement pathway from the ward to the internal flow hub and then on to the service to improve the process and ensure referrals to the service are appropriate. There has been some work to increase the number of weekend discharges at GSTT which was successful. Following this the weekly wash up meeting after the weekend (to review those patients who were not discharged at the weekend as expected) has now been reinstated.
Additional Comments	

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

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

Alliance and Programmes	CYPA (Owner)

What does the data/intelligence indicate around ***progress against the outcome?***	Planned deep dive update, see enclosed papers.

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

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

Alliance and Programmes	LDA (Owner)

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

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

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

Alliance and Programmes	LWNA (Owner)

What does the data/intelligence indicate around progress against the outcome?	LWNA's Community Living and Support Service (CLaSS) helps people with serious mental health conditions to leave inpatient care and live in the community. In the last quarter of 2024/25, April to June, CLaSS started working with 34 new people, fewer than the 47 new clients in the last quarter, January to March. Since this data is submitted quarterly, this repeats the report made in July. LWNA's Individual Placement and Support (IPS) helps people with a serious mental illness find and sustain paid employment. The IPS service helped 14 people find work in the last quarter, April to June, a significant improvement on the 8 people supported in the previous quarter. This is less than the original placement target of 36 per quarter, but the team also helped 9 people to sustain employment for at least 13 weeks and 2 for 26 weeks or more. Again, this quarterly information was previously reported in July. There were 43 restrictive incidents and seclusions for inpatients in August, well over both the 37 seen in July and the average of 35 for financial year 2024/25. Positive friends and family survey responses for LWNA services were at 82.4% in August, an improvement of 2.9% points on the 79.5% average for the previous financial year.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Of the new people supported by CLaSS in the first quarter of 2025/26, April to June, 50% were for Black services users, down from the 54% seen in the previous financial year. However, there are too few people involved to be sure that this small difference is statistically significant. More intensive LWNA services presents a mixed picture in the first quarter, April to June, with the proportion of Black people newly accepted into inpatient care rising by 4%, but the equivalent figure for more intensive community support (focused support and home treatment) falling by 4%. Both figures remain much higher than might be expected though, given that the Black adult population of Lambeth is 21.7%. Of the 79 restrictive incidents and seclusions reported for Lambeth acute inpatients with a stated ethnicity in July and August, 40 (51%) were for Black compared 56% in the preceding 3 months Apr-Jun. However, the numbers involved are too small, highly variable and linked to the same people involved multiple times to draw any firm conclusions.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Black service users remain more likely to need intensive forms of support, such as inpatient care or home treatment and focused support in the community, than White services users, who typically access less intensive forms of support earlier in the development of their illness. LWNA is using the PCREF framework to engage with local communities and build trust to improve access, experience and outcomes. Improved access to early forms of support will, over time, reduce the level of inequality seen in the more intensive services.

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

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

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

What does the data/intelligence indicate around ***progress against the outcome?***	Lambeth continues to see high numbers of new rough sleepers and those who are only seen once (transient rough sleepers) The total number of people verified as bedded down during Q1 was 178 and 100 of those were new. 53 of the new rough sleepers were only seen once by the outreach team. The number of rough sleepers successfully supported into accommodation during Q1 was 64 and the number of those returning to rough sleeping after being in settled accommodation remains low at 2. Hot SWEP (Severe Weather Emergency Protocol) has been activated, and our outreach team work hard to support vulnerable rough sleepers to drink water, encourage them to cool spaces and offer accommodation where appropriate. The number of residents registered with GP's continues to be at its highest level. This has been achieved through contract monitoring and consistent messaging to Providers to ensure each resident is being supported to register when being accommodated in their service. SWEP (Severe Weather Emergency Protocol) continues to be activated when temperatures fall to zero or below and all rough sleepers are supported by our outreach team to accept emergency accommodation. Rough sleepers can then be assessed fully and access health services as required. The number of people (both rough sleepers and those accommodated in supported accommodation) engaged with the Integrated Health Network (IHN) means that health and substance use issues continues to be addressed proactively and effectively, therefore reducing health inequalities across the homeless population in Lambeth. There is proactive work in increasing the IHN team's presence across rough sleeping outreach services to ensure rough sleepers are at the centre of this work.
Does the data/intelligence identify any ***health inequalities and whether they are reducing?***	For as long as people sleep rough there will be health inequalities, however the outreach team work hard to support individuals to engage with health services while on the street and to move people away from the street as quickly as possible. This is indicated by the numbers engaged with the IHN and other outcomes around engagement in treatment services. The data shows that the adults supported housing pathway continues to effectively support people to access health care via GP registrations and engagement with services.
What are the ***challenges hindering any progress*** *and* ***are there actions which can be taken*** *to address these?*	Prevention of new rough sleepers hitting the street is an area that needs more focus in Lambeth and the rest of London. A large proportion of these individuals would be assessed as not priority need under Housing legislation so are not offered accommodation. They often run out of "good will" situations, such as sofa surfing and end up sleeping rough. Local Government and Councils need to explore how to better support this group.

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