

LAMBETH TOGETHER CARE PARTNERSHIP (FORMERLY LAMBETH TOGETHER STRATEGIC BOARD)

Date: Thursday 8 January 2026

Time: 1.00 pm

Venue: Microsoft Teams

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Members of the Committee

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

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

Further Information

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

Access for Members of the Committee

In line with legislation, Committee members must attend via Microsoft Teams.

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

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AGENDA

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Lambeth Together

Integrated Assurance Report

25 November 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

ID	Outcome	Measures tracked	Nov-25			Vs previous update	Sep-25	Comments
			Measures Reported with a target	On plan/ target	% measures on track (where have a target)		% measures on track (where have a target)2	
A	<i>People maintain positive behaviours that keep them healthy</i>	5	1	1	100%	—	100%	
B	<i>People are connected to communities which enable them to maintain good health</i>	1	1	1	100%	—	100%	
C	<i>People are immunised against vaccine preventable diseases</i>	3	3	0	0%	—	0%	Flu indicators will be validated at year end positon.
D	<i>People have healthy mental and emotional wellbeing</i>	3	3	2	67%	↑	33%	
E	<i>People have healthy and fulfilling sexual relationships and good reproductive health</i>	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	<i>People receive early diagnosis and support on physical health conditions</i>	5	5	2	40%	↓	60%	LD AHC performance is behind monthly trajectory though YE target is expected to be achieved in line with previous years One Cancer screening programme tracking above national target.
G	<i>People who have developed long term health conditions have help to manage their condition and prevent complications</i>	4	3	3	100%	—	100%	Cardiovascular and Diabetes measures above previous year trajectory.
H	<i>When emotional and mental health issues are identified; the right help and support is offered early and in a timely way</i>	4	2	1	50%	—	50%	
I	<i>People have access to joined-up and holistic health and care delivered in their neighbourhoods</i>	3	2	2	100%	—	100%	
J	<i>People know where to go to get the right help, and are treated at the right time, in the right place, for their needs</i>	4	1	1	100%	—	100%	
K	<i>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</i>	4	2	2	100%	—	100%	
L	<i>Women have positive experiences of maternal healthcare and do not experience a disproportionate maternal mortality rate</i>	0	0	0	-	—	-	
M	<i>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</i>	3	1	1	100%	—	100%	
N	<i>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</i>	4	3	2	67%	↑	33%	Measures tracked against previous year activity
O	<i>People who are homeless, or at risk of becoming homeless, (including rough sleepers and refugees) have improved health</i>	4	4	4	100%	—	100%	Measures tracked against previous year activity
	Total	50	32	23	72%	↓	75%	



Health and Care Plan: Key headlines (1)

	Outcome	Key Headlines
A	People maintain positive behaviours that keep them healthy	<p>In Q2 2025-2026, there was a total of 1337 Health checks completed. This compares favourably to the same period last year where 746 health checks were completed when the service was severely impacted by the Synovis Lab Cyber attack. The Practices continue to acclimate to the new ways of working as set forth by the new model despite the issues experienced in a significant portion of 24/25 and the holdover it carried through to 25/26.</p> <p>There are the following challenges ongoing capacity of primary care, improving uptake of the service especially amongst key demographics, recommissioning of the service for 26-27 and infrastructure limitations impacting Incorporating/ embedding At scale model/ Neighbourhood model.</p>
B	People are connected to communities which enable them to maintain good health	<p>The percentage of residents coping financially has increased by almost 3% since last reporting. The number of residents in the dataset have also increased as the council now has access to additional information for residents in receipt of benefits Universal Credit. This suggests positive progress against the action.</p>
C	People are immunised against vaccine preventable diseases	<p>The lack of resources limiting the type of support social prescribers can provide to residents.</p>
D	People have healthy mental and emotional wellbeing	<p>Planned deep dive, see enclosed presentation along with highlight report updates.</p> <p>Data shows that the improvement in Black service users' access to short term support seen during the last quarter of 2024/25 is being sustained through to September and October, in which Black services users were 34.0% of those accessing short-term support (up 5.3% points on Q1 2025/26). This is also much higher than the 18.7% of the Lambeth 18-64 population that identifies as Black. The proportion of those new to focused support during September and October from Black communities fell to 50.0%, lower than the 2024/25 average of 53.1%. The numbers involved however are relatively low and so need to be viewed over a longer period to establish a reliable downward trend.</p> <p>The latest data on waiting times for a second appointment with STS shows Black services users receiving a second appointment more quickly than White service users (waiting on average 27 and 32 days respectively). This may reflect the fact that, In September and October, 42% of STS referrals for Black service users were prioritised as being urgent, compared to 35% for White service users.</p>

Health and Care Plan: Key headlines (2)



	Outcome	Key Headlines
E	People have healthy and fulfilling sexual relationships and good reproductive health	<p>The latest available data on number of STI tests and number of STI diagnosis is up to Q4 24/25. Number of tests remain steady. There were 16,098 tests taken by Lambeth residents between January and March 2025. This is similar to the previous quarter where 16,218 tests were undertaken. Number of new STI diagnosis have decreased slightly with 2,300 new diagnoses in Q4 24/25 compared to 2,423 in Q3 24/25. This is also lower than the same time period in the previous year (2,522, Q4 23/24). Diagnosis of chlamydia appears to be on a downward trend with 721 diagnosis this quarter, compared to 819 in the previous quarter and 1010 in the same quarter the previous year. Please note, quarterly data from GUMCAD are provisional and subject to change.</p> <p>On Reproductive Health, challenges on IT limitations preventing practices from facilitating inter-practice referrals continue, offers will seek to find a solution for the new contract from April 2026.</p>
F	People receive early diagnosis and support on physical health conditions	Planned deep dive, see enclosed presentation along with highlight report updates
G	People who have developed long term health conditions have help to manage their condition and prevent complications	<p>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% of improve from prior year baseline by 10 percentage points. The measure is cumulative from April 2025. As of 15 October 2025, 46.8% 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. The National Diabetes Audit (24/25) shows that 72.4% of patients with type-2 Diabetes in Lambeth had had their 8 Care Processes measured and recorded to support diabetes treatment and care. This is 15 percentage points higher than the national average (57.6%), 7 points higher than the South East London average (65.4%), and 4 points higher than the London average (68.1%). Lambeth outperforms 40 of 42 boroughs.</p>
H	When emotional and mental health issues are identified; the right help and support is offered early and in a timely way	<p>The number of people open to Lambeth Single Point of Access (SPA) at the end of October was 196, down 3% from the 203 open at the end of September and 67% from the 595 open at the end of June, but up 40% increase from the 140 seen at the end of August following the concerted effort to reduce that June total. People still open to SPA at the end of October, had been open to SPA, on average, for 7.6 days in the case of urgent referrals and 15.9 days for routine referrals, respectively a 61% and 52% increase from the end of September.</p> <p>Lambeth CAMHS referrals remain high (caseload 114 / 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.</p> <p>First contact within 28 days is being achieved, with Lambeth performing well on this measure (avg. 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.</p> <p>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.</p>



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	<p>On the Health and Wellbeing Bus, 252 people were seen for a Vital 5 check during this period. Out of this total, 10 had a GP follow up form submitted, having their details sent over and linked with their GP records to receive a follow up call and further support from their GP. Over 20 were instructed to go to their GP within the same day, 7 days, 3 weeks or a year. Over 90 were signposted to seek further support by either self referring to their GP or local pharmacy.</p> <p>The data shows that we're reaching people with complex health conditions, identified through our outreach and ensuring that they're seeking support beyond our limitations, contributing to a more joined up and holistic health and care approach.</p>
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	<p>Lambeth Pharmacy First Plus Service data shows from May 2024 to September 2025 most interventions (1343) 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, 59% of patients would have visited general practice to request the medication on prescription and 41% 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 pension credit guarantee credit are the top social vulnerability eligibility groups accessing Lambeth Pharmacy First Plus Service in September 2025. General Practice feedback has been that the service has had a positive impact for patients and reduced GP appointments for minor conditions.</p> <p>Data from August 2025 shows a 5.08% increase (17,369 August 2025 vs 16,528 in April 2025) in repeat prescriptions being ordered via the NHS app.</p>
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	<p>For quarters 1 and 2 of 2025/26 both the size of practice end of life care registers as a proportion of list size and the proportion of patients on those registers with advanced care plans have remained static. There are no regularly published datasets providing insight into inequalities at end of life at borough level. Demographic information collected by palliative care services provides a limited proxy for the characteristic of ethnicity only. This indicates that service provision is broadly in line with the borough's diversity.</p>
L	Women have positive experiences of maternal healthcare and do not experience a disproportionate maternal mortality rate	<p>Data from 2023 shows that stillbirths per 1,000 births and neonatal death rates are higher than both South East London and national averages. However, because the absolute numbers are small, minor changes in the number of cases result in larger percentage fluctuations</p>



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	In November 2025, the number of people cared for in specialist inpatient units was 11 which represents a steady downwards trend since 22/23. This evidences the effective work to facilitate discharge to the community and prevent admission.
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	Planned deep dive, see enclosed presentation along with highlight report updates
O	People who are homeless, or at risk of becoming homeless, (including rough sleepers and refugees) have improved health	<p>The number of rough sleepers successfully supported into accommodation during Q2 was 54, a decrease from 64 in the previous quarter. This remains a positive overall figure for move on. The summer months involve a different rough sleeping landscape with higher numbers of intermittent rough sleeping (i.e. seasonal workers rough sleeping in Waterloo but rejecting all engagement with outreach teams) as well as individuals from other boroughs rough sleeping in Lambeth for a single night or for short periods of time before returning to their originating borough. This is characteristic of the warmer months and makes effective move on more challenging.</p> <p>The number of those returning to rough sleeping after being in settled accommodation remains low at 3. This represents an increase of 1 from the previous quarter. Two of the individuals represented in this data were (and remain) in stable accommodation but rough slept for one night before returning to their bedspaces (one was from Lambeth, one from Westminster). The one client who was homeless is now accommodated.</p>

Finance



Overall Finance Position (2025/26 M06)

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	323	323	0	645	645	0
Community Health Services	15,232	15,110	123	30,465	30,465	(0)
Mental Health Services	12,112	12,869	(757)	24,128	25,173	(1,045)
Continuing Care Services	17,955	17,333	622	35,911	34,644	1,267
Prescribing	21,927	22,215	(289)	43,998	44,577	(579)
Other Primary Care Services	1,994	1,815	179	3,989	3,631	358
Delegated Primary Care Services	48,227	48,406	(179)	96,454	96,812	(358)
Corporate Budgets	2,333	2,284	49	4,666	4,666	0
Total	120,104	120,356	(251)	240,255	240,613	(358)
Equalisation of Ring Fence Delegated Primary Care						358
Revised Full Year Forecast Variance						0

- The borough is reporting an overall **£251k year to date overspend position** and a forecast breakeven position at Month 06 (September 2025) after the “equalisation” of the ring fenced delegated primary care budgets. The reported forecast position includes **£1,045k overspend on Mental Health Services** and **£579k overspend on Prescribing** offset by underspend on Continuing Health Care (CHC) Services and Primary Care Services.
- The key risks within the 2025-26 Lambeth's finance position are **exponential growth in referrals to independent sector providers for ADHD & ASD assessments, Mental Health Cost Per Case 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 M06 for this specific budget is £2.2m 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 through 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 6, noting previous year (2024-25) overspend position was driven by locum reimbursements, retainer scheme and list size growth.
- The Continuing Healthcare budget is **forecasting £1,267k 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 M06 is 552.
- Prescribing actual data is available two months in arrears and the borough is **reporting a £579k forecast overspend position** against in year budget at month 6 based on four 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 M6 Updates

Integrated Health & Adult Social Care	Budget £'000	Forecast £'000	Variance £'000
Adult Social Care			
Expenditure	181,237	194,525	13,288
Income	-59,552	-65,967	-6,415
Net	121,685	128,558	6,873
Public Health			
Expenditure	44,150	45,711	1,561
Income	-44,150	-45,711	-1,561
Net	0	0	0
Integrated Commissioning			
Expenditure	12,432	12,570	138
Income	-12,299	-12,437	-138
Net	133	133	0
Senior Management			
Expenditure	1,851	1,986	135
Income	-198	-333	-135
Net	1,653	1,653	0
IHASC Directorate Total			
Expenditure	239,670	254,792	15,122
Income	-116,199	-124,448	-8,249
Net	123,471	130,344	6,873

Following a directorate level restructure, Adult Social Care & Integrated Health & Care have merged to form a single directorate.

- Breakeven position in Public Health, and Integrated Commissioning and Senior Management divisions

Adult Social Care:

- Overspend reduced by £1.173m due to early decommissioning of contracts in Supported Housing, in preparation for the Vulnerable Adults Pathway contracts to commence in 2026/27 (£673k reduction), and a £500k grant contribution towards placement costs.
- However, both factors are one-off mitigations against the current financial year's position, and £8m underlying pressure remains
- Demand management actions have been able curb any further increases in the forecast for the current year.
- Long-term support placements remain the primary driver of the overspend, especially in **Older People (OP)** and **Adults with Learning Disabilities (ALD)**.

Mitigations & Actions:

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

Quality



Quality update enclosed with LTAG pack

Risk Summary

Risk highlights



Director / lead	leads for the 7 priority areas, lead commissioners
Management Lead	Andrew Eyes, 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 October, there were 9 active risks on the South East London Risk register for Lambeth.
- Since the last update to this group the following risk scores have been adjusted
 - Integrated Community Equipment Service reduced score from 12 to 6 considering new provider PEH continuing to improve delivery, 92% deliveries and 100% repairs have been completed on time.
 - The risk on Diagnostic waiting times for neurodiversity assessments (CYP) increased score to 16, following discussion at Place Executive Leads (PELs) meeting in October, agreement by all PELs risk should be escalated to BAF.
- SEL Risk forum took place in November and risk leads met to discuss risks across SEL, receive updates from risk leads and review Local Care Partnership comparative report, no significant changes noted at this time.

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.					
0 (Pending)		9 Active			29 Inactive	
0 New	0 Escalated	9 Review due within 30 days	Review Overdue		29 Closed	0 Rejected

Lighter low risk score,
darker higher risk score



Likelihood ▾	Consequence				
	Negligible	Minor	Moderate	Major	Catastrophic
Almost Certain	0	0	0	0	0
Likely	0	0	1	142	129
Possible	0	128	2	135	608 609 572 605
Unlikely	0	0	1	634	0
Rare	0	0	0	0	0

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	16
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	6

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	Sep-25	National standard	66.7%	76.0%	71.1%	Above	1
IAPT discharge	Aug-25	Operating plan	533	570	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	Q1 25/26	Local trajectory	55%	57.0%	53.6%	Above	1
LD and Autism - Annual health checks	Aug-25	Local trajectory	358	439	N/A	N/A	-
Bowel Cancer Coverage (60-74)	Mar-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)	Mar-25	Corporate Objective	59.7%	58.6%	63.1%	Below	6
Percentage of patients with hypertension treated to NICE guidance	Sep-25	Corporate Objective	76.0%	66%	67.0%	Above	2
Appointments seen within two weeks	Aug-25	Operating plan	-	92.5%	88.6%	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	50%
Adults with Learning Disabilities	Focus on LDA Health Inequalities	50%
	NHSE Learning Disability and Autism Programme	50%
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	50%
Medicines Optimisation	Deliver Medicines Optimisation Priorities	50%
Primary Care	Improve Access to Primary Care	50%
	Shift to Neighbourhoods by working collaboratively with Integrated Health and Care providers	25%
Public Health	Age-Friendly Lambeth	50%
	Health Intelligence	50%
	Infection Prevention and Control of Communicable Diseases	50%
	Sexual Health	50%
	Staying Healthy	50%
	Substance Misuse	50%
Public HealthCPC: People Focussed		
Services	Lambeth HEART	50%

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 Q2 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%			12.1%								Data source - SEL Vital 5 dashboard (as of September 25)- Of those with a smoking status, 30,280 (12.1%) are recorded as smoking in the past 5 years.
		Plan							12.6%			12.5%			12.3%		
		Variance							-0.5%								
	Number of adults insubstance misuse opiate clients in treatment	Actual	927					922									March 2025 (April 2024 to March 2025) August 2025 (Sept 2024 to Aug 2025)
	Number of adults insubstance misuse non-opiate clients in treatment	Actual	552					598									March 2025 (April 2024 to March 2025) August 2025 (Sept 2024 to Aug 2025)
	Number of adults insubstance misuse alcohol clients in treatment	Actual	560					563									March 2025 (April 2024 to March 2025) August 2025 (Sept 2024 to Aug 2025)
	Uptake of the NHS Health Check for all eligible adults	Actual		0.66%	1.31%	1.83%	1.93%	1.95%	2.00%	2.00%							Data Source - EZ Analytics
		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		0.4%	0.8%	1.2%	1.3%	1.0%	0.8%	0.0%							
B	Percentage of low-income residents coping financially	Actual	77.7%			79.3%			81.2%								
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%			2%									
C	Proportion of Lambeth registered children by age 2 that have received one dose of MMR	Actual	82.6%			76.14%											
		Plan	83.5%			79.5%			80.9%			79.9%			82.6%		Plan = against previous year position
		Variance	-0.9%			-3.4%											
	Proportion of Lambeth registered population who are over the age of 65 receiving immunisation for Flu	Actual							36.4%								Data source - Imms Form Week 43
		Plan							41.2%	49.3%	52.6%	54.0%	54.4%	54.7%			Flu uptake in 24/25 (data source EZA)
	Proportion of Lambeth registered population who are within the 'at risk cohort' receiving immunisation for Flu	Actual							18.7%								Data source - Imms Form Week 43 category under 65 at risk
		Plan							24.6%	30.2%	32.8%	34.0%	34.4%	34.6%			Flu uptake "At Risk" cohort (SEL COVID & FLU Vaccinations Dashboard)

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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																	
	Number of Entering treatment with Short-Term Support with Living Well Centres.	Actual	143	125	150	151	208	183	130	182									
		Variance	12	-18	25	1	57	-25	-53	52							Against previous month's position		
	Number of Entering treatment with Focused Support with Living Well Centres.	Actual	27	37	39	32	39	26	25	42									
		Variance	27	10	2	-7	7	13	-1	17							Against previous month's position		
	LWNA Short Term Waiting Time	Actual	27.3	25.6	30.4	26.5	26.6	24.7	31.1	26.7									
		Plan	26.0	26.0	26.0	26.0	25.96	25.96	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	-5.1	-0.7									
E	Rates of STI testing	Actual																	
		Plan																	
		Variance																	
		Actual																	
		Plan																	
	Rates of STI diagnoses	Variance																	
		Actual																	
		Plan																	
		Variance																	
		Actual																	
F	Number of LARC uptake in primary care	Plan				319			272			276			299		24/25 Out turn		
		Variance																	
		Actual	64%	2.80%	7.6%	14.3%	21.4%	25.9%	31.7%	38.5%									
		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%	1.7%	3.5%									
	Uptake of SMI health checks	Actual	83%	3.9%	8.0%	13.2%	20.2%	25.6%	32.3%	40.4%								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%	-5.5%	-3.7%									
		Actual																	
		Plan																	
G	Proportion of Bowel Cancer screening for those aged 60-74	Variance																	
		Actual																	
		Plan																	
		Variance																	
		Bowel cancer screening – 2.5 year coverage (ages 60-74) Mar 25 - 61.8%. 25/26 ambition of 64.6%																	
	Proportion of cervical Cancer Screening aged 25-64	Actual																	
		Plan																	
		Variance																	
		Bowel cancer screening – 3.5/5.5 year coverage (ages 25-64) June 24 - 62.7%. 25/26 ambition of 64.6%																	
		Actual																	
H	Proportion of breast cancer screening for women aged 50-70	Plan																	
		Variance																	
		Actual																	
		Plan																	
		Variance																	
I	Number of new PrEP users (and continuers) resident in Lambeth	Actual																	
		Plan																	
		Variance																	
		Breast cancer screening – 36-month coverage (ages 50-70) Mar 25 - 59.6%. 25/26 ambition of 60.2%																	
		Actual																	
J	Number of new PrEP users (and continuers) resident in Lambeth	Plan																	
		Variance																	
		Actual																	
		Plan																	
		Variance																	
K	Number of new PrEP users (and continuers) resident in Lambeth	Actual																	
		Plan																	
		Variance																	
		Breast cancer screening – 36-month coverage (ages 50-70) Mar 25 - 59.6%. 25/26 ambition of 60.2%																	
		Actual																	
L	Number of new PrEP users (and continuers) resident in Lambeth	Plan																	
		Variance																	
		Actual																	
		Plan																	
		Variance																	

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%	54.3%	59.9%							
		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%	15.8%	14.9%							
	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%	50.9%	55.5%							
		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%	10.7%	8.6%							
	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%	61.3%	66.5%							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%	21.1%	19.7%							
	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%	10.2%	12.1%	14.6%							
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	36%	28.8%	27.4%	22.3%	37.7%	40.9%	44.9%								
		Actual	24.2%			25.2%			26.6%								
	Access to Lambeth Talking Therapies for Black African and Caribbean residents to ensure they are as least as good as those of White residents	Plan	21.7%			21.7%			21.7%								Page 25
		Variance	2.5%			3.5%			4.9%								
		Actual	50.3%			47.8%			47.0%								
	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	Plan	48.0%			48.0%			48.0%								
		Variance	2.3%			-0.2%			-1.0%								
		Actual		26	17	7											
	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															
		Actual				3,670			2,476							More than 3000 interactions in the first quarter	
I	Health and Wellbeing Bus - No of interactions -	Plan															
		Variance															
		Actual				3,228										878 Hi 5 interactions and 982 opportunistic BP checks	
	Beacons service - No of interactions (brief opportunistic exchange), Hi 5 and BP check	Plan															
		Variance															
		Actual				237			132							58 1-1 Vital 5 checks delivered; 10% advised to see GP within 3 weeks, 85 showed high risk or possibly dependency after Audit C questionnaires.	
		Plan															
	Vital 5 & Women and Girls community interactions	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%	90%	90%								
		Plan	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%								
		Variance	0.0%	-1.0%	-1.0%	-0.3%	0.2%	0.1%	0.1%								
	Improve access to healthcare professionals through increased use of community pharmacies - GPs and NHS 111 direct people to pharmacies to support people with minor ailments and advice around self-care and common clinical conditions	Actual	2,500														
		Plan															
		Variance															
	Patients to be admitted, transferred, or discharged within 4 hours of arrival to A&E - GSTT sites	Actual	74%			77.70%											
		Plan															
		Variance															
	Patients to be admitted, transferred, or discharged within 4 hours of arrival to A&E - KCH sites	Actual	71.9%			71.6%											
		Plan															
		Variance															
K	No. of people who require no service or a reduced service following reablement	Actual		7	15	12	6	3	3	3							
		Actual		47	38	36	36	34	30	32							
		Actual	100%	100%	100%	100%	100%	100%	100%								
	Proportion of carers of the users of Adult Social Care Services are offered a carers assessment	Plan	100%	100%	100%	100%	100%	100%	100%								
		Variance	0%	0%	0%	0%	0%	0%	0%								
		Actual	2087			2111			2156								
	Number of people identified as being in their last year of life on practice registers	Plan	1988			2013			2082								
		Variance	99			98			74								
		Actual	46%			46%			50.0%								
	Proportion of people with Personalised Care and Support Plan(PCSP)/UCP	Plan	48%			49.4%			46.0%								
		Variance	-2%			-3%			4%								
		Actual															
L	Continuity of maternity care for women	Plan															
		Variance															
		Actual															
	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.	Plan															
		Variance															
		Actual															
	Infant and maternal mortality	Plan															
		Variance															

Q2 data under validation

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Impact measures performance trend (5)

Outcome	Impact measure	Target/Plan	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year to Date	Comments
M	Number of supported employment and supported internships we create through our health and care partners.	Actual															
		Plan															
		Variance															
	Proportion of people with LDA who are known to ASC services and are in work	Actual															
		Plan															
		Variance															
	Number of children and adults with learning disabilities and/or autism currently cared for in specialist inpatient units	Actual	14			10											At the end of Q1, there were 9 adults and one children in specialist inpatient setting
		Plan															
		Variance															
	Waiting times for an ASD diagnosis for children and young people	Actual															
		Plan															
		Variance															
N	Number of people per quarter supported by the Living Well Network Alliance to stay in their own homes (ClaSS)	Actual	8			14			15								Number of service users starting paid employmenet during each quarter
		Plan	36			36			36								IPS Performance Target
		Variance	-28			-22			-21								Variance from Target
	Number of people per quarter supported by the Living Well Network Alliance into paid employment (IPS)	Actual	47			34			61								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			12								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			625								Count of Lambeth SPA "signpost to other agency" + relevant events for all other Lambeth teams
		Plan															
		Variance	492			415			625								
	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%	88.1%	84.4%							From PEDIC
		Plan	78.4%	78.4%	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%	9.7%	6.0%							
	Seclusions and restrictive interventions on inpatient setting	Actual	31	25	28	31	37	43	27	49							Restrictive incidents + seclusions
		Plan	32	32	32	32	32	32	32	32							Median value Apr-23 to Dec-24
		Variance	1	7	4	1	-5	-11	5	-17							
O	Number of rough sleepers brought into accommodation	Actual	62			64			54								
		Plan	52			44			44								Plan = against previous year position
		Variance	10			20			10								
	Proportion of people living in our supported housing that are registered with a GP	Actual	98%			98%			99%								
		Plan	92%			90.0%			90.0%								Plan = against previous year position
		Variance	6%			8%			9%								
	Number of rough sleepers who have returned to the streets after being in settled accommodation	Actual	1			2			3								Plan = against previous year position
		Plan				1			2								
		Variance				1			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			100								Plan = against previous year position
		Plan				28			60								
		Variance				57			40								

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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

The commissioned NHS Health service came into effect in 24-25 where PH commissions 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 in it's second and final contractual year

Q2 2025-2026, saw a total of 1337 Health checks completed. This compares favourably to the same period last year where 746 health checks were completed when the service was severely impacted by the Synovis Lab Cyber attack. The Practices continue to acclimate to the new ways of working as set forth by the new model despite the issues experienced in a significant portion of 24/25 and the holdover it carried through to 25/26

Key outcomes for those who had a Health check this quarter were as follows:

23% of patients who had a health check were referred to lifestyle services or prescribed medication. This includes:-

37% patients prescribed statins,

11% prescribed antihypertensives,

23% referred to the National Diabetes Prevention Programme (NDPP),

2% referred to smoking cessation services,

1% referred to alcohol services,

26% referred to weight management.

8% of patients who had a health check were diagnosed with a health condition and added to appropriate registers. This includes:-

31% diagnosed with hypertension,

10% diagnosed with diabetes,

3% with chronic kidney disease (CKD),

56% with non-diabetic hyperglycaemia.

88% of patients were identified with low 10-year cardiovascular disease (CVD) risk,

11% with moderate risk, and

1% with high risk.

All patients received appropriate advice and support.

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

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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

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 53% (incl. White British 30% and White Other 23%)
- Black: Eligible 17%, Uptake 19%
- Asian: Eligible 6%, Uptake 6%
- 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?

Challenges

- 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

Actions

- 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 Health checks



B1. People are connected to communities which enable them to maintain good health

Alliance and Programmes	NWDA (owner) with contributions from CYP and Staying Healthy
Update Month	
<i>What does the data/intelligence indicate around progress against the outcome?</i>	Social Prescribing; Demand remains high and pressure is being placed on social prescribing teams to meet the demand (volume of referrals being made into social prescribing). The majority of referrals into social prescribing have more than one presenting support need. This high demand is making some Primary Care Networks (PCN) make decisions to limit the type of support they can provide to patients i.e. one Lambeth PCN social prescribing team have made the decision to stop accepting any referral for a housing related need. The percentage of residents coping financially has increased by almost 3% since last reporting. The number of residents in the dataset have also increased as the council now has access to additional information for residents in receipt of benefits Universal Credit. This suggests positive progress against the action.
<i>Does the data/intelligence identify any health inequalities and whether they are reducing?</i>	Social Prescribing - The lack of resources is leading to decisions such as limiting the type of support social prescribers. Taking the housing example: poor quality housing (cold, damp, overcrowding) leads to poorer physical and mental health outcomes, disproportionately experienced by low-income and minority ethnic communities. Removing this type of support will impact our ability to reduce health inequalities.
<i>What are the challenges hindering any progress and are there actions which can be taken to address these?</i>	Social prescribing ; Wider economical, political and social factors continue to 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.; Additionally, there are ongoing challenges of no centralised CRM/database for social prescribing in Lambeth. Residents coping financially; The financial wellbeing of residents continues to be challenged due to wider economic factors linked primarily to austerity, continuing high inflation for food and energy and the welfare benefits system not keeping pace with the costs of essentials (e.g. Universal Credit (allowances and two-child policy), Healthy Start Vouchers being insufficient to meet the cost of infant formula). There are also challenges centring around uncertainty – both in terms of future government policy, with the Autumn budget and National Child Poverty strategy on the horizon, future funding as central government are yet to announce allocation of the new Crisis and Resilience Fund (replacing the Household Support Fund) and internal resourcing due to current financial pressures. The council continues to provide reactive responses to poverty, increases in the cost of living and changes to welfare policy as well as longer-term approaches to poverty reduction through the borough's Tackling Poverty Action Plan, designed with local communities and launched in September.



C. People are immunised against vaccine preventable diseases

Alliance and Programmes	Staying Healthy (owner) with contributions from NWDA/CYP
Update Month	November 2025
<i>What does the data/intelligence indicate around progress against the outcome?</i>	<p>Childhood Immunisations: The data indicates that Lambeth did not meet its ≥90% uptake ambition in 24/25, with coverage remaining below the locally agreed target and broadly aligned with wider London performance. Uptake varies by vaccine type and age cohort; positioning Lambeth mid-range compared with statistical peers. Recent data quality issues, particularly inflated denominators, limit precise interpretation; however, the overall trajectory shows a gradual decline in key vaccines such as MMR. This pattern mirrors regional trends and reinforces the need for strengthened GP delivery, consistent call/recall processes, and improved data recording and flows.</p> <p>Influenza: The ambition to deliver a 2% improvement across priority groups (65+, under-65s at clinical risk, and pregnant women) was not achieved in 24/25 and remains the target for the current season. Uptake continues to decline among over-65s – currently 42.4%, down from 43.4% at the same point last year – reflecting similar trends across SEL and London. There's variation across practices; the borough's performance remains below London averages but comparable to statistical peers. Targeted interventions are now in progress to support practices with lower uptake, strengthen call/recall, and reduce inequalities in coverage.</p>
<i>Does the data/intelligence identify any health inequalities and whether they are reducing?</i>	<p>Childhood Immunisations: National reporting does not provide insights into vaccination inequalities. As part of local efforts, Lambeth Public Health undertook a study to understand the predictors of childhood vaccination uptake and timeliness in a diverse urban population, recently published in the British Journal of General Practice (BJGP)¹. The study showed that lower uptake was associated with deprivation and non-White British ethnicity.</p> <p>Influenza: Uptake of the flu vaccine remains lower among Black and mixed ethnic populations across all eligible groups compared with the White population. Areas of deprivation across the borough also record lower uptake.</p>
<i>What are the challenges hindering any progress and are there actions which can be taken to address these?</i>	<p>Childhood Immunisations: Barriers vary across communities, including practical access issues (e.g. GP registration), mistrust around data-sharing, and misinformation such as concerns about MMR and autism. System-level issues – data quality, inconsistent call/recall, and limited appointment flexibility – also hinder progress.</p> <p>Influenza: Declining uptake driven by vaccine fatigue, low risk perception, and barriers identified in local engagement.</p>
<i>Additional Comments</i>	<p>Actions to Improve Childhood Immunisations Coverage: Standardising call/recall, improving data flows, and targeting support to low-uptake practices. Expanding community-led programmes and culturally informed engagement to address mistrust and misinformation.</p> <p>Actions to Improve Flu Vaccination Coverage: Public Health-led outreach strategy to raise awareness, understand community barriers, and co-design locally tailored solutions with residents, primary care and VCS partners.</p>



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 182 new people in October, more than the 130 new people seen in September and more than the monthly average of 156 for 2024/25. This makes 1129 new people supported so far in 2025/26. The number of people Focused Support (FS) started supporting in October rose to 42 from 25 in September, which means that 240 new people have been supported so far in 2025/26. The Lambeth Single Point of Access (SPA) referred 189 people to STS in October, and 123 in September.

People attending a second STS appointment in October had waited an average of 26.7 days. This is 1.9 days more than the average wait of 24.8 days in 2024/25 but less than the average of 31.1 days in September. This corresponds with a peak number of 664 people working with STS at the end of August being reduced to 600 at the end of October, an improvement but still 15% 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 is being sustained through to September and October, in which Black services users were 34.0% of those accessing short-term support (up 5.3% points on Q1 2025/26). This is also much higher than the 18.7% of the Lambeth 18-64 population that identifies as Black. The proportion of those new to focused support during September and October from Black communities fell to 50.0%, lower than the 2024/25 average of 53.1%. The numbers involved however are relatively low and so need to be viewed over a longer period to establish a reliable downward trend.

The latest data on waiting times for a second appointment with STS shows Black services users receiving a second appointment more quickly than White service users (waiting on average 27 and 32 days respectively). This may reflect the fact that, In September and October, 42% of STS referrals for Black service users were prioritised as being urgent, compared to 35% for White service users.

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

We believe that social and economic factors that disproportionately affect Black communities lie behind their need for more intensive services. We use the PCREF framework to engage with our local communities and build trust to improve access, experience and outcomes. Greater access to services for Black people in the early stages of their illness will reduce their need for more intensive forms of support.



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

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

Alliance and Programmes

Sexual Health

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

Reproductive Health

Total LARC activity in primary care for Q2 was 643 – total LARC fittings were 339. This included activity within GPs and Hub activity from the new LARC Hub. This is an increase from Q1 where there were 545 total LARC activity including 296 LARC fittings (Note: this is a correction from figures previously reported). The GP LARC training programme started in August, two clinicians have now completed training. The Hub will train one clinician per month going forward.

STI testing and diagnosis

The latest available data on number of STI tests and number of STI diagnosis is up to Q4 24/25. Number of tests remain steady. There were 16,098 tests taken by Lambeth residents between January and March 2025. This is similar to the previous quarter where 16,218 tests were undertaken. Number of new STI diagnosis have decreased slightly with 2,300 new diagnoses in Q4 24/25 compared to 2,423 in Q3 24/25. This is also lower than the same time period in the previous year (2,522, Q4 23/24). Diagnosis of chlamydia appears to be on a downward trend with 721 diagnosis this quarter, compared to 819 in the previous quarter and 1010 in the same quarter the previous year. Please note, quarterly data from GUMCAD are provisional and subject to change.

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

Reproductive Health

No change from previous reporting period.

STI testing and diagnosis

In Q4 the majority of STIs were diagnosed in GBMSM (51.8%) followed by women (23.2%) and heterosexual men (18.9%). These are similar proportions to diagnoses in Q3 (53.7%, 22.2% and 18.5% respectively).

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

Reproductive Health

Challenges around IT limitations preventing practices from facilitating inter-practice referrals continue, offers will seek to find a solution for the new contract from April 2026

STI testing and diagnosis

The new service model at GSTT is starting to be mobilised which will offer Lambeth residents allocated booked appointments, they will also expand their remote offer, by user secure lockers for appropriate interventions.

The Outreach Alliances clinical inreach offer, will go live in Q3.

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

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



Alliance and Programmes

Sexual Health

Additional Comments

The refreshed LSLBB sexual and reproductive health strategy will be going to Lambeth's Health and Wellbeing Board in November for final sign off followed by a launch in December.

The sexual health team presented a deep dive to LTAG on this outcome in September.

From the end of October 2025, NHSE will now provide all contraception activity through the 'Pharmacy First' programme. The primary care LARC contracts are due to end in March 26, officers are currently going through governance to ensure continuation of the service for April 26, with a development for neighbourhood models.

The London Sexual Health Programme (LSHP) is about to start a piece of work looking at capacity and demand across London, this will inevitably provide insights into further service development and access opportunities.



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?

SMI health checks have been performed consistently since April and closely track the 24/25 trajectory. There is variation between PCNs ranging from AT Medics at 57% and 31% at Streatham PCN. Progress has been steady this year but has slowed recently and is below the 24/25 trajectory. There is significant variation between PCNs with AT Medics at 77% and Clapham PCN at 25%. For both SMI and LDA health checks, data from previous years show that approximately 30% to 40% of health checks become due from December to March each year. We, therefore, expect progress to accelerate in the last quarter of 25/26 and to meet the national target, as a minimum, and to achieve last year's position of 64% for SMI health checks and 80% for LDA health checks.

On cancer screening programme,

- Bowel Cancer screening aged 60-74-Upward trend. Most recent data shows upward trend with 61.8% screened (January 2025) compared to 50.9% in January 2020. Note for the financial year of 25/26 the national target has increased to 62% (from 60%) so Lambeth is sitting just below that currently
- Cervical Cancer screening aged 25-64-shows levels are quite stable but not increasing with 62.7% screening in June 2024 compared to 62.8% in April 2023 but down from 66.7% in April 2019. National target is 80%. **No update to data since last report in September**. More recent estimated data taken from primary care coding shows 61.4% which is a drop (not official data). Below national target of 80%.
- Breast cancer screening aged 50-70-Very good upward trend in the past year. Most recent data shows 57.9% screened in January 2025 which is a significant increase from 55.0% in January 2024. Not returned to pre-covid levels which were 61% in November 2019 but 3% in a year is promising. Below national target of 80%.

Source for all of above is the SEL screening dashboard. There are other sources but this is most accurate and comes from Open Exeter directly.

Data to date for 25/26 on PrEP activity shows 399 Lambeth residents have started PrEP and 2114 Lambeth residents are continuing to use PrEP routinely, although the majority of the activity data from July, Aug and September is still to be uploaded into the activity grouper. However, even without this the trend shows a gradual increase in resident accessing via specialist Sexual Health Services.

Up until 12/11/25 115 Lambeth residents have accessed PrEP digitally via the new online service, of these 20% were new to PrEP and the rest were channel shift away from more expensive in-clinic provision, this is great in the first 4 weeks of the new service.

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

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



Alliance and Programmes

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

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

We performed local audits on the SMI and LDA registers to identify those who had not attended for health check in the previous 3 years. The findings from the SMI audit showed that 72% of those who didn't attend were male and 52% were between 30 and 50 years of age. In terms of ethnicity, 37% were African or Caribbean and 25% were White. 70% of people on the LD register who hadn't attended were under the age of 40. Even distribution of African or Caribbean (37%) and White (32%) people. Analysis of gender and ethnicity revealed the highest number of non-attendees were Black females and White males.

- 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 (69.4%), then white (66.8%) and then significantly lower for mixed (61.9%), Asian (54.3%) and other (51.6%). Significantly lower for those with LD (44.0%) compared to non-LD (63.7). There has not been a significant improvement in the past 2 years.
- Breast cancer screening aged 50-70-1st and 2nd deprivation quintile have lowest rates. White (63.2%) and black (63.5%) ethnicity have similar rates, lower in Asian (59.0%), mixed (58.5%) and "other" (53.7%) ethnicities, Significantly lower in LD (44.4%) compared to non-LD (61.5%) and SMI (48.1%) compared to non-SMI (61.7%). Rates overall are improving which promising.

On PrEP activity, of the in-clinic activity only 33 identify as female, 18 are new to PrEP and 17 are continuing, whilst these are still small numbers it's welcome to see female residents are accessing PrEP, 12 of these accessed within central London but 21 where within local Trusts.



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?

Practices are commissioned to deliver health checks under the Lambeth Offer local commissioning scheme. We have identified low achieving practices and are providing additional clinical and data quality support. The data quality improvement facilitator is available to practices all year to support with coding and other data issues and to ensure data entered complies with the commissioned scheme within the Lambeth Offer. Materials and resources are regularly shared with general practice that support engagement to attend health checks.

The Clinical Lead has participated in open Q&A sessions for carers to ask questions and gain more information on how to get on the practice register and what to expect from an annual health check. We have been collaborating with the Paediatric team at GSTT to develop staff learning events and establish GP and Paediatric joint clinics for the transfer of young people with complex needs. We have connected with SEND leads in SEL who have used their contacts and networks to share resources and materials for school staff to share with parents and carers, and for staff learning.

On cancer screening programme 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. The breast screening incentive has been removed from the local PMS contract and not included in the new Lambeth offer so there is now no local primary care incentives for cancer screening and combining this with primary care workload pressures makes it difficult for GPs to take on additional screening promotion. Due to staffing changes within the NWDA there is now less capacity for focus on cancer projects. There are however numerous ongoing and planned projects locally. SELCA have funded projects with IRMO (Latin American community) and LAMSOM (Somali community) to promote screening and early cancer diagnosis within their communities. This is in line with our priorities to reduce inequalities locally and has been supported by the NWDA. SELCA have also funded a PCN project to increase breast and cervical screening especially aimed at those from minority communities. 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. SELCA are in the process of funding three Lambeth practices with lower screening rates to undertake specific screening promotion which will aim to reduce inequalities further. Overall work is continuing in line with our objectives to continue to improve above screening numbers.

Additional Comments (1/2)

EZ Analytics enables us to identify the number of SMI health checks with one core check missing and the specific check that is missing i.e. 27 health checks would be complete if BMI was recorded. Alcohol and smoking assessments are the 2nd and 3rd highest missing checks. Whilst it is understood that cholesterol and HbA1c can be challenging for people to engage with, smoking and alcohol are more easily achievable. The data quality improvement facilitator is looking to confirm whether this is accurate or if there is a coding issue. We are looking into adding data fields to the LD health check to incorporate more information about younger patients, as suggested by the Paediatric team.

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

Additional Comments (2/2 cont.)

The Lambeth led PrEP in communities pilot project has further progressed with Kings contracting directly with 5 GPs across SEL to start to provide PrEP for residents within their individual Boroughs. The next step will be for Kings to contract with Turning Point so that PrEP could be delivered via the clinical outreach part of the Outreach Alliance.

Kings have also been awarded funding to partner with the Ernest Foundation to work specifically targeting Black Heritage women for PrEP as part of the SEL Women's Health Hub work.

Public Health commissioners are continuing to work with ICB colleagues and clinical cabinet on an agreed approach to opt out testing for HIV, across primary care in 2026/27 two recent developments have been the automated pop-up alert on all GP systems and the streamlining of the HIV test request into one form 'only'.

A HIV training and education package has been procured for Lambeth, Southwark and Lewisham staff to access, while the Lambeth HIV GP Champion will offer bespoke training, as necessary.



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 November 2025, among patients with hypertension, 22,085 of 39,814 aged 79 years and under (55.47%) have blood pressure ≤140/90 mmHg, while 4,000 of 6,011 aged 80 years and over (66.54%) have blood pressure ≤150/90 mmHg indicating there is still work to do to meet the national target. The Medicines Optimisation team supported Know Your Numbers Week (8-14 September), led by Blood Pressure UK, which focused on "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 provided free blood pressure checks for staff and the public. Campaign materials were shared with GP practices and community pharmacies. Further awareness of the blood pressure checking service was promoted through participation in the Lambeth Inspire event, with additional promotion planned for Ask Your Pharmacist Week in November.

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. As of 15 October 2025, 46.8% 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. The National Diabetes Audit (24/25) shows that 72.4% of patients with type-2 Diabetes in Lambeth had had their 8 Care Processes measured and recorded to support diabetes treatment and care. This is 15 percentage points higher than the national average (57.6%), 7 points higher than the South East London average (65.4%), and 4 points higher than the London average (68.1%). Lambeth outperforms 40 of 48 boroughs.

Problematic polypharmacy (prescribing of 10 or more concurrent medicines) increases the risk of drug interactions and adverse drug reactions (ADR), impairing medication adherence and impacting on a patient's quality of life, this risk increases with the number of prescribed medicines a patient is on and when specific therapeutic combinations are concurrently prescribed. In conjunction with the patient, SMRs provide a holistic medication review to ensure prescribed medicines are safe, effective and personalised to patients' current needs. SMRs improve outcomes, reduce unnecessary or inappropriate prescribing and polypharmacy, reduce harm and improve patient outcomes. The number of coded Structured Medication Reviews (SMR) in Lambeth for patients who are 65 years or over and prescribed 10 or more medicines continues to be tracked to indicate progress. There has been an increasing trend of people over the age of 65 who are taking 10 or more medicines received a structured medication review since 01 April 2025. On 15 October 2025, a total of 446 of the 3470 (12.85%, previously 8.58%) patients have had a SMR.

More black and minority ethnic people have been identified with hypertension when comparing 1 November 2024 to 1 November 2025 data; 12,563 and 13,713 respectively and within these cohorts, blood pressure control has remained consistent with higher absolute numbers in comparison to the previous year; 24,388 and 25,416 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?

The number of people open to Lambeth Single Point of Access (SPA) at the end of October was 196, down 3% from the 203 open at the end of September and 67% from the 595 open at the end of June, but up 40% increase from the 140 seen at the end of August following the concerted effort to reduce that June total. People still open to SPA at the end of October, had been open to SPA, on average, for 7.6 days in the case of urgent referrals and 15.9 days for routine referrals, respectively a 61% and 52% increase from the end of September.

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 115% of target at the end of September (the latest available data), up from 107% at the end of August. So far in the financial year 2024/25, 3,273 people have completed their treatment with LTT.

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 (avg. 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.

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

SPA showed no significant inequalities in their processes. 36% of Black service users introduced to SPA received onward referrals to Community Mental Health Services or other parts of the SLaM Trust, compared to 30% for White service users. Average days open to SPA for urgent referrals were 6.9 days and 6.4 days for Black and White service users respectively, not significantly different given the volumes.

Access to Lambeth Talking Therapies (LTT) Recovery for Black service users continues to improve. In July to September 2025 (the latest period for which data is available), 26.6% of new clients identified themselves as Black, better than the 25.2% seen in the previous quarter, and the 18.7% Black adult population of Lambeth. Attendance and treatment completion continues to be roughly equal between Black and White groups, but Mixed and Asian clients attend on average one session fewer. Reliable recovery rates for Black service users remain a concern at 47.0% in the quarter, July to September (1% point below the 48.0% target and 2.5% points below the current whole service average). LTT note that starting severities are higher for members of the global majority but that improving these recovery rates remains the focus for the service.

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 began 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.

On CAMHS activity, 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.

Additional Comments

*The data-set is still being actively developed, with more insights becoming available as the process continues.

**(Addendum following feedback from September LTAG) – Reporting development is discussed regularly through monthly contract management meetings and, at times, via the Children's Alliance Emotional Wellbeing and Mental Health Working Group. Progress has been made towards establishing the measures needed to track disparities in access, engagement, and outcomes. Work is ongoing, with an expectation that periodic, more detailed reporting will be introduced later in the year. This is expected to be in place by the end of the 2025/26 reporting year (Q4).*

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), Woman and Girls 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?

252 people were seen at the Health and Wellbeing Bus for a Vital 5 check during this period. Out of this total, 10 had a GP follow up form submitted, having their details sent over and linked with their GP records to receive a follow up call and further support from their GP. Over 20 were instructed to go to their GP within the same day, 7 days, 3 weeks or a year. Over 90 were signposted to seek further support by either self referring to their GP or local pharmacy.

The data shows that we're reaching people with complex health conditions, identified through our outreach and ensuring that they're seeking support beyond our limitations, contributing to a more joined up and holistic health and care approach.

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

Through this data collection, we've identified 40% of the total being overweight, 38% living with class 1/2 obesity and 5% living with class 2/3 obesity. This shows a very large percentage of people having an unhealthy BMI which speaks to struggles and health inequalities of the communities we target.

I feel it is too early in our Vital 5 delivery to tell if the health inequalities are reducing. I believe we will be able to see a trend over following quarters.

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

One of the challenges is getting service user permission to take details and their receptiveness to following up with the GP. We are aiming to address this by working to solidify use of the EMIS platform on site so that visits to the bus are recorded and allows for GPs to prompt service users for appointments.

Additional Comments

The evaluation team has sent us Lambeth data indicating 15.5% of BP checks done being Stage 1-2 Hypertension with majority with this result being female 17.9%

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 1704 consultations between May 2024 and September 2025 with Lambeth residents/registered patients to provide advice and guidance on self-care and supply of medicines where appropriate.

The NHS Pharmacy First Service increases GP capacity through triaging of low-acuity conditions to community pharmacy. GP referrals to NHS Pharmacy First supports the national approach to increasing GP access. Data from the last 12-months rolling data from 31 July 2024 to 30 June 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 September 2025 shows most interventions (1343) 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, 59% of patients would have visited general practice to request the medication on prescription and 41% 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 pension credit guarantee credit are the top social vulnerability eligibility groups accessing Lambeth Pharmacy First Plus Service in September 2025. General Practice feedback has been that the service has had a positive impact for patients and reduced GP appointments for minor conditions.

Data from August 2025 shows a 5.08% increase (17,369 August 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

Additional Comments

NHS England will be running a 'Think pharmacy first' campaign to increase public awareness that pharmacists can provide some prescription medicines if needed, without seeing a GP, from 20 October to mid January 2026. SEL ICB communications team and Medicines Optimisation Team are developing a comms plan for January 2026 onwards. SEL ICB will be utilising the various national campaigns throughout November to promote the NHS Pharmacy First service, supported by the SEL Communications and Engagement team. The campaigns include; Ask Your Pharmacist Week (3-10 November), Self-Care Week (17-24 November) and World Antimicrobial Awareness Week (18-24 November). Promotional materials will be shared with primary care teams via borough Medicines Optimisation teams and will be published on the public website.

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

J4. Improve access to healthcare professionals through increased use of community pharmacies - GPs and NHS 111 direct people to pharmacies to support people with minor ailments, advice around self-care and common clinical conditions Number of people accessing healthcare professionals through increased use of community pharmacies

Lambeth Pharmacy First Plus Service	
Total number of patient interventions	
May-24	87
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
Aug-25	108
Sept-25	123
Total – 1704	

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	3559
Jun-25	3471
Total – 39,368	

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

1. Universal credit (47%)
2. Patients aged under 16 years (28%)
3. Pension Credit Guarantee Credit (8%)



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 41 per month from Aug – October 2025. 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 87%.

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. The outcome when RSW's provide the reablement care is 96% requiring no ongoing support or a reduced level of support.

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.

For quarters 1 and 2 of 2025/26 both the size of practice end of life care registers as a proportion of list size and the proportion of patients on those registers with advanced care plans have remained static.

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. 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.

There are no regularly published datasets providing insight into inequalities at end of life at borough level. Demographic information collected by palliative care services provides a limited proxy for the characteristic of ethnicity only. This indicates that service provision is broadly in line with the borough's diversity.



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

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

Alliance and Programmes

NWDA (Owner)

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

The majority of reablement referrals are made via the hospital discharge route. However we are increasing the number of people who are offered a reablement service via our front door team in Adult Social Care. This extends the reablement offer to people living in the community at home. Community Referrals to Reablement are now at 20% which is an increase from 17% in the last year. This will help to offer a more equitable service for those residents living at home who may benefit from reablement care.

There is a named linked physiotherapist from GSTT Rehab and Reablement Team working closely with the ASC front door managers to help identify appropriate referrals to reablement.

A number of the community referrals to Reablement are declined. We are introducing a weekly meeting to look at the reasons why community referrals are declined to improve the referral acceptance rate.

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

The Discharge Operational Delivery Group (DODG) has a dedicated workstream looking at the reablement pathway from the ward to the internal flow hub and then on to the service to improve the process and ensure referrals to the service are appropriate.

There has been some work to increase the number of weekend discharges at GSTT which was successful. Following this the weekly wash up meeting after the weekend (to review those patients who were not discharged at the weekend as expected) has now been reinstated.

Key challenges include varying levels of capacity and professional confidence within Primary Care to initiate PCSP conversations. A recent survey of Lambeth GPs showed that GPs recognize Advance Care Planning (PCSP) as a primary care commitment, but that confidence in initiating and holding these conversations is not consistently high. Other challenges include variable data capture across PCNs, partly to different coding practice occurring in different practices within PCNs.

SEL Ageing Well Funding (£64k non-recurrent for 1 year) project is underway to help address these barriers project resource to help address these barriers, working with primary care to support identification of people in the last year of their life and uptake of Universal Care Plans. Primary Care working with GP lead champions to increase completion and quality of UCP / ACP in Lambeth, including addressing data capture.

Additional Comments

Data caveat: Q1 data will be available in the second week of July, therefore this update is substantively consistent with the May report to LTAG. Key change is the inclusion of update Q4 data following corrected data capture for the Vauxhall Surgery).



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 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.

It is unlikely that practice register sizes can grow much further given the comparatively low level of mortality in Lambeth. There is an opportunity to improve on the take up of advance care planning in the borough and this is actively being addressed through Lambeth Together's frailty programme.

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)

<p><i>What does the data/intelligence indicate around progress against the outcome?</i></p>	<p>Total births have fallen from 4,392 in 2017 to 3,365 in 2023, while perinatal deaths (stillbirths plus neonatal deaths) increased slightly from 17 in 2022 to 21 in 2023. Stillbirths increased from 14 to 18 cases, while neonatal deaths remained stable at 3 cases. Rates per 1,000 births are 5.35 for stillbirths, 0.90 for neonatal deaths, and 6.24 combined, which places Lambeth above the South East London and national averages. However, because the absolute numbers are small, minor changes in the number of cases result in larger percentage fluctuations, so the recent uptick may overstate the magnitude of change. Provider-level data show that neither King's College Hospital nor Guy's & St Thomas' are national outliers for stillbirths.</p>
<p><i>Does the data/intelligence identify any health inequalities and whether they are reducing?</i></p>	<p>There are a number of initiatives seeking to ensure service equity for our residents.</p> <p>King's College Hospital and Guy's & St Thomas':</p> <ul style="list-style-type: none">• Applying the <i>Saving Babies' Lives care bundle</i>: stop-smoking support, growth surveillance, action on reduced movements, safe monitoring in labour, reducing preterm birth, stronger diabetes care.• Equity programmes: multi-language education, anti-racism and cultural safety training, community outreach, safeguarding pathways. <p>South East London LMNS:</p> <ul style="list-style-type: none">• Equality and equity action plan.• Regular review of perinatal deaths, with external input and independent investigations where needed.• Workstreams on fetal wellbeing, smoke-free pregnancy, perinatal optimisation and pelvic health
<p><i>What are the challenges hindering any progress and are there actions which can be taken to address these?</i></p>	<p>Challenges include small absolute numbers of perinatal deaths, which make trends appear volatile and complicate interpretation of progress.</p> <p>Workforce pressures may limit the consistency of continuity of care, though the group pregnancy care pilot aims to support address this.</p> <p>Continuity/enhanced midwifery care is not currently tracked at Lambeth place as it is not nationally mandated and is not reflected in trust datasets. This can limit our understanding around delivering this outcome.</p> <p>Actions underway to achieve the outcome include, Expanding preconception and targeted support initiatives; Piloting continuity of care through small midwife teams to provide peer support and more consistent tracking; Applying established care bundles, like <i>Saving Babies' Lives</i>, and equity-focused interventions in provider settings; Improving data and reporting by gaining LMNS permission to use validated dashboards, adding measures such as preterm birth, and tracking group pregnancy care; Continuing oversight through the CYP Alliance and SEL LMNS quality and safety meetings to monitor impact and adjust interventions.</p>
<p><i>Additional Comments</i></p>	



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 number cared in LD specialist unit, LDA in 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?

M5: Figures are reported quarterly. In Nov 2025 the number of people cared for in specialist inpatient units was 11 (10 adults and 1 YP). This indicates a steady downwards trend since 22/23 which evidences the effective work to facilitate discharge to the community and prevent admission.

No. of people in inpatient settings	2022/23	2023/24	2024/25	01/07/2025	01/11/2025
Adults	15	13	11	9	10
Children	1	2	3	1	1
Total	16	15	14	10	11

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

M5: 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?

M2: 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 second quarter of 2025/26, July to September, CLaSS started working with 61 new people, more than the 49 new clients in the last quarter, April to July. 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 15 people find work in the last quarter, July to September, a slight improvement on the 14 people supported in the quarter April to June. This is less than the original placement target of 36 per quarter, but the team also helped 6 people to sustain employment for at least 13 weeks and 8 for 26 weeks or more.

There were 49 restrictive incidents and seclusions for inpatients in October, approaching double the 27 seen in September and much higher than the monthly average of 35 for financial year 2024/25. Positive friends and family survey responses for LWNA services were at 84.4% in October, an improvement of 4.9% 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 second quarter of 2025/26, July to September, 54% were for Black services users, unchanged from the previous financial year. More intensive LWNA services present a mixed picture in the first quarter, July to September, with the proportion of Black people newly accepted into inpatient care falling by 4% points, but the equivalent figure for more intensive community support rose, focused support and home treatment, rose by 11% points by 4% points respectively. All of these figures however remain much higher than might be expected, given that the Black adult population of Lambeth in 2025 is estimated to be 18.7%.

Of the 49 restrictive incidents and seclusions reported for Lambeth acute inpatients with a stated ethnicity in October 29 (59%), were for Black service users compared with 61 or 107 (57%) in the preceding quarter, July to September, and 58 of 97 (60%) April to June. Although the numbers each quarter are too low to be sure they are significant in themselves, these restrictive incident and seclusion rates for Black inpatients so far this year have been quite stable at close to 60% which is consistently higher than might be expected, given that over the same period 51% of inpatients are from Black communities.

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 will continue to use 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?

The number of rough sleepers successfully supported into accommodation during Q2 was 54, a decrease from 64 in the previous quarter. This remains a positive overall figure for move on. The summer months involve a different rough sleeping landscape with higher numbers of intermittent rough sleeping (i.e. seasonal workers rough sleeping in Waterloo but rejecting all engagement with outreach teams) as well as individuals from other boroughs rough sleeping in Lambeth for a single night or for short periods of time before returning to their originating borough. This is characteristic of the warmer months and makes effective move on more challenging.

The number of those returning to rough sleeping after being in settled accommodation remains low at 3. This represents an increase of 1 from the previous quarter. Two of the individuals represented in this data were (and remain) in stable accommodation but rough slept for one night before returning to their bedspaces (one was from Lambeth, one from Westminster). The one client who was homeless is now accommodated.

The number of residents registered with GP's continues to be at its highest level at 99%. 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.

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, 100 in Q2 which is an increase of 15 from Q2.

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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