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Lambeth Together

Integrated Assurance Report

27 January 2026

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Our Health, Our Lambeth

Lambeth Together health and care plan 2023-28

Lambeth Together Health and Care Plan Scorecard – January 2026

ID	Outcome	Measures tracked	Jan-26			Vs previous update	Nov-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	*People maintain positive behaviours that keep them healthy*	5	1	1	100%	–	100%	
B	*People are connected to communities which enable them to maintain good health*	1	1	1	100%	–	100%	
C	*People are immunised against vaccine preventable diseases*	3	3	0	0%	–	0%	Flu indicators will be validated at year end positon.
D	*People have healthy mental and emotional wellbeing*	3	3	2	67%	–	67%	
E	*People have healthy and fulfilling sexual relationships and good reproductive health*	3	1	1	100%	–	100%	LARC activity is monitored via EZ and SH team maintain a log, commentary support progress against plan. STI testing and diagnoses rate is monitored via quarterly GumCAD reports.
F	*People receive early diagnosis and support on physical health conditions*	5	5	2	40%	–	40%	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	*People who have developed long term health conditions have help to manage their condition and prevent complications*	4	3	3	100%	–	100%	Cardiovascular and Diabetes measures above previous year trajectory.
H	*When emotional and mental health issues are identified; the right help and support is offered early and in a timely way*	4	2	1	50%	–	50%	
I	*People have access to joined-up and holistic health and care delivered in their neighbourhoods*	3	2	2	100%	–	100%	
J	*People know where to go to get the right help, and are treated at the right time, in the right place, for their needs*	4	1	1	100%	–	100%	
K	*Older adults are provided with the right health and care support at the right time, live healthy and active later lives and are supported to age well*	4	2	2	100%	–	100%	
L	*Women have positive experiences of maternal healthcare and do not experience a disproportionate maternal mortality rate*	0	0	0	-		-	
M	*People with learning disabilities and/or autism achieve equal life chances, live as independently as possible and have the right support from health and care services*	3	1	1	100%	–	100%	
N	*People using mental health support services can recover and stay well, with the right support, and can participate on an equal footing in daily life*	4	3	2	67%	–	67%	Measures tracked against previous year activity
O	*People who are homeless, or at risk of becoming homeless, (including rough sleepers and refugees) have improved health*	4	4	4	100%	–	100%	Measures tracked against previous year activity
	Total	50	32	23	72%	–	72%	

Health and Care Plan: Key headlines (1)

	Outcome	Key Headlines
A	***People maintain positive behaviours that keep them healthy***	Main challenges with NHS Health checks are, 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. Below are described actions to mitigate known challenges, • Continue regular NHS Health check 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 Health checks 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 Health check at work and Health checks online pilots. • To continue to seek out other proof of concept initiatives to enhance uptake and impact of Health Checks
B	***People are connected to communities which enable them to maintain good health***	The Back on Track service will be ending on 31/03/26 if additional funding is not secured. The Back on Track service is a financial link worker project working in Stockwellbeing and Fiveways PCNs with social prescribing focusing exclusively on financial matters. The service works closely with Lambeth Council to give vulnerable patients “breathing space” from Council Tax and rent arrears to focus on income maximisation and debt management. The project has been running for the past 4 years with great results but without additional funding residents could lose this vital support and face greater financial and health inequalities as a result.
C	***People are immunised against vaccine preventable diseases***	Childhood immunisation coverage in Lambeth continues to be challenging overall, with sustained difficulty achieving the locally agreed 90% uptake ambition. Published COVER data are now available for Q1 and Q2 2025/26 (with Q3 due to be published end of March 2026). The latest data show that, in Q2 compared to Q1 2025/26, uptake of the 6-in-1 primary immunisation at 12 months declined; MMR1 uptake at 24 months remained broadly stable; and uptake of both MMR1 and MMR2 at age 5 improved. This broadly aligns with the picture across London and statistical peers. On Influenza, the ambition to deliver a 2% improvement in uptake across priority groups (65+, under-65s at clinical risk, and pregnant women) was not achieved in 2024/25 and remains the target for the current season, which is now underway. Uptake to date is currently outperforming the same period last year, indicating positive early progress, although there remains variation across practices.
D	***People have healthy mental and emotional wellbeing***	The Lambeth Living Well Centres’ Short-Term Support service (STS) began helping 200 new people in December, more than the 169 new people seen in November and many more than the monthly average of 156 for 2024/25. This makes 1498 new people supported so far in 2025/26. The number of people Focused Support (FS) started supporting in December rose to 38 from 31 in November, which means that 309 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.

Health and Care Plan: Key headlines (2)

	Outcome	Key Headlines
E	***People have healthy and fulfilling sexual relationships and good reproductive health***	On Reproductive Health, total LARC activity in general practice for Q3 was 661 – total LARC fittings were 319. This is an increase from Q2 where there were 408 total appointments and 200 total LARC fittings. LARC Hub data is not yet available for Q3. STI testing and diagnosis shows the latest available data on number of STI tests and number of STI diagnosis is up to Q1 25/26. There were 15,308 tests taken by Lambeth residents between April and June 2025. This is less than the previous quarter where 16,098 tests were undertaken. This may be due to seasonal variation. Number of new STI diagnoses have decreased slightly with 2,231 in Q1 25/26 compared to 2,300 new diagnoses in Q4 24/25 (and 2,423 in Q3 24/25). Please note, quarterly data from GUMCAD are provisional and subject to change.
F	***People receive early diagnosis and support on physical health conditions***	SMI health checks have increased by 10 percentage points to 48.7% from last month and is exceeding the 24/25 trajectory by 5 percentage points and is on track to meet the end of year target. LD health checks have increased since December by 14 percentage points since last month, however, is 3 percentage points below the 24/25 trajectory. The number of Lambeth residents accessing PrEP continues to increase. At the time of writing this report clinical activity data shows 607 PrEP starts and 3027 continuers, this is an increase of 308 starts and 1913 continuing from the previous update, activity data is until October 2025.
G	***People who have developed long term health conditions have help to manage their condition and prevent complications***	Planned deep dive, see enclosed presentation along with highlight report updates.
H	***When emotional and mental health issues are identified; the right help and support is offered early and in a timely way***	The number of people open to Lambeth Single Point of Access (SPA) at the end of December was 73, down 49% from the 142 open at the end of November and 88% from the 602 open at the end of June. People still open to SPA at the end of December, had been open to SPA, on average, for 6.1 days in the case of urgent referrals and 7.3 days for routine referrals, respectively a 31% and 52% improvement from the end of November. ON CYP activity, Lambeth continues to see high and sustained demand into CAMHS, with referrals averaging around 110–120 per month in the baseline period. Overall CAMHS caseload has steadily increased over time (2950 at the end of Nov, an increase of 189 over a 6-month period), reflecting both demand growth and longer durations of care, particularly within the neurodevelopmental pathway.

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***	In Q3, 64 people were seen by the Health and Wellbeing Bus and team for a Vital 5 check during period. Out of this total, 17 GP follow up forms were submit, having their details sent over and linked with their GP records to receive a follow up call and further support from their GP. This was a much larger number than previous 2 quarters which could indicate the team have increased confidence in obtaining people's details to submit forms, which can have been achieved through our recent conversations regarding the process and guidance in approaching service users with requesting this information.
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***	Planned deep dive, see enclosed presentation along with highlight report updates.
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***	Planned deep dive, see enclosed presentation along with highlight report updates.
L	***Women have positive experiences of maternal healthcare and do not experience a disproportionate maternal mortality rate***	The Local Maternity and Neonatal System (LMNS) has provided a provider-level report covering current activity and quality oversight across King's College Hospital and Guy's and St Thomas'. The report includes some outcome measures (for example preterm birth), but does not include perinatal mortality or any measures that allow continuity of care across maternity pathways to be tracked. The Alliance will use this report as a starting point and continue to work with the LMNS to further validate and strengthen the data.

Health and Care Plan: Key Headlines (4)

	Outcome	Key Headlines
M	***People with learning disabilities and/or autism achieve equal life chances, live as independently as possible and have the right support from health and care services***	On number of people in inpatient settings figures are reported quarterly. In January 2026 the number of people cared for in specialist inpatient units was 12 (10 adults and 2 YP). This indicates a steady downwards trend since 22/23 which evidences the effective work to facilitate discharge to the community and prevent admission. Number of supported employment and supported internships we create through our health and care partners. There are currently 6 interns on the Lambeth Council Supported Internships programme, and there are 7 on the King's College Hospital programme. In addition, we have 2 young people attending aspects of the Supported Internship programme at Lambeth Council with a view to taking part in the full programme next academic year.
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***	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 third quarter of 2025/26, October to December, CLaSS started working with 46 new people, down slightly on the 50 new clients in the previous quarter, July to September. LWNA's Individual Placement and Support (IPS) helps people with a serious mental illness find and sustain paid employment. The IPS service helped 9 people find work in the third quarter, October to December, down from the 15 people supported in the quarter July to September. This is much less than the original placement target of 36 per quarter, but the team also helped 4 people to sustain employment for 26 weeks or more.
O	***People who are homeless, or at risk of becoming homeless, (including rough sleepers and refugees) have improved health***	The number of rough sleepers successfully supported into accommodation during Q3 was 95, a steep increase from 54 in the previous quarter. A steep increase from 54 in the previous quarter. This is largely due to our having activated the Severe Weather Emergency Protocol (SWEP) three times in this quarter which accounts for 31% of accommodation placements. During SWEP, everyone rough sleeping is offered emergency bedspaces within our Vulnerable Adult's Pathway, and the outreach team continue to work with them to move them straight from SWEP into a stable accommodation outcome to avoid a return to the streets. The outreach team have also done particularly well with supporting rough sleepers into winter night shelters and to No Second Night Out.

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Finance

Finance: South East London ICB: Lambeth

Overall Finance Position (2025/26 M09)

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	485	485	0	646	646	0
Community Health Services	22,869	22,878	(9)	30,492	30,474	18
Mental Health Services	18,334	19,771	(1,438)	24,445	26,214	(1,769)
Continuing Care Services	26,933	25,262	1,671	35,911	33,924	1,986
Prescribing	33,034	33,451	(417)	43,998	44,534	(536)
Other Primary Care Services	2,992	2,770	221	3,989	3,694	295
Delegated Primary Care Services	72,341	72,562	(221)	96,454	96,749	(295)
Corporate Budgets	3,500	3,506	(6)	4,666	4,661	6
Total	180,487	180,685	(198)	240,600	240,895	(295)
Equalisation of Ring Fence Delegated Primary Care			221			295
Revised Full Year Forecast Variance			**23**			**0**

- The borough is reporting an overall **£23k year to date underspend position** and a forecast breakeven position at Month 09 (December 2025) after the "equalisation" of the ring fenced delegated primary care budgets. The reported forecast position includes **£1,769k overspend on Mental Health Services** and **£536k 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 M09 for this specific budget is £2.7m overspend**) and Mental Health placements expenditure 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 9, noting previous year (2024-25) overspend position was driven by locum reimbursements, retainer scheme and list size growth.

- The Continuing Healthcare budget is **forecasting £1,986k 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 M09 is 549.

- Prescribing actual data is available two months in arrears and the borough is **reporting a £536k forecast overspend** position against in year budget at month 9 based on seven 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 M8 Updates

Integrated Health & Adult Social Care	Budget £'000	Forecast £'000	Variance £'000
Adult Social Care			
Expenditure	181,267	194,117	12,850
Income	-56,059	-62,113	-6,054
Net	**125,208**	**132,004**	**6,796**
Public Health			
Expenditure	-45,460	-44,888	738
Income	-45,460	-44,888	-738
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	2,020	169
Income	-198	-833	-635
Net	**1,653**	**1,187**	**-466**
IHASC Directorate Total			
Expenditure	239,700	257,230	17,530
Income	-112,706	-123,906	-11,200
Net	**126,994**	**133,324**	**6,330**

The Integrated Health and Adult Social Care (IHASC) directorate is forecasting an overspend of £6.331m as of November 2025.

The IHASC forecast position has improved, with the projected overspend reducing from £8m in Q1 and from £6.873m in Q2.

The key reasons behind this reduction in the past month are a £100k reduction in forecast spend on placements in Adult Social Care, and a one-off contribution of £500k from Public Health Grant towards Adults Commissioning posts which meet Public Health outcomes, captured under Senior Management – Integrated Health & Care.

However, it should be recognised that many of the forecast reductions have been made through non-recurrent interventions. This leaves ASC with a significant underlying pressure, circa £8m.

Increased demand management efforts and enhanced monitoring of new placement costs has meant that the forecast spend has held steady through the first two quarters and is now starting to fall, avoiding the incremental increases throughout the year seen in previous years.

Mitigations & Actions:

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

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Quality

Quality item will be discussed
at the next LTAG in March 2026

Risk Summary

Risk highlights

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

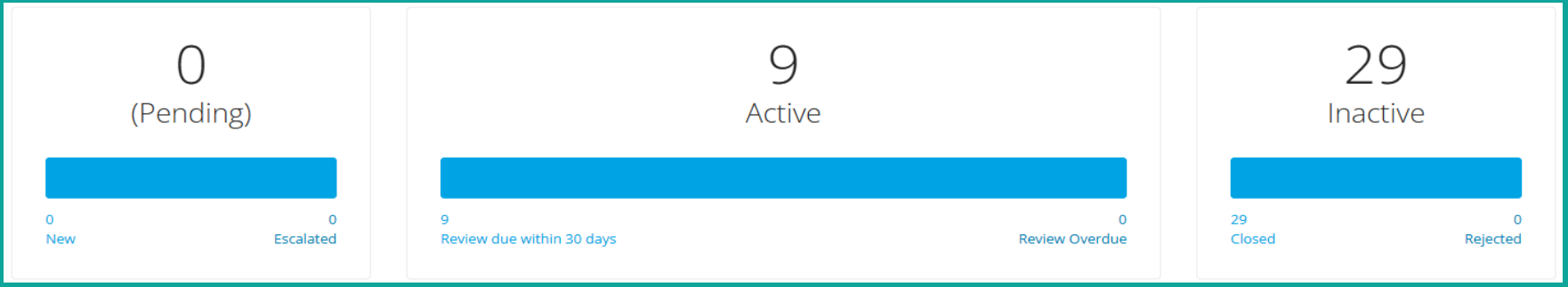
Lambeth Risk Register

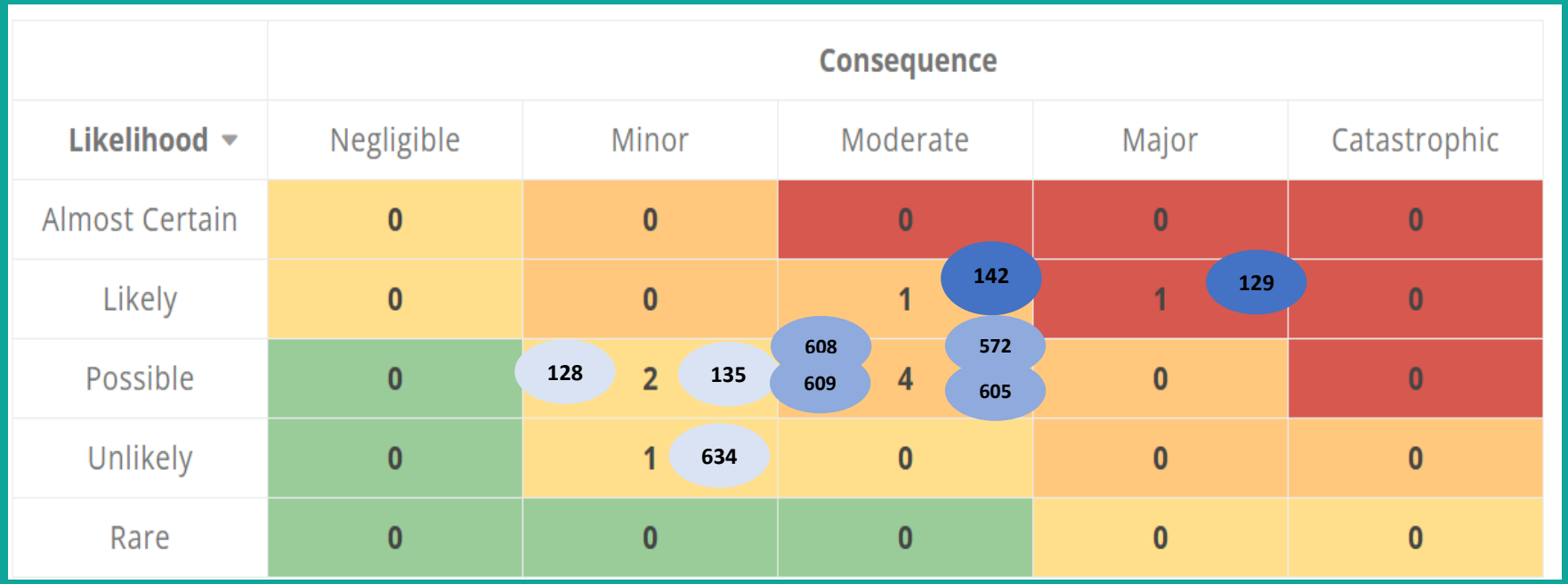
- As of December, there were 9 active risks on the South East London Risk register for Lambeth.
- Since the last update to this group the following risk score has been adjusted
    - Integrated Community Equipment Service reduced score from 6 to 4 reflecting positive changes with new provider.

- SEL Risk forum will take place in February 2026 and risk leads will meet to discuss risks across SEL, receive updates from risk leads and review Local Care Partnership comparative report, and prepare SEL and LCP risk profiles for 26/27 aligned with SEL Risk Framework.

Risk highlights

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





Lighter low risk score, darker higher risk score

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

Risk highlights

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

Risk ID	Risk Title	Current Rating
128	CAMHS waiting times	6
129	Diagnostic waiting times for neurodiversity assessments - children and young people	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	4

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	Nov-25	National standard	66.7%	75.3%	70.9%	Above	1
IAPT discharge	Oct-25	Operating plan	533	565	N/A	N/A	-
IAPT reliable improvement	Oct-25	Operating plan	66%	66%	68%	Below	4
IAPT reliable recovery	Oct-25	National standard	48%	44%	47%	Below	4
SMI Healthchecks	Q2 25/26	Local trajectory	55%	55.0%	53%	Above	2
LD and Autism - Annual health checks	Oct-25	Local trajectory	580	701	N/A	N/A	-
Bowel Cancer Coverage (60-74)	Apr-25	Corporate Objective	62.9%	61.8%	67.9%	Below	6
Cervical Cancer Coverage (25-64 combined)	Jun-25	Corporate Objective	63.3%	62.7%	66.9%	Below	6
Breast Cancer Coverage (50-70)	Apr-25	Corporate Objective	57.8%	59.1%	63.1%	Above	6
Percentage of patients with hypertension treated to NICE guidance	Nov-25	Corporate Objective	77.3%	67%	68.0%	Below	5
Appointments seen within two weeks	Aug-25	Operating plan	-	91.0%	89.1%	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.

At the time of writing this report we were finalising Q3 position and this information will be available in March LTAG assurance report.

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%			12.0%					Data source - SEL Vital 5 dashboard (as of December 25) - Of those with a smoking status, 30,105 (12.0%) are recorded as smoking in the past 5 years.
		Plan							12.6%			12.5%			12.3%		
		Variance							-0.5%			-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%	1.24%	1.73%	2.34%	2.72%	3.16%	3.65%	4.13%	4.55%					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%	0.7%	1.1%	1.7%	1.7%	1.9%	1.7%	1.7%	1.4%					
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%			77.6%								
		Plan	83.5%			79.5%			80.9%			79.9%			82.6%		Plan = against previous year position
		Variance	-0.9%			-3.4%			-3.3%								
	Proportion of Lambeth registered population who are over the age of 65 receiving immunisation for Flu	Actual								36.4%			52.8%				Data source - Imms Form Week 1 2026
		Plan								41.2%	49.3%	52.6%	54.0%	54.4%	54.7%		Flu uptake in 24/25 (data source EZA)
		Variance															
	Proportion of Lambeth registered population who are within the 'at risk cohort' receiving immunisation for Flu	Actual								18.7%			30.6%				Data source - Imms Form Week 1 2026 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)
		Variance															

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

Impact measures performance trend (2)

Outcome	Impact measure	Target/Plan	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year to Date	Comments
D	Number of community organisations and volunteers undertaking mental health awareness and suicide prevention training	Actual	Target - 16 suicide prevention training sessions booked for the next 12 months. STORM 5 suicide prevention Level 1 training sessions booked for the next 12 months. MHA 6 half-day sessions over the next 12 months														Target - 16 suicide prevention training sessions booked for the next 12 months. STORM 5 suicide prevention Level 1 training sessions booked for the next 12 months. MHA 6 half-day sessions over the next 12 months
		Plan															
		Variance															
	Number of Entering treatment with Short-Term Support with Living Well Centres.	Actual	143	125	150	151	208	183	130	182	169	200					
		Plan															
		Variance	12	-18	25	1	57	-25	-53	52	-13	31					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	31	38					
		Plan															
		Variance	27	10	2	-7	7	-13	-1	17	-11	7					Against previous month's position
	LWNA Short Term Waiting Time	Actual	27	26	30	27	27	25	31	27	31	30					
		Plan	26	26	26	26	26	26	26	26	26	26					Average time from introduction received by SLaM to 2nd contact by a Short-Term Support team
		Variance	-1	0	-4	-1	-1	1	-5	-1	-5	-4					
E	Rates of STI testing	Actual	Currently working with Sexual health commissioners to report the data														
		Plan															
		Variance															
	Rates of STI diagnoses	Actual															
		Plan															
		Variance															
	Number of LARC uptake in primary care	Actual															
		Plan				319			272			276			299		24/25 Out turn
		Variance															
F	Uptake of SMI health checks	Actual	64%	2.80%	7.6%	14.3%	21.4%	25.9%	31.7%	38.5%	43.9%	48.7%					
		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%	3.9%	3.7%					
	Uptake of LD/AHC health checks	Actual	83%	3.9%	8.0%	13.2%	20.2%	25.6%	32.3%	40.4%	46.3%	54.8%					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%	-4.0%	-1.8%					
	Proportion of Bowel Cancer screening for those aged 60-74	Actual	Bowel cancer screening – 2.5 year coverage (ages 60-74) April 25 - 61.8%. **25/26 ambition of 64.6%**														Bowel cancer screening – 2.5 year coverage (ages 60-74) April 25 - 61.8%. 25/26 ambition of 64.6%
		Plan															
		Variance															
	Proportion of cervical Cancer Screening aged 25-64	Actual	Cervical cancer screening – 3.5/5.5 year coverage (ages 25-64) June 24 - 62.7%. **25/26 ambition of 64.6%**														Cervical cancer screening – 3.5/5.5 year coverage (ages 25-64) June 24 - 62.7%. 25/26 ambition of 64.6%
		Plan															
		Variance															
	Proportion of breast cancer screening for women aged 50-70	Actual	Breast cancer screening – 36-month coverage (ages 50-70) April 25 - 59.8% . **25/26 ambition of 60.2%**														Breast cancer screening – 36-month coverage (ages 50-70) April 25 - 59.8% . 25/26 ambition of 60.2%
		Plan															
		Variance															
	Number of new PrEP users (and continuers) resident in Lambeth	Actual															
		Plan															
		Variance															

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

Impact measures performance trend (3)

Outcome	Impact measure	Target/Plan	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year to Date	Comments
G	Proportion of people with Type 2 diabetes who have all 8 care processes measured and recorded on an annual basis	Actual	76%	13.8%	21.5%	30.7%	40.0%	47.1%	54.3%	59.9%	66.4%	68.3%					
		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%	15.1%	10.5%					
	Proportion of people aged 79 or under with hypertension who achieve a blood pressure measure less than or equal to 140/90mmHg this FY	Actual	70%	12.3%	21.9%	31.3%	39.9%	45.7%	50.9%	55.5%	58.6%	62.4%					
		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%	5.1%	2.1%					
	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%	70.5%	73.3%					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%	16.9%	13.0%					
	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%	17.4%	19.4%					
		Plan															
		Variance															
H	Proportion of referrals to the Living Well Network Alliance Single Point of Access, which were processed during the month (i.e. triaged, referred onwards or otherwise responded to) within 72 hours.	Actual	34%	36%	28.8%	27.4%	22.3%	37.7%	40.9%	44.9%	44.0%	44.9%					
		Plan															
		Variance															
	Access to Lambeth Talking Therapies for Black African and Caribbean residents to ensure they are as least as good as those of White residents	Actual	24.2%			25.2%			26.6%								
		Plan	21.7%			21.7%			21.7%								
		Variance	2.5%			3.5%			4.9%								
	Recovery rates for Lambeth Talking Therapies for Black African and Caribbean residents to ensure they are as least as good as those of White residents	Actual	50.3%			47.8%			47.0%								
		Plan	48.0%			48.0%			48.0%								
		Variance	2.3%			-0.2%			-1.0%								
	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		26	17	7											
		Plan															
		Variance															
I	Health and Wellebing Bus - No of interactions -	Actual				3,670			2,476			3,089					More than 3000 interactions in the first quarter
		Plan															
		Variance															
	Beacons service - No of interactions Interactions (brief opportunistic exchange), Hi 5 and BP check	Actual				3,228			-			-			-		878 Hi 5 intereactions and 982 opportunistic BP checks
		Plan															
		Variance															
	Vital 5 & Women and Girls community interactions	Actual				237			132			124					58 1-1 Vital 5 checks delivered; 10% advised to see GP within 3 weeks, 85 showed high irsk or possibly dependency after Audit C questionnaires.
		Plan															
		Variance															

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Impact measures performance trend (4)

Outcome	Impact measure	Target/Plan	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year to Date	Comments
J	Percentage of General practice appointments seen within two weeks	Actual	90%	89%	89%	90%	90%	90%	90%	88%	89%						
		Plan	90.0%	90.0%	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%	-1.9%	-1.0%						
	Improve access to healthcare professionals through increased use of community pharmacies - GPs and NHS 111 direct people to pharmacies to support people with minor ailments and advice around self-care and common clinical conditions	Actual	2,500														
		Plan															
		Variance															
	Patients to be admitted, transferred, or discharged within 4 hours of arrival to A&E - GSTT sites	Actual	74%			77.70%			78.2%								
		Plan															
		Variance															
	Patients to be admitted, transferred, or discharged within 4 hours of arrival to A&E - KCH sites	Actual	71.9%			71.6%			72.4%								
		Plan															
		Variance															
K	No of community referrals to reablement	**Actual**		7	15	12	6	3	3	3	5	8					
	No of people who require no service or a reduced service following reablement	**Actual**		47	38	36	36	34	30	32	29	39					
	Proportion of carers of the users of Adult Social Care Services are offered a carers assessment	**Actual**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					
		Plan	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					
		Variance	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%					
	Number of people identified as being in their last year of life on practice registers	**Actual**	2087			2111			2156			2199					
		Plan	1988			2013			2082			2045					
		Variance	99			98			98			74					
	Proportion of people with Personalised Care and Support Plan(PCSP)/UCP	**Actual**	46%			46%			50.0%			51.6%					
		Plan	48%			49.4%			46.0%			44.9%					
		Variance	-2%			-3%			4%			7%					
L	Continuity of maternity care for women	Actual	Work is undeway to source the data														
		Plan															
		Variance															
	Patient experience indicators on maternity care The benefits of continuity of care in maternity include improved maternal and foetal outcomes, increased satisfaction with care, reduced healthcare costs, and better communication and trust between the healthcare provider and the patient.	Actual															
		Plan															
		Variance															
	Infant and maternal mortality	Actual															
		Plan															
		Variance															

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Impact measures performance trend (5)

Outcome	Impact measure	Target/Plan	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year to Date	Comments
M	Number of children and adults with learning disabilities and/or autism currently cared for in specialist inpatient units	Actual	14			10											At the end of Q1, there were 9 adults and one children in specialist inpatient settting
N	Number of people per quarter supported by the Living Well Network Alliance to stay in their own homes (ClaSS)	Actual	8			14			15			9					Number of service users starting paid employmenet during each quarter
		Plan	36			36			36			36					IPS Performance Target
		Variance	-28			-22			-21			-27					Variance from Target
	Number of people per quarter supported by the Living Well Network Alliance into paid employment (IPS)	Actual	47			38			50			46					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			-15			12			-4					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			691					Count of Lambeth SPA "signpost to other agency" + relevant events for all other Lambeth teams
		Plan															
		Variance	492			415			625			691					
	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%	83.3%						From PEDIC
		Plan	78.4%	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%	4.9%						
	Seclusions and restrictive interventions on inpatient setting	Actual	31	25	28	31	37	43	27	49	38	74					Restrictive incidents + seclusions
		Plan	32	32	32	32	32	32	32	32	32	32					Median value Apr-23 to Dec-24
		Variance	1	7	4	1	-5	-11	5	-17	-6	-42					
O	Number of rough sleepers brought into accommodation	Actual	62			64			54			95					
		Plan	52			44			44			55					Plan = against previous year position
		Variance	10			20			10			40					
	Proportion of people living in our supported housing that are registered with a GP	Actual	98%			98%			99%			98%					
		Plan	92%			90.0%			90.0%			98%					Plan = against previous year position
		Variance	6%			8%			9%			0%					
	Number of rough sleepers who have returned to the streets after being in settled accommodation	Actual	1			2			3			0					
		Plan				1			2			1					Plan = against previous year position
		Variance				1			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			107					
		Plan				28			60			82					Plan = against previous year position
		Variance				57			40			25					

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

A. People maintain positive behaviours that keep them healthy

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

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

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

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

Q3 2025-2026, saw a total of 1212 Health checks completed. This activity is lower than the same period last year where 1511 Health Checks were completed. It should be noted that Q3 24/25 was an outlier as activity was higher than normal due to the resumption of the service (catching up on itself) from the Cyber attack/ critical incident that halted the service for much of Q1 and Q2 that year. Activity for Q3 25/26 falls in line with normal expected activity trends for this time of year.

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:-
32% patients prescribed statins,
12% prescribed antihypertensives,
26% referred to the National Diabetes Prevention Programme (NDPP),
5% referred to smoking cessation services,
25% referred to weight management.

10%of patients who had a health check were diagnosed with a health condition and added to appropriate registers. This includes:-
30% diagnosed with hypertension,
7% diagnosed with diabetes,
2% with chronic kidney disease (CKD),
60% with non-diabetic hyperglycaemia.

81% of patients were identified with low 10-year cardiovascular disease (CVD) risk,
17% with moderate risk, and
2% with high risk.

All patients received appropriate advice and support.

A. People maintain positive behaviours that keep them healthy

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

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

Does the data/intelligence identify any health inequalities and whether they are reducing?	The Lambeth population that are eligible for an NHS Health Check is around 90,000 people. Current data shows uptake is largely in line with the demographics of that eligible cohort: • White: Eligible 51% (incl. White British 22% and White Other 29%), Uptake 52% (incl. White British 29% and White Other 23%) • Black: Eligible 17%, Uptake 19% • Asian: Eligible 6%, Uptake 7% • Other: Eligible 8%, Uptake 10% • 40-50 age group: Eligible 61%, Uptake 54% • 51-60 age group: Eligible 28%, Uptake 30% • 61+ age group: Eligible 11%, Uptake 16% This demonstrates the opportunity to pick up risk factors at an earlier stage and to start prevention early. • Female: Eligible 42%, Uptake 51% • Male: Eligible 58%, Uptake 49%
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	<u>Challenges</u> • Ongoing capacity of primary care • Improving uptake of the service especially amongst key demographics • Recommissioning of the service for 26-27 • Infrastructure limitations impacting Incorporating/ embedding At scale model/ Neighbourhood model <u>Actions</u> • Continue regular NHS Health check 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 Health checks 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 Health check at work and Health checks online pilots. • To continue to seek out other proof of concept initiatives to enhance uptake and impact of Health Checks

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

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

Alliance and Programmes	NWDA (owner) with contributions from CYP and Staying Healthy
*What does the data/intelligence indicate around **progress against the outcome?***	Demand for the service remains high, suggesting the need for social prescribing is still very much needed. Age UK Lambeth Link Workers report an average yearly caseload of approximately 300 patients which exceeds the NHS's recommended guidelines for Link Worker caseloads (between 200-250 annually).
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	High demand into the service would suggest that health inequalities remain high, with repeat referrals being made. Unfortunately wider political and economic factors impact the work of Link Workers and although they provide support around finances, housing, [physical inactivity etc. health inequalities remain.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	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. Lack of funding to develop social prescribing models also plays a part. More investment into targeted social prescribing (see below) or opportunities to develop peer support models and group activities would alleviate pressures and help address health inequalities in an innovative way. It will also worke nicely with Lambeth's Neighbourhood model.
Additional Comments	The Back on Track service will be ending on 31/03/26 if additional funding is not secured. The Back on Track service is a financial link worker project working in Stockwellbeing and Fiveways PCNs with social prescribing focusing exclusively on financial matters. The service works closely with Lambeth Council to give vulnerable patients "breathing space" from Council Tax and rent arrears to focus on income maximisation and debt management. The project has been running for the past 4 years with great results but without additional funding residents could lose this vital support and face greater financial and health inequalities as a result.

C. People are immunised against vaccine preventable diseases

Alliance and Programmes	**Staying Healthy (owner) with contributions from NWDA/CYP**
Update Month	**November 2025**

*What does the data/intelligence indicate around **progress against the outcome?***	**Childhood Immunisations**: Childhood immunisation coverage in Lambeth continues to be challenging overall, with sustained difficulty achieving the locally agreed 90% uptake ambition. Published COVER data are now available for Q1 and Q2 2025/26 (with Q3 due to be published end of March 2026). The latest data show that, in Q2 compared to Q1 2025/26, uptake of the 6-in-1 primary immunisation at 12 months declined; MMR1 uptake at 24 months remained broadly stable; and uptake of both MMR1 and MMR2 at age 5 improved. This broadly aligns with the picture across London and statistical peers. **Influenza:** The ambition to deliver a 2% improvement in uptake across priority groups (65+, under-65s at clinical risk, and pregnant women) was not achieved in 2024/25 and remains the target for the current season, which is now underway. Uptake to date is currently outperforming the same period last year, indicating positive early progress, although there remains variation across practices. Targeted interventions are in progress to support lower performing practices, including strengthening call/recall arrangements and focused work to reduce inequalities in uptake. This is complemented by Lambeth Public Health-led community engagement and outreach with VCS partners and community pharmacies, including awareness raising, myth-busting, and improving access through MECC activity and pop-up clinics offering opportunistic vaccination.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	**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 found that lower uptake was associated with higher deprivation and non-White British ethnicity. Findings from the local health equity audit have been shared with system partners, including primary care, to inform targeted improvement action. **Influenza:** Data from previous seasons indicate inequalities in influenza vaccine uptake, with lower coverage among Black and mixed ethnic groups across eligible cohorts and in areas of higher deprivation. An outreach and engagement plan, led by Lambeth Public Health, is in place to address these inequalities. Uptake will be monitored throughout the current campaign to assess whether the gaps are narrowing.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	**Childhood Immunisations:** Barriers to uptake vary across communities and include practical access issues (e.g. GP registration), mistrust regarding data sharing, and misinformation (including concerns about MMR and autism). Progress is also hindered by system-level issues, including data quality, inconsistent call/recall arrangements, and limited appointment flexibility. The Vaccination in New Spaces (ViNS) service is addressing these barriers by improving accessibility and flexibility, including targeted outreach to families who are not reachable through routine practice systems, have persistently not attended (DNA'd) appointments, or have expressed a preference for home-based vaccination. **Influenza:** Uptake in the previous season was affected by vaccine fatigue, low perceived risk, and wider barriers identified through local engagement. During the current season, Lambeth Public Health, working with system partners, will continue to use practice-level intelligence and community feedback to identify and address barriers to uptake in real time, with learning captured to strengthen planning and delivery for the 2026/27 campaign.
Additional Comments	**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. The refresh of the 2023–25 Childhood Immunisation Strategy is underway, incorporating community feedback to shape improvement priorities and recommendations. **Actions to Improve Flu Vaccination Coverage**: For this year Public Health-led outreach strategy is in place to raise awareness, understand community barriers, and co-design locally tailored solutions with residents and stakeholders including Primary Care and VCS partners.

1. Predictors of Childhood Vaccination Uptake and Timeliness in a Diverse Urban Population | British Journal of General Practice

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 200 new people in December, more than the 169 new people seen in November and many more than the monthly average of 156 for 2024/25. This makes 1498 new people supported so far in 2025/26. The number of people Focused Support (FS) started supporting in December rose to 38 from 31 in November, which means that 309 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 December had waited an average of 29.8 days. This is 5.0 days more than the average wait of 24.8 days in 2024/25 but less than the average of 30.8 days seen in November. This corresponds with 616 people working with STS at the end of December and 600 at the end of November, both significantly 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 continues through 2025/26. Black services users were 28.7% of those accessing short-term support in the quarter April to June, 30.3% July to September and 31.4% October to December. These are all much higher that the 18.7% of the Lambeth 18-64 population that identifies as Black. The proportion of those new to focused support during the quarter October to December from Black communities was at 51.0%, slightly lower than the 2024/25 average of 53.1%. In the quarter October to December, waiting times for a second appointment with STS continues to show Black services users being seen more quickly than White service users (waiting an average of 25 and 32 days respectively). This is despite their being no significant difference in the priority attached to referrals for Black and White service users (with 36% and 37% respectively being considered urgent).
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	We believe that social and economic factors that disproportionately affect Black communities lie behind their need for more intensive services. We use the PCREF framework to engage with our local communities and build trust to improve access, experience and outcomes. Greater access to services for Black people in the early stages of their illness will reduce their need for more intensive forms of support.

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

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

Alliance and Programmes | **Sexual Health**

*What does the data/intelligence indicate around **progress against the outcome?***	**Reproductive Health** Total LARC activity in general practice for Q3 was 661 – total LARC fittings were 319. This is an increase from Q2 where there were 408 total appointments and 200 total LARC fittings. LARC Hub data is not yet available for Q3. **STI testing and diagnosis** The latest available data on number of STI tests and number of STI diagnosis is up to Q1 25/26. There were 15,308 tests taken by Lambeth residents between April and June 2025. This is less than the previous quarter where 16,098 tests were undertaken. This may be due to seasonal variation. Number of new STI diagnoses have decreased slightly with 2,231 in Q1 25/26 compared to 2,300 new diagnoses in Q4 24/25 (and 2,423 in Q3 24/25). 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?***	**STI testing and diagnosis** The 25-34 year age group (50.2%) followed by the 35-44 year age group (20.3%), 20-24 year age group (15%) and 45-64 year age group (11.4%). Proportions of new STI diagnoses across age brackets are similar to testing proportions – 45.4% of diagnoses in 25-34 year age group, 22.9% in 35-44 age group, 20-24 year age group (14.4%) and 45-64 age group (12.3%). 54.7% of STI tests were taken by males compared to 43.2% in females which is a similar proportion to last quarter.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	**Reproductive Health** Officers are currently taking papers through governance for the new LARC contracts to begin in April 2026. This will be a continuation of the previous model whilst further discussions and solutions are looked at for inter-practice referrals with PCNs and the neighbourhood models to devel over the period of the contract term. **STI testing** The Walworth Road site in Southwark has been closed temporarily due to the services inability to fully staff it consistently but the final decision on this site will not be made until after the staff consultation exercise has completed. A range of service access options remain available including Minnie Kidd House, community outreach, pharmacy and online. Impact on residents' access to services following the closure will be monitored.

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 LSLSBB SH strategy has now been formally signed off, and PH have been asked to update informal cabinet on the work plan for 26/27. This is likely to be at the end of February. Commissioners are working with GSTT Service Manager to start doing some targeted service promotion within the location of Minnie Kidd House.

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 increased by 10 percentage points to 48.7% from last month and is exceeding the 24/25 trajectory by 5 percentage points and is on track to meet the end of year target.

LD health checks have increased since December by 14 percentage points since last month, however, is 3 percentage points below the 24/25 trajectory.

On cancer screening programme,

1. Bowel Cancer screening aged 60-74-Upward trend. Most recent data shows upward trend with 61.8% screened (April 2025) compared to 51.4% in April 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
2. Cervical Cancer screening aged 25-64-shows levels are quite stable but not increasing with 62.7% screening in June 2024 compared to 62.8% in April 2023 but down from 66.7% in April 2019. National target is 80%. **No update to data since last report in November**. More recent estimated data taken from primary care coding shows 63.8% which is an increase and positive (not official data). Below national target of 80%.
3. Breast cancer screening aged 50-70-Very good upward trend in the past year. Most recent data shows 59.1% screened in April 2025 which is a significant increase from 55.7% in April 2024. Not returned to pre-covid levels which were 61% in November 2019 but 3.4% 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.

The number of Lambeth residents accessing PrEP continues to increase. At the time of writing this report clinical activity data shows 607 PrEP starts and 3027 continuers, this is an increase of 308 starts and 1913 continuing from the previous update, activity data is until October 2025.

For the new Digital PrEP service 284 prescriptions have been issued to Lambeth residents, whilst we are still waiting for improvements to the data reports we can identify that 63 were new to PrEP and 221 previous access PrEP within a sexual health clinic.

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?

Uptake of SMI health checks among men is lower than for women; Uptake of LD health checks are lower in younger people. Both groups experience high levels of deprivation, particularly multifactorial deprivation. There are similar levels of uptake among ethnic groups for both SMI and LD health checks. We will continue to monitor the data to measure impact of planned activities.

On cancer screening programme,

1. 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
2. Cervical Cancer screening aged 25-64-Current data shows highest screening in those with black ethnicity (69.8%), then white (66.9%) and then significantly lower for mixed (61.8%), Asian (54.4%) and other (51.9%). Significantly lower for those with LD (45.8%) compared to non-LD (63.9). There is a slight month to month improvement.
3. Breast cancer screening aged 50-70-1st and 2nd deprivation quintile have lowest rates. White (63.0%) and black (63.0%) ethnicity have similar rates, lower in Asian (57.8.0%), mixed (58.5%) and “other” (54.2%) ethnicities, Significantly lower in LD (44.9%) compared to non-LD (61.1%) and SMI (48.4%) compared to non-SMI (61.4%). Rates overall are improving which promising.

Across the service 25% are new to PrEP and of the 18 – 25 age group 55% are new to PrEP. Across the IMD 1- 3 25% are new to PrEP and 6.1% are female or Trans, 13.7% are non – GBMSM and a total of 59% are non-white British. The above data is showing that some of the groups which have been missing from in-clinic activity are starting to access PrEP via the digital on-line 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

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

From April 2026, the NHSE metric for LD health checks will change from Health Check Completed to Health Check and Health Action Plan Completed. Local Lambeth data on the new metric and NHSE data match confirming that Lambeth is prepared for the change. Activities focused on improving data quality and reducing inequalities continue as planned.

On cancer screening programme there are numerous ongoing challenges. There is a lag in the data so we are 9-18 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. Due to staffing changes within the NWDA there is now less capacity for focus on cancer projects. There are however numerous 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. These are now coming to an end. This has been 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 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.

The online provider is working on improved activity reporting so that we receive more Borough focused reporting regularly. Education and Training sessions are starting in January which should help to amply awareness and knowledge, with specific training now arranged with Preventx and the Outreach Alliance.

Training has been arranged for GPs to attend online for HIV and PrEP but attendance is so far low from Lambeth.

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 15 December 2025, among patients with hypertension, 24,149 of 39,926 aged 79 years and under (60.48%) have blood pressure ≤140/90 mmHg, while 4,339 of 6,025 aged 80 years and over (72.02%) 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.
To strengthen blood pressure identification and diagnosis, an Ambulatory Blood Pressure Monitoring (ABPM) referral resource pack was launched for GP practices and community pharmacies in December 2025. This supports referrals into the nationally commissioned Community Pharmacy hypertension case-finding advanced Service, alongside encouragement of the use of AccuRx to facilitate and increase referrals.

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 December 2025, 58.2% 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.

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 December 2025, a total of 642 of the 3496 (18.36%, previously 12.85%) patients have had a SMR.

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)

*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	More black and minority ethnic people have been identified with hypertension when comparing 15 December 2024 to 15 December 2025 data; 13,943 and 14,951 respectively and within these cohorts, blood pressure control has remained consistent with higher absolute numbers in comparison to the previous year; 24,479 and 25,480 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 previous 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.
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 December was 73, down 49% from the 142 open at the end of November and 88% from the 602 open at the end of June. People still open to SPA at the end of December, had been open to SPA, on average, for 6.1 days in the case of urgent referrals and 7.3 days for routine referrals, respectively a 31% and 52% improvement from the end of November. 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 fell to 97% of target at the end of December, down from 107% at the end of November. So far in the financial year 2025/26, 4,931 people have completed their treatment with LTT.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	SPA showed no significant inequalities in their processes. In the quarter October to December, 41% of Black service users discharge by SPA received onward referrals to Community Mental Health Services or other parts of the SLaM Trust, compared to 35% for White service users. Average days open to SPA for urgent referrals were 8.0 days and 9.3 days for Black and White service users respectively. 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.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	A clinically led project to redesign the Lambeth Single Point of Access is underway, with a new model about to enter a trial phase. This new model will be more closely aligned with Lambeth's strategy for neighbourhood-based care, reduce hand-offs between teams with service users needing to tell their story multiple times and consistently apply a stepped care approach to meet national standard for accessing services. Lambeth Talking Therapies continues to focus on having more new clients access the service who are then assessed as being recovered and showing significant improvement in their symptoms when they complete treatment (i.e. are in "Reliable Recovery"). The LTT service is also working to increase session numbers for Black clients and ensure that reliable recovery rates are consistently over 48% for all ethnic groups.

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?***	Lambeth continues to see high and sustained demand into CAMHS, with referrals averaging around 110–120 per month in the baseline period. Overall CAMHS caseload has steadily increased over time (2950 at the end of Nov, an increase of 189 over a 6-month period), reflecting both demand growth and longer durations of care, particularly within the neurodevelopmental pathway. Performance on first contact within 28 days remains strong, with Lambeth achieving over 95% compliance in the baseline data, ensuring early advice and signposting while children and young people wait for full assessment or treatment. The number of children and young people waiting longer than 52 weeks shows improvement, with baseline data indicating a reduction from earlier peaks, reflecting targeted waiting list management activity.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	The baseline dataset does not currently provide a Lambeth-level breakdown of waiting times, access or outcomes by ethnicity, deprivation or other protected characteristics. As a result, the data cannot yet be used to quantify inequalities in access or waiting times, or to demonstrate whether gaps are narrowing for under-represented groups. Neurodevelopmental pathways account for a disproportionate share of longer waits, which is relevant to inequality given known links with deprivation and unmet need, but this is not disaggregated in the current dataset.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Ongoing pressure is driven by high demand into neurodevelopmental pathways, where children and young people typically remain open to services for longer. Current data does not provide routine breakdowns by ethnicity or deprivation, restricting insight into disparities in access or waiting times.
Additional Comments	Further work is underway through system governance to improve the consistency and usefulness of reporting, including demographic breakdowns where available.

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?***	As of mid December, 64 people were seen by the Health and Wellbeing Bus and team for a Vital 5 check during Q3. Out of this total, 17 GP follow up forms were submit, having their details sent over and linked with their GP records to receive a follow up call and further support from their GP. This was a much larger number than previous 2 quarters which could indicate the team have increased confidence in obtaining people's details to submit forms, which can have been achieved through our recent conversations regarding the process and guidance in approaching service users with requesting this information. The data shows that we're improving our ability to reach 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?***	During this period, we've identified 25% of these 64 people that would be categorised as stage 2 hypertensive. This indicates a large percentage of the people we're reaching are struggling with keeping a healthy blood pressure range which would be due to various factors and wider determinants of health such as ethnicity, diet, stressful living conditions etc.. 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?*	We have some challenges aligning the reporting structure for the clinical team as they are not yet on EMIS. We are addressing this by working with the GP Federation to use an interim solution (Vital 5 follow up form) before using the EMIS template.
Additional Comments	

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

Tracks General practice appointments, Community Pharmacy activity and ED 4h 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?	Overall access and utilisation of digital and telephone routes into general practice continue to improve. Uptake and use of the NHS App has increased by 5% since the start of January, supporting wider access to services and information. Telephone demand on practices remains high, with approximately 85,000 calls received each month. Performance remains strong, with the majority of calls answered within five minutes. There is also a gradual shift towards patients opting for call-back options, suggesting increasing acceptance of alternative access models and potential smoothing of peak demand pressures. Across the urgent and emergency care system, NHS 111 and A&E activity during core hours continues to perform better than most comparator boroughs, indicating appropriate use of primary and community-based services and effective front-door access. Online consultation is now active in all practices and continues to be well-utilised. In November alone, 50,000 online requests were submitted in Lambeth, of which 60% related to clinical issues and 30% to administrative requests, demonstrating the role of online access in managing both care needs and operational demand. The Bridges for Health programme is now live, with practices actively engaging in training materials to support adoption of risk stratification, which is expected to improve proactive care and care navigation over time. In the past 12 months, around 2 million general practice appointments were delivered. Face-to-face and telephone consultations remain the most commonly used modalities, reflecting ongoing patient preference and clinical need. However, Did Not Attend (DNA) rates remain persistently high, with 133,000 appointments missed, including 98,000 face-to-face appointments. This represents a significant impact on access, capacity, and value for money, and continues to be a key challenge in maximising available primary care capacity.
Does the data/intelligence identify any health inequalities and whether they are reducing?	The current dataset does not include segmentation required to identify health inequalities; further analysis is being explored.
What are the challenges hindering any progress and are there actions which can be taken to address these?	DNA rates remain stubbornly high, with 98,000 appointments not used for their intended purpose, representing an estimated financial impact of around £4.41m. It is too early to draw firm conclusions from a single month's data; however, early indications suggest that while patients are increasingly finding online care convenient, overall patient behaviours and demand patterns have not yet materially shifted. General practice continues to account for around a third of all patient requests between 8am and 9am on weekdays, indicating sustained pressure at peak access times.

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 ED 4h 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 31 August 2024 to 31 July 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 a had a positive impact for patients and reduced GP appointments for minor conditions. Data from October 2025 shows a 16.18% increase (19,203 October 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 ED 4h 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)	
Jul-24	1704
Aug-24	1667
Sept-24	1820
Oct-24	1647
Nov-24	2152
Dec-24	2334
Jan-25	2391
Feb-25	2355
Mar-25	2361
Apr-25	2293
May-25	2445
Jun-25	2328
Jul-25**	2349
Total – 27,846	

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 increased slightly to an average of 53 per month from October 2025 to December 2025. This is an increase from last quarter.

For this financial year 12% of referrals to Reablement have come from the community. This is a decrease from the previous quarter. We are reviewing the process for identifying referrals suitable for Reablement from the community (ASC Front Door Team iCAS).

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 of people with a reduced or no need for care at the end of Reablement remains steady at 88% which is a small increase from the previous quarter. This data is up to end of October 2025.

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. This has improved outcomes. When RSW's provide reablement care 96% of people require no ongoing support or a reduced level of support.

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

On End of Life Care, 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 increased slightly. Practice end of life care register sizes are in line with Lambeth's underlying demographics: the unadjusted annual mortality rate for Lambeth is also 0.47%.

There is nevertheless scope to improve the proportion of people identified as being in the last year of their lives who have end of life care plans, with achievement elsewhere in South East London being as high as 85%.

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. 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:

Quarter	Census	Service data
Asian or Asian British	7%	9%
Black, Black British, Caribbean or African	24%	28%
Mixed	8%	5%
White	55%	54%
Other ethnic group	6%	6%

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

The Reablement service is currently undergoing a review to consider alternative ways of offering this service. We are working closely with Commissioning and GSTT colleagues. This change is likely to take place in Autumn 2026.

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

We have 2 other workstreams within the DODG group:
1. To roll out a Trusted Assessor discharge process for patients on Pathway 3 (patients discharged to care homes).
2. A new workstream focusing on Housing and hospital discharges. Winter Pressures funding has been agreed for 6 months for an Assessor to sit within the hospital social work teams at GSTT & KCH. The postholder will be the link with Housing and help to facilitate discharges where there are repairs and housing issues. Recruitment to this post is in progress.

On End of life Care, 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.

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

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

Alliance and Programmes	CYPA (Owner)

*What does the data/intelligence indicate around **progress against the outcome?***	The Local Maternity and Neonatal System (LMNS) has provided a provider-level report covering current activity and quality oversight across King's College Hospital and Guy's and St Thomas'. The report includes some outcome measures (for example preterm birth), but does not include perinatal mortality or any measures that allow continuity of care across maternity pathways to be tracked. The Alliance will use this report as a starting point and continue to work with the LMNS to further validate and strengthen the data.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	The report suggests ongoing disparity in some outcomes, including preterm birth, for Black women and birthing people, based on provider-level snapshots. However, the data is not presented in a way that allows trends over time or reduction in inequality to be assessed, and there is no Lambeth-resident view. As such, the report cannot yet be used to demonstrate whether inequalities in access or outcomes are narrowing.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	The LMNS has caveated the report due to data accuracy and stability issues, particularly following recent system changes. Where data is reported, it is aggregated at provider level and reflects a wide and complex catchment, limiting its use for place-based assurance. Current reporting does not support routine monitoring of perinatal mortality or continuity of care.
Additional Comments	The LMNS has confirmed that perinatal mortality broken down by key demographics, including ethnicity, is intended to be included in future reporting (initially at trust level). Work is also underway to develop a place-level dashboard, which will provide more meaningful assurance for Lambeth partners over time.

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?***	On number of people in inpatient settings figures are reported quarterly. In January 2026 the number of people cared for in specialist inpatient units was 12 (10 adults and 2 YP). This indicates a steady downwards trend since 22/23 which evidences the effective work to facilitate discharge to the community and prevent admission. Number of supported employment and supported internships we create through our health and care partners. There are currently 6 interns on the Lambeth Council Supported Internships programme, and there are 7 on the King's College Hospital programme. In addition, we have 2 young people attending aspects of the Supported Internship programme at Lambeth Council with a view to taking part in the full programme next academic year.
Does the data/intelligence identify any ***health inequalities and whether they are reducing?***	Ethnic background of those supported in inpatient settings is monitored. The proportion of inpatients who are Black/Black British has fallen from 50% (22/23) to 27% (July 25) indicating there is no longer an over-representation of people from Black backgrounds in the most restrictive settings. This demonstrates the hard work of the whole Lambeth Together network and partners to achieve this result.
What are the ***challenges hindering any progress*** *and* ***are there actions which can be taken*** *to address these?*	On the number of supported employment and supported internships It continues to be a challenge to present updated data that evidences the work to support people with LD into paid work, due to the discontinuation of this measure in the ASCOF data process. An alternative method of ensuring sufficient data collection and reporting is in development.
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 third quarter of 2025/26, October to December, CLaSS started working with 46 new people, down slightly on the 50 new clients in the previous quarter, July to September. LWNA's Individual Placement and Support (IPS) helps people with a serious mental illness find and sustain paid employment. The IPS service helped 9 people find work in the third quarter, October to December, down from the 15 people supported in the quarter July to September. This is much less than the original placement target of 36 per quarter, but the team also helped 4 people to sustain employment for 26 weeks or more. There were 74 restrictive incidents and seclusions for inpatients in December, almost double the 38 seen in November 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 83.3% in November (the last month for which data is available), a fall of 1.1% from November but still higher than 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 third quarter of 2025/26, October to December, 46% were for Black services users, down from 52% the previous quarter and 54% the previous financial year. This fall comes as the proportion of Black people newly admitted as inpatients fell to 40%, from 49% in the previous quarter, July to September. The equivalent figures for more intensive community services, focused support and home treatment, were roughly stable, at 50% and 33% respectively. All of these figures however remain much higher than might be expected, given that the Black adult population of Lambeth is 2025 is estimated to be 18.7%. Of the 152 restrictive incidents reported for Lambeth acute inpatients with a stated ethnicity in the third quarter, October to December, 53 (35%), were for Black service users compared with 49 of 95 (52%) in the preceding quarter, July to September, and 46 of 78 (59%) April to June. This fall appears to be less the result of a falling rate of incidents involving Black services users and more about a disproportionately high number of incidents reported for two White service users involved in 13 and 31 incidents respectively. More time will be required to monitor the trend once this anomaly has passed.
*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 Q3 was 95, a steep increase from 54 in the previous quarter. A steep increase from 54 in the previous quarter. This is largely due to our having activated the Severe Weather Emergency Protocol (SWEP) three times in this quarter which accounts for 31% of accommodation placements. During SWEP, everyone rough sleeping is offered emergency bedspaces within our Vulnerable Adult's Pathway, and the outreach team continue to work with them to move them straight from SWEP into a stable accommodation outcome to avoid a return to the streets. The outreach team have also done particularly well with supporting rough sleepers into winter night shelters and to No Second Night Out. The number of those returning to rough sleeping after being in settled accommodation was zero in Q3. This represents a reduction of 3 from the previous quarter and is a great outcome to have no cases of this. This reflects the effectiveness of the support systems in place that help individuals sustain settled accommodation after being successfully moved on The number of residents registered with GP's continues to be at a high level of 98%. 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 continued 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 evidenced by the numbers engaged with the IHN, 107 in Q3 which is an increase of 7 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 a focus area for Lambeth and the rest of London. The Government's new Homelessness Strategy, focuses on prevention activities and solutions, rather than supporting people when they reach crisis point or end up sleeping rough. The PRS market continues to be a challenge/barrier.