Lambeth together

Lambeth Together

Integrated Assurance Report

12 May 2026

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Our Health, Our Lambeth

Lambeth Together health and care plan 2023-28

Lambeth Together Health and Care Plan Scorecard – May 2026

			May-26				Mar-26	
ID	Outcome	Measures tracked	Measures Reported with a target	On plan/ target	% measures on track (where have a target)	Vs previous update	% measures on track (where have a target)2	Comments
A	*People maintain positive behaviours that keep them healthy*	5	1	1	100%	–	100%	
B	*People are connected to communities which enable them to maintain good health*	1	1	1	100%	–	100%	
C	*People are immunised against vaccine preventable diseases*	3	3	0	0%	–	0%	Local performance on Immunisation against agreed impact measures was below national uptake targets.
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	3	60%	↑	40%	National target for LD and SMI AHC was achieved in 25/26 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	2	67%	↓	100%	Cardiovascular measure on proportion of people aged 79 or under with hypertension who achieve a blood pressure marginally missed year-end target of 80%.
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	3	100%	↑	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	24	75%	–	72%	

Health and Care Plan: Key headlines (1)

	Outcome	Key Headlines
A	***People maintain positive behaviours that keep them healthy***	Initial analysis indicates that 6102 Health checks have been performed for 25-26 (though final figure likely to increase due to Q4 validation process still to be completed) confirming newly established baseline trend of between 6000 and 7000 Health Checks per year. Challenges for next year are, ongoing capacity of primary care, improving uptake of the service especially amongst key demographics, mobilising and optimizing recommissioned service for 26-27 and infrastructure limitations impacting Incorporating/ embedding At scale model/ Neighbourhood model.
B	***People are connected to communities which enable them to maintain good health***	Planned deep dive, see enclosed presentation along with highlight report updates.
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 Q3 2025/26 (with Q4 due to be published at the end of June 2026). The latest data show that, in Q3 compared to Q2 2025/26, uptake of the 6-in-1 primary immunisation at 12 months increased by 2.4 pp (88.6% Q3 vs 86.2% Q2); MMR1 uptake at 24 months increased by 2.5pp (80.1% Q3 vs 77.6 Q2); and uptake of both MMR1 and MMR2 at age 5 improved. Lambeth vaccination uptake 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 remained the target for the now completed 2025/26 season. Compared to the previous season, uptake increased for under-65s with long-term conditions by 2.3pp (31.5%) and for pregnant women by 6.1pp (37.5%), while uptake for 65+ fell by 0.7pp (53.8%).
D	***People have healthy mental and emotional wellbeing***	New data analysis has reconfirmed that Black residents in Lambeth are under-represented in accessing low to medium intensity forms of support, such as short-term support and talking therapies. 28% of all service users during the quarter October to December 2025 (the latest period for which data is available). Black service users are however over-represented in accessing high to very high intensity support, such a focused support and acute care. 53% or all users of these services, over the same period, were Black. These figures are both showing positive trends, but changing extremely slowly, with each moving by just 1 percentage point per year in a positive direction. For context, the Black 18-64 population of Lambeth is estimated to be 18.7%.

Health and Care Plan: Key headlines (2)

	Outcome	Key Headlines
E	***People have healthy and fulfilling sexual relationships and good reproductive health***	LARC activity in Q4 saw a decrease in LARC fittings at GP practices but an increase in LARC Hub appointments which was required and welcome and equals an overall increase from the previous reporting period. The provider has planned increased activity with a staff rota to ensure increased access across 2026/27. Between Q1 and Q3 in 25/26 the total activity for LARC was 1882, compared to 1,544 in Q1-3 24/25 showing an increase in overall activity compared to the same period last year. The GP LARC training programme is being well utilised. Further analysis is needed to understand if the decreases are being seen across all population cohorts and STIs. National analysis of the decrease in chlamydia testing and diagnosis shows the biggest decrease has been in 15-24 year age group. We are awaiting the refresh of the annual SPLASH supplement report that will report indicators for Lambeth broken down by different demographics.
F	***People receive early diagnosis and support on physical health conditions***	The national target of 60% has been achieved. End of year performance for SMI health check is 66% which exceeds the national target by 6%. Lambeth has met or surpassed the target for the last 4 years. The national target for 25/26 has been achieved. End of year performance for LD health checks with Health Action Plan is 80% which exceeds the national target by 5%. Lambeth has met or surpassed the target for the last 4 years.
G	***People who have developed long term health conditions have help to manage their condition and prevent complications***	The Lambeth ambition for the proportion of people with Type 2 diabetes, who meet all 8 Care Process metrics, was 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 31 March 2026, 77% 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.
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 March was 48. This is down 35% from the 74 open at the end of February and the lowest number ever in the almost 6-year history of SPA. As at the end of March, those people open to SPA has been open, on average, for 5.7 days in the case of urgent referrals and 9.9 days for routine referrals. In March, 62% of all referrals received were closed within 3 days and 90% within 7 days, both of which are best-even end of month results for the team. CAMHS caseload in Lambeth was 2,980 active cases at the end of January, reflecting sustained demand and longer durations of care, particularly within the neurodevelopmental pathway. Performance on first contact within 28 days remains strong, with good compliance, supporting 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 has reduced (2 for Lambeth, compared to 7 and 8 for Lewisham and Southwark), indicating continued improvement in long waits.

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***	Planned deep dive, see enclosed presentation along with highlight report updates.
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***	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 1 February 2024 to 31 January 2026 shows a positive increase in activity across SEL ICB, being the 3rd highest London ICB to provide Pharmacy First consultations.
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***	The number of accepted referrals to Reablement has increased slightly to an average of 54 per month from December 2025 to March 2026. This is an increase from last quarter. In the last 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%.
L	***Women have positive experiences of maternal healthcare and do not experience a disproportionate maternal mortality rate***	Since the last update to Lambeth Assurance, no additional information has been provided by the Local Maternity and Neonatal System (LMNS) to support an updated view of maternity performance. This is still due to the data gap following the EPIC implementation in late 2023. The issue has been raised on several occasions and has now been escalated to executive leads at King's College Hospital and Guy's and St Thomas'. Work will continue with assurance colleagues and the LMNS to obtain the necessary access to maternity data, so that progress against agreed priorities can be monitored.

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***	To follow
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 Individual Placement and Support (IPS) helps people with a serious mental illness find and sustain paid employment. The IPS service helped 10 people find work in the fourth quarter, January to March, up slightly from the 10 people who successfully found employment in the previous quarter. This is still well below the original placement target of 36 per quarter, but the team also helped 5 people to sustain employment for 13 weeks or more and 1 for 26 weeks. The IPS service placed 48 people in 2025-26, slightly less than the 51 achieved in 2024-25. Both figures fall substantially short of the targets set when the service was created.
O	***People who are homeless, or at risk of becoming homeless, (including rough sleepers and refugees) have improved health***	The outreach team continue to support rough sleepers into accommodation, and 52 individuals were accommodated during Q4. This is less than Q3 but more in line with the quarterly norm (the increase in Q3 was due to numerous SWEP activations). Hostel and supported housing services continue to support people to sustain tenancies and not return to the street and this is evidenced by zero people being seen rough sleeping after being placed into settled accommodation during Q4. This is the first time this financial year that this has occurred.

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Finance

Finance: South East London ICB: Lambeth

Overall Finance Position (2025/26 M12)

	2025-26 @M12		
	Annual Budget	Draft Outturn	Draft Outturn Variance
	£'000s	£'000s	£'000s
Acute Services	646	566	80
Community Health Services	30,692	30,864	(173)
Mental Health Services	24,758	27,003	(2,246)
Continuing Care Services	35,911	33,742	2,169
Prescribing	43,998	44,374	(377)
Other Primary Care Services	3,999	3,279	720
Delegated Primary Care Services*	96,619	96,619	0
Corporate Budgets#	4,666	4,603	64
Total	**241,288**	**241,050**	**238**

- The draft 2025-26 year-end financial outturn position (*subject to external audit*) for Lambeth Place is **£238k underspend**. The draft outturn financial position includes **£2,246k overspend on Mental Health Services (including Learning Disabilities)** and **£377k overspend on Prescribing** offset by significant savings delivered by Continuing Health Care (CHC) team and underspend in Primary Care Services.

- The main underlying risk within the 2025-26 Lambeth's finance position is the **exponential growth in referrals to independent sector providers for ADHD & ASD assessments (£2.9m overspend)**.

- **Mental Health (including Learning Disabilities)** reported overspend position was driven by increased ADHD and ASD assessments under the Right to Choose process, Mental Health and Learning Disabilities (LD) placement expenditure mitigated by constraining investments.

- **Prescribing**: Key areas of current pressures in the prescribing budget include respiratory systems, endocrine systems and appliances – reflecting the ICB's investment in the management of long-term conditions.

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

- Further risks remain associated with demand driven budgets (Mental Health including Learning Disability Services, Audiology, Interpreting Service, Cardiovascular Diagnostic Service, Prescribing and Continuing Health Care Services).The significant financial challenges is recognised within the Lambeth health and social care system, and local partners are working to mitigate them and ensured resources available are used in the most efficient and effective way.

Lambeth Council M10 Updates

Integrated Health & Adult Social Care	Budget £'000	Forecast £'000	Variance £'000
Adult Social Care			
Expenditure	181,574	190,874	9,300
Income	-56,059	-62,390	-6,331
Net	**125,515**	**128,484**	**2,969**
Public Health			
Expenditure	44,100	43,977	123
Income	-44,100	-43,977	--123
Net	**0**	**0**	**0**
Integrated Commissioning			
Expenditure	12,571	18,429	5,858
Income	-12,349	-18,273	-5,924
Net	**222**	**156**	**-66**
Senior Management			
Expenditure	1,851	1,953	102
Income	-198	-825	-627
Net	**1,653**	**1,128**	**-524**
IHASC Directorate Total			
Expenditure	240,096	255,233	15,137
Income	-112,706	-125,465	-12,759
Net	**127,390**	**129,768**	**2,378**

The Integrated Health and Adult Social Care (IHASC) directorate is forecasting an overspend of £2.378m at January 2026.

The IHASC forecast position has improved throughout the year, 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 reductions in placement costs and additional non-recurrent contributions towards ASC pressures in Adult Social Care from grant funding, 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.

Increased demand management efforts and enhanced monitoring of new placement costs has meant that the forecast spend has reduced significantly since Q1 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 enclosed with LTAG pack

Risk Summary

Risk highlights

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

Lambeth Risk Register

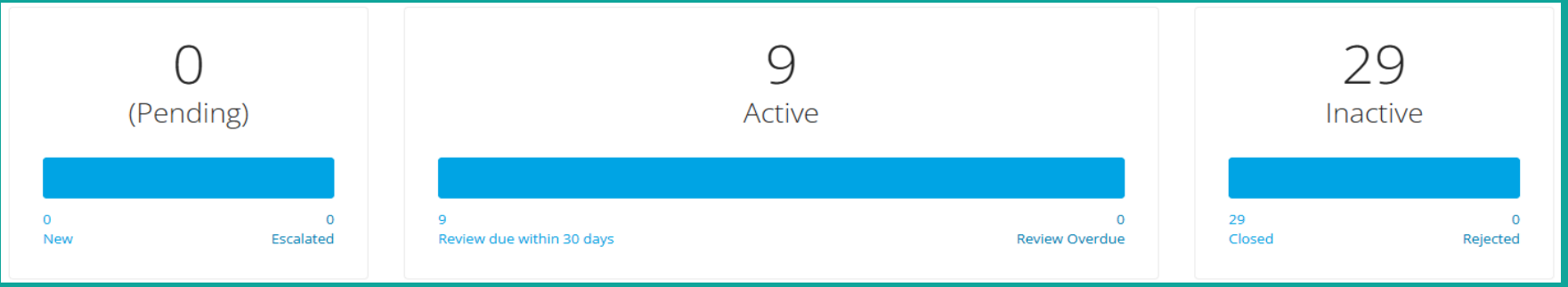
- In 25/26 risks were assessed each month, Local Care Partnership risk owners reviewed every month local risks. Every quarter SEL Risk Forum meeting was held to discuss risks across boroughs and SEL position across local care partnerships to identify/ flag/ compare local risk against ICB and system risks.
- SEL Risk team asked Local Care Partnership partners to review risks as we complete 25/26 financial year cycle.
- As of March, there were nine risks on Lambeth risk register. Following discussions with risk owners and approval of proposed actions at Senior Management Team meeting on 28th April, it was agreed five risks would be closed and four carried over to 26/27.
- The table on the next slide shows rationale supporting above decisions in relation to 25/26 LCP risk review.

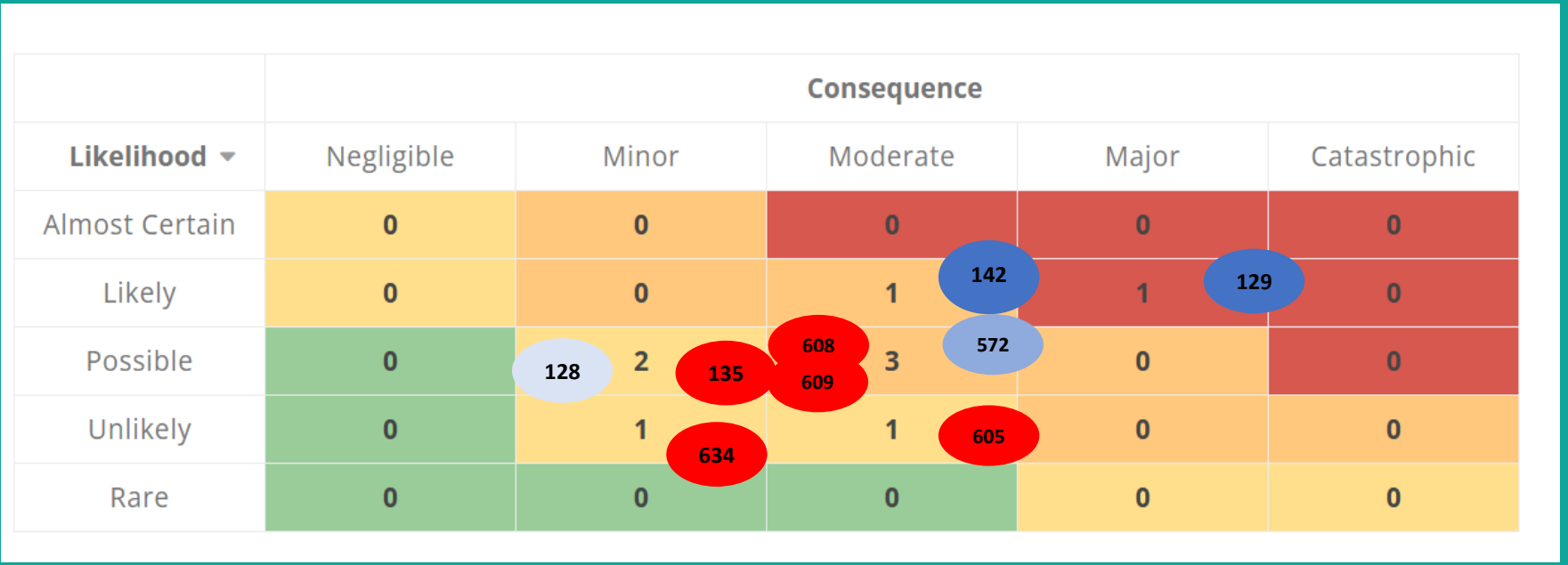
Risk highlights

Risk ID	Lead	Risk Title	Current Rating	Action	Rationale/ Actions
128	Dan S	**CAMHS waiting times**	6	**Continue in 26/27**	Demand for CAMHS services remains high. NHS Medium Term planning framework guidance references operational performance objectives for ICBs, particularly on CYP waiting times, if not managed appropriately could affect ICBs reputation. **Action** - adjust risk content for 26/27 to ensure assurances and controls are up to date.
129	Dan S	**Diagnostic waiting times for neurodiversity assessments - children and young people**	16	**Continue in 26/27**	NHS Medium Term planning framework guidance references operational performance objectives for ICBs, particularly on Learning disabilities, autism and ADHD, if not managed appropriately could affect ICBs reputation. **Action** - adjust risk content for 26/27 to ensure assurances and controls are up to date
135	Jane B	**Failure to safeguard adults**	6	**Close**	Target rating achieved and risk exposure has reduced since Safeguarding lead is in post.
142	Ese I	**Immunisation Rates protect Children, including vulnerable groups from communicable diseases.**	12	**Continue in 26/27**	Lambeth vaccination uptake still behind national targets **Action** - adjust risk content for 26/27 to ensure assurances and controls are up to date. Agree risk owner, Public Health managed this risk for the last two years. Proposal for risk to be managed by Primary Care directorate.
572	Ese I	**Increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population - Seasonal Flu Vaccination**	9	**Continue in 26/27**	Lambeth vaccination uptake still behind national targets **Action** - adjust risk content for 26/27 to ensure assurances and controls are up to date. Agree risk owner, Public Health managed this risk for the last two years. Proposal for risk to be managed by Primary Care directorate.
605	Ed O	**Delivery of overall Place/borough productivity & efficiency requirement and achievement of financial balance for 2025-26.**	6	**Close**	Budgets managed to stay within allocated resources in 25/26. Productivity and efficiency requirements were delivered.
608	Anna M	**Delivery of Delegated Primary Care productivity & efficiency requirement and managing expenditure within allocated financial resources for 2025-26**	9	**Close**	Expenditure in 25/26 managed within allocated resources.
609	David O	**Delivery of productivity & efficiency requirement and achievement of financial balance for Mental Health for 2025-26 financial year**	9	**Close**	Risk managed within allocated resources, overall borough met expected efficiencies.
634	Jane B	**Integrated Community Equipment Service**	4	**Close**	Residual risk is manageable. New provider stabilised in terms of delivery of CE functions.

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

Closed risks

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	Mar-26	National standard	66.7%	73.2%	71.6%	Above	2
IAPT discharge	Feb-26	Operating plan	533	500	N/A	N/A	-
IAPT reliable improvement	Feb-26	Operating plan	67%	69%	68%	Above	3
IAPT reliable recovery	Feb-26	National standard	48%	48.0%	47%	Above	3
SMI Healthchecks	Q3 25/26	Local trajectory	62%	58.7%	56%	Above	2
LD and Autism - Annual health checks	Feb-26	Local trajectory	1176	1296	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	Dec-25	Corporate Objective	80%	73%	74.0%	Below	5
Appointments seen within two weeks	Feb-26	Operating plan	-	92.0%	90.7%	Above	2

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	100%
Adults with Learning Disabilities	Focus on LDA Health Inequalities	100%
	NHSE Learning Disability and Autism Programme	100%
Children & Young People	CYP - Mental Health Support	100%
	Pull together a comprehensive dataset for Lambeth women using maternity services	100%
Long Term Conditions Optimisation	Deliver Long Term Conditions Optimisation Priorities	100%
Medicines Optimisation	Deliver Medicines Optimisation Priorities	100%
Primary Care	Improve Access to Primary Care	100%
	Shift to Neighbourhoods by working collaboratively with Integrated Health and Care providers	100%
Public Health	Age-Friendly Lambeth	100%
	Health Intelligence	100%
	Infection Prevention and Control of Communicable Diseases	100%
	Sexual Health	100%
	Staying Healthy	100%
	Substance Misuse	100%
Public HealthCPC: People Focussed Services	Lambeth HEART	100%

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 Q4 position across the areas of focus within the 25/26 plan. We are pleased to report all actions have been listed as Green and trajectories have met year-end objectives.

Appendix:
Health and Care Plan Outcomes: Detailed assurance narrative

Impact measures performance trend (1)

Outcome	Impact measure	Target/Plan	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year to Date	Comments
A	Smoking prevalence reduction	Actual	12.3%			12.2%			12.1%			12.0%			11.8%		Data source - SEL Vital 5 dashboard (as of March 26) - Of those with a smoking status, 29,796 (12.0%) are recorded as smoking in the past 5 years.
		Plan							12.6%			12.5%			12.3%		
		Variance							-0.5%			-0.5%			-0.5%		
	Number of adults insubstance misuse opiate clients in treatment	Actual	927					922				916	909				January 2025 (Feb 2025 to Jan 2025)
		Plan															
		Variance															
	Number of adults insubstance misuse non-opiate clients in treatment	Actual	552					598				623	628				January 2025 (Feb 2025 to Jan 2025)
		Plan															
		Variance															
	Number of adults insubstance misuse alcohol clients in treatment	Actual	560					563				574	567				January 2025 (Feb 2025 to Jan 2025)
		Plan															
		Variance															
	Uptake of the NHS Health Check for all eligible adults	Actual		0.7%	1.2%	1.7%	2.3%	2.7%	3.2%	3.7%	4.1%	4.6%	5.1%	5.9%	6.2%		Data Source - EZ Analytics (including HC done by H Hubs)
		Plan		0.2%	0.5%	0.6%	0.6%	1.0%	1.3%	2.0%	2.5%	3.2%	4.0%	4.6%	5.3%		
		Variance		0.4%	0.7%	1.1%	1.7%	1.7%	1.9%	1.7%	1.7%	1.4%	1.1%	1.3%	1.0%		
B	Percentage of low-income residents coping financially	Actual	77.7%			79.3%			81.2%			80.6%			81.0%		
		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%			0.4%			0.2%		
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%	53.6%			Data source - Imms Form Week 5 2026, March data not yet available
		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%	33.4%			Data source - Imms Form Week 5 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	178	191	196		
		Plan															
		Variance	12	-18	25	1	57	-25	-53	52	-13	31	-22	13	19		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	40	35	39		
		Plan															
		Variance	27	10	2	-7	7	-13	-1	17	-11	7	2	-5	9		Against previous month's position
	LWNA Short Term Waiting Time	Actual	27	26	30	27	27	25	31	27	31	30	33.1	32.7	28.8		
		Plan	26	26	26	26	26	26	26	26	26	26	26	26	25.96		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	-7.1	-6.8	-3		
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%	53.9%	58.9%	65.6%		
		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%	3.9%	3.9%	5.6%		
	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%	63.8%	73.8%	80%		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%	0.9%	4.6%	4.5%		
	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%** Cervical cancer screening – 3.5/5.5 year coverage (ages 25-64) June 24 - 62.7%. **25/26 ambition of 64.6%** Breast cancer screening – 36-month coverage (ages 50-70) April 25 - 59.1% . **25/26 ambition of 60.2%**														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%
		Plan															
		Variance															
	Proportion of breast cancer screening for women aged 50-70	Actual															Breast cancer screening – 36-month coverage (ages 50-70) April 25 - 59.1% . 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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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%	71.6%	74.4%	77.1%		
		Plan	77%	6.4%	12.8%	19.3%	25.7%	32.1%	38.5%	44.9%	51.3%	57.8%	64.2%	70.6%	77%		Year end target of 77%
		Variance	-1%	7.3%	8.7%	11.5%	14.3%	15.0%	15.8%	14.9%	15.1%	10.5%	7.4%	3.8%	0.1%		
	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%	65.6%	68.8%	72.6%		
		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%	-1.4%	-4.9%	-7.8%		
	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%	76.4%	78.9%	81.9%		Year end target of 80%
		Plan	77%	7%	13%	20%	27%	33%	40%	47%	54%	60%	67%	74%	80%		
		Variance	4.1%	8.0%	13.7%	18.4%	21.5%	22.4%	21.1%	19.7%	16.9%	13.0%	9.4%	5.2%	1.5%		
	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%	22.9%	27.3%	33.3%		
		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%	56.0%	56.6%	61.8%		
		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%			24.2%					Q4 Talking Therapies data not available due to year-end validation & verification processes
		Plan	21.7%			21.7%			21.7%			21.7%					
		Variance	2.5%			3.5%			4.9%			2.5%					
	Recovery rates for Lambeth Talking Therapies for Black African and Caribbean residents to ensure they are as least as good as those of White residents	Actual	50.3%			47.8%			47.0%			42.1%					
		Plan	48.0%			48.0%			48.0%			48.0%					
		Variance	2.3%			-0.2%			-1.0%			-5.9%					
	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											2				The number of 52-week waiters reflects the position as of January 2026, rather than the end of Q4 2025/26. For context, this figure remained unchanged at 2 in the preceding months (November and December 2025).
		Plan															
		Variance															
I	Health and Wellebing Bus - No of interactions -	Actual				3,772			4,574			4,152			3,447		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				253			361			246			165		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%	89.5%	89.4%	90.2%	89.5%		
		Plan	90.0%	90.0%	90.0%	90.0%	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%	-0.5%	-0.6%	0.2%	-0.5%		
	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%			78.8%			75.4%		
		Plan	78%			78%			78%			78%			78%		
		Variance	-4.0%			-0.3%			0.2%			0.8%			-2.6%		
	Patients to be admitted, transferred, or discharged within 4 hours of arrival to A&E - KCH sites	Actual	71.9%			71.6%			72.4%			69.3%			69.8%		
		Plan	75.0%			75.0%			75.0%			75.0%			75.0%		
		Variance	-3.1%			-3.4%			-2.6%			-5.7%			-5.2%		
K	No of community referrals to reablement	**Actual**		7	15	12	6	3	3	3	5	8	2	8	6		
		Plan															
		Variance															
	No of people who require no service or a reduced service following reablement	**Actual**		47	38	36	36	34	30	32	29	39	41	26	34		
		Plan															
		Variance															
	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%	100%	100%	100%		
		Plan	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
		Variance	0%	0%	0%	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			2210		
		Plan	1988			2013			2082			2045			2087		
		Variance	99			98			98			74			154		
	Proportion of people with Personalised Care and Support Plan(PCSP)/UCP	**Actual**	46%			46%			50.0%			51.6%			52.9%		
		Plan	48%			49.4%			46.0%			44.9%			46.0%		
		Variance	-2%			-3%			4%			7%			7%		

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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
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			10		Number of service users starting paid employmenet during each quarter
		Plan	36			36			36			36			36		IPS Performance Target
		Variance	-28			-22			-21			-27			-26		Variance from Target
	Number of people per quarter supported by the Living Well Network Alliance into paid employment (IPS)	Actual	47			38			50			46			62		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			16		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			493		Count of Lambeth SPA "signpost to other agency" + relevant events for all other Lambeth teams
		Plan															
		Variance	492			415			625			691			493		
	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%	81.4%	80.8%	83.7%	78.6%		From PEDIC
		Plan	78.4%	78.4%	78.4%	78.4%	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%	3.0%	2.4%	5.3%	0.2%		
	Seclusions and restrictive interventions on inpatient setting	Actual	31	25	28	31	37	43	27	49	38	74	45	34	30		Restrictive incidents + seclusions
		Plan	32	32	32	32	32	32	32	32	32	32	32	32	31		Median value Apr-23 to Dec-24
		Variance	1	7	4	1	-5	-11	5	-17	-6	-42	-13	-2	1		
O	Number of rough sleepers brought into accommodation	Actual	62			64			54			95			52		
		Plan	52			44			44			55			62		Plan = against previous year position
		Variance	10			20			10			40			-10		
	Proportion of people living in our supported housing that are registered with a GP	Actual	98%			98%			99%			98%			97%		
		Plan	92%			90.0%			90.0%			98%			98%		Plan = against previous year position
		Variance	6%			8%			9%			0%			-1%		
	Number of rough sleepers who have returned to the streets after being in settled accommodation	Actual	1			2			3			0			0		
		Plan				1			2			1			1		Plan = against previous year position
		Variance				1			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			107		
		Plan				28			60			82			116		Plan = against previous year position
		Variance				57			40			25			-9		

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A. People maintain positive behaviours that keep them healthy

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

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

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

From 24-25, PH directly commissioned the NHS Health Checks service 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 has now completed it's second and final contractual year and is transitioning into its next contract phase building on further learning. Q4 2025-2026, saw a total of 1655 Health checks completed. This activity is lower than the same period last year where 1999 Health Checks were completed. It should be noted that Q4 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.

Initial analysis indicates that 6102 Health checks have been performed for 25-26 (though final figure likely to increase due to Q4 validation process still to be completed) confirming newly established baseline trend of between 6000 and 7000 Health Checks per year. Key outcomes for those who had a Health check so far this year were as follows:

17% of patients who had a health check were referred to lifestyle services or prescribed medication. This includes:-
31% patients prescribed statins,
9% prescribed antihypertensives,
30% referred to the National Diabetes Prevention Programme (NDPP),
4% referred to smoking cessation services,
26% referred to weight management.

9% of patients who had a health check were diagnosed with a health condition and added to appropriate registers. This includes:-
29% diagnosed with hypertension,
8% diagnosed with diabetes,
2% with chronic kidney disease (CKD),
61% with non-diabetic hyperglycaemia.

88% of patients were identified with low 10-year cardiovascular disease (CVD) risk,
11% with moderate risk, and
1% with high risk.

All patients received appropriate advice and support.

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. Latest 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 • Mobilising and optimizing recommissioned service for 26-27 • Infrastructure limitations impacting Incorporating/ embedding At scale model/ Neighbourhood model <u>Actions</u> • Continue regular NHS Healthcheck Steering Group meeting focussing on implementing Strategy and Action plan with LMC representation • Steering Group to address scope and shape Neighbourhood working model • Refining targeted invite approach with GPs to increase key demographic uptake. • Consideration of the evaluation of the effectiveness of DHSC Healthcheck at work and Healthchecks online pilots. • To continue to seek out other proof of concept initiatives to enhance uptake and impact of Health Checks

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?***	See enclosed deep dive presentation
Does the data/intelligence identify any ***health inequalities and whether they are reducing?***	
What are the ***challenges hindering any progress*** *and* ***are there actions which can be taken*** *to address these?*	

C. People are immunised against vaccine preventable diseases

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

Alliance and Programmes	Staying Healthy (owner) with contributions from NWDA
*What does the data/intelligence indicate around **progress against the outcome?***	**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 Q3 2025/26 (with Q4 due to be published at the end of June 2026). The latest data show that, in Q3 compared to Q2 2025/26, uptake of the 6-in-1 primary immunisation at 12 months increased by 2.4 pp (88.6% Q3 vs 86.2% Q2); MMR1 uptake at 24 months increased by 2.5pp (80.1% Q3 vs 77.6 Q2); and uptake of both MMR1 and MMR2 at age 5 improved. Lambeth vaccination uptake 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 remained the target for the now completed 2025/26 season. Compared to the previous season, uptake increased for under-65s with long-term conditions by 2.3pp (31.5%) and for pregnant women by 6.1pp (37.5%), while uptake for 65+ fell by 0.7pp (53.8%). Targeted interventions supported lower-performing practices, including strengthened call/recall and focused work to reduce inequalities. This was complemented by Lambeth Public Health-led community engagement and outreach with VCS partners and community pharmacies, including awareness raising, myth-busting, and improved 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 insight into vaccination inequalities. Locally, Lambeth Public Health led a study on uptake and timeliness, published in the British Journal of General Practice. This identified lower uptake among more deprived communities and non-White British groups. The findings have been shared with system partners and have informed the childhood immunisation strategy refresh to support targeted improvement. **Influenza:** Data from previous seasons showed inequalities in influenza vaccine uptake, with lower coverage among Black and mixed ethnic groups and in more deprived areas. An outreach and engagement plan, led by Lambeth Public Health, was in place to address these gaps. Uptake was monitored throughout the 2025/26 campaign to assess progress in reducing inequalities.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	**Childhood Immunisations:** Barriers to uptake emerged through community engagement as part of the strategy refresh. These include access issues, mistrust and misinformation, alongside system challenges such as data quality and appointment availability. The Vaccination in New Spaces (ViNS) service is helping to improve access through targeted outreach, with ongoing work to strengthen GP engagement. **Influenza:** Uptake in 2024/25 was affected by vaccine fatigue, low perceived risk, and barriers identified through local engagement. During the 2025/26 season, Lambeth Public Health worked with partners to use local data and community insight to respond to these in real time, with learning captured to inform planning for 2026/27.
Additional Comments	**Actions to Improve Childhood Immunisations Coverage**: The childhood vaccination strategy refresh is complete and progressing through governance for sign-off. Delivery of the agreed priorities will be overseen by the Vaccination Ops Group. **Actions to Improve Flu Vaccination Coverage**: A Public Health-led outreach was in place to raise awareness, understand barriers, and develop locally tailored solutions with residents and partners, alongside targeted support for GP practices.

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 196 new people in March, more than the 177 new people seen in February and 26% more than the monthly average of 156 for 2024/25 and bringing the total number of people helped in 2025/26 to 2049. The monthly average for 2025/26 was 170, showing significant progress on this measure. Focused Support (FS) started supporting 39 new people in March, up from 30 in February, which means that 402 new people have been supported so far in 2025/26 or an average of 34 per month, compared to 44 in 2024/25. While the number of new people supported by FS fell, the number of people being supported at the end of each month grew by 10%, suggesting that each person it being supported for longer. People attending a second STS appointment in March had waited an average of 28.8 days, down from 31.9 days in February. The monthly average across all of 2025-26 was also 28.8 days, up from 24.8 days in 2024-25, suggesting that the success in increasing the number of new people being supported has been achieved at the cost of longer wait times for a second contact.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	New data analysis has reconfirmed that Black residents in Lambeth are under-represented in accessing low to medium intensity forms of support, such as short-term support and talking therapies. 28% of all service users during the quarter October to December 2025 (the latest period for which data is available). Black service users are however over-represented in accessing high to very high intensity support, such a focused support and acute care. 53% or all users of these services, over the same period, were Black. These figures are both showing positive trends, but changing extremely slowly, with each moving by just 1 percentage point per year in a positive direction. For context, the Black 18-64 population of Lambeth is estimated to be 18.7%*. The proportion of all those accessing short term support in the first three months of 2025/26, identifying as Black, was 27.5%. This proportion is less than the 30.9% seen in the months October to December, the 29.2% average for 2025-56 and the 31.9% average for 2024/25. But while the proportion is down, the actual number of Black people supported was up, with 15% more Black people being supported in 2025-26 than in 2024-25. In the quarter January to December, Black people accessing short-term support waited 31 days, on average, for a second contact, compared to 35 days for White people. This is despite 35% of STS referrals being rated urgent for both groups. The proportion of those new to Focused Support during the quarter January to March from Black communities was at 40.4%, which brings the 2025/26 average of 48.9%. This is lower than the 53.0% seen in 2024/25, which could be seen as supporting earlier findings suggesting that the need for intensive support is being reduced by better access to less intensive services such as talking therapies and short-term support.
*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?***	**LARC activity** This quarter sees a decrease in LARC fittings at GP practices but an increase in LARC Hub appointments which was required and welcome and equals an overall increase from the previous reporting period. The provider has planned increased activity with a staff rota to ensure increased access across 2026/27. Between Q1 and Q3 in 25/26 the total activity for LARC was 1882, compared to 1,544 in Q1-3 24/25 showing an increase in overall activity compared to the same period last year. The GP LARC training programme is being well utilised. **Pharmacy Activity** NHSE are now commissioning all contraception within pharmacies. Most Lambeth pharmacies are registered to provide this service. Monitoring data will be available via the ICB medicines optimisation team. **STI** For the calendar year 2025 STI testing and diagnosis data are available until the end of September. From January to September 2025 there were 47,268 STI tests completed and 6,622 new STI diagnoses. For the same time period in 2024 (January-September) there were 50,460 tests completed and 8,057 new diagnoses. Although data for 2025 is not yet complete and is considered provisional, the data suggests a decrease in both number of test and number of diagnosis compared to the previous year. This is consistent with the decrease in testing, diagnoses and positivity rates seen between 2023 and 2024, although it is too early to determine whether we are seeing a continuing downward trend. As there appears to be a reduction in test positivity over time this could either mean poorer targeting of testing (e.g. less testing in higher risk groups/more testing in lower risk groups) or a genuine reduction in STI transmission.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	Further analysis is needed to understand if the decreases are being seen across all population cohorts and STIs. National analysis of the decrease in chlamydia testing and diagnosis shows the biggest decrease has been in 15-24 year age group. We are awaiting the refresh of the annual SPLASH supplement report that will report indicators for Lambeth broken down by different demographics.

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 are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	We are still building our GUMCAD dashboard which will help us to monitor differences in testing uptake and diagnoses by different demographic groups on a quarterly basis. The clinical in-reach part of the outreach Alliance will be stood us very soon after successful CQC registration, the Alliance is now entering its second year and this will be a really valuable addition to the service offer for targeted groups. The GSTT staff consultation has now closed, we are awaiting final updates, once confirmed the new service model will go live, which will increase access to bookable evening and weekend appointments for residents. The new online STI service will have a broader testing treatment pathway once it commences later in the year.

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?

The national target of 60% has been achieved. End of year performance for SMI health check is 66% which exceeds the national target by 6%. Lambeth has met or surpassed the target for the last 4 years. The national target for 25/26 has been achieved. End of year performance for LD health checks with Health Action Plan is 80% which exceeds the national target by 5%. Lambeth has met or surpassed the target for the last 4 years.

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-**No update to data since last report in March** More recent estimated data from March 2026 shows Lambeth bowel screening at 60.3%. This is not official data and includes all eligible age groups.
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 March**. More recent estimated data taken from primary care coding shows 65.7% in March 2026 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%. **No update since last report in March** Unofficial estimated data from March 2026 shows breast screening in Lambeth at 60.6% which is an ongoing positive increase.

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

On Prep activity, current reporting is up until January with current trend for in clinic activity similar to the previous months. Total numbers are currently 841 new residents and 3738 continuing to use PrEP. 64% of male users are accessing in central London with other users accessing within SEL with a reasonable split across LGT, Kings and GSTT.
Online prescriptions until 13/4/26 total 834, 77.7% were existing users channel shifting and 22.3% were new users.

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

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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?

On SMI and LD, see below year end insights,

- 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

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 (71.2), then white (68.6%) and then significantly lower for mixed (63.8%), Asian (56.6%) and other (54.0%). Significantly lower for those with LD (47.2%) compared to non-LD (60.7). There has been an increase in all of these percentages apart from non-LD ince the last report in March.
3. Breast cancer screening aged 50-70-1st and 2nd deprivation quintile have lowest rates. White (62.5%) and black (62.0%) ethnicity have similar rates, lower in Asian (57.6%), mixed (58.9%) and “other” (54.1%) ethnicities, Significantly lower in LD (45.7%) compared to non-LD (60.7%) and SMI (48.8%) compared to non-SMI (60.9%). Rates overall are improving which promising.

All age groups and IMD deciles are represented in the online digital PrEP data, 799 identify as male, 19 female and 16 either Non binary, Trans-Female, other or Trans-Male

The majority of users are white British, 43.2% and Other White Background (26.6%) whilst all other ethnicities are now represented within the data the numbers remain small. It is hoped that the PrEP in Communities work will support increased access by these ethnicities.

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

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

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

Additional Comments	Prep in our Community As part of the South East London “PrEP in our Community” project, which is led by Lambeth and Kings a series of PrEP workshop have been launched. These online workshops are aimed at supporting PrEP prescribers in community and primary care settings, including GPs. These are being promoted via the South London HIV network, the SEL training hub, SEL primary care newsletter and SELnet. Contact has been made with Brixton Prison about PrEP access for people being released, this is a positive start. The Outreach Alliance should be supported to be able to provide PrEP in collaboration with Kings. Injectable clinics have been developed across Trusts for complex PrEP users, numbers are very small. Simple, easy-to-read guidance for staff on the injectable clinic is in motion.

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?*

On SMI/ LD programme the challenges for 26/27:

- The team facilitating the SMI and LD health checks has been stable over past 4 years. Due to the ICB organisational change programme, there will be a change in commissioning staff in 2026/27 and there will no longer be a CCPL post from September 2026.
- Practices have new Ardens templates and will need to ensure that data are being recorded in the right way to count towards achievement. Practices also must adjust from EZ Analytics dashboards to the Ardens Manager tool.

Actions to address:

- The SMI Service Improvement Facilitator role has been commissioned for a further year to the end of March 2027.
- The locally commissioned SMI health check scheme for 2026/27 is now live.
- By the end of August 2026, the CCPL and Data Quality Service Improvement Facilitator will meet with practices identified as requiring additional support to review working practices and identify areas for improvement and a plan to meet end of year targets.
- More proactive engagement with the Health Check Liaison Team and other SLaM teams

On cancer screening programme there are numerous ongoing challenges. There is a lag in the data so we are 9-22 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 which have recently ended. 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. SELCA are currently funding three Lambeth practices with lower screening rates to undertake specific screening promotion which will aim to reduce inequalities further. There is a cervical HPV self sampling pilot running locally involving numerous practices in Lambeth. This aims to increase screening and is especially beneficial to those reluctant or unable to attend normal screening. Overall work is continuing in line with our objectives to continue to improve above screening numbers

PrEP in our Community
GP contracts: Agreed and legally cleared – key milestone achieved (5 across SEL, 1 in Lambeth).
Medication transfer from King's to GP practices approved.
Practices being onboarded to KFM distribution system → medication delivery expected imminently.

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.
As of 31 March 2026, among patients with hypertension, 29,203 of 40,183 aged 79 years and under (73%) have blood pressure ≤140/90 mmHg, while 4,914 of 5,998 aged 80 years and over (83%) have blood pressure ≤150/90 mmHg, demonstrating the need for continued action to improve blood pressure control, particularly in the under-80 cohort. To support continued improvements in 2026-27, the Lambeth Offer local improvement scheme will include an indicator focusing on improving BP control in patients from black, Asian or multi-ethnic backgrounds aged under 80.

The Lambeth ambition for the proportion of people with Type 2 diabetes, who meet all 8 Care Process metrics, was 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 31 March 2026, 77% 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. To support continued improvements in 2026-27, the Lambeth Offer local improvement scheme will include an indicator focusing on improving 8 care process measurement and recording in for patients with type 2 diabetes, to help inform treatment and care plan development.

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 31 March 2026, a total of 1193 of the 3569 (33.43%, previously 25.68%) 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 March 2025 to 31 March 2026 data; 16,548 and 18,148 respectively and within these cohorts, blood pressure control has remained consistent with higher absolute numbers in comparison to the previous year; 24,872 and 25,679 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. 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 (Lambeth Offer) – LTC section and Premium Specification KPIs focusing on completion of the 8 Care Processes and Enhanced Prevention. Access to Ardens Manager 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 March was **48**. This is down 35% from the 74 open at the end of February and **the lowest number ever in the almost 6-year history of SPA**. As at the end of March, those people open to SPA has been open, on average, for 5.7 days in the case of urgent referrals and 9.9 days for routine referrals. In March, 62% of all referrals received were closed within 3 days and 90% within 7 days, both of which are best-ever end of month results for the team. Lambeth Talking Therapies (LTT) is now measuring access by the number of people completing treatment rather than attending a first appointment. By that measure, the service was at 95% of target at the end of March, up from 94% at the end of February but with 6,463 people completing treatment in 2025/26, the LTT service finished the financial year April to March at 101% of target.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	In January to March, Black people discharged by SPA were somewhat more likely to receive an onward referral to Community Mental Health Services or other parts of the SLaM Trust than their White counterparts, referral rates being 42% and 35% respectively. Average days open to SPA also showed a very small difference, with referrals for Black people being completed in 6.2 days compared to 6.5 days for White people. Analysis of Lambeth Talking Therapies (LTT) data by ethnicity for January to March will be available form the end of May. Referring to data from the previous quarter, October to December, access to LTT for Black service users fell to 24.2% from 26.6% in the second quarter, but still higher than the 21.7% estimated Black population of Lambeth*. Reliable Recovery Rate for LTT's Black clients fell to 42.1%, below the 48% target, repeating a pattern seen in other London ICBs. LTT has reviewed therapy outcomes for Black clients and found that their starting severity score on depression and anxiety measures are typically higher than the service average. Black clients had a reliable improvement rate of 70.2%, year to date, which is above the service average of 68.6%. This shows that Black clients make significant (and slightly bigger) improvements in therapy, but because of the higher starting severity, the service struggles to get scores down to the reliable recovery level.

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

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

Alliance and Programmes	LWNA and CYPA (owners)

*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	A new model for the Lambeth Single Point of Access is being trialled, with pathway decisions now being made with more senior input and a more consistent application of national triage standards and "stepped-care" approach. Next steps will integrate SPA and Crisis Outreach Service into a combined Single Point of Access and Rapid Response team. These changes will help to minimise hand-offs between teams and reduce the number of times that people need to retell their story before they get support. 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"). LTT is offering up to 2 additional sessions to Black clients to help with initial engagement and account for the higher starting severity scores.
Additional Comments	*LWNA serves the 18-64 age group, but LTT has no upper age limit, so different benchmarks apply for the Black population of Lambeth. LTT uses the 21.7% estimate from the 2021 Census while LWNA uses the 18.7% 18-64 housing-led projection for 2026 from the GLA made in 2016.

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

Impact Measure H.5.2 — Number of children and young people waiting longer than 52 weeks for an assessment and commencing treatment with Child and Adolescent Mental Health Services (CAMHS).

Data was taken from the M9 (to the end of Dec 2025) "South London and Maudsley NHS Foundation Trust (SLaM) Baseline Data Set" which captures performance for the whole calendar year (Jan-Dec 2025)

*What does the data/intelligence indicate around **progress against the outcome?***	The most recent data available is from Month 10 (January 2026), which at the time of reporting represents the latest dataset provided. Overall CAMHS caseload in Lambeth was 2,980 active cases at the end of January, reflecting sustained demand and longer durations of care, particularly within the neurodevelopmental pathway. Performance on first contact within 28 days remains strong, with good compliance, supporting 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 has reduced (2 for Lambeth, compared to 7 and 8 for Lewisham and Southwark), indicating continued improvement in long waits.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	The current dataset does not provide demographic breakdowns across waiting times, which limits what can be interpreted in relation to health inequalities. Neurodevelopmental pathways account for some of the longer waits (longer waits below 52 weeks), but this is not disaggregated within the data currently available.
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	Ongoing pressure is driven by neurodevelopmental pathways, where children and young people can remain open to services for longer. Current data does not provide routine breakdowns by ethnicity or deprivation, restricting insight into disparities in access and waiting times.
Additional Comments	The CAMHS report continues to develop, with feedback and good cooperation between provider and system partners to improve the quality and usefulness of reporting.

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?***	See enclosed deep dive presentation
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	
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?	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 2061 consultations between September 2024 and February 2026 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 1 February 2024 to 31 January 2026 shows a positive increase in activity across SEL ICB, being the 3rd highest London ICB to provide Pharmacy First consultations. 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 September 2024 to February 2026 shows most interventions (1490) 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, 68% would have gone without medication and 32% of patients would have visited general practice to request the medication on prescription as they are unable to buy the medicines over the counter to deal with minor conditions due to the current cost of living crisis. People who are receiving support through universal credit, patient aged under 16 years or receive support through income-based Jobseeker's Allowance are the top social vulnerability eligibility groups accessing Lambeth Pharmacy First Plus Service in February 2026. 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 February 2026 shows a 19.7% increase (19,786 February 2026 vs 16,528 in April 2025) in repeat prescriptions being ordered via the NHS app.

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 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.
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.

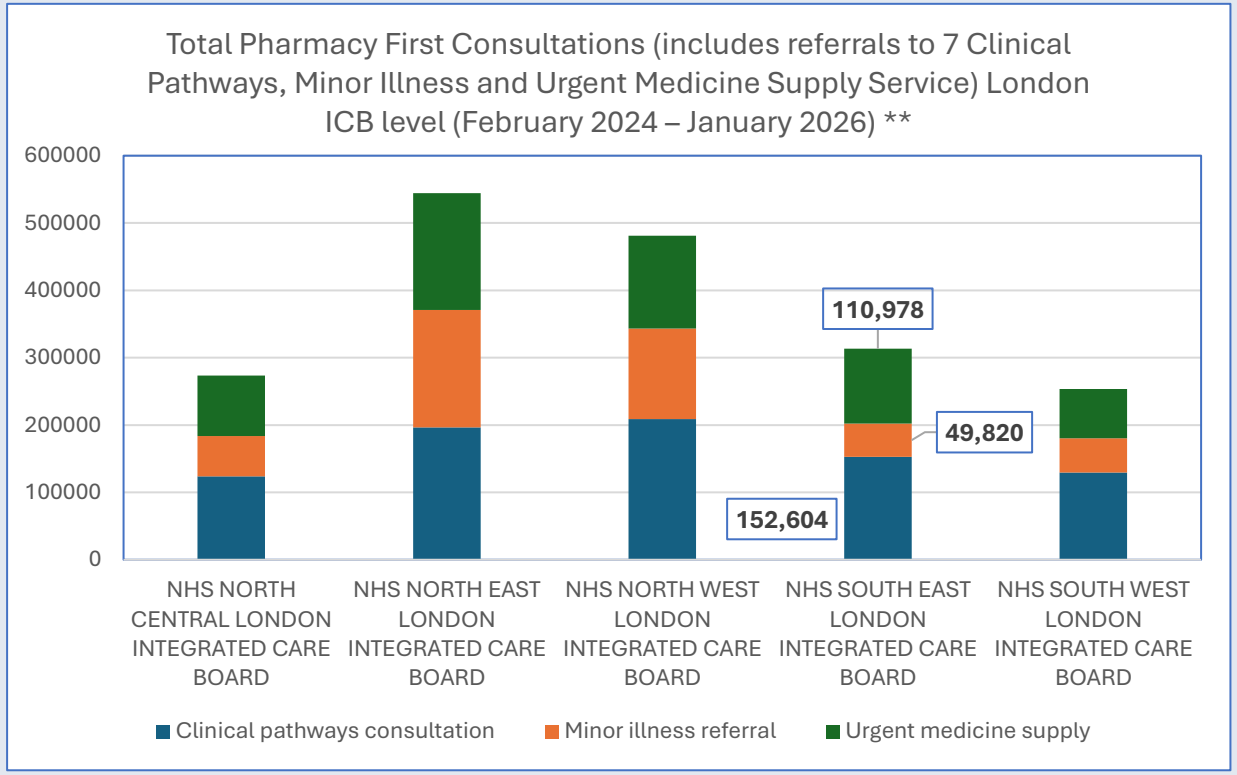
J. People know where to go to get the right help, and are treated at the right time, in the right place, for their needs

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	
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
Oct-25	156
Nov-25	185
Dec-25	129
Jan-26	120
Feb-26*	114
Total – 2061	

Top 3 social vulnerability eligibility criteria for accessing Lambeth Pharmacy First Plus Service (Feb 26):

1. Universal credit (60%)
2. Patients aged under 16 years (19%)
3. Income-based Jobseeker's Allowance (5%)



*** Most recent data supplied by Provider at time of writing report**
**** From August 2025 Pharmacy First consultation data is only being provided at ICB level and not borough level by NHS Business Services Authority**

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 54 per month from December 2025 to March 2026. This is an increase from last quarter.

In the last 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%.

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.

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.

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.
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.

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?***	Since the last update to Lambeth Assurance, no additional information has been provided by the Local Maternity and Neonatal System (LMNS) to support an updated view of maternity performance. This is still due to the data gap following the EPIC implementation in late 2023. The issue has been raised on several occasions and has now been escalated to executive leads at King's College Hospital and Guy's and St Thomas'. Work will continue with assurance colleagues and the LMNS to obtain the necessary access to maternity data, so that progress against agreed priorities can be monitored.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	
Additional Comments	

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

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?***	At the time of writing, the most recent data available to the Children and Young People Alliance in relation to ASD diagnosis is the Autism and Related Disorders dataset from February 2026. This was presented and discussed at the March Lambeth Together Assurance Group meeting as part of the Outcome M deep-dive. In the absence of any updated data since that point, there is no further update on ASD diagnosis for this assurance meeting. The Alliance is continuing discussions with partners in community paediatrics to support more regular and consistent reporting in this area.
*Does the data/intelligence identify any **health inequalities and whether they are reducing?***	
*What are the **challenges hindering any progress** and **are there actions which can be taken** to address these?*	
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 fourth quarter of 2025/26, January to March, CLaSS started working with 62 new people, up 19 from the 43 new clients in the previous quarter, October to December. CLaSS supported all the people that were referred to them. LWNA's Individual Placement and Support (IPS) helps people with a serious mental illness find and sustain paid employment. The IPS service helped 10 people find work in the fourth quarter, January to March, up slightly from the 9 people who successfully found employment in the previous quarter. This is still well below the original placement target of 36 per quarter, but the team also helped 5 people to sustain employment for 13 weeks or more and 1 for 26 weeks. The IPS service placed 48 people in 2025-26, slightly less than the 51 achieved in 2024-25. Both figures fall substantially short of the targets set when the service was created. There were 30 restrictive incidents for inpatients in March, fewer than the 39 occurring in February and a little higher than 32 average for financial year 2024/25. Positive friends and family survey responses for LWNA services were at 78.6% in March, a fall of 5.1% points from February however, taken as a whole, results for 2025-26 show a clearly positive trend climbing by around 7% points from the start of the year, continuing progress made in 2024-25.
*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, January to March, 44% were for Black services users, down slightly from 46% the previous quarter and 54% the previous financial year. This fall corresponds to the falling proportion of Black people discharged from inpatient care, which was 43% January to March, down from 49% in the quarter October to December. This trend has been seen across other intensive services such as Focused Support and the Home Treatment Team. While this would seem to indicate some progress is being made, all these figures however remain much higher than might be expected, given that the Black adult (18-64) population of Lambeth in 2026 is estimated to be 18.7%*. Of the 112 restrictive incidents reported for Lambeth acute inpatients with a stated ethnicity in the third quarter, October to December, 50 (47%), were for Black service users, compared with 53 of 152 (35%) in the third quarter, October to December. These quarterly numbers are quite small and so can be skewed by individual patients being involved in multiple incidents. **Comparing restrictive incidents falling in this financial year 2025-26 with the year before shows more clearly that progress is being made, with the proportion of restrictive incidents involving Black people falling to 45% from 60% in 2024-25.**

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 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.
Additional Comments	*Source: GLA 2016 Housing-Led Population Projections for 2026, which support a focus on the 18-64 age group serves by the LWNA.

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 outreach team continue to support rough sleepers into accommodation, and 52 individuals were accommodated during Q4. This is less than Q3 but more in line with the quarterly norm (the increase in Q3 was due to numerous SWEP activations). Hostel and supported housing services continue to support people to sustain tenancies and not return to the street and this is evidenced by zero people being seen rough sleeping after being placed into settled accommodation during Q4. This is the first time this financial year that this has occurred. The number of residents registered with GP's continues to be at a high level – 97%. 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. In Q4, 107 individuals were supported via the team which is the same number as Q3.
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. The adults supported housing pathway continues to effectively support people to access health care via GP registrations and engagement with physical, mental health and substance use 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 predominately focusing support and resources to people when they reach crisis point or end up sleeping rough. The PRS market continues to be a challenge/barrier, and residents are having to accept offers of accommodation further away from Lambeth.