South East London Integrated Care System

NHS South East London







Annual Health Inequalities Information for NHS South East London

Publication September 2026

We are a partnership of NHS commissioners and providers, the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark and the voluntary and community sector

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1. Health Inequalities

Health inequalities are systematic, unfair and avoidable differences in health across the population and between different groups within society. They arise because of the conditions in which people are born, grow, live, work and age. Within healthcare, health inequalities are also driven by different group inequalities access, their experiences and their outcomes.

South East London Integrated Care Board (SEL ICB) has a responsibility to address these inequalities, including working to ensure equity of access with regards to healthcare access, experience and outcomes. Reducing inequalities represents a core priority for the South East London system and is a golden thread that runs through our strategic and operational planning objectives and priorities, enabling investment to support a step change in action and outcomes related to inequalities in our population.

NHS England Statement on Information on Health Inequalities
This is the third iteration of South East London ICB Health Inequalities report. This report supports the ICB in demonstrating how we meet our legal duties on health inequalities through data analysis and evidence-based response.

NHS England requirement for the publication of this report is for each ICB to collect, analyse and publish data both qualitative and quantitative data based on a set of core and supporting measures. This report should be read alongside our South East London ICB Annual Report and Annual Accounts 25/26, published on our South East London Integrated Care Board website:
https://www.selondonics.org/icb/meetings-board-papers-reports/reports/

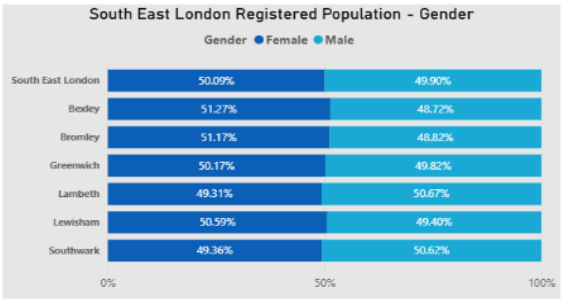
2. South East London

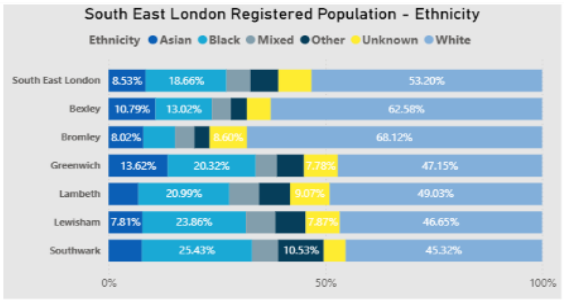
Throughout this report, reference to South East London population relates to patients registered with a South East London General Practice. This cohort represents the majority of South East London residents, although it is recognised that it may include a small number of patients who live outside South East London.

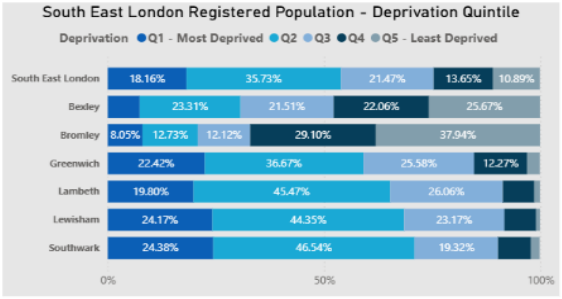
Each section within this report focuses on a specific health domain (care pathway), examining health inequalities by age, ethnicity and gender profile and deprivation. The report recognises that a wide range of improvement activity is already underway across South East London to address variation in access, experience and outcomes. In some domains (care pathway) we have included examples of actions being taken to address health inequalities and improve outcomes.

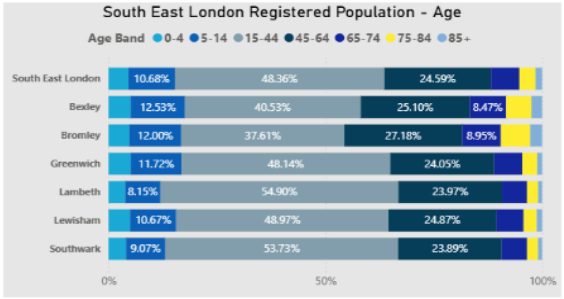
SEL Population Profile

The South East London population is extremely diverse and varies greatly in demographic breakdowns between boroughs. The below visuals display this variation by gender, ethnicity, deprivation and age. For each visual, the South East London average is at the top, followed by the breakdown for each of the six boroughs.









Index of Multiple Deprivation (IMD)

To further enhance our readers' understanding of health inequalities we have included an explanation of the Index of Multiple Deprivation (IMD) referred to in this report. The Index of Multiple Deprivation (IMD) is the official national measure of relative deprivation for all small areas (e.g., neighbourhoods) in England. It ranks every area in the country based on different indicators of deprivation. These indicators include levels of income, employment, education, crime and many others, which are combined to produce a deprivation score for the area. The scores for each area are then ranked from most deprived (rank 1) to least deprived. These rankings can then be divided into deciles (10 equal groups) or quintiles (5 equal groups). This then gives every area in England an Index of Multiple Deprivation.

The area a patient lives in can then be joined up on this Index of Multiple Deprivation to understand the differences between levels of deprivation. In the report, some metrics refer to deciles simply as 'D', e.g. D2 represents Decile 2. Quintiles are referred to as 'Q' e.g. Q1 represents Quintile 1, the most deprived quintile, made up of patients living in the most deprived 20% of England. A table showing the percentage of the South East London population that reside in each decile and quintile is set out below.

Deprivation Decile	% of SEL Population	Deprivation Quintile	% of SEL Population
1	1.37%	1	18.16%
2	16.80%		
3	20.20%	2	35.73 %
4	15.53%		
5	11.92%	3	21.47%
6	9.55%		
7	7.27%	4	13.65%
8	6.38%		
9	6.83%	5	10.89%
10	4.06%		
Unknown	0.09%	Unknown	0.09%

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3. Summary of Key Findings

- This report highlights both longstanding and emerging inequalities across South East London. Some of these inequalities are already recognised and are being addressed through existing partnership and improvement programmes. Others require further analysis to deepen our understanding of population need and to inform more targeted action.

- Over half of South East London's population live in the two most deprived quintiles, and the findings of this report as with last year's, continues to show a clear relationship between deprivation and poorer health outcomes. As with last year's report, the data indicates persistent health inequalities, driven by deprivation which undoubtedly has an impact on the health outcomes for our South East London population. The ICB's Five Year Strategic Commissioning Plan, borough-based population health improvement plans and care pathway Improvement activity provide the framework for sustained action to reduce inequalities, improve population health and support equitable access to consistently high-quality services.

- The report also identifies variation by age, gender and ethnicity, with the most significant differences emerging when ethnicity is analysed in greater detail by subgroups. These patterns point to inequalities that cannot be fully explained through quantitative data alone. Health behaviours, service access, trust, communication needs and lived experience are shaped by a complex range of social, cultural and structural factors. Continued engagement with local people and communities will therefore be essential to understand lived experience, identify barriers and shape services that are accessible, meaningful and culturally responsive.

- Data quality: improving ethnicity recording was a specific requirement for this year's NHS England Statement on Information on Health Inequalities reporting. Review of the available datasets shows that, across almost all sources, 'Not Stated' ethnicity is the largest contributor to incomplete recording. Variation in 'Unknown' and 'Not Stated' categories continues to affect interpretation and limits the extent to which inequalities can be fully understood. Completeness is not the only issue: patients may also have different ethnicities recorded across different datasets, creating inconsistency and reducing confidence in comparative analysis. To address this, the ICB is working with providers through the annual contracting round to develop Data Quality Improvement Plans. In addition, the South East London ICB Analytics and Insights Team has developed the South East London Ethnicity Register, which brings together the most complete ethnicity information available from multiple data sources to support more robust and consistent reporting.

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Next Steps

- We will continue to strengthen the quality, completeness and consistency of our data to improve our understanding of population needs, access, experience and outcomes across South East London. This will support more robust analysis of inequalities and help identify where targeted action is most needed.

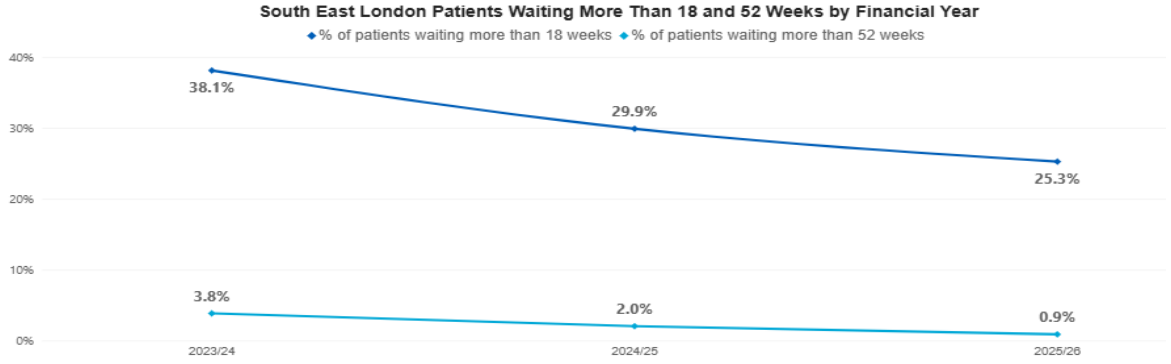
- The insights from this report will continue to inform strategic commissioning priorities, borough-based population health improvement plans and care pathway Improvement activity. By using data alongside community insight and partnership learning, we will focus improvement activity on reducing unwarranted variation, improving health outcomes and ensuring equitable access to high-quality, effective and sustainable care.

4. Elective care and Community services

Overview: South East London waiting list size has steadily declined. The composition of the waiting list by gender has remained stable over time with females making up a larger proportion of the waiting list compared to males. DNA rates have decreased across South East London ICB. Those in deciles 1 to 4 (most deprived and more deprived) make-up over 65% of DNA outpatient appointments, the data indicates that this group is over-represented in DNAs compared with their share of the South East population of 55%. Those of Black ethnicity have a higher DNA rate of 13.3% and the scale of this DNA rate suggests that this group significantly contribute to the total number of missed outpatient appointments (~32%) relative to their share of the total number of outpatient appointments (~23%).

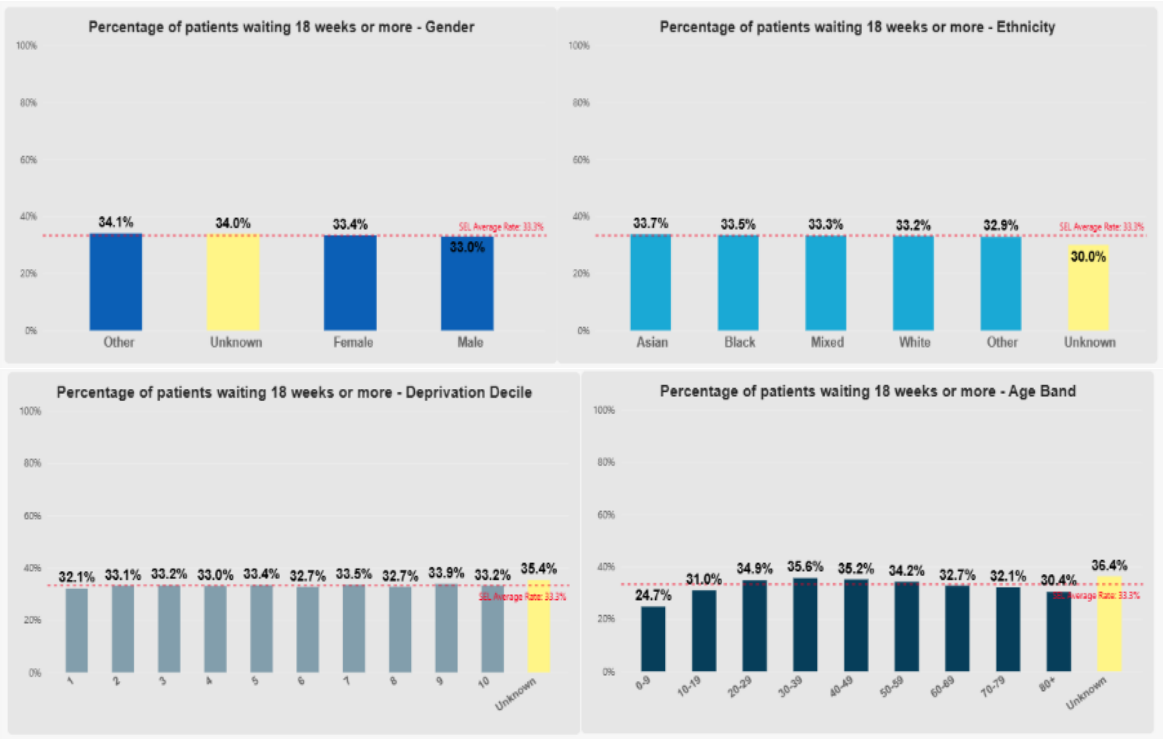
Activity Reporting Period: 2023 to 2026.
Data Source: National Waiting List Minimum Dataset, Primary Care Discovery Dataset, Local Secondary Uses Service (SUS).

The proportion of patients waiting more than 18 and 52 weeks has declined by 12.8% and 2.9% respectively, between 2023/24 and 2025/26.



4.1. Inequalities in percentage of people waiting over 18 weeks for elective treatment.

Looking at the ethnic, age, gender profile and deprivation, there are no significant variance observed in the percentage of patients waiting more than 18 weeks. The only notable exception is among those aged 0-9, with a lower proportion waiting longer than 18 weeks.



4.2. Inequalities in percentage of people waiting over 52 weeks for elective treatment.

Looking at the ethnic, age, gender profile and deprivation, there are no significant variance observed in the percentage of patients waiting more than 52 weeks. The only notable exception is among those aged 0-9 and 10-19, with a lower proportion waiting longer than 52 weeks.

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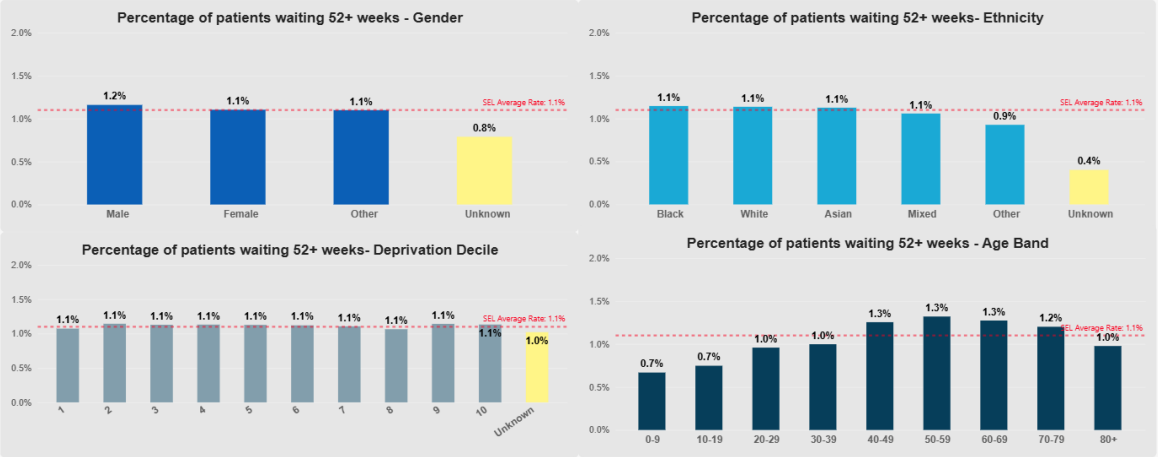
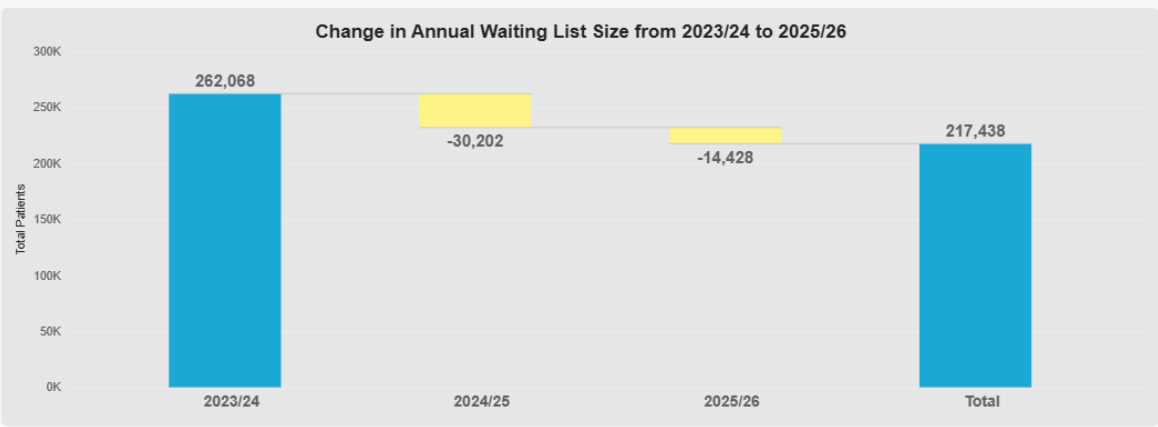
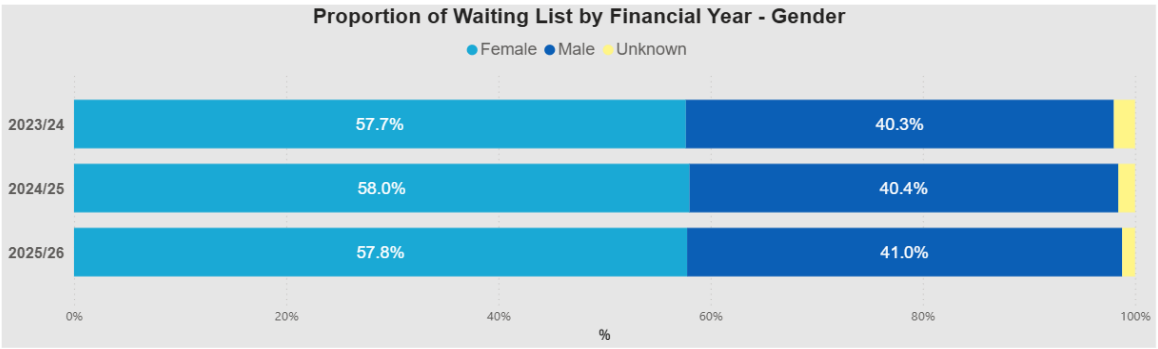


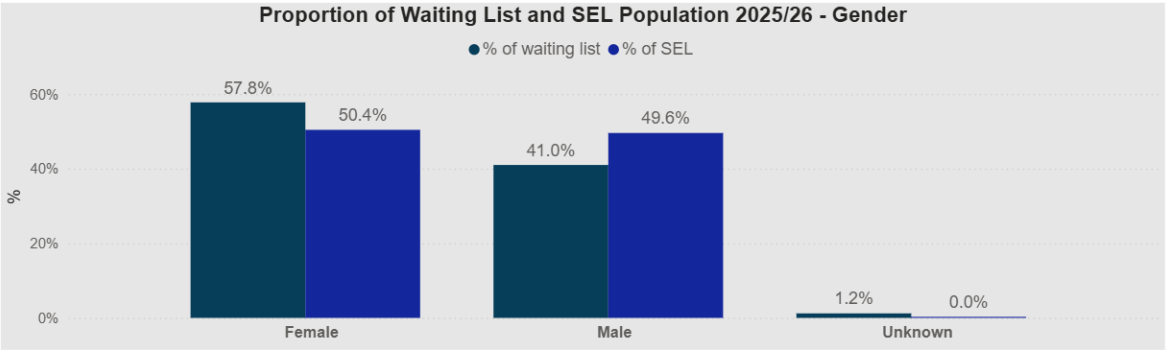
4.3. Inequalities in annual change in size of waiting list

The waiting list size has steadily declined between 2023/24 (262,068 patients) and 2025/26 (217,438 patients). The current 2025/26 size is 5.4% less than the previous year, demonstrating a significant reduction in patients waiting for elective treatment.

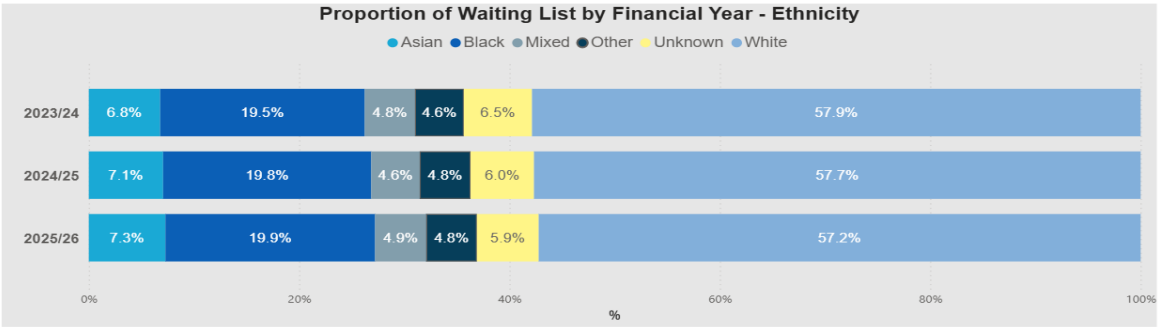


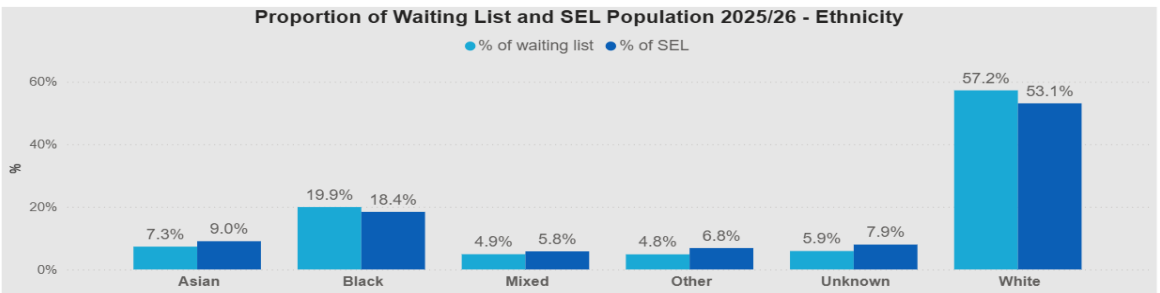
The composition of the waiting list by gender has remained stable over time. Females make-up a larger proportion of the waiting list (~58%), compared to males (40%-41%). The South East London population is split more evenly between females and males, indicating that females are overrepresented on the waiting list by 7%.



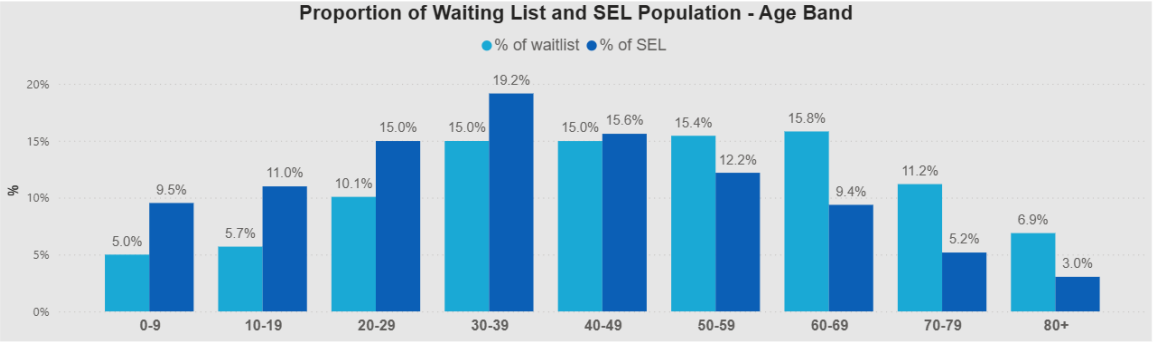


Looking at the ethnic profile over the last three years, the proportion of patients on the waiting list has remained stable. Those of White ethnicity make-up the largest group on the waiting list, this is unsurprising given this group make-up 53% of South East London population. However, this 4% difference could be considered an overrepresentation on the waitlist. Those of Black ethnicity are the only other group with a higher percentage on the waiting list compared to their percentage make-up of the South East London population.

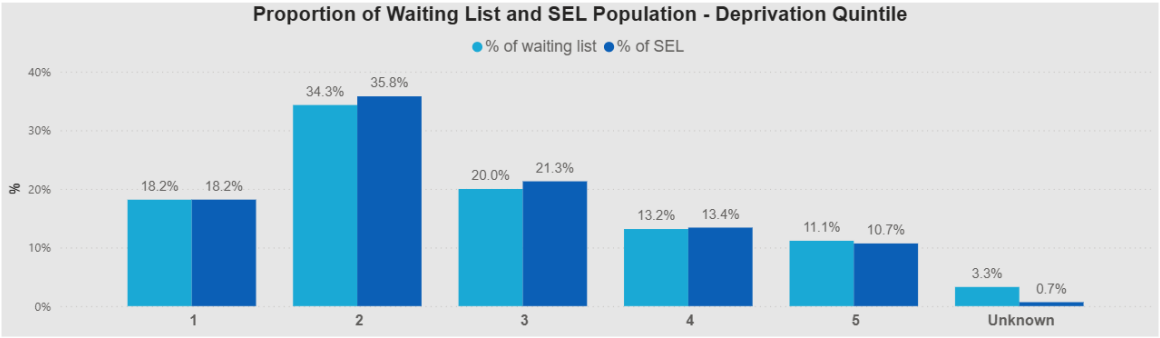




Over 60% of the waiting list is comprised of those aged 30- 69. For those aged 49 and below, the proportion of the waiting list they occupy is much lower than their percentage make-up of the South East London population. This gap is widest for those aged 10-19 with a 5.3% difference and smallest for those aged 40-49 with a 0.6% difference. This pattern is reversed for those aged 50 and over the proportion on the waiting list is higher than their percentage make-up of the South East London population. Those aged 60-69 have a 6.4% difference whilst those aged 80+ are on the waiting list 2.3 times more than their percentage make-up of the South East London population.



Except for those in quintile 1 (most deprived), the proportion of patients on the waiting list reduces as deprivation reduces. The largest proportion of South East London population and those on the waiting list (35.8% and 34.5% respectively) fall within quintile 2 (next most deprived). Although this is a high percentage, this aligns with the distribution of South East London population when split across all quintiles. The percentage of patients on the waiting list is within 1.5% of their respective percentage make-up of the South East London population. The data observed indicates that the distribution of the waiting list by deprivation is representative of the distribution of their South East London population make-up.



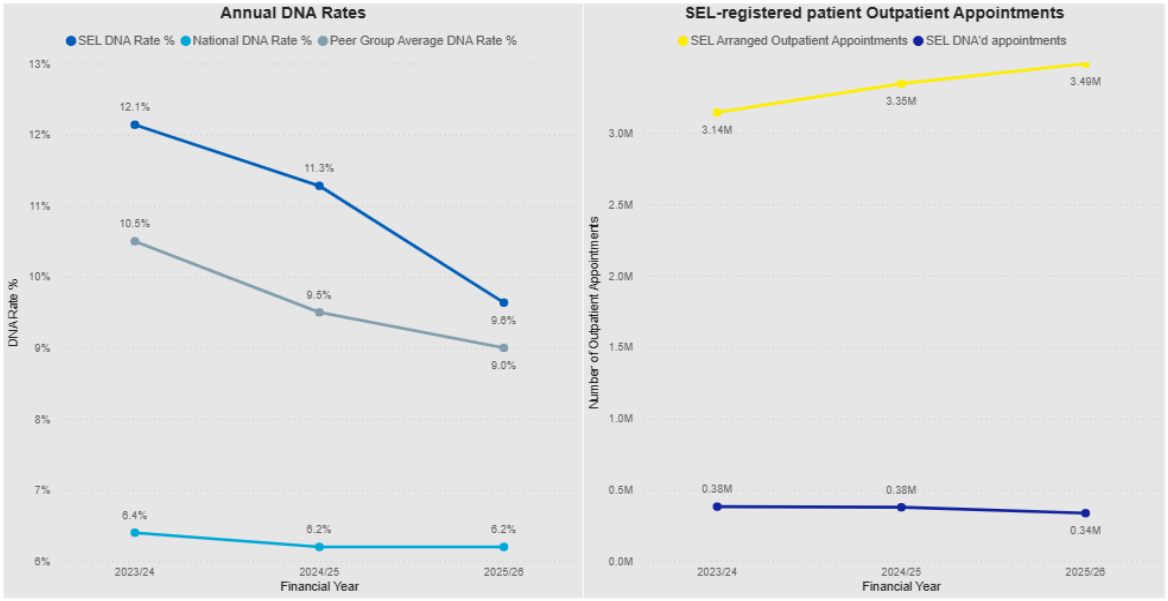
4.4. Inequalities in rates of Did-Not-Attends/Was Not Brought across elective services

Overview of Outpatient Did-Not-Attend (DNA) rates

There were ~3.5M South East London ICB outpatient appointments arranged for patients in 2025/26 with ~340K missed outpatient appointments, providing a DNA rate of around 9.6%. This is larger than both the national average of 6.2% and peer average of 9.0%.

DNA rates have decreased across South East London ICB, the Peer Group and Nationally over the last three financial years, and South East London ICB has made significant progress in reducing the gap between both comparator groups. In 2023/24, South East London ICB's annual DNA rate was 1.6% higher than the peer group average and 5.7% higher than the national average. By 2025/26, these gaps have reduced to 0.6% and 3.4% respectively.

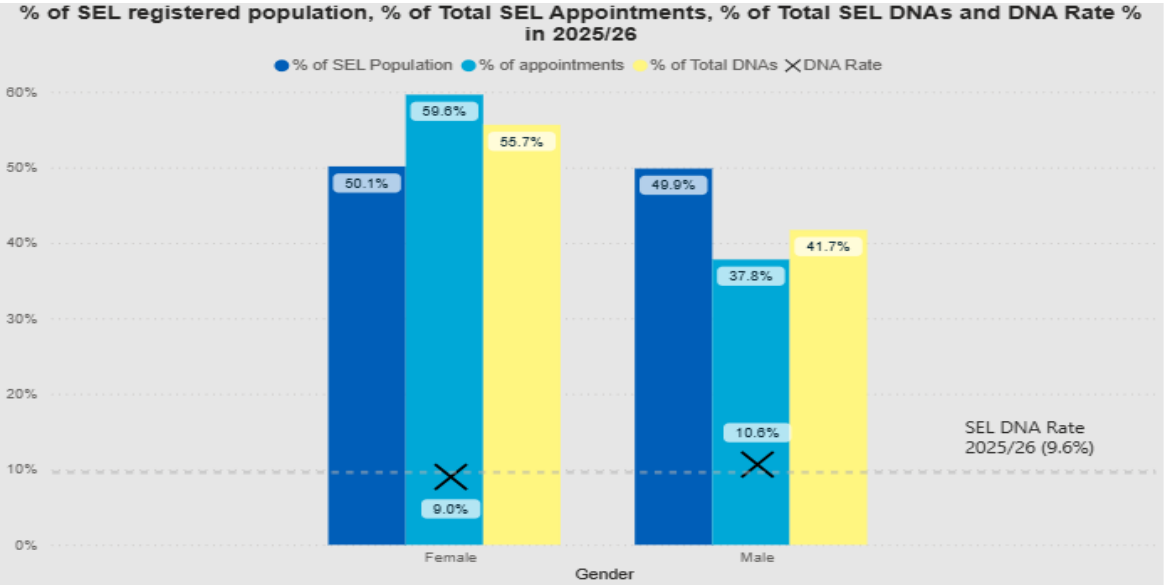
Whilst South East London ICB has a higher annual DNA rate, the reduction in rate of 2.5% from 2023/24 to 2025/26, is greater compared to its peer group and nationally who for the same period have a reduction rate of 1.5% and 0.2% respectively. This large reduction in DNA rates is set against the context of a year-on-year increase in outpatient appointments.



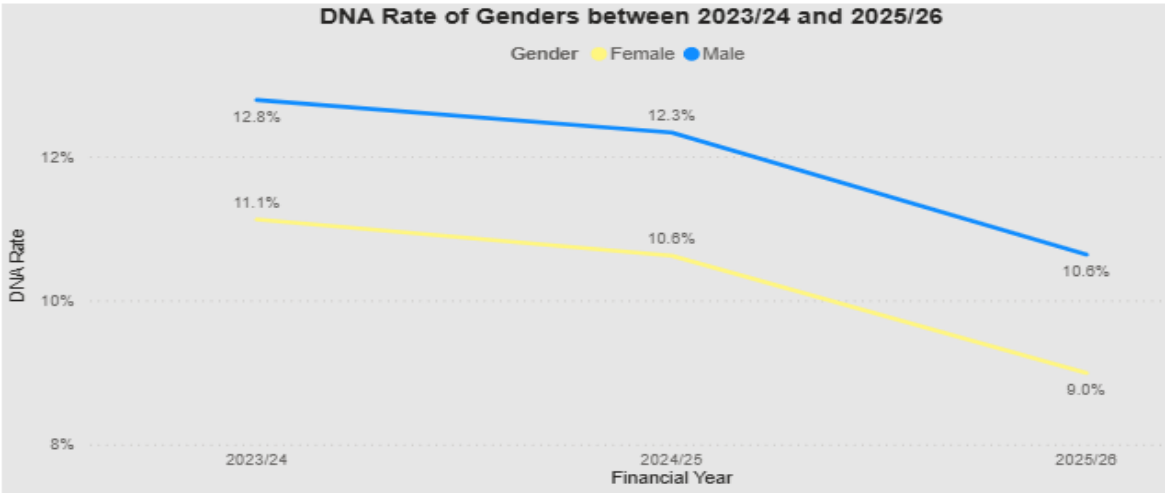
DNA Rates and Gender

Females make-up a larger proportion of outpatient appointments compared to males (~60% vs ~38%) despite the overall South East London registered population being split 50:50. However, males are more likely to DNA outpatient appointments than females (10.6% vs 9.0%).

The gender split in outpatient attendances for females is driven by Maternity and Gynaecology, which are two of the highest volume specialties in terms of number of appointments. Of the more than 20 specialties captured, the only specialties where males have noticeably higher appointments than females were Paediatrics, Cardiology and Urology.

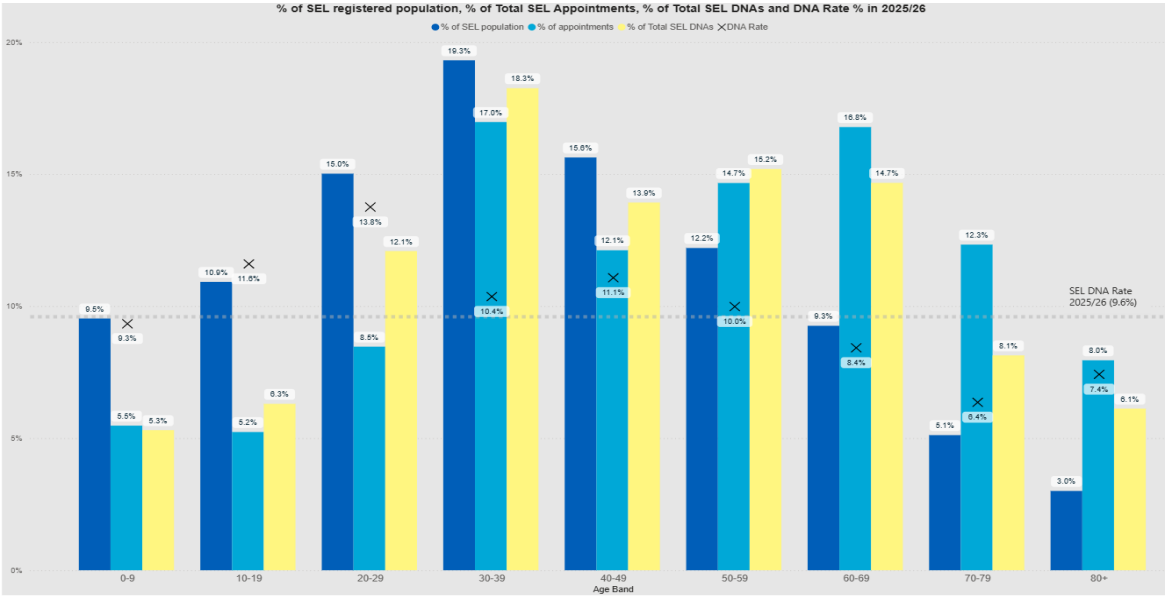


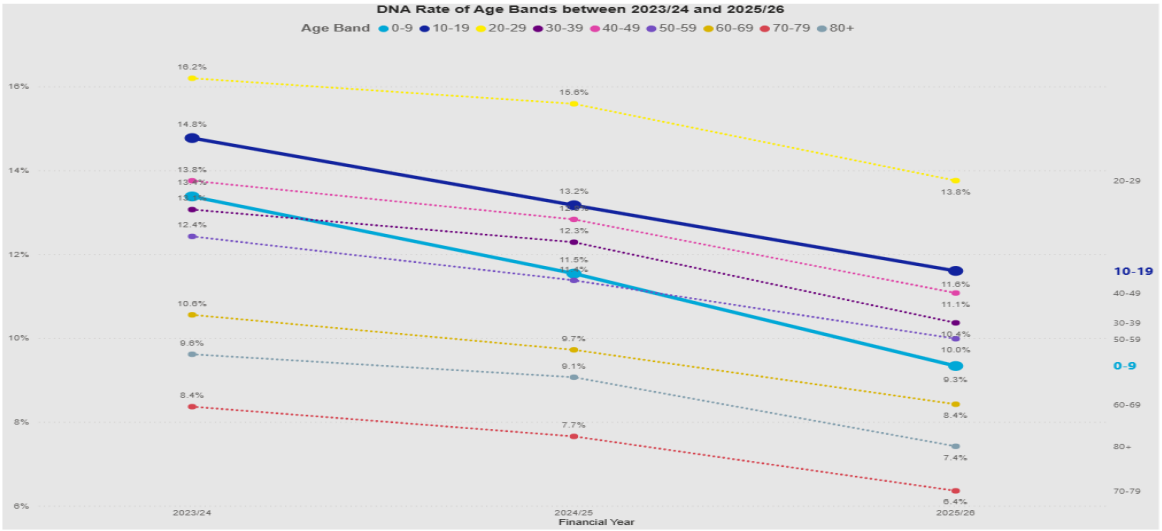
Whilst DNA rates have continued to reduce for both males and females, the similar rate of reductions means the percentage difference observed between genders has remained consistent.



DNA Rates and Age

DNA rates are generally higher among adolescents and working-age adults, particularly those aged 20–49, in comparison those aged 60 and over have the lowest DNA rates. The data indicates a progressive decline in DNA rates for those aged 40-79. Those aged 0-9 and 10-19 have the highest percentage decrease (4.0% and 3.2% respectively).



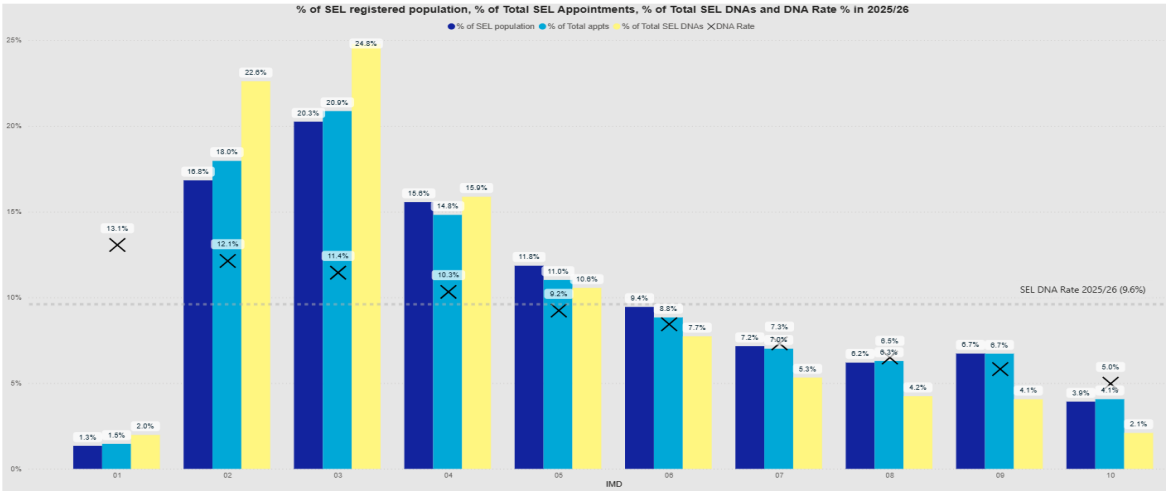


DNA Rates and Index of Multiple Deprivation (IMD) deciles

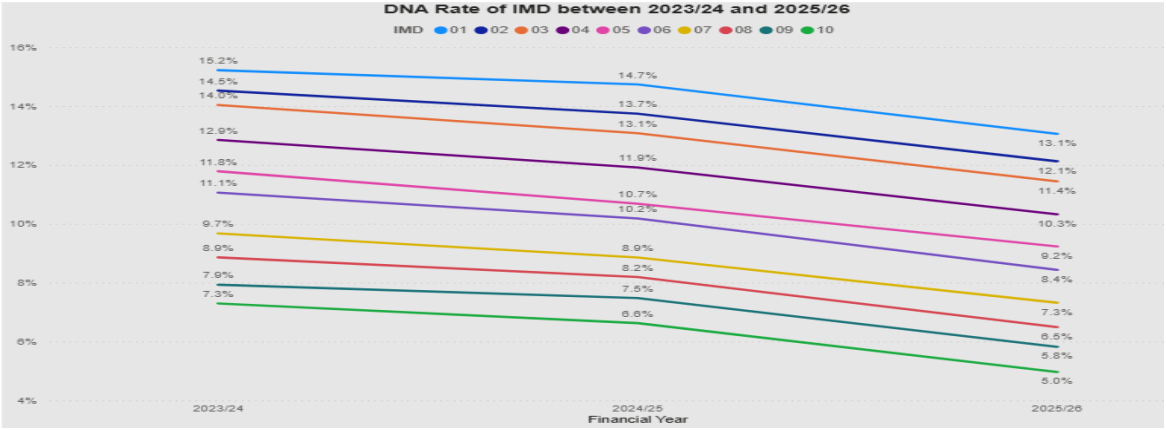
The share of outpatient appointments and share of South East London population closely align across all deciles, meaning, no one decile group has an excessive share of arranged outpatient appointments relative to their population size.

However, those in deciles 1 to 4 (most and more deprived) make-up over 65% of DNA outpatient appointments, the data indicates that this group is over-represented in DNAs compared with their share of the South East population of 55%.

The data observed indicates a corelation between DNA rate and deprivation, with those in decile 1 (most deprived) more than twice likely to DNA than those in decile 10 (least deprived).



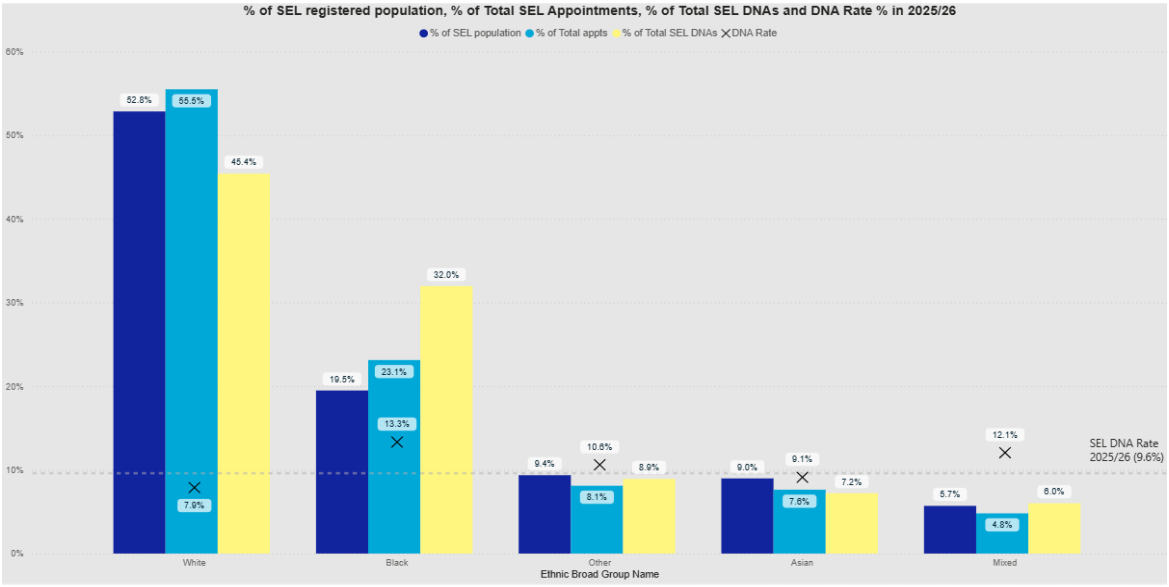
The financial year-on-year percentage change in DNA rates is similar across all deciles.



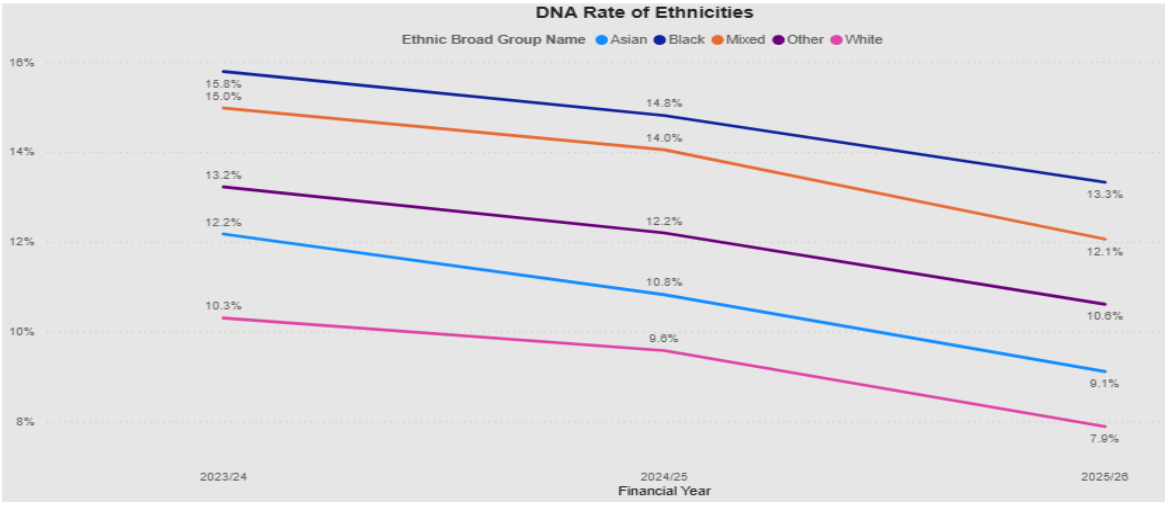
DNA Rates and Ethnic Groups

Those of White ethnicity and Black ethnicity make-up about ~80% of arranged outpatient appointments, whilst making up 72% of the South East London population.

The data observed indicates that those of Black ethnicity have a higher DNA rate of 13.3% and the scale of this DNA rate suggests that this group significantly contribute to the total number of missed outpatient appointments (~32%) relative to their share of the total number of outpatient appointments (~23%).



The data observed indicates steady reduction in DNA rates across all ethnic groups. Those of Asian ethnicity have the highest overall reduction in DNA rate from 2023/26 of 3%. Those of Mixed ethnicity have the highest single year reduction for 2025/26 of 2%.



When the ethnic profile is broken down further by age and deprivation, focusing on those of Black ethnicity and White ethnicity, the following is observed:

- For those of Black ethnicity aged 70 and over have a smaller percentage of appointments and higher DNA rates.
- The percentage of appointments for those of Black and White ethnicity aged 30-69 although not too dissimilar, there is a higher DNA rate within those of Black ethnicity.
- Those in deciles 1 to 4 (most and more deprived) have a higher DNA. However, what is observed is that as deprivation reduces the DNA rates for those of White ethnicity is lower in comparison to those of Black ethnicity.

Black ethnicity DNA rate in 2025/26

IMD	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80+	Total
01	10.6%	15.6%	16.2%	13.0%	13.7%	12.8%	14.7%	12.8%	13.1%	**13.8%**
02	12.8%	14.6%	18.1%	14.7%	14.6%	13.4%	12.5%	12.1%	13.8%	**14.0%**
03	11.7%	15.2%	16.9%	14.5%	14.1%	13.2%	12.3%	11.6%	13.2%	**13.6%**
04	12.4%	14.4%	17.1%	14.6%	14.1%	12.7%	11.7%	10.2%	12.0%	**13.3%**
05	12.8%	14.0%	15.8%	13.1%	14.6%	12.3%	10.9%	10.1%	10.4%	**12.6%**
06	11.7%	13.9%	16.3%	13.5%	12.8%	11.9%	10.6%	9.9%	11.3%	**12.3%**
07	11.6%	14.1%	16.8%	12.5%	11.8%	9.3%	9.9%	11.0%	11.2%	**11.6%**
08	12.3%	17.5%	14.1%	11.0%	11.6%	10.8%	8.6%	9.4%	9.7%	**11.0%**
09	11.3%	10.6%	14.3%	10.8%	10.7%	10.7%	9.6%	7.2%	11.4%	**10.7%**
10	8.4%	10.7%	10.3%	15.4%	7.6%	10.2%	7.2%	3.0%	6.8%	**9.1%**
Total	**12.2%**	**14.6%**	**17.0%**	**14.1%**	**14.0%**	**12.8%**	**11.8%**	**11.0%**	**12.5%**	**13.3%**

% of total Black ethnicity appointments in 2025/26

IMD	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80+	Total
01	0.1%	0.2%	0.3%	0.4%	0.4%	0.5%	0.5%	0.1%	0.1%	**2.4%**
02	1.4%	1.8%	2.6%	4.0%	3.8%	5.1%	5.4%	2.0%	1.1%	**27.1%**
03	1.4%	1.8%	2.9%	4.5%	4.2%	5.6%	5.8%	2.1%	1.2%	**29.5%**
04	0.8%	1.0%	1.5%	2.6%	2.2%	3.0%	3.3%	1.2%	0.8%	**16.5%**
05	0.5%	0.6%	0.9%	1.5%	1.4%	1.8%	2.0%	0.8%	0.5%	**10.1%**
06	0.3%	0.4%	0.5%	1.1%	0.9%	1.2%	1.4%	0.6%	0.4%	**6.7%**
07	0.2%	0.2%	0.3%	0.5%	0.4%	0.5%	0.6%	0.3%	0.1%	**3.2%**
08	0.1%	0.1%	0.2%	0.3%	0.3%	0.4%	0.4%	0.2%	0.1%	**1.9%**
09	0.1%	0.1%	0.2%	0.3%	0.2%	0.2%	0.3%	0.1%	0.1%	**1.5%**
10	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	**0.6%**
Total	**4.9%**	**6.3%**	**9.4%**	**15.3%**	**13.8%**	**18.3%**	**19.8%**	**7.4%**	**4.4%**	**99.5%**

White ethnicity DNA rate in 2025/26

IMD	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80+	Total
01	10.4%	11.4%	14.2%	12.1%	14.2%	13.5%	9.8%	11.0%	11.6%	**12.1%**
02	9.9%	13.7%	14.0%	11.1%	13.0%	11.4%	9.4%	8.2%	9.3%	**10.8%**
03	9.4%	12.3%	12.2%	10.0%	11.1%	10.4%	8.9%	7.4%	8.1%	**9.7%**
04	8.7%	10.9%	12.5%	8.9%	10.1%	9.1%	7.7%	5.8%	7.2%	**8.7%**
05	7.2%	9.0%	11.7%	7.9%	9.3%	8.4%	6.3%	5.2%	6.8%	**7.6%**
06	7.1%	8.2%	10.5%	7.9%	8.5%	7.1%	5.7%	4.9%	6.6%	**7.0%**
07	7.1%	8.6%	10.2%	7.9%	8.0%	6.5%	5.1%	4.1%	5.5%	**6.4%**
08	7.2%	7.3%	10.1%	7.7%	7.2%	6.4%	3.9%	3.8%	5.0%	**5.8%**
09	7.1%	7.4%	9.7%	7.1%	6.5%	5.4%	3.7%	3.0%	4.9%	**5.2%**
10	6.2%	6.6%	7.7%	6.5%	6.4%	4.7%	3.4%	2.9%	4.4%	**4.6%**
Total	**8.1%**	**9.9%**	**11.7%**	**8.8%**	**9.8%**	**8.5%**	**6.7%**	**5.2%**	**6.3%**	**7.9%**

% of total White ethnicity appointments in 2025/26

IMD	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80+	Total
01	0.1%	0.0%	0.1%	0.2%	0.1%	0.2%	0.2%	0.1%	0.1%	**1.0%**
02	0.6%	0.6%	1.2%	2.3%	1.7%	2.0%	2.6%	1.9%	1.0%	**13.8%**
03	0.8%	0.7%	1.4%	3.0%	2.0%	2.5%	3.0%	2.2%	1.3%	**16.7%**
04	0.6%	0.5%	1.1%	2.6%	1.6%	1.9%	2.4%	1.9%	1.2%	**13.9%**
05	0.6%	0.5%	0.8%	2.1%	1.3%	1.6%	1.9%	1.8%	1.0%	**11.4%**
06	0.5%	0.4%	0.6%	1.8%	1.0%	1.2%	1.6%	1.6%	1.1%	**9.8%**
07	0.4%	0.4%	0.5%	1.3%	0.9%	1.1%	1.5%	1.6%	1.3%	**9.0%**
08	0.4%	0.4%	0.5%	1.1%	0.8%	1.0%	1.4%	1.6%	1.3%	**8.5%**
09	0.4%	0.5%	0.5%	1.1%	0.8%	1.2%	1.7%	2.0%	1.6%	**9.6%**
10	0.2%	0.3%	0.3%	0.6%	0.4%	0.7%	1.0%	1.3%	1.2%	**6.0%**
Total	**4.5%**	**4.1%**	**6.9%**	**16.0%**	**10.5%**	**13.3%**	**17.1%**	**16.1%**	**11.0%**	**99.6%**

** Percentage of appointments sum up to less than 100% due to omission of patients with unknown IMD from visuals*

Given the data indicates that males are more likely to DNA and those of Black ethnicity are more likely to DNA, the data has been broken down further to focus on Black males. Though it must be noted that overall Black males have few arranged outpatient appointments, representing only ~8% of all arranged outpatient appointments in 2025/26, they still have some of the highest DNA rates with some age group and deciles combined having DNA rates over twice the South East London average.

Black Male DNA rate in 2025/26

IMD	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80+	Total
01	9.9%	20.5%	21.9%	22.7%	17.9%	14.2%	18.0%	14.7%	24.4%	17.6%
02	13.1%	16.3%	23.8%	22.3%	19.6%	15.8%	14.1%	14.0%	15.7%	16.7%
03	11.5%	15.6%	22.3%	21.2%	18.2%	15.6%	14.3%	12.2%	15.3%	15.9%
04	11.9%	14.8%	22.4%	20.2%	19.3%	15.9%	13.4%	9.2%	12.7%	15.4%
05	12.9%	13.9%	19.7%	19.7%	18.9%	15.4%	12.3%	12.9%	11.2%	14.9%
06	11.4%	13.2%	20.1%	18.0%	15.4%	14.2%	12.2%	10.8%	12.0%	13.8%
07	9.4%	12.5%	20.6%	21.4%	14.4%	11.1%	9.8%	8.9%	12.9%	12.8%
08	11.1%	19.6%	20.1%	17.5%	16.3%	14.8%	9.5%	7.3%	10.1%	13.1%
09	13.1%	9.5%	14.3%	11.4%	11.2%	12.6%	8.0%	9.6%	14.0%	10.8%
10	8.7%	14.4%	13.3%	17.1%	9.6%	14.1%	9.9%	6.1%	9.6%	11.1%
Total	12.0%	15.4%	22.2%	20.8%	18.3%	15.4%	13.5%	12.0%	14.0%	15.6%

Black male appointments as a percentage of all appointments in 2025/26

IMD	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80+	Total
01	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
02	0.2%	0.2%	0.2%	0.2%	0.2%	0.4%	0.5%	0.2%	0.1%	2.2%
03	0.2%	0.2%	0.2%	0.2%	0.3%	0.5%	0.6%	0.2%	0.1%	2.4%
04	0.1%	0.1%	0.1%	0.1%	0.1%	0.2%	0.3%	0.1%	0.1%	1.3%
05	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.2%	0.1%	0.0%	0.8%
06	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	0.0%	0.5%
07	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.3%
08	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
09	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	0.6%	0.7%	0.6%	0.7%	0.9%	1.5%	1.9%	0.7%	0.4%	8.0%

Improvement activity

• Reducing outpatient Did Not Attends (DNAs) remains a priority across South East London through provider-led improvement programmes. **Measures implemented:** • Enhanced appointment reminder systems • Wider use of patient-facing digital platforms. • Improvements to booking and partial-booking processes and strengthened management of appointments through electronic patient record systems.	• Providers are also making greater use of data/reports such as this to identify patients and services with higher rates of non-attendance, helping to target interventions and better understand variation in DNA rates • Whilst DNA performance has improved significantly across South East London, providers recognise that further work is required, particularly to better understand and address the inequalities associated with non-attendance and to ensure that improvement is sustained across all specialties and population groups.

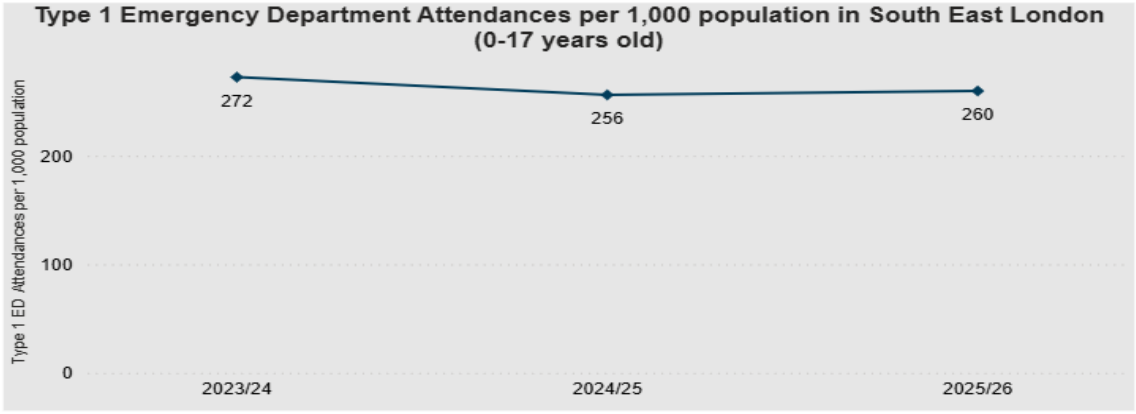
5. Urgent and Emergency Care

Overview: Those aged 0-4 consistently over the last three years have the highest rate of emergency department attendances, with males having higher rates. Children under 1 make-up over 18,000 of emergency department attendances in 2025/26, this equates to around 18% of all attendances for under 18s, while making up less than 5% of the under 18s South East London population. The most frequent complaint for those aged 0-17 is 'fever' which accounts for 13% of all attendances. For those aged 0-4 this increases to 20% of all attendances.

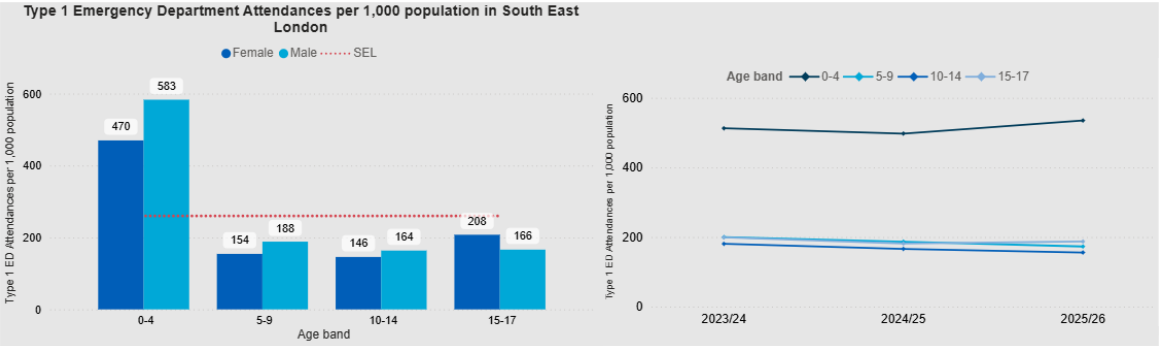
Activity Reporting Period: 2023 to 2026.
Data Source: Emergency Care Dataset (ECDS).

5.1. Inequalities in children and young people (CYP) emergency department attendances

Looking at Type 1 emergency department attendances, there has been just over 100,000 attendances for those aged 0-17 years old in 2025/26. This equates to a rate of 260 attendances per 1,000 population in South East London. The slight increase in rate between 2024/25 and 2025/26 can be attributed to a decline in under 18 population. The overall population of 0-17 in South East London decreased by 1.6% between 2024/25 and 2025/26, with emergency attendances only decreasing by 0.2%.



Looking at the age profile, those aged 0-4 consistently over the last three years have the highest rate of emergency department attendances. When the age profile is broken down further by gender, those aged 0–4 have the greatest difference in attendance rates between males and females, with males having around a 19% higher rate of attendance than females.

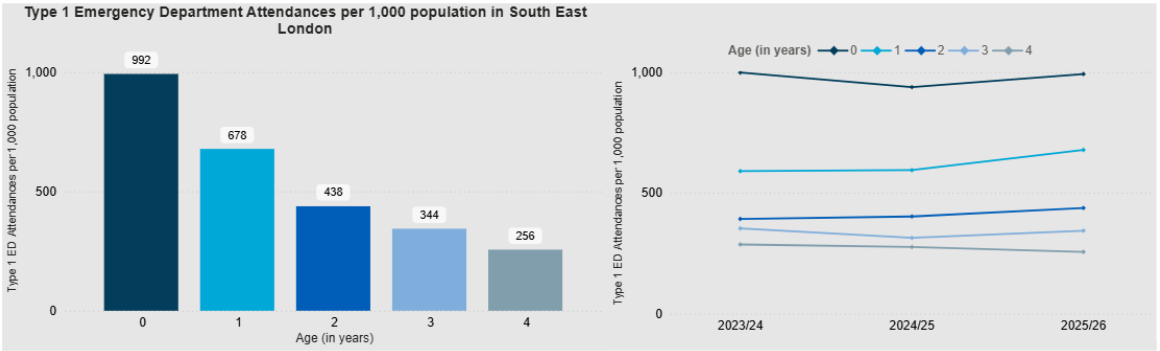


Percentage of attendances by top 10 chief complaints by age band

	0-4	5-9	10-14	15-17	Total
Abdominal pain	1.9%	9.5%	10.5%	9.8%	**5.9%**
Asthenia	4.5%	2.8%	3.2%	4.6%	**3.9%**
Cough	3.8%	2.0%	0.9%	0.6%	**2.6%**
Difficulty breathing	6.2%	2.9%	1.5%	0.7%	**4.0%**
Dyspnoea	9.3%	4.6%	2.7%	2.3%	**6.3%**
Eruption	4.8%	3.7%	2.1%	1.7%	**3.7%**
Fever	20.0%	10.8%	4.4%	2.3%	**13.2%**
Injury of head	6.1%	6.5%	4.7%	3.8%	**5.6%**
Vomiting	6.5%	5.4%	2.9%	2.3%	**5.1%**
Other reason	29.6%	42.5%	55.0%	59.1%	**40.3%**
Unknown	7.3%	9.3%	12.2%	12.9%	**9.3%**
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

The chief complaint is what a child presented at the emergency department for. The most frequent complaint for 0-17 years old is 'fever' which accounts for 13% of all attendances. For those aged 0-4 this increases to 20% of all attendances. The second most frequent complaint for this age group is Dyspnoea, commonly known as shortness of breath which accounts for 9%. For those aged 5-17 around 10% of attendances are due to abdominal pain. It should be noted that the level of unknown recording of chief complaint increases as children get older, with nearly 13% of records for 15-17 having an unknown chief complaint.

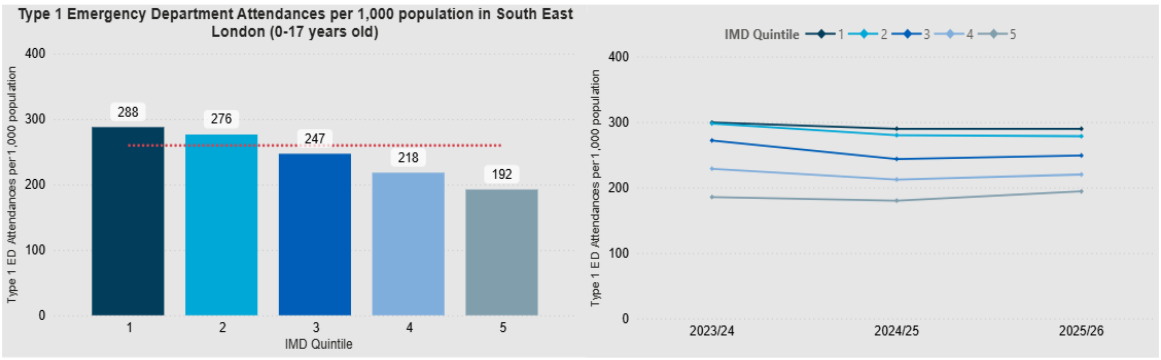
When the data for those aged 0-4 is broken down further, emergency department attendances for under 1s is nearly four times the rate of those aged 4.



In 2025/26, children under 1 make-up over 18,000 of emergency department attendances. This equates to around 18% of all attendances for under 18s, while making up less than 5% of the under 18s South East London population.

There is a clear corelation between emergency department attendances and deprivation, those in quintile 1 (most deprived) have a 50% higher rate of attendances compared to those living in quintile 5 (least deprived).

A slightly improvement in emergency department attendances is observed from 2023/24, were those in the most deprived area had a higher rate of 62% compared to those in the least deprived area, although this is due to a slight increase in the rate of emergency department attendances in the least deprived population, rather than a reduction in rate of attendances.



Percentage of attendances by top 10 chief complaints by IMD Quintile (0 to 17 years old)

	1	2	3	4	5	Unknown	Total
Abdominal pain	6.2%	5.8%	5.4%	5.6%	6.7%	5.6%	**5.9%**
Asthenia	3.8%	3.8%	3.5%	4.4%	5.1%	4.7%	**3.9%**
Cough	2.4%	2.3%	2.4%	2.7%	4.0%	2.3%	**2.6%**
Difficulty breathing	3.9%	4.1%	4.6%	4.5%	2.7%	1.0%	**4.0%**
Dyspnoea	6.0%	6.2%	6.2%	7.3%	7.3%	4.3%	**6.3%**
Eruption	3.7%	3.7%	3.6%	3.6%	3.2%	7.0%	**3.7%**
Fever	12.7%	13.7%	13.4%	13.2%	12.2%	12.2%	**13.2%**
Injury of head	5.6%	5.6%	5.8%	5.8%	4.9%	4.6%	**5.6%**
Vomiting	5.2%	5.2%	5.0%	4.6%	5.0%	7.0%	**5.1%**
Other reason	42.3%	41.2%	39.6%	36.2%	36.9%	48.7%	**40.3%**
Unknown	8.1%	8.2%	10.3%	12.1%	11.9%	2.7%	**9.3%**
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Percentage of attendances by top 10 chief complaints by IMD Quintile (0 to 4 years old)

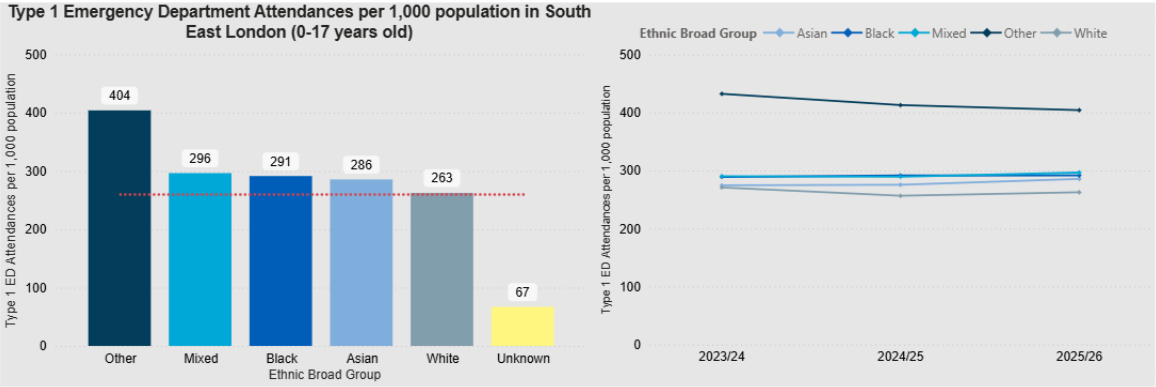
	1	2	3	4	5	Unknown	Total
Abdominal pain	2.0%	2.0%	1.7%	1.8%	2.1%	2.3%	**1.9%**
Asthenia	4.4%	4.3%	4.0%	4.8%	5.7%	4.7%	**4.5%**
Cough	3.8%	3.5%	3.5%	3.8%	6.1%	3.3%	**3.8%**
Difficulty breathing	6.4%	6.2%	6.8%	6.7%	4.0%	1.8%	**6.2%**
Dyspnoea	9.2%	8.8%	9.2%	10.5%	10.6%	5.8%	**9.3%**
Eruption	4.8%	4.9%	4.6%	4.4%	4.1%	9.6%	**4.8%**
Fever	20.1%	20.8%	19.6%	19.4%	18.7%	18.2%	**20.0%**
Injury of head	6.3%	6.2%	6.4%	5.9%	5.1%	4.4%	**6.1%**
Vomiting	6.8%	6.9%	6.2%	5.9%	6.5%	5.3%	**6.5%**
Other reason	30.4%	30.1%	30.0%	27.2%	25.2%	42.5%	**29.6%**
Unknown	5.7%	6.1%	8.0%	9.7%	11.8%	2.1%	**7.3%**
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

IMD Quintile & Age Band	0-4	5-9	10-14	15-17
1	575	211	186	221
2	555	186	173	205
3	514	158	139	175
4	476	137	121	145
5	466	124	107	122

When the age profile is broken down further by deprivation, those aged 0-4 living in quintile 1 (most deprived) have the highest rate of emergency department attendances compared to the South East London average, which is 575 vs 260 attendances per 1,000 population. The data observed, however, indicates that irrespective of quintile this age group have noticeably higher attendances above the South East London average, than any other age group.

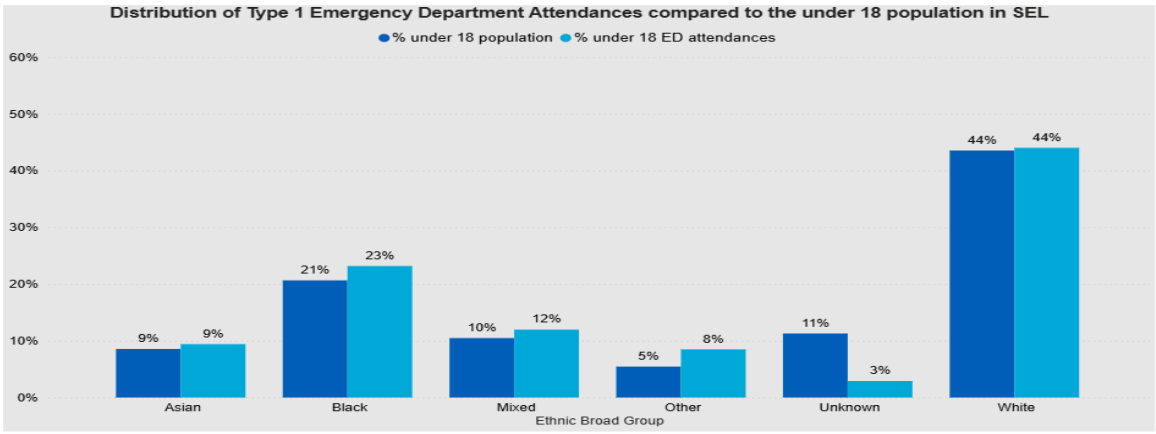
Across all quintiles there is little variation in chief complaint presentation. Fever remains the most frequent complaint. What is observed is that there is a significantly high presentation noted as 'other reason' across all quintiles. The data suggests that there are other factors that also significantly impact the reasons for emergency department attendances.

Looking at the ethnic profile, those of Other ethnicity have the highest emergency department attendances for under 18s, which has been consistent for the last three years. Those of Other ethnicity have a 54% higher rate of attendance compared to those of White ethnicity.



When comparing emergency department attendances and population size for under 18s based on ethnic profile, the data indicates slightly higher attendances than population size. The only variance is observed in those of Unknown ethnicity who have significantly lower attendances than the population size.

For future reports, using the ethnicity register (**see Data Quality section for more information**) developed by the South East London ICB Analytics and Insights Team could help reduce this sort of variation between two datasets and provide a more accurate rate.



When the ethnic profile is broken down further by deprivation, those of Other ethnicity have a rate above the South East London average of 260 per 1,000 population within quintiles 1 to 4 (most deprived to next least deprived). Looking at the ethnic profile by deprivation and age, the data observed shows that those in quintile 1 (most deprived) have a higher attendance rate. Particularly, those aged 0-4 have higher emergency department attendances across all ethnic groups, with those of Other ethnicity having significantly higher rate three times the South East London average (789 vs 260 per 1,000 population).

Ethnic group & IMD Quintile	1	2	3	4	5
Asian	363	316	275	222	207
Black	306	297	265	261	225
Mixed	348	324	270	242	198
Other	433	418	417	321	255
White	301	285	265	235	216

Ethnic group & Age band	0-4	5-9	10-14	15-17
Asian	603	189	146	162
Black	591	222	209	226
Mixed	556	196	172	185
Other	789	282	255	370
White	578	160	145	174

Percentage of attendances by top 10 chief complaints by ethnic group (0 to 17 year olds)

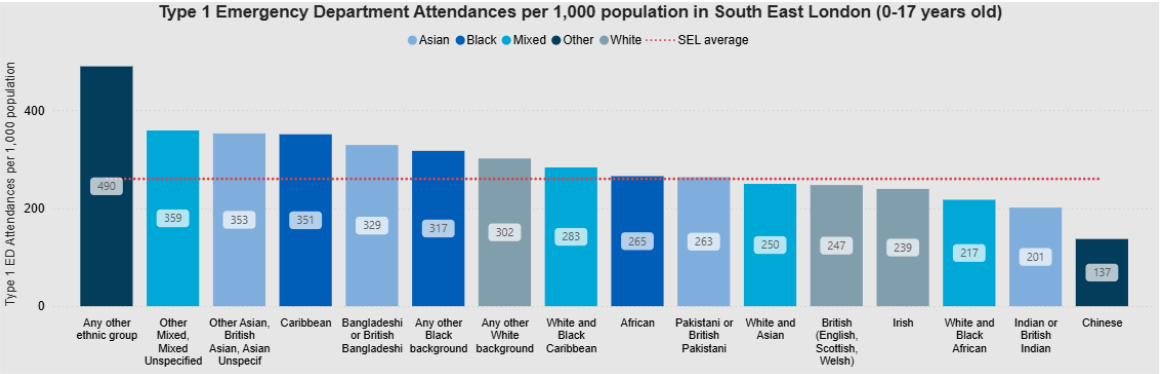
	Asian	Black	Mixed	Other	White	Unknown	Total
Abdominal pain	5.7%	6.3%	5.6%	6.5%	5.7%	4.9%	**5.9%**
Asthenia	3.7%	4.1%	4.3%	2.9%	4.0%	3.7%	**3.9%**
Cough	2.7%	2.3%	2.6%	2.1%	2.7%	3.0%	**2.6%**
Difficulty breathing	5.1%	3.4%	4.5%	3.9%	4.0%	3.1%	**4.0%**
Dyspnoea	5.7%	6.2%	7.3%	5.1%	6.7%	4.9%	**6.3%**
Eruption	4.1%	3.2%	4.0%	4.0%	3.7%	3.6%	**3.7%**
Fever	17.2%	11.7%	13.7%	14.1%	12.9%	13.5%	**13.2%**
Injury of head	4.4%	4.9%	6.3%	5.4%	6.1%	5.9%	**5.6%**
Vomiting	6.0%	5.4%	5.1%	5.2%	4.7%	6.4%	**5.1%**
Other reason	36.0%	44.4%	39.6%	43.2%	38.6%	43.4%	**40.3%**
Unknown	9.2%	8.1%	7.0%	7.6%	11.0%	7.7%	**9.3%**
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Percentage of attendances by top 10 chief complaints by ethnic group (0 to 4 year olds)

	Asian	Black	Mixed	Other	White	Unknown	Total
Abdominal pain	1.9%	2.2%	2.1%	2.1%	1.8%	1.4%	**1.9%**
Asthenia	3.9%	4.4%	5.0%	3.1%	4.7%	4.2%	**4.5%**
Cough	3.8%	4.0%	3.5%	3.2%	4.0%	4.5%	**3.8%**
Difficulty breathing	6.8%	5.8%	6.4%	6.3%	6.1%	5.3%	**6.2%**
Dyspnoea	7.1%	9.5%	9.8%	7.6%	9.9%	7.3%	**9.3%**
Eruption	4.9%	4.3%	5.0%	5.2%	4.8%	4.9%	**4.8%**
Fever	23.4%	20.1%	19.4%	23.2%	18.9%	20.3%	**20.0%**
Injury of head	4.4%	5.3%	6.8%	5.3%	6.8%	6.1%	**6.1%**
Vomiting	6.9%	8.2%	6.1%	6.6%	5.9%	6.5%	**6.5%**
Other reason	29.1%	30.3%	30.6%	32.1%	28.5%	33.1%	**29.6%**
Unknown	7.9%	5.8%	5.3%	5.3%	8.7%	6.5%	**7.3%**
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Across all ethnicities there is little variation in chief complaint presentation. Fever remains the most frequent complaint. What is observed is that there is a significantly high presentation noted as 'other reason' across all quintiles. The data suggests that there are other factors that also significantly impact the reasons for emergency department attendances.

When the ethnic profile is broken down by subgroups, those of Any other ethnicity remain the group with the highest emergency department attendances. This higher rate within this group could be attributed to data quality issues within recorded Ethnicity. (**see Data Quality section for more information)**. Those of Black ethnicity across all subgroups have attendances rate above the South East London average with those of Caribbean descent having the highest rate of 351 per 1,000 population.



Improvement activity

• CYP Urgent and Emergency Care (UEC) Delivery group have developed improvement plans. • There is a focus on Same Day Emergency Care (SDEC) provision and on-going work in place to ensure all sites meet the requirements of the NHSE Regional UEC checklist.	• In collaboration with UEC clinicians work undertaken to support the now launched South East London Healthier Together website • The Integrated Neighbourhood Team (INT) development and how this can support high intensity users has commenced.

6. Maternity

Overview: Booking rates varies across population characteristics, with women living within Core20 (most deprived) areas consistently less likely to book by 10 weeks of pregnancy compared to the rest of South East London population. Differences are also observed by age, ethnicity and borough. Delivery method show the clearest variation in Post-partum Haemorrhage (PPH) rates and a further break down of delivery pathways shows that emergency caesarean deliveries account for a larger proportion of deliveries among Black women and women living in the most deprived areas.

Activity Reporting Period: 2024 to 2026.
Data Source: Maternity Services Data Set (MSDS), Maternity Services Monthly Statistics (NHSED, provisional).

6.1. Maternity Services Data Set (MSDS)- Core20 group valid ethnicity by provider and year

MSDS Ethnicity Coding Completeness, Core 20 Population vs General Population, by Provider and Year

Provider	2022/23	2023/24	2024/25	2025/26
RJ1 - Guy's and St Thomas' NHS Foundation Trust	**98%**	**99%**	**98%**	**98%**
Core20	98%	98%	98%	98%
Non-Core20	98%	99%	98%	98%
Unknown	100%	95%	96%	95%
RJ2 - Lewisham and Greenwich NHS Trust	**100%**	**100%**	**100%**	**100%**
Core20	100%	100%	100%	100%
Non-Core20	100%	100%	100%	100%
Unknown	100%	100%	100%	87%
RJZ - King's College Hospital NHS Foundation Trust	**98%**	**99%**	**99%**	**98%**
Core20	98%	99%	99%	97%
Non-Core20	98%	99%	99%	98%
Unknown	100%	100%	100%	100%
Total	**99%**	**99%**	**99%**	**99%**

Across all providers and years, MSDS shows consistently high levels of valid ethnicity recording, with minimal variation between groups. Completeness across all South East London providers has remained at around 99%.

Across providers, completeness is uniformly high:

- Lewisham and Greenwich NHS Trust maintain 100% completeness across all years and between both Core20 (most deprived) and Non-Core20 population.
- Guy's and St Thomas' and King's College Hospital both consistently record 98–99% completeness.

There is no meaningful difference in recording levels between Core20 (most deprived) and Non-Core20 populations, with both groups showing similarly high levels of completeness across all providers.

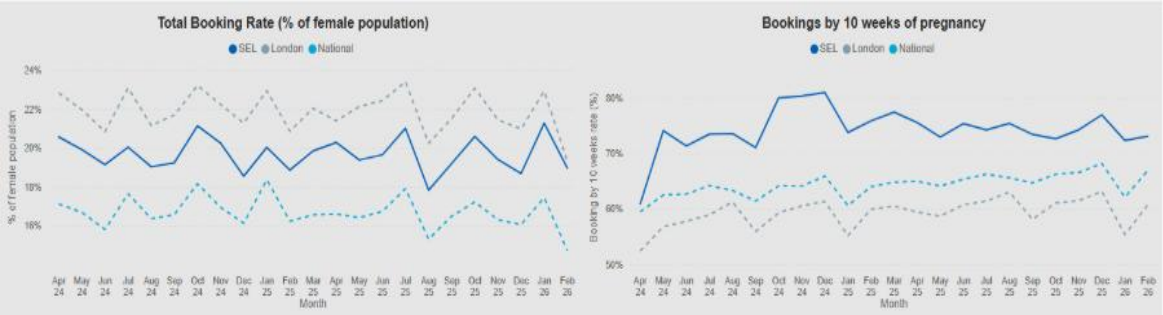
The only variation observed is within the 'Unknown' Core20 (most deprived) category, where completeness is slightly lower and more variable compared to the Core20 and Non-Core20 population. 'Unknown' Core20 status means the provider has not been able to provide the postcode of the patient; making it also likely that they have not been able to collect other demographic information such as ethnicity status. However, the number of records affected is minimal, with 21 patients (0.5%) at Guy's and St Thomas', 13 patients (0.2%) at Lewisham and Greenwich, and 21 patients (0.3%) at King's College Hospital in the latest year 2025/26.

This consistency indicates no material disparity in ethnicity recording between Core20 (most deprived) and Non-Core20 population and supports the robust use of MSDS data for maternity equity and health inequalities analysis over time.

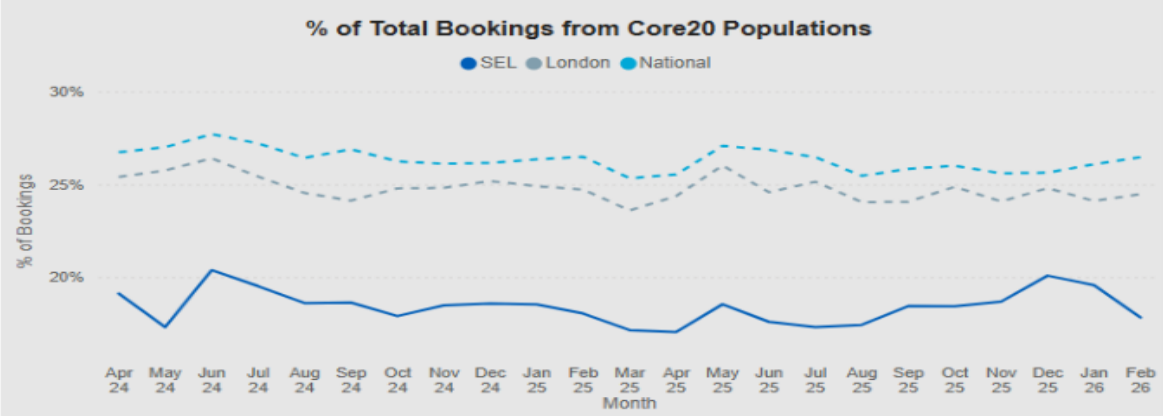
6.2. Inequalities in gestational age at booking

Booking is defined as attending the first antenatal booking appointment by 10 weeks gestation. This section examines inequalities in early bookings among women residing in South East London, comparing Core20 (most deprived) and Non-Core20 population.

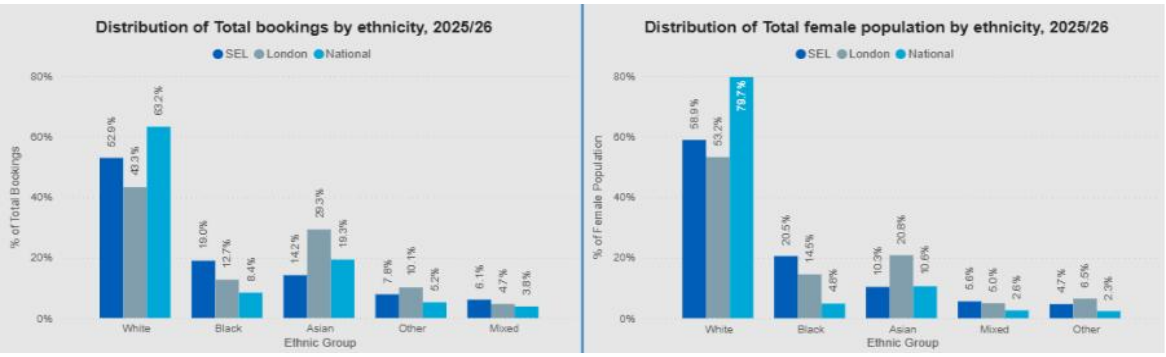
Benchmarking shows that total booking rates in South East London broadly follow London and national trends and booking by 10 weeks of pregnancy rates are consistently higher in South East London.



The proportion of total bookings rates for Core20 (most deprived) population is lower in South East London (approx. 17%–20%) than in London (24%–26%) and nationally (26%–28%).

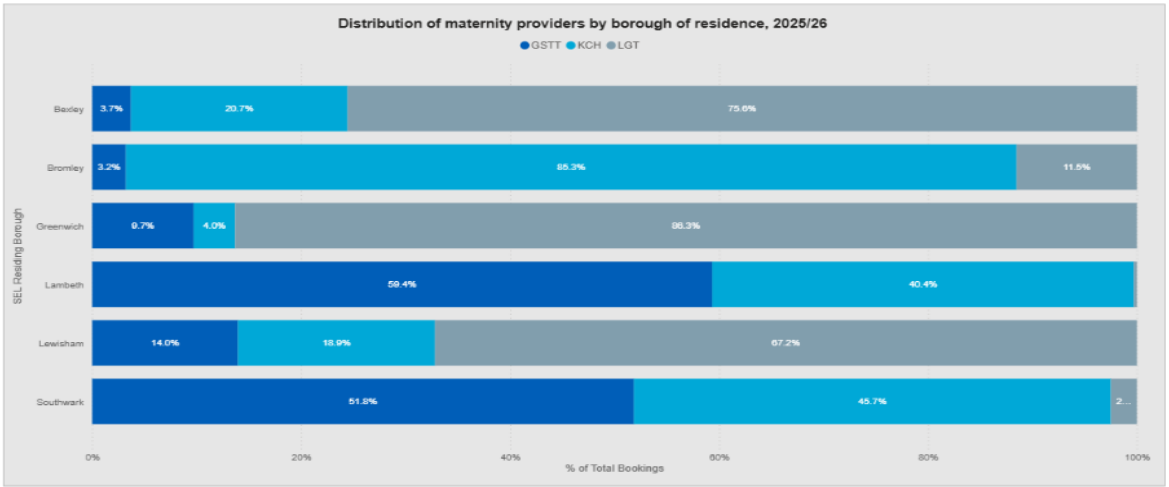


South East London has a more ethnically diverse booking population compared to the national population, with London showing a similar ethnic profile to South East London. However, findings should be interpreted cautiously given differences in population estimates and data sources. In addition, there are complex reasons for the variation in booking by 10 weeks of pregnancy rates observed across our Core20 population.



Booking rates varies across population characteristics, with women living within Core20 (most deprived) areas consistently less likely to book by 10 weeks of pregnancy compared to the rest of South East London population. Differences are also observed by age, ethnicity and borough.

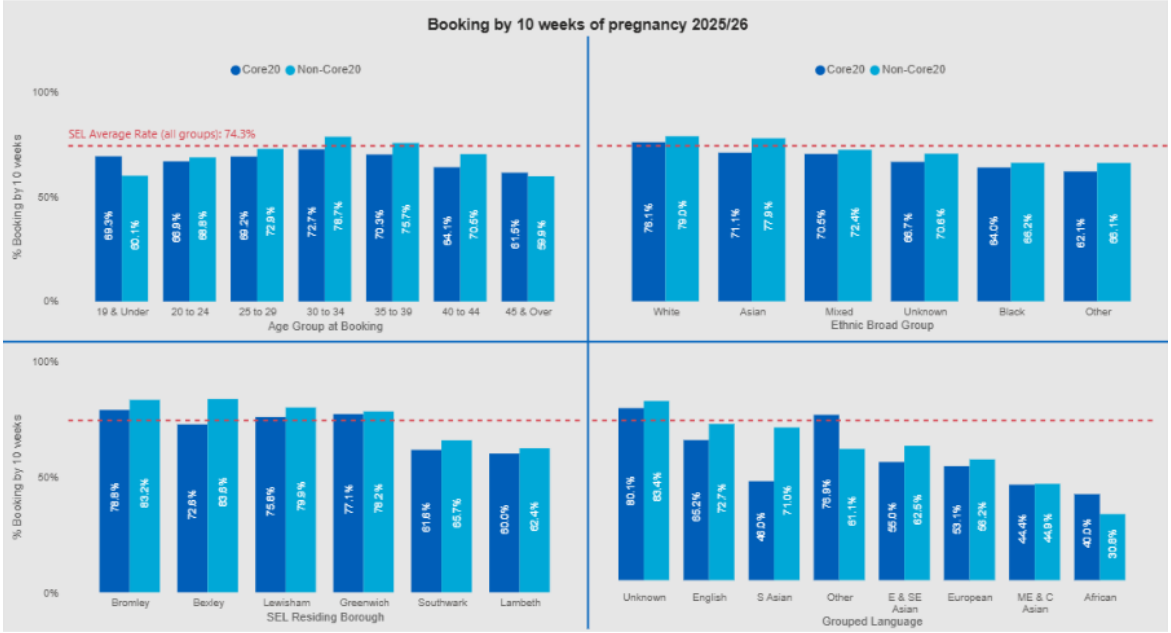
When looking at total booking rates by the mother's borough of residence, variations are observed particularly in Lambeth and Southwark, where booking rates are lower than the South East London average and are (4.4% and 3.9% respectively) lower in Core20 (most deprived) population.



It is important to consider that variation in booking at provider level may influence the differences observed when the data is broken down by demography, for instance, the demographic make-up of Lambeth and Southwark will be very different to other boroughs, such as Bromley and Bexley.

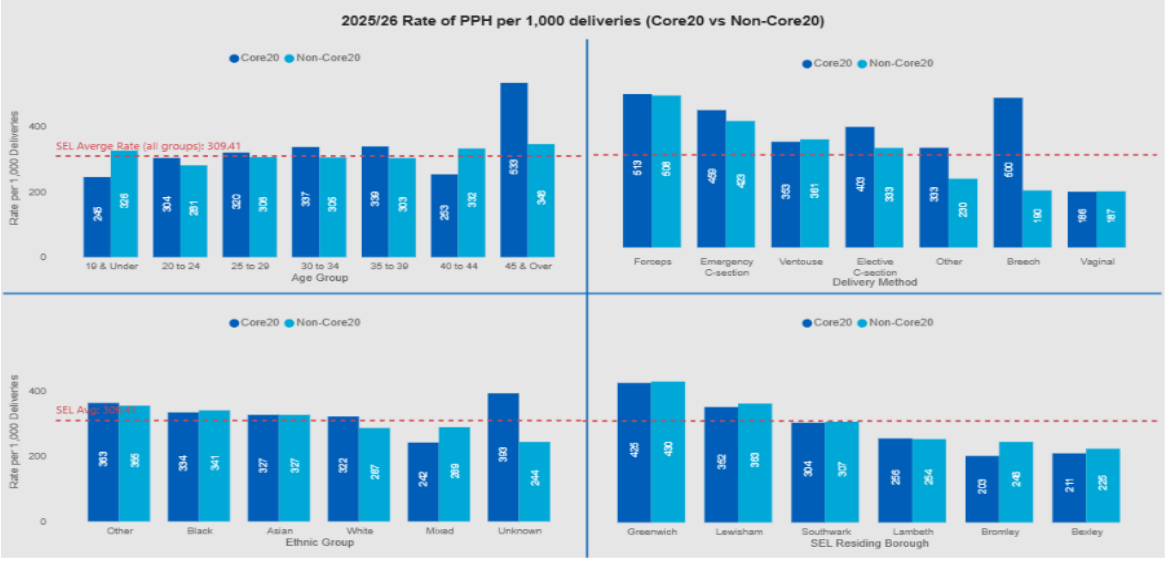
When looking at booking by 10 weeks of pregnancy by age and ethnic profile, among those aged 40-44, the booking rate is 6.4% lower in Core20 (most deprived) population compared to Non-Core20 population. A similar gap is observed among those of Asian ethnicity (6.8%). Only those of White ethnicity have a booking rate higher than the South East London average for both Core20 and Non-Core20 population.

A variation is also observed across grouped language categories, indicating that language and communication needs may influence access to maternity care. Those with language recorded as Unknown at time of booking account for 8,310 bookings, representing 37% of all bookings in 2025/26, and 6,875 of booking by 10 weeks representing 41.2%. Comparison of 2024/25 and 2025/26 data indicate that the overall pattern of inequalities remains broadly consistent across South East London, although findings for some language groups should be interpreted with caution due to small numbers.



6.3. Inequalities in women who have a post-partum haemorrhage (PPH)

Post-partum haemorrhage (PPH) refers to excessive bleeding following childbirth, typically defined as blood loss of more than 500ml after delivery. This section examines inequalities in the rate of PPH among women residing in South East London, comparing Core20 (most deprived) and Non-Core20 population.



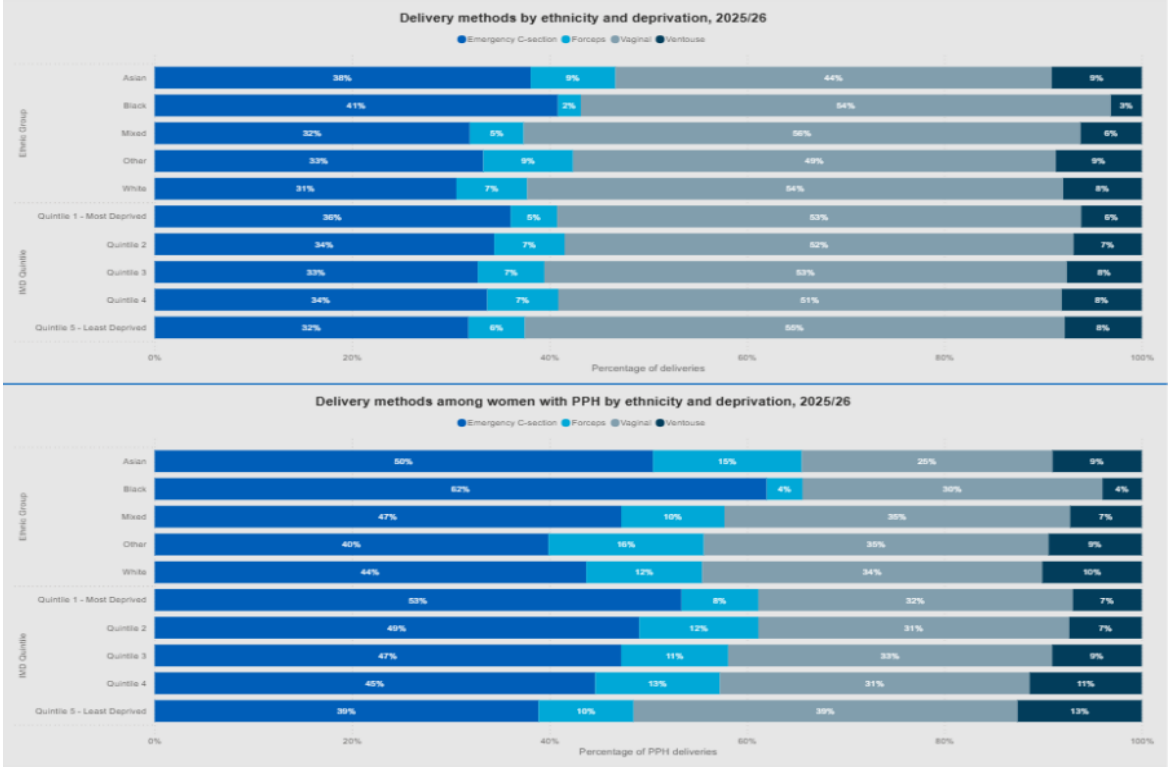
In 2025/26, 307 per 1,000 deliveries in South East London included a post-partum haemorrhage (PPH). Rates vary across maternal characteristics and delivery methods. Differences between Core20 (most deprived) and Non-Core20 population is generally modest, although some variation is observed by age and borough of residence. Comparison between 2024/25 and 2025/26 suggests that the overall pattern remain broadly similar, with no clear widening of differences between Core20 and Non-Core20 population.

Delivery method showed the clearest variation in PPH rates. In 2025/26, forceps deliveries recorded PPH rates of approximately 505 per 1,000 deliveries, compared with around 187 per 1,000 for vaginal births. Higher rates were also observed among emergency caesarean deliveries. This is consistent with Royal College of Obstetricians and Gynaecologists (RCOG) patient information identifying caesarean section, forceps or ventouse delivery, and prolonged labour as recognised factors associated with post-partum haemorrhage.

A further break down of delivery pathways shows that emergency caesarean deliveries account for a larger proportion of deliveries among Black women and women living in the most deprived areas. Among women experiencing PPH, emergency caesarean deliveries accounted for an even greater proportion of cases across these groups. The data suggest that ethnicity and deprivation have a strong correlation with delivery pathways and delivery pathways in this case emergency caesarean has an impact on PPH due to surgical delivery increasing the risk of PPH.

Surgical delivery will always increase the risk of PPH, but there are several other risk factors that will increase a woman's risk of PPH across all types of delivery methods. These include anaemia, placental issues, previous PPH, uterine fibroids, high BMI. When considering Core20 (most deprived) population and health inequalities there will be increased chance of intervention and poorer outcomes due to medical, social and economic risks.

This is the case nationally, as reported by the Royal College of Obstetricians and Gynaecologists[1].



Improvement activity

SEL Local Maternity and Neonatal System (LMNS) Improvement activity Reducing inequalities for those experiencing the poorest outcomes and the experience of maternity services care remains a key priority for South East London Integrated Care Board (ICB). The LMNS is leading a range of improvement initiatives that address both national priorities and the needs of our local population. **Post-partum Haemorrhage (PPH)** Ethnicity is recognised as a risk factor for PPH, with evidence demonstrating higher rates of severe maternal morbidity among some ethnic groups. It is therefore essential that all women and birthing people particularly those from Black, Asian and other global	**Booking by 10 weeks of pregnancy** To improve access, all maternity providers across South East London offer self-referral pathways, allowing women and birthing people to refer themselves directly to maternity services without the need to visit their GP. This enables earlier assessment, triage and appropriate support based on individual needs. Ensuring women and birthing people receive clear and accurate information about when and how to access maternity care is essential. To support this South East London has launched the NHS endorsed website Healthier Together, which provides trusted information and resources from preconception through

1 Heavy bleeding after birth (postpartum haemorrhage) | RCOG

majority communities receive ongoing holistic assessment, personalised care planning and appropriate information throughout pregnancy and birth. All NHS maternity providers and Integrated Care Boards are required to fully implement the care bundle by March 2027. Across South East London, maternity services are working collaboratively to strengthen clinical practice, improve outcomes and reduce inequalities in care and outcomes for women and birthing people.	pregnancy, birth and early parenthood and extends to children and young people.

7. Mental Health

Overview: The South East London recovery rate is 50%, and reliable recovery rate is 47%. This is slightly higher than the London and national recovery rates for Q3 2025/26 (48% and 49% respectively). Completed physical health check rates remain lower in more deprived areas, ranging from 52% in quintile 1 (most deprived) to 59% in quintile 5 (least deprived) with the least deprived group having the largest rate increase in 2024/25 of 6.7%. All ethnic groups have significantly lower rates of diagnosed SMI than LD, ADHD and/or autism, except for those of Black ethnicity where the rates of diagnosed SMI and LD, ADHD and/or autism are similar.

Activity Reporting Period: 2021 to 2026.
Data Source: Improving Access to Psychological Therapies (IAPT) dataset, Primary care data via Discovery Data Service, Mental Health Services Data Set (MHSDS).

There are two measures within the NHS Talking Therapies data:

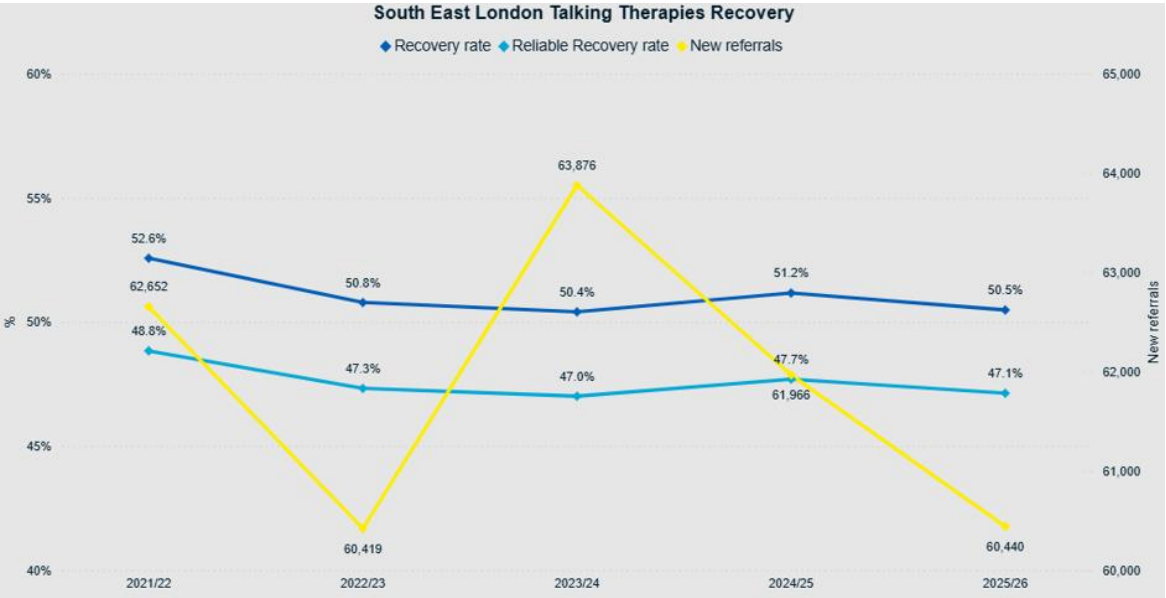
- Recovery is measured in terms of ‘caseness’, which means a patient has significant enough symptoms of anxiety or depression at the time of referral to be regarded as a clinical case of the condition. A referral is recovered if the patient was defined as a clinical case at the start of the referral and is no longer considered a clinical case at the end of their treatment. This is determined by patient questionnaires administered before and after treatment. The recovery rate is a measure of how many referrals moved to recovery.

- Reliable improvement is when a referred patient shows clinically significant improvement in their condition following a course of treatment. This is measured by the difference in patient questionnaire scores before and after treatment. A referral has reliably recovered if it meets the criteria for both recovery and reliable improvement, i.e., a patient has moved from being a clinical case at the start of treatment to not being a clinical case at the end of

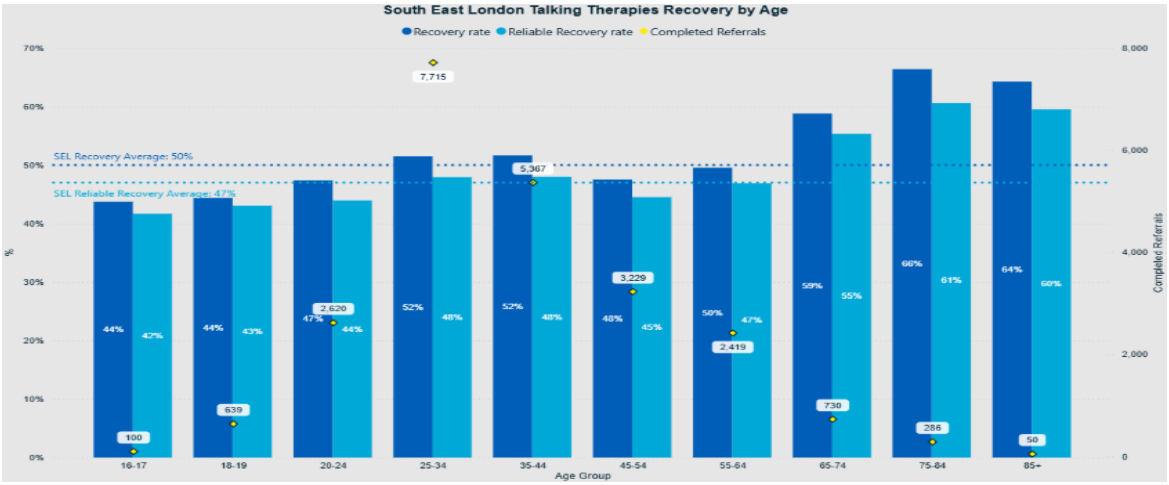
treatment and there has also been a clinically significant improvement in their condition.

In 2025/26, there were 60,440 new Talking Therapies referrals, 36,173 referrals with a first contact, and 23,156 referrals completed treatment. Of the completed treatments, 1,543 referrals were not regarded as a clinical case at the time of referral (excluded from recovery rate calculations) and 10,910 referrals moved to recovery.

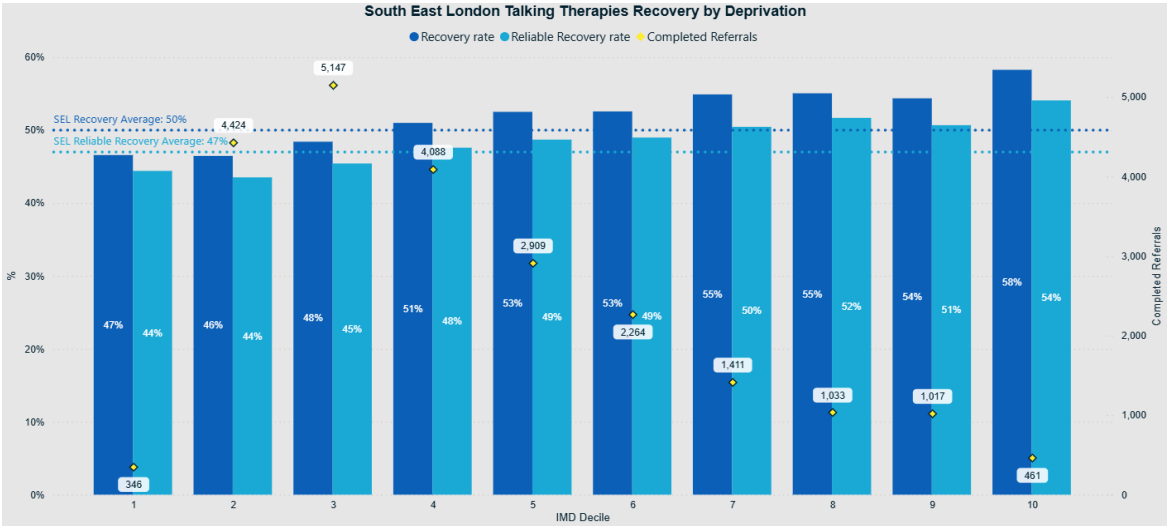
The South East London recovery rate is 50%, and reliable recovery rate is 47%. This is slightly higher than the London and national recovery rates for Q3 2025/26 (48% and 49% respectively). Recovery and reliable recovery rates have both decreased by about 2% since 2021/22. The number of new referrals has been variable since 2021/22 however, a steady decrease by about 5% is observed since 2023/24.



Recovery and reliable recovery rates increase with age. The highest recovery and reliable recovery rates in 2025/26 are for those aged 75-84 (66% and 61% respectively). However, the number of new referrals and completed referrals decreases as age increases, with those aged 25-34 making up over 30% of new referrals and completed referrals in 2025/26.

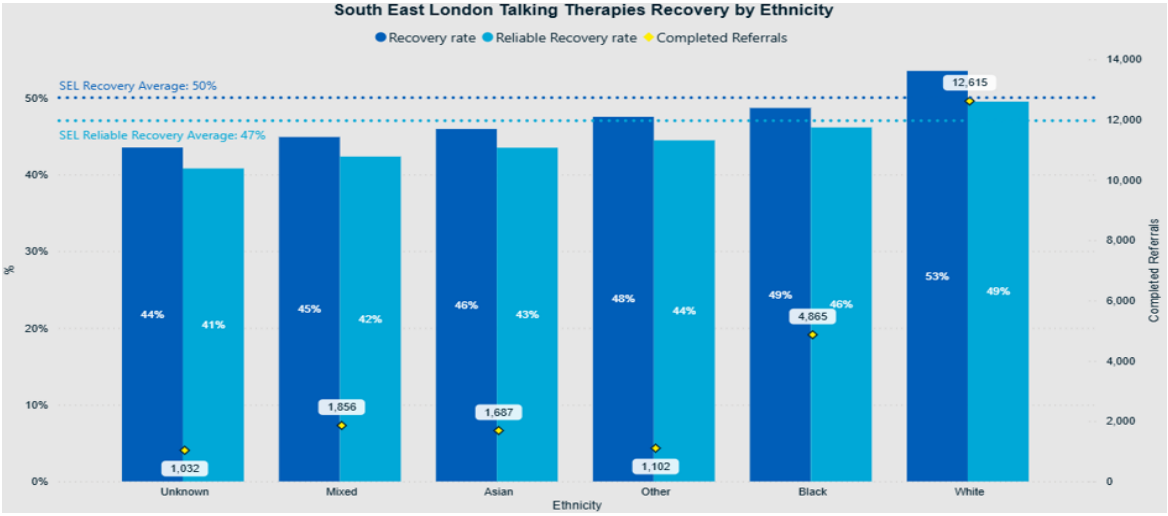


Recovery rates increase as deprivation decreases and patients in deciles 1 and 2 (most and more deprived) have the lowest recovery and reliable recovery rates. Those in decile 10 (least deprived) and decile 1 (most deprived) have the lowest number of new and completed referrals. Those in deciles 2, 3, and 4 (most and more deprived) have the largest number of completed referrals this is driven by those aged 25-34, with a little over a third of referrals (34%) for each of these deciles for this age group.



Looking at the ethnic profile for recovery rates, those of White ethnicity have slightly higher recovery rates while those of Unknown and Mixed ethnicity have the lowest recovery rates. The proportion of new Talking Therapies referrals by ethnic group is similar to the South East London registered population. Those of White ethnicity make-up 50% of new Talking Therapies referrals in 2025/26 and make-up 53% of the South East London registered population. Those of Black ethnicity make-up 21% of new

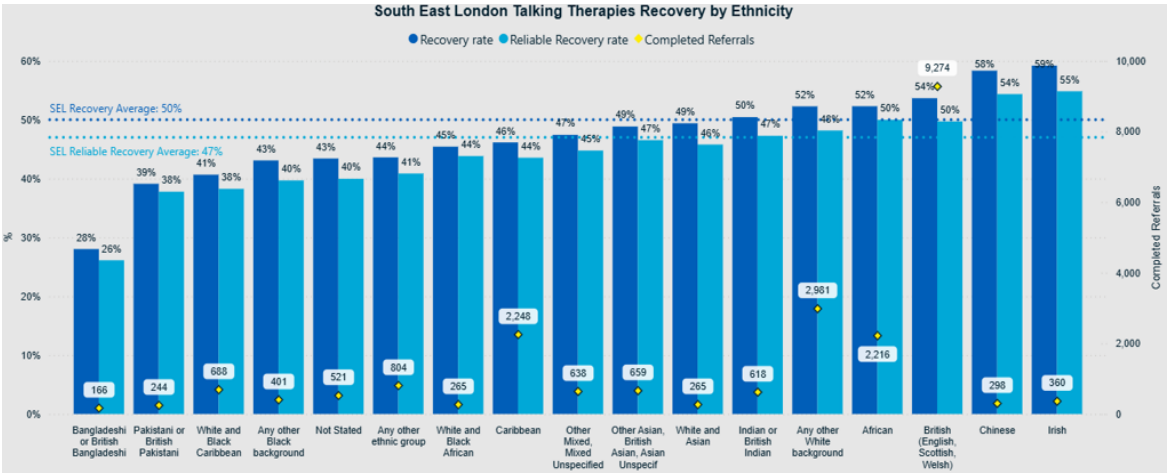
Talking Therapies referrals and make-up 19% of the South East London registered population.



When the ethnic profile is broken down further by subgroups, it is observed that recovery rates vary greatly. Those of Irish and Chinese descent have the highest recovery rates which is above the South East London average. Those of Bangladeshi and Pakistani descent have the lowest recovery rates which is below the South East London average.

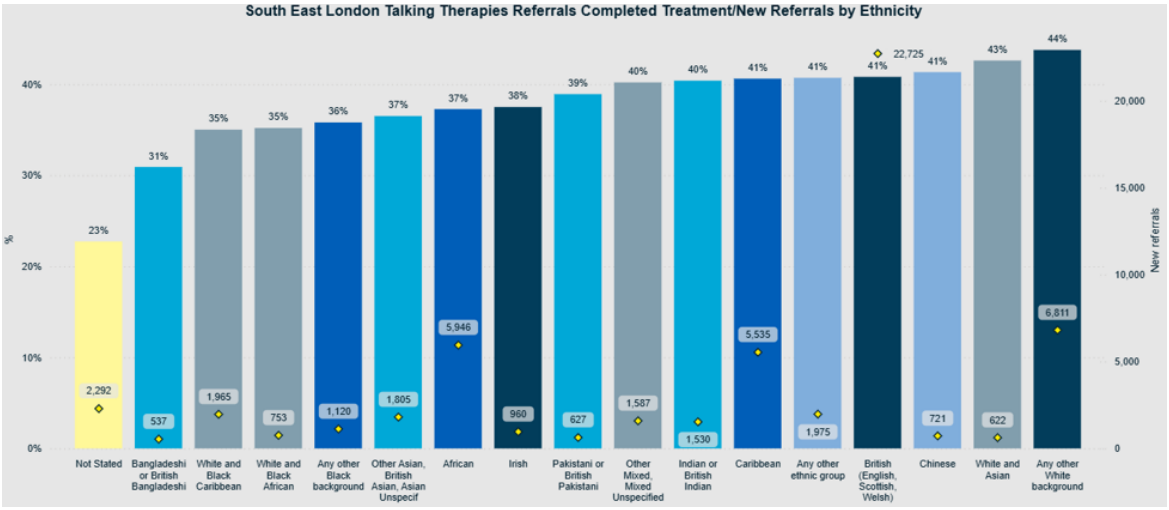
Recovery rates vary within ethnic subgroups:

- Those of African descent have a recovery rate of 52%, compared to 43% for those of Any other Black background.
- Similarly, those of Indian or British Indian descent have a recovery rate of 50% compared to those of Pakistani and Bangladeshi descent with recovery rates of 39% and 28% respectively.
- Those of White British, Irish and Any other White background descent are the only group where the recovery rates and reliable recovery rates are above the South East London average for all ethnicities.



When comparing the proportion of referrals completed treatment to new referrals in 2025/26 by ethnic profile:

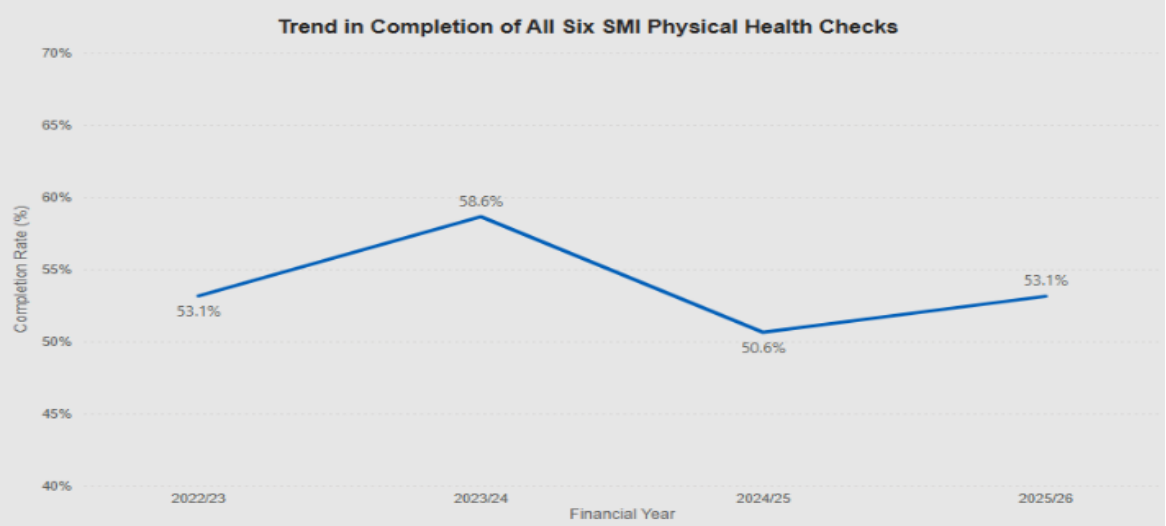
- Those of Pakistani descent have a completion rate of 39%, this is the median for South East London. The data suggests that whilst this group is completing treatment at a rate similar to other ethnic groups, a lower portion completing treatment move to recovery, resulting in a low recovery rate.
- Those of Bangladeshi descent and Not stated ethnicity have the lowest completion rate of all ethnic groups (31% and 23% respectively). For those of Bangladeshi descent, the following is observed in the data, they have a low referral rate, low completion and recovery rate and a lower portion moving to recovery. Further work would need to be undertaken to understand what the driving factors are.



7.1. Rates of eligible patients with severe mental illness (SMI) receiving an annual physical health check – whole population

As of 31 March 2026, the number of adults registered with a GP in South East London is ~1.72 million of those, 1.3% had a recorded SMI diagnosis.

Overall, 53.1% of patients on the SMI register had all physical health check completed, an increase of 2.4% from the previous year. There is no consistent trend in completion rates over the last four years.

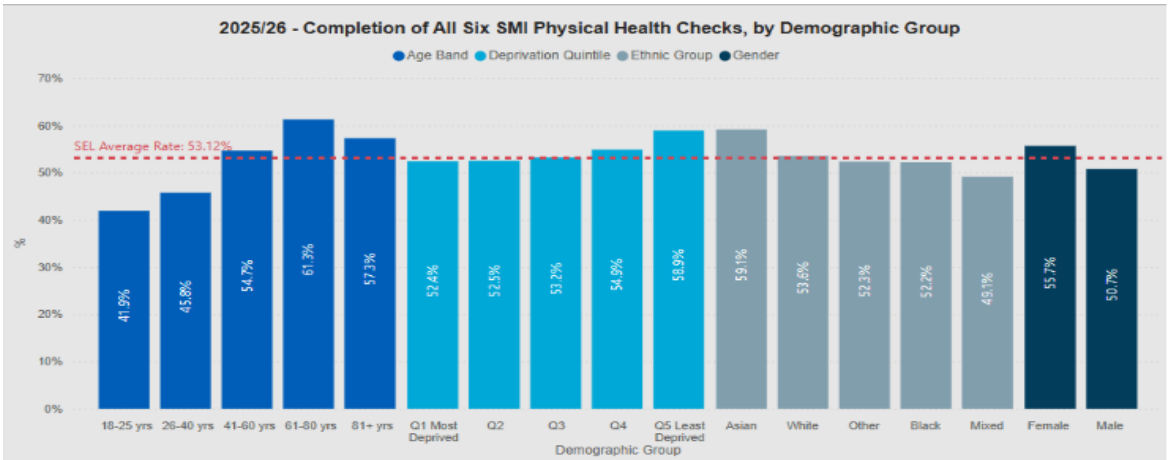


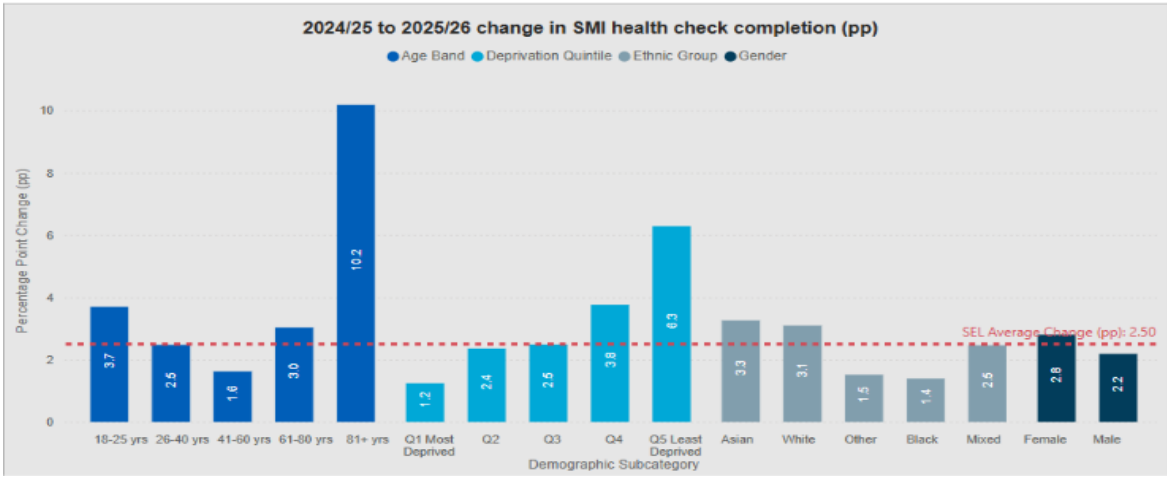
The data observed indicates that the percentage of patients with all health check completed is higher among females (56%) than males (51%) with a 5% gap noted, however, there have been improvements overall in both groups of 2.8% and 2.1% respectively.

Completed physical health check rates remain lower in more deprived areas, ranging from 52% in quintile 1 (most deprived) to 59% in quintile 5 (least deprived) with the least deprived group having the largest rate increase in 2024/25 of 6.7%.

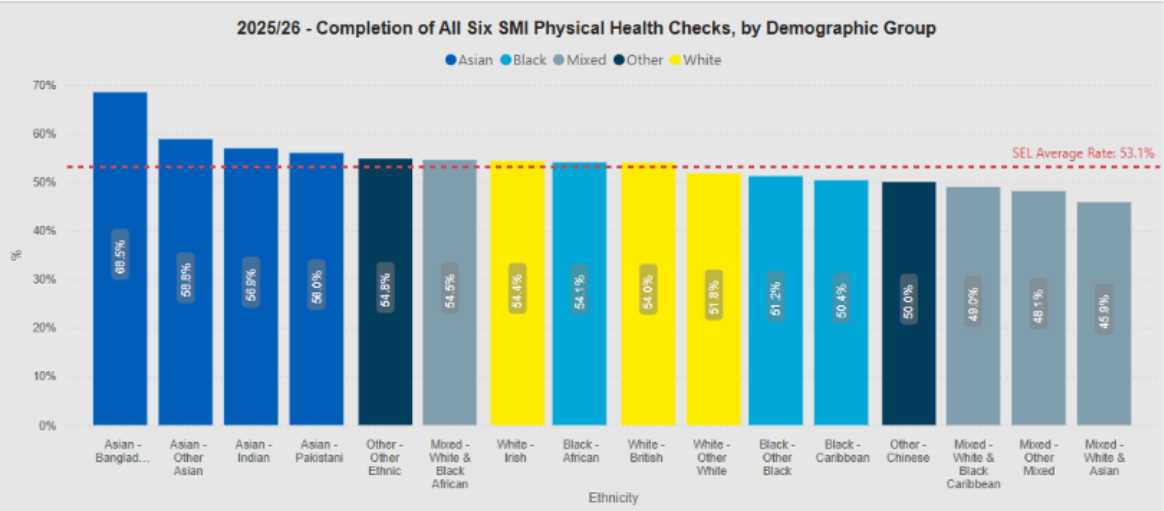
Differences in completed physical health check rates are more pronounced by age, ranging from 42% for those aged 18-25 years old to 61% for those aged 61-80 years old, with improvements observed across all age groups.

Looking at the ethnic profile, completed physical health check rates range from 49% for those of Mixed ethnicity to 59% for those of Asian ethnicity. The largest year on year improvement is observed among those of Asian ethnicity 3.2%, whilst the smallest improvement is observed among those of Black ethnicity 1.4%.





When the ethnic profile is broken down further by subgroups, considerable variation is observed. Those of Asian ethnicity have higher than average completed physical health check rates, the highest rate of all ethnicities, while lower rates are observed among those of Mixed ethnicity. Notably, those of Bangladeshi descent have consistently higher rates year-on-year from 2023/24 to 2025/26. Those of Any other ethnicity show the largest improvement between 2024/25 and 2025/26, increasing from approximately 47% to 54%.



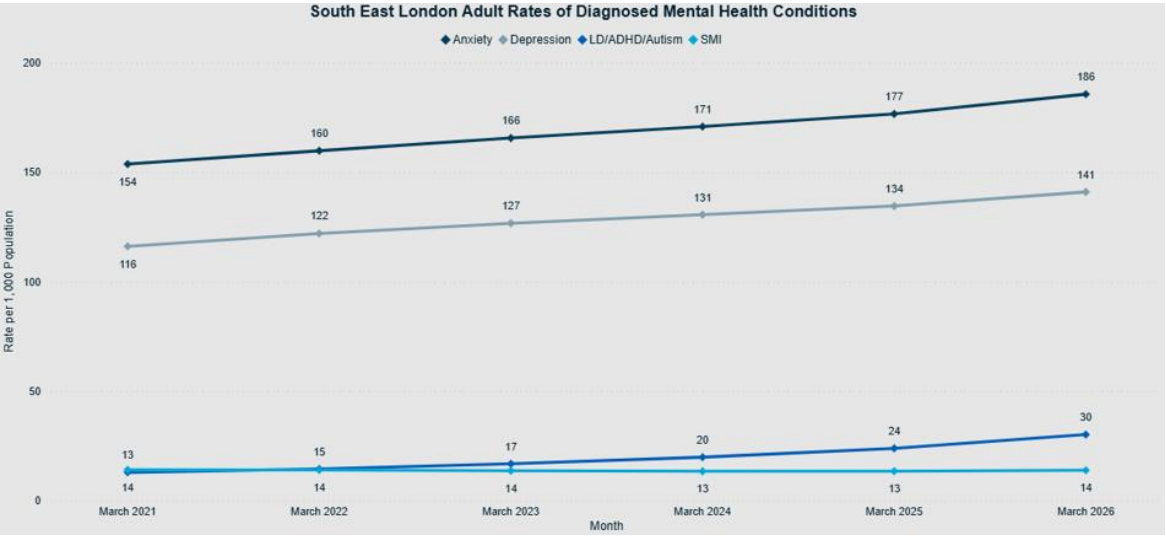
Following an overall decline in the number of completed physical health check rates between 2023/24 and 2024/25, improvement in 2025/26 appear to have been driven particularly by improvements among adults aged 81 and over. The number of completed physical health check rates within this group increased from 290 to 362, while the number of SMI patients aged 81 and over increased slightly. Improvements were particularly evident among older females.

Completed physical health check rates by GP registered borough range from 50% in Lewisham to 60% in Bexley, this is likely driven by the local demography within Bexley, with those aged over 60 in Bexley having the highest rates of over 68%. While rates improved in most boroughs in 2025/26, a minimal decline was observed in Lambeth, despite it having the largest SMI cohort.

7.2. Inequalities in rates of diagnosed mental health conditions – adults

The South East London adult rate of diagnosed anxiety is 186 per 1,000 population and depression rate is 141 per 1,000 population (March 2026). The rate of Severe Mental Illness (SMI) is much less at 14 per 1,000, population and the rate of adults with ADHD, a learning disability (LD) and/or autism is 30 per 1,000 population.

Since March 2021, rates of diagnosed anxiety and depression have increased by 20% and 22% respectively. LD, ADHD and/or autism has also increased since March 2021 the rate has more than doubled (although these are much smaller numbers compared to anxiety and depression). This increase in diagnosis of LD, ADHD and/or autism may partially be attributed to reduced stigma and increased awareness over the last few years.[2] The rate of diagnosed SMI remains consistent.



The increase in rate of diagnosed LD, ADHD and/or autism from March 2021 to March 2026 is variable by age profile. The rate for those aged 18-19 increased by 75% (from 55 per 1,000 in 2021 to 96 per 1,000 in 2026) and by 85% for those aged 20-24 (40 per 1,000 in 2021 to 74 per 1,000 in 2026). The rate for those aged 25-34 has almost

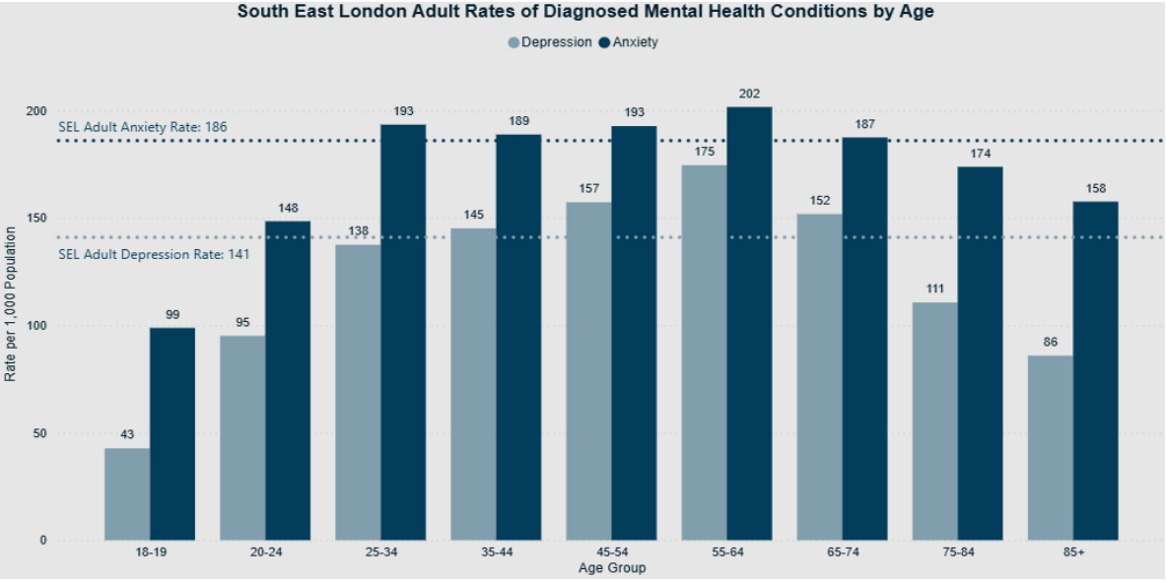
[2] Independent review into mental health conditions, ADHD and autism: terms of reference - GOV.UK.

tripled in the same period. The data indicates a smaller proportion of diagnosis for those aged 45 and over and it is observed that the rate has remained more consistent since March 2021 for those age 55+. Please note these ages are the age at the time, not age of first diagnosis.

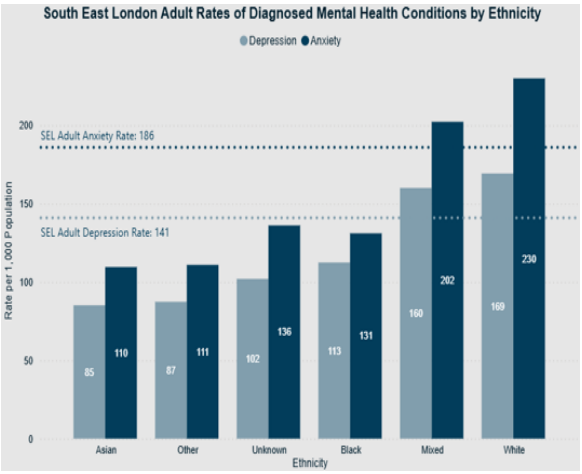
Depression and Anxiety

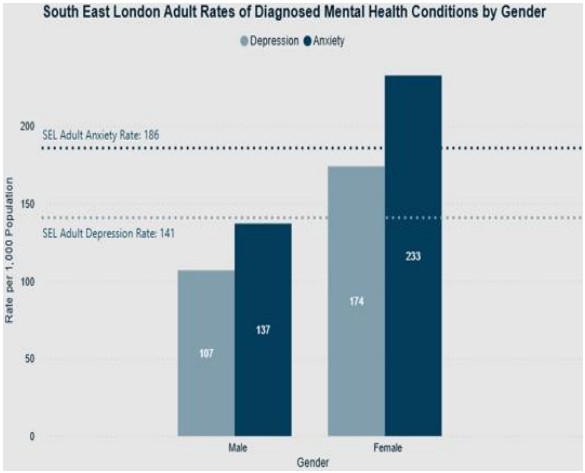
The rate of diagnosed depression increases with age, peaking at 175 per 1,000 population for those aged 55-64 and then decreases as age increases. The rate of diagnosed depression is lowest for the youngest and oldest adults; those aged 18-19 have a rate of 43 per 1,000 population.

The rate of diagnosed anxiety follows a similar pattern, those aged 18-19 have the lowest rate of 99 per 1,000 population. This increases with age those aged 55-64 have the highest rate 202 per 1,000 population and rates decreases slightly as age increases.

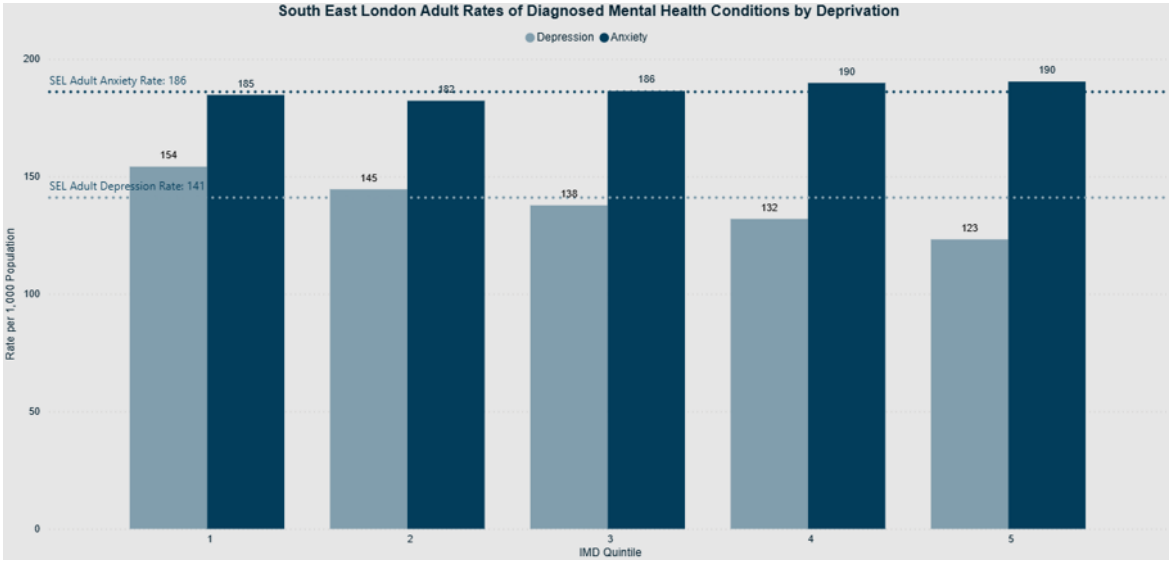


Looking at the ethnic and gender profile, those of White ethnicity have the highest rates of diagnosed depression and anxiety 169 per 1,000 population and 230 per 1,000 population respectively, followed closely by those of Mixed ethnicity. Those of Other and Asian ethnicity have the lowest rates. Compared to adult males, adult females have higher rates of diagnosed depression and anxiety 174 per 1,000 population and 233 per 1,000 population respectively.

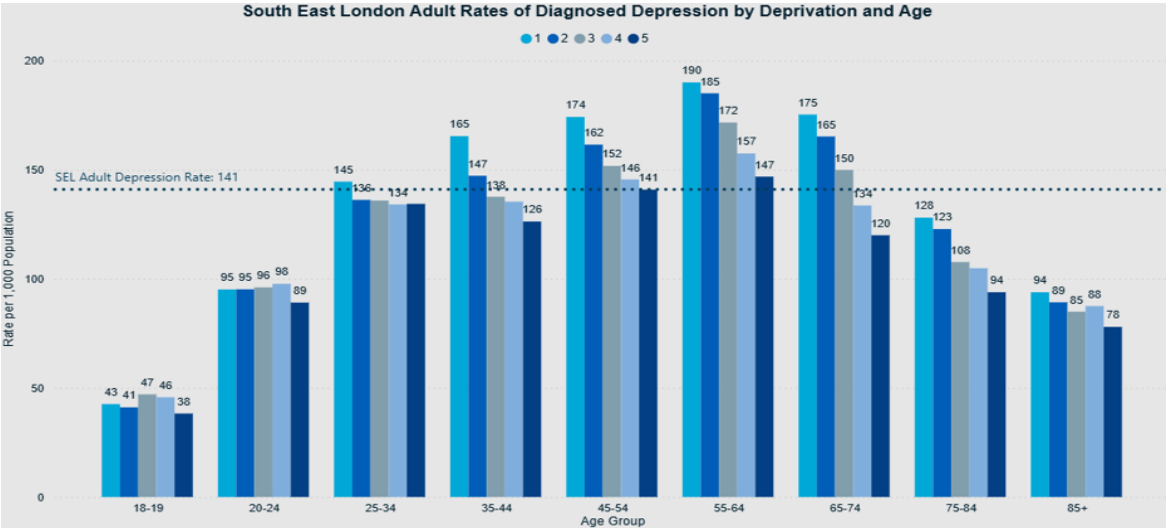




Looking at deprivation, there is little difference in the rate of diagnosed anxiety, however the rate of diagnosed depression decreases as deprivation decreases. Those in quintile 5 (least deprived) have the lowest rate of diagnosed depression.

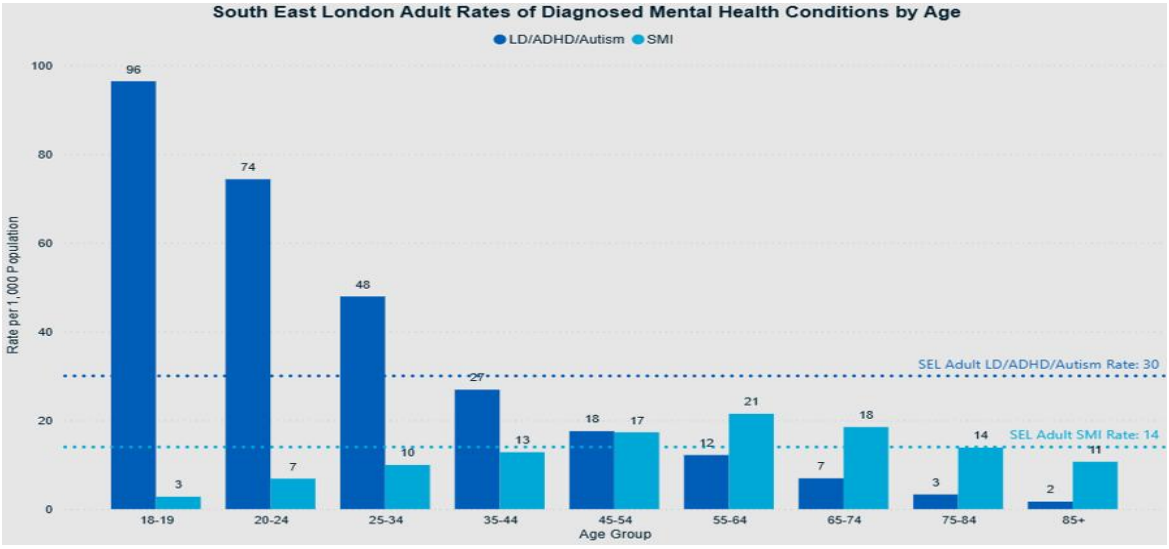


The rate of diagnosed depression for those aged 35 and below is generally below the South East London average. For those aged between 45-74, the rate of diagnosed depression suggests a clear relationship between depression and deprivation, with those within quintiles 1 to 3 (most, next most and middle deprived) having rates higher than the South East London average. The rate of diagnosed depression drops below the South East London average across all quintiles for those aged 75 and over.



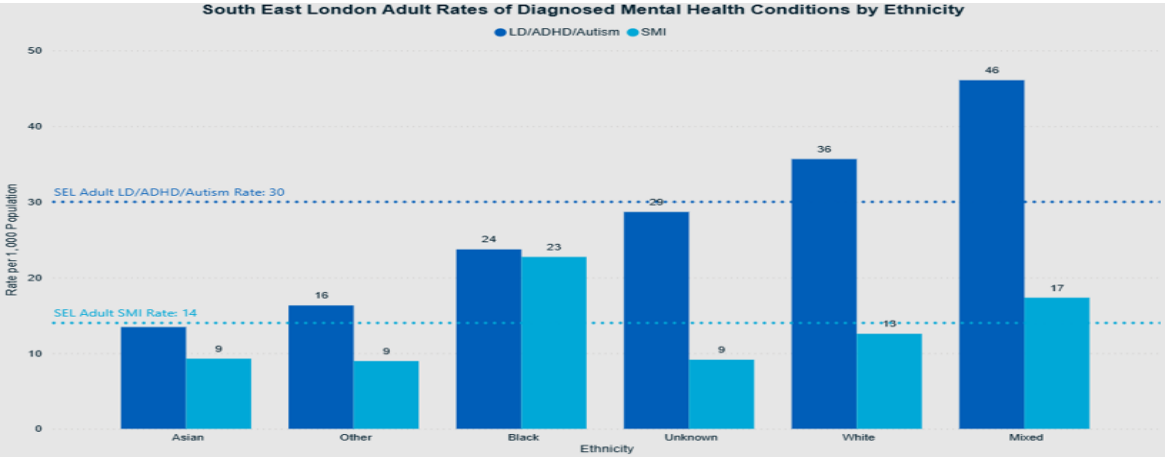
Learning Disability (LD), Autism, ADHD and Severe Mental Illness (SMI)

Those aged 55-64 have the highest rate of SMI across all age groups 21 per 1,000 population. In contrast, the rate of diagnosed LD, ADHD and/or autism decreases as age increases. Those aged 18-19, have the highest rate of 96 per 1,000 population compared to 2 per 1,000 population for those aged 85+.



Looking at the ethnic profile for the rate of diagnosed LD, ADHD and/or autism. Those of Mixed ethnicity have the highest rate of diagnosis 46 per 1,000 population, this is more than triple the rate observed in those of Asian ethnicity 13 per 1,000 population. This is mainly driven by a diagnosis of ADHD, with almost twice the number of those

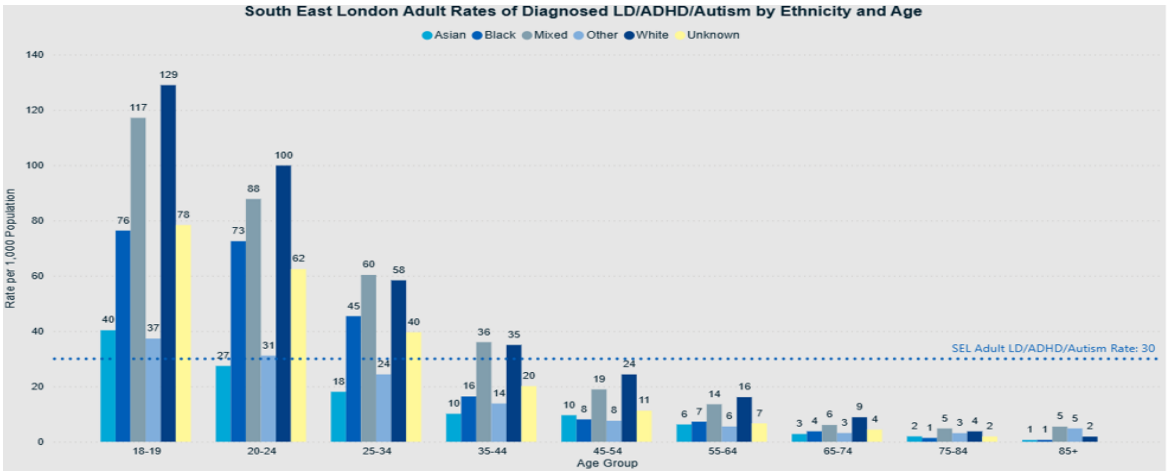
of Mixed ethnicity diagnosed with ADHD compared to autism. For SMI, those of Black ethnicity have the highest rate of diagnosis 23 per 1,000 population. All ethnic groups have significantly lower rates of diagnosed SMI than LD, ADHD and/or autism, except for those of Black ethnicity where the rates of diagnosed SMI and LD, ADHD and/or autism are similar.



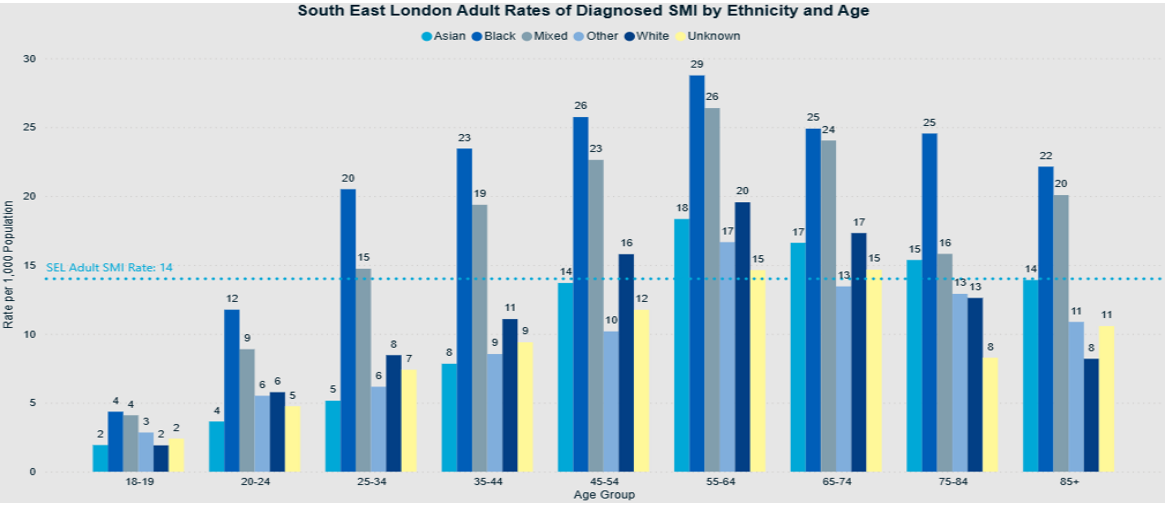
Looking at the ethnic and age profile for diagnosed LD, ADHD, and/or autism there are differences observed. As age increases, particularly those aged 55+, the rate of diagnosed LD, ADHD and/or autism is similar across different ethnic groups, although much smaller.

For those aged 35 and below a variance in diagnosis rate based on ethnic profile is observed. Those of White ethnicity have the highest rate for those aged 25 and below, however, for those aged 25-34 those of Mixed ethnicity have a slightly higher rate than those of White ethnicity.

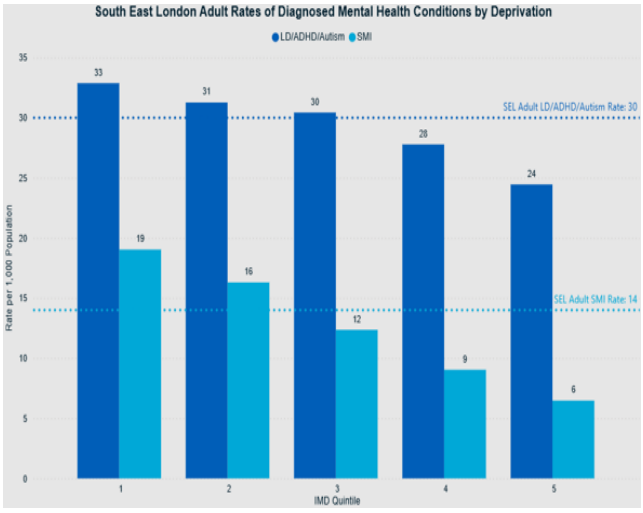
While rates of diagnosed LD, ADHD, and/or autism decrease for all ethnic groups between the ages of 18-19 and 20-24, the rate of decrease varies. For those of White and Mixed ethnicity this decreases by 22% and 25% respectively, for those of Asian ethnicity this decreases by 33% and for those of Black ethnicity this decreases by 5%.

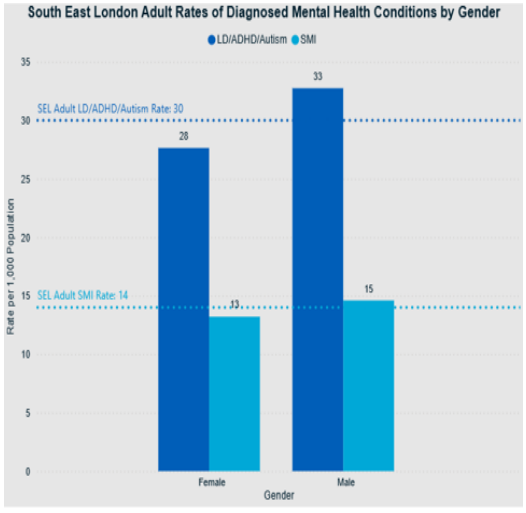


Rate of diagnosed SMI generally increases with age for all ethnic groups, however, a variance is observed. Those of Asian, Other, White and Unknown ethnicity have similar rates for all age groups. Those of Black and Mixed ethnicity consistently have higher rates of diagnosed SMI across all age groups.



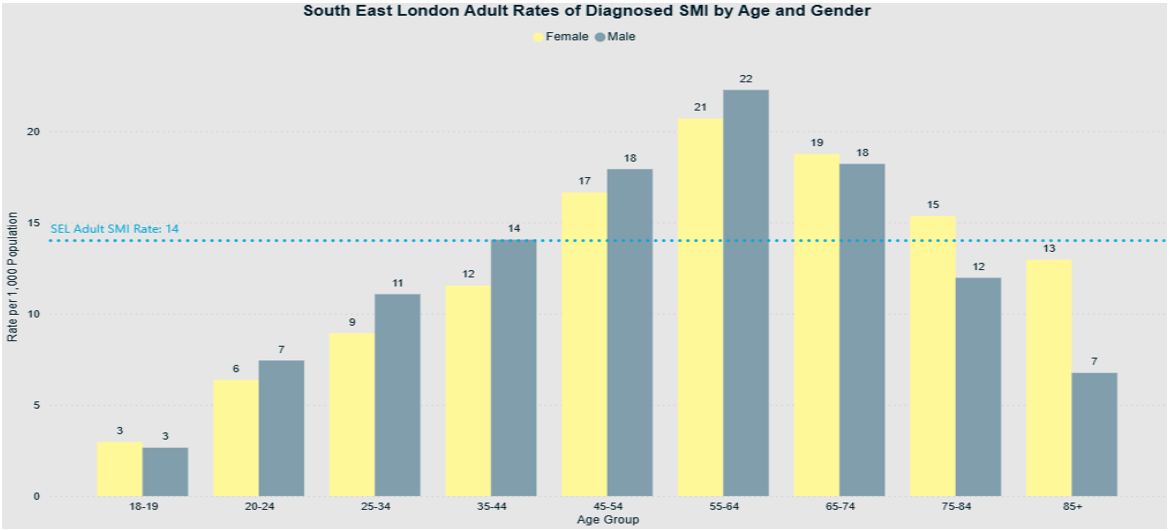
Those in quintile 1 (most deprived) have the highest rate of diagnosed LD/ADHD/Autism and SMI with rates decreasing in quintiles 4 and 5 (next least and least deprived). There is no significant difference in the rate of diagnosed SMI between males and females. Males have slightly higher rates of diagnosed LD, ADHD and/or autism.





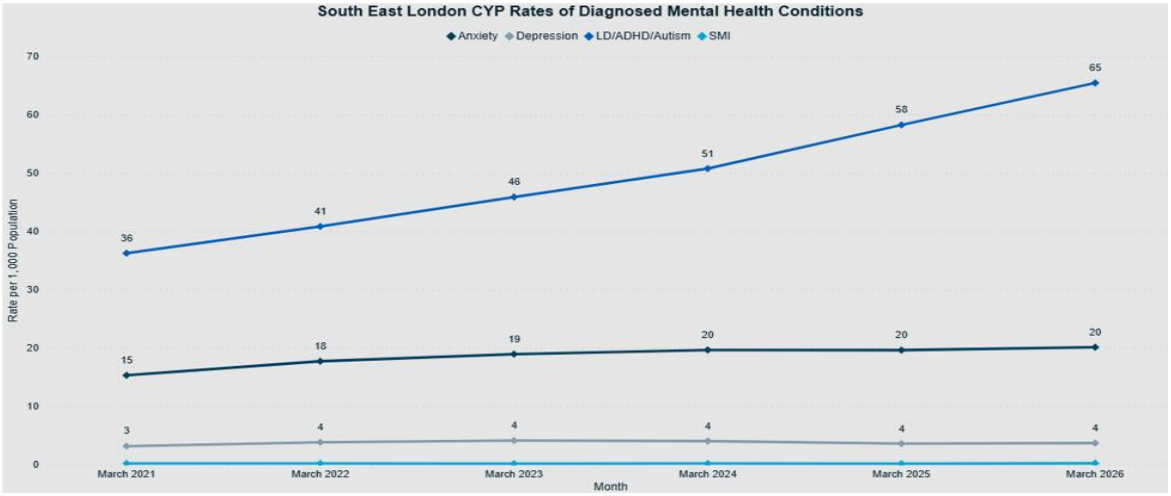
Looking at the rate of diagnosed SMI by age and gender profile, while the rates between males and females are similar across age groups, males have slightly higher rates of diagnosed SMI in those aged 65 and below. Females above the age of 65

have higher rates of diagnosed SMI than males, and the difference is greater as age increases. Females aged 85+ have diagnosed SMI rate of 13 per 1,000 population, which is almost double that of males of the same age of 7 per 1,000 population.



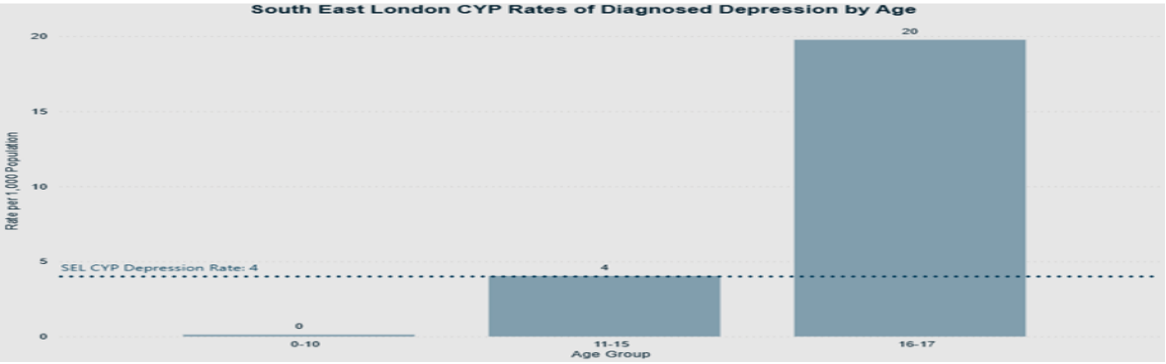
7.3. Inequalities in rates of diagnosed mental health conditions – Children and Young People (CYP)

The rate of diagnosed Severe Mental Illness (SMI) and depression for Children and Young People (CYP) in South East London has remained consistent since March 2021 with low numbers, less than 5 per 1,000 population. The rate of diagnosed LD, ADHD and/or autism has increased steadily by 80% from 36 per 1,000 population in March 2021 to 65 per 1,000 population in March 2026.

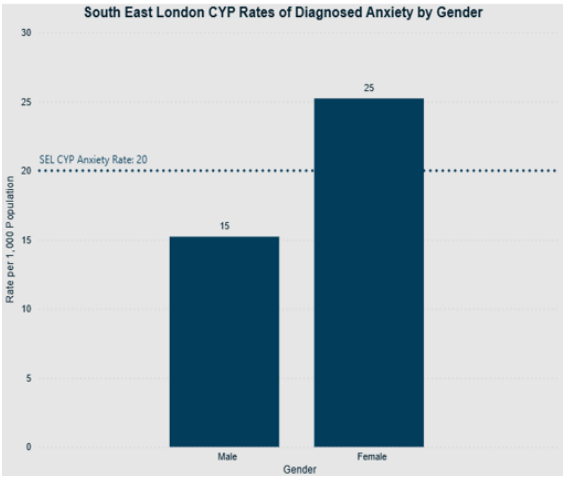


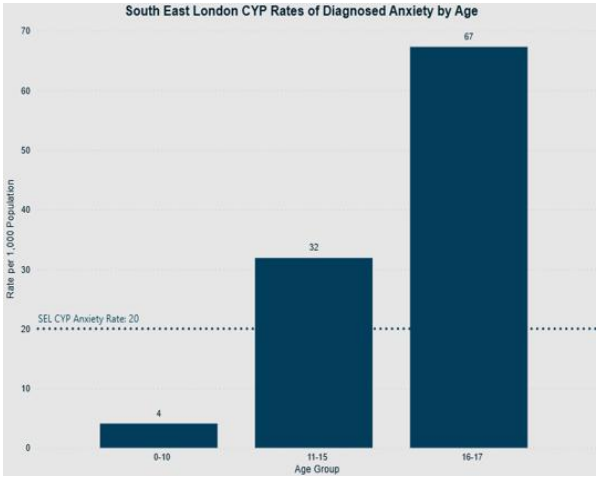
Depression and Anxiety

The South East London CYP rate of diagnosed depression is 4 per 1,000 population (March 2026). While the overall CYP rate of diagnosed depression is low and no large variance is observed by other demographics, there are differences noted by age profile. The rate of diagnosed depression increases with age, those aged 16-17 have a higher rate of depression of 20 per 1,000 population compared to 4 per 1,000 population for those aged 11-15.

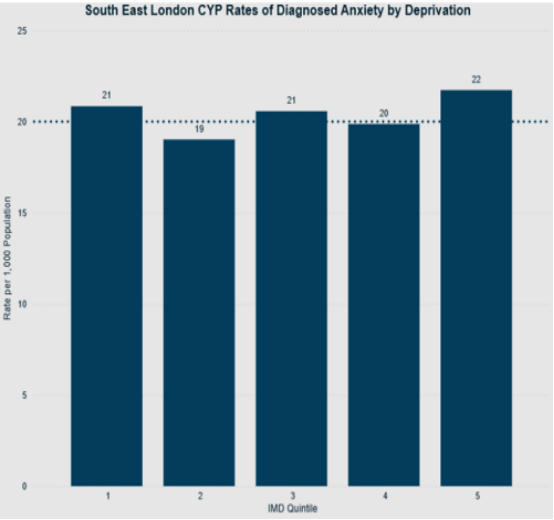


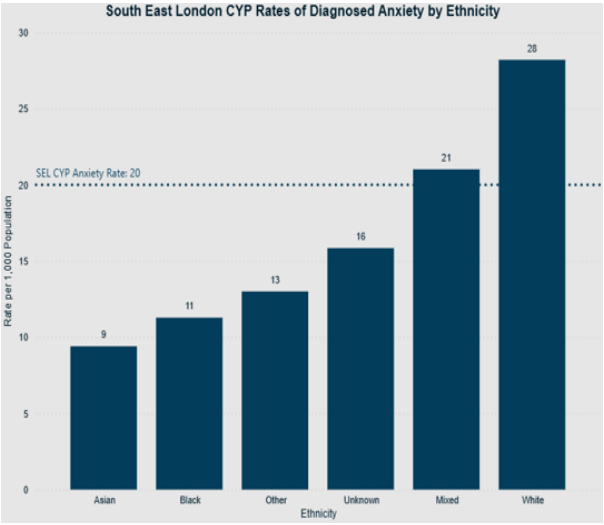
The rate of diagnosed anxiety is 20 per 1,000 population. For CYP, anxiety is more common among females (25 per 1,000 population) and like depression, the rate of diagnosed anxiety increases with age. The rate more than doubles between those aged 11-15 (32 per 1,000 population) and those aged 16-17 (67 per 1,000 population). There is no clear correlation between the rate of diagnosed anxiety and deprivation.



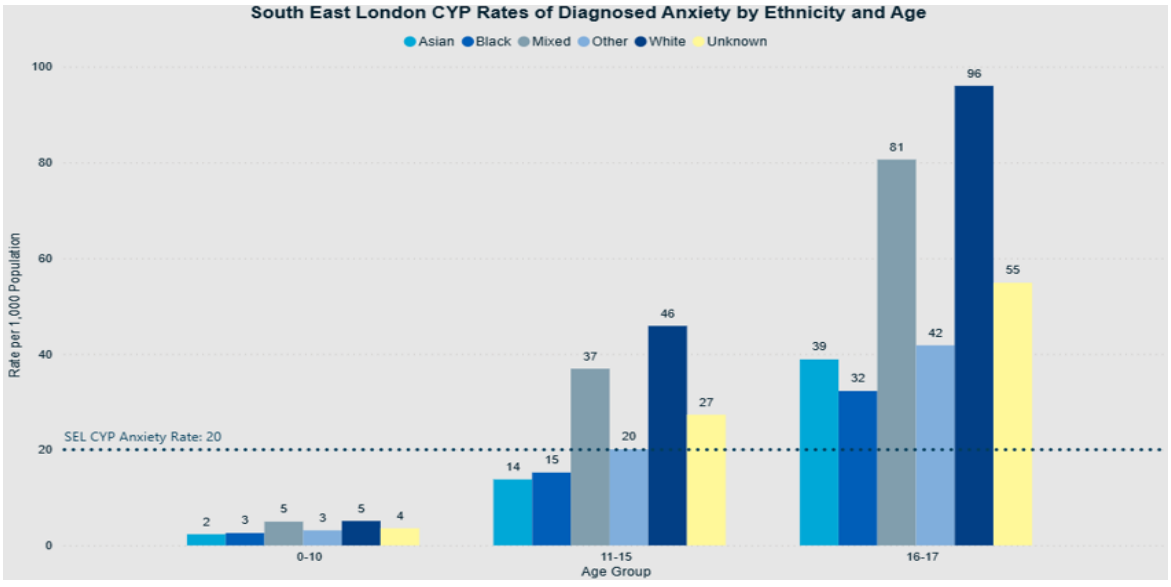


Looking at the ethnic profile, a variance is observed. Those of White ethnicity have three times the rate of diagnosed anxiety than those of Asian ethnicity and over twice the rate of those of Black ethnicity.

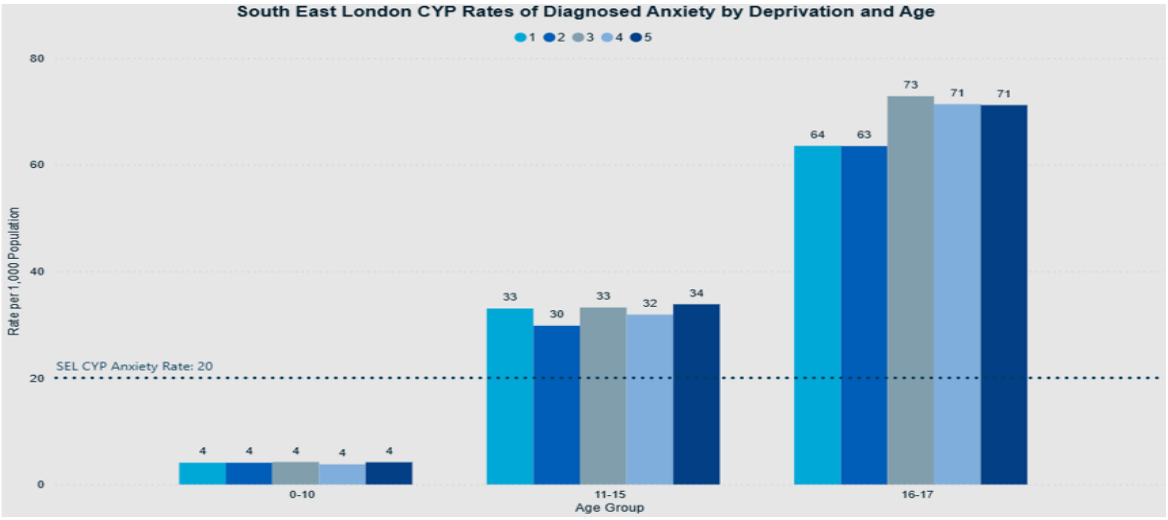




Looking at the rate of diagnosed anxiety by ethnic and age profile. Those of Black and Asian ethnicity have the lowest rates of diagnosis for those aged between 11-17. For most ethnicities, the rate of diagnosis doubles when comparing those aged between 11-15 and 16-17.

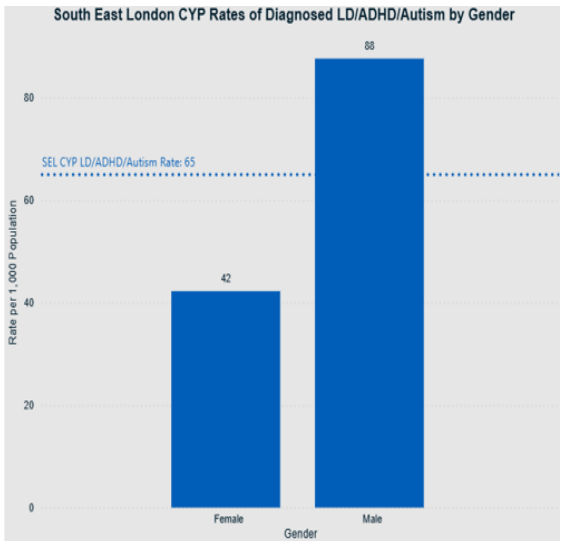


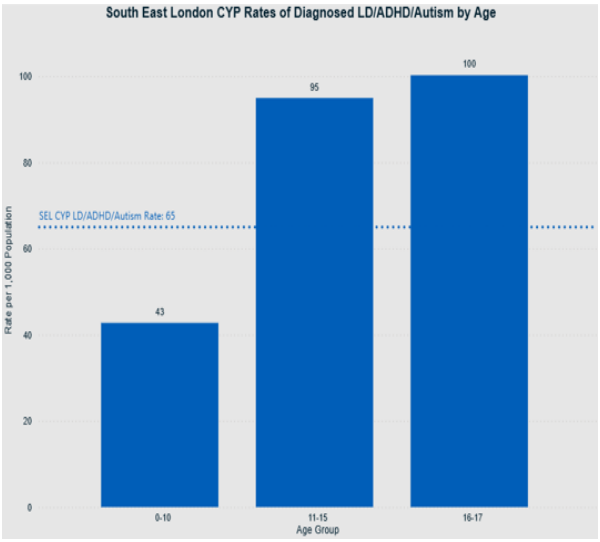
Looking at rate of diagnosed anxiety by age profile and deprivation, for under 16s there is no clear correlation between the rate of diagnosed anxiety and deprivation. For those aged 16-17, the rate of diagnosed anxiety is higher in quintiles 3, 4 and 5 (middle, next least and least deprived).



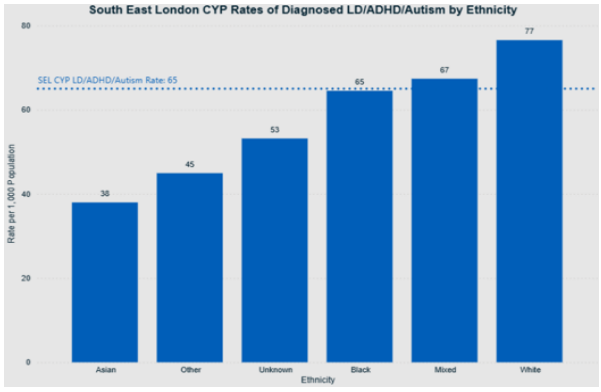
Learning Disability (LD), Autism, and ADHD

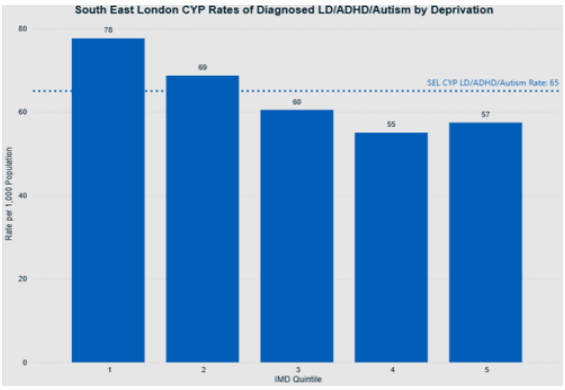
The rate of diagnosed LD, ADHD and/or Autism is 65 per 1,000 population in South East London (March 2026). LD, ADHD and/or autism diagnosis is twice as common among males. LD, ADHD and/or autism diagnosis increases with age. Across all age groups the rate of diagnosed LD, ADHD and/or Autism is higher in comparison to the rate of diagnosed depression and anxiety diagnosis. The following is observed, the rate for those aged 0-10 is 43 per 1,000 population, for 11-15 is 95 per 1,000 population and for 16-17 is 100 per 1,000 population.



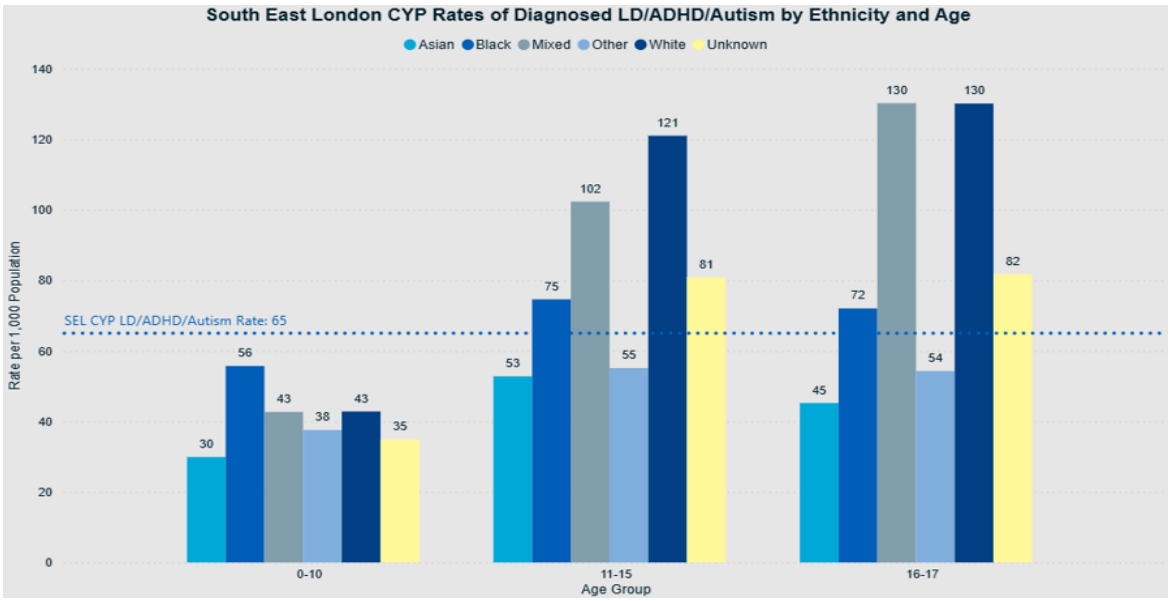


Looking at the ethnic profile, those of White ethnicity have the highest rate of diagnosed LD, ADHD and/or autism, followed closely by those of Mixed ethnicity. Those of Asian ethnicity have the lowest rates of diagnosis, half the rate of those of White ethnicity. The rate of diagnosed LD, ADHD and/or autism is lower in quintiles 3, 4 and 5 (middle, next least and least deprived).



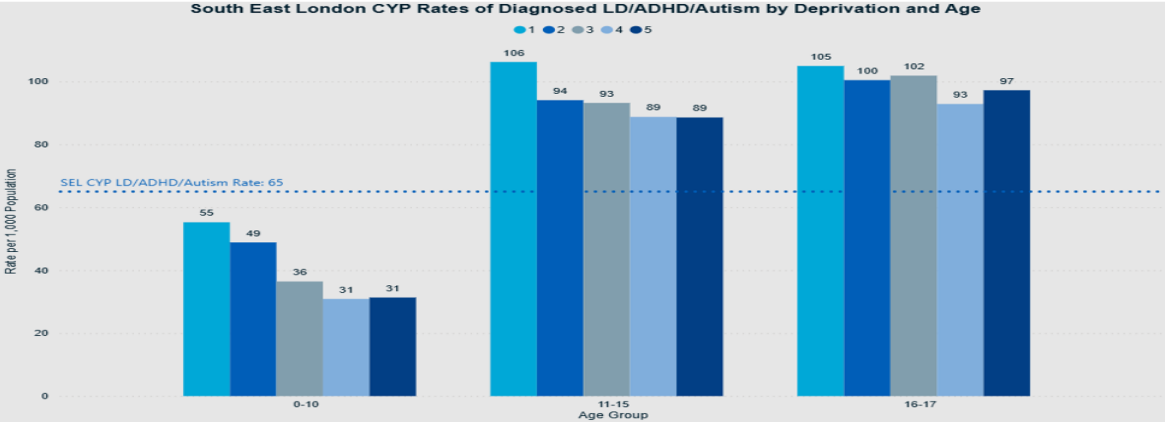


Looking at the ethnic and age profile, for those aged 0-10 those of Black ethnicity have the highest rate of diagnosed LD, ADHD, and/or autism. For those aged 11-15 those of White ethnicity have the highest rate. When the diagnosis rate for those aged 11-15 and 16-17 is compared, the data indicates that there is an increase in diagnosis rate as age increases for those of Mixed and White ethnicity. In contrast, there is a minimal decrease in diagnosis as age increases for those of Asian, Black and Other ethnicity.



For those aged 0-10 there is a clear correlation between the rate of diagnosed LD, ADHD, and/or autism and deprivation, with more deprived areas having higher rates. A similar

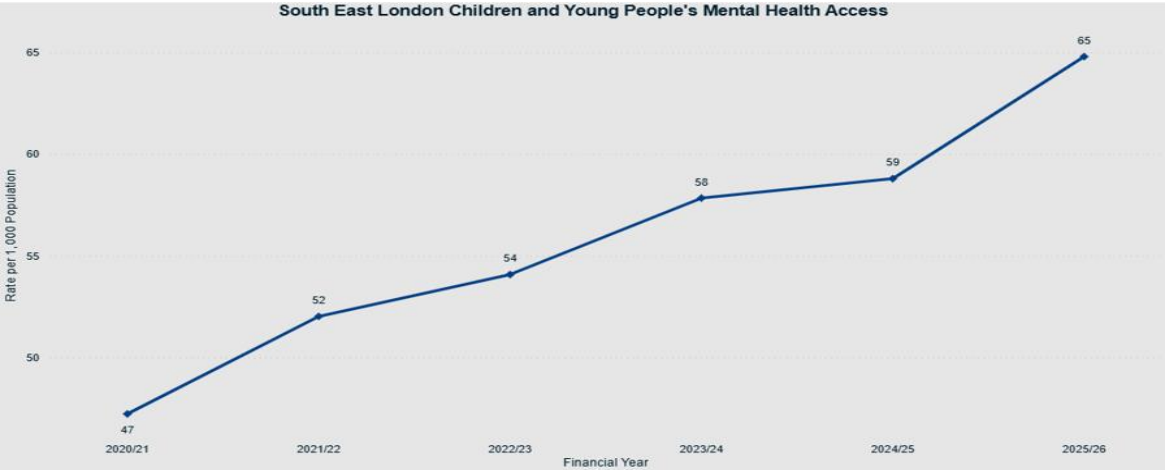
trend is observed for those aged 11-15 however the difference in diagnosed rate is less. Across all age groups those in quintile 1 (most deprived) have the highest rate of diagnosed LD, ADHD, and/or autism. This suggests that whilst age and deprivation both impact the rate of diagnosed LD, ADHD and/or autism, deprivation may have a slightly greater impact than age.



7.4. Inequalities in access rates to Children and Young People (CYP) mental health services for 0–17 years old

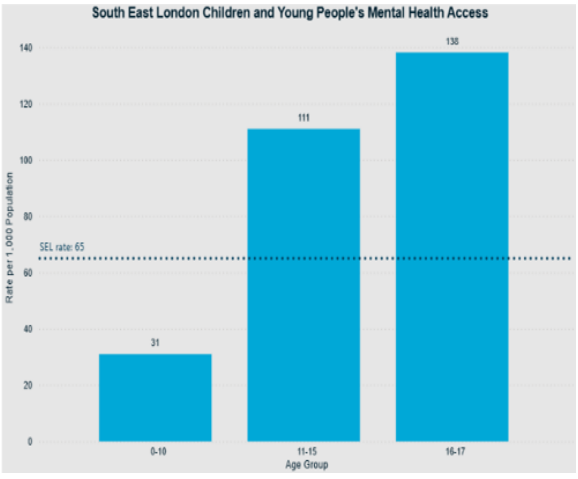
Access to mental health services for Children and Young People (CYP) is defined as open referrals with at least one contact, also called the caseload. These rates are calculated using distinct patients, so patients who may have more than one referral are counted once. This includes referrals to all services for those aged 0-17, and the services with the highest caseload in 2025/26 include Community Mental Health Team (Functional), Mental Health Support Team, and Neurodevelopment team. However, 12% of caseload in 2025/26 have no team referred to listed.

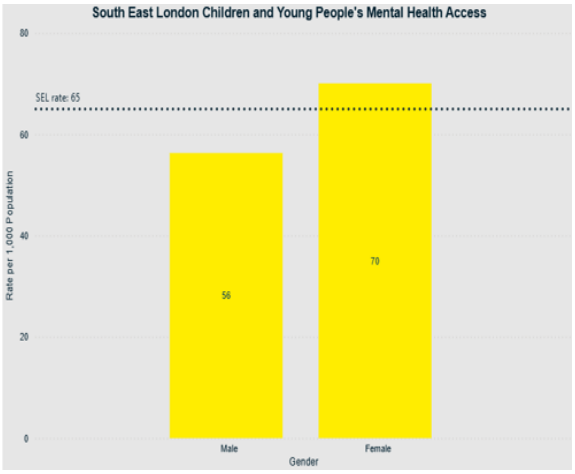
Since 2020/21, CYP access has increased steadily from 47 per 1,000 population in 2020/21 to 65 per 1,000 population in 2025/26. Referrals to the Community Mental Health team has increased from 406 referrals in 2020/21 to 10,793 referrals in 2025/26 while referrals to General Psychiatric Service have fallen from 9,561 to 1,977 in the same period. Data quality for the service referred has remained consistent for Mental Health Trusts in South East London, where a South East London patient is seen within a different Mental Health Trust outside of South East London, it is possible recording of 'serviced referred to' is poorer.



In 2025/26, the South East London mental health CYP access rate is 65 per 1,000 population. A variance is observed when looking at age, gender, ethnicity profile and deprivation.

Those aged 16-17 have the highest rate of 138 per 1,000 population. The lower rate of access for children under 11 years old is expected as mental health conditions are typically not diagnosed until school age. Females have a higher rate of mental health access of 70 per 1,000 population and is above the South East London average.



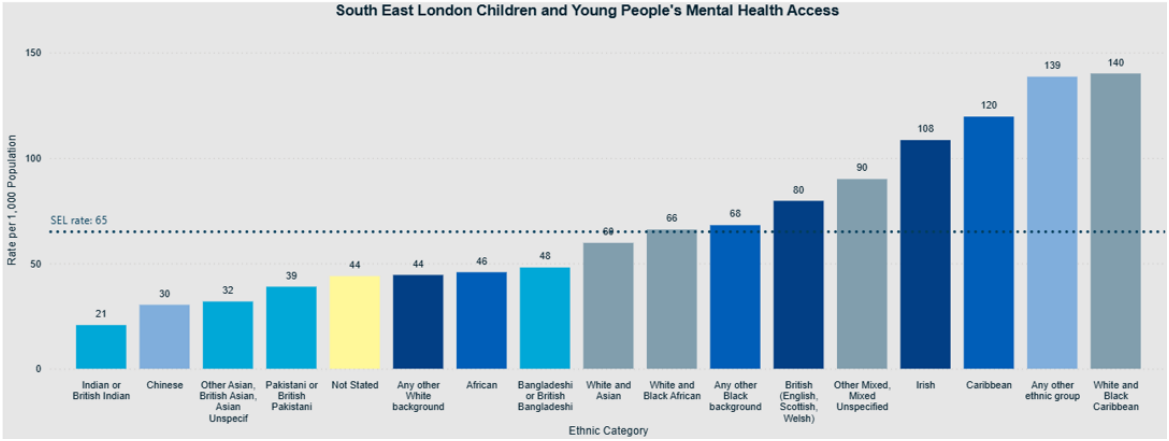


Looking at the ethnic profile, a variance is observed in access to mental health services. Those of Asian ethnicity have the lowest access rate of 30 per 1,000 population, when broken down further into subgroups, all those of Asian descent are below the South East London average, with those of Indian descent having the lowest rate of 21 per 1,000 population. Those of Other ethnicity have the highest access rate of 112 per 1,000 population, while those of Other ethnicity make-up 5% of the South

East London registered population aged 0-17, they make-up 9% of the CYP mental health caseload.

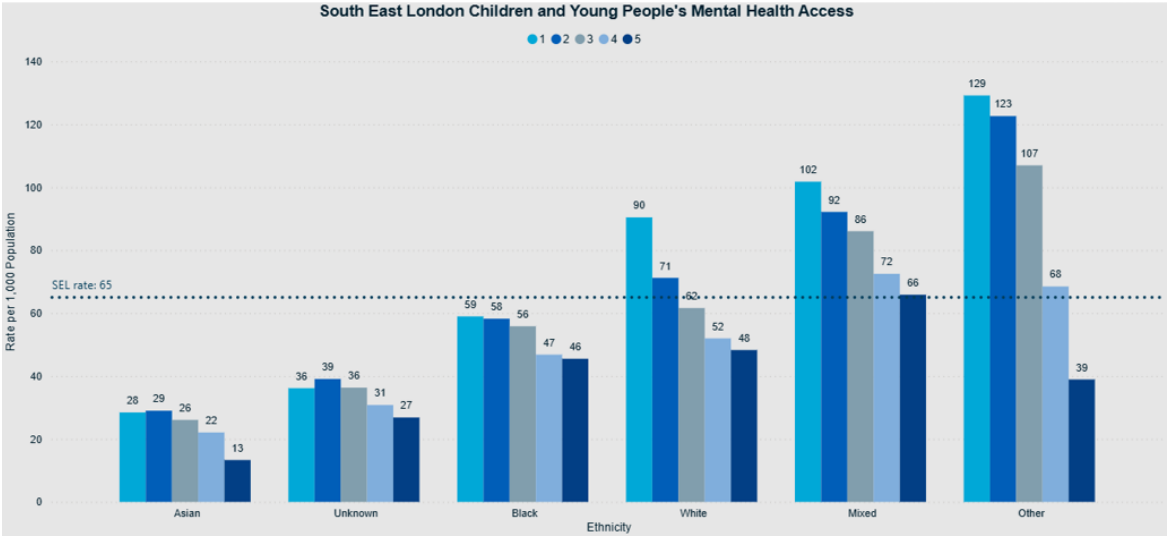
Those of Any other ethnicity have an access rate of over four times that of those of Chinese descent, indicating significant variation within ethnic groups. Those of Chinese descent are 1.3% of the South East London registered population aged 0-17 and 0.6% of CYP mental health caseload. Those of Any other ethnicity are 4% of South East London registered CYP population and 9% of caseload.

When the ethnic profile is broken down further into subgroups, further variance is observed. Those of Indian descent have the lowest rate of 21 per 1,000 population compared to those of White and Black Caribbean descent with the highest rate of 140 per 1,000 population. Those of Mixed ethnicity have a higher-than-average rate of access and make-up 15% of CYP patients on the mental health caseload in 2025/26 but only make-up 10% of the South East London CYP population in March 2026 according to primary care records. These differences can be possibly attributed to the difference in recording of ethnicity between MHSDS and primary care records. (**see Data Quality section for more information)**.

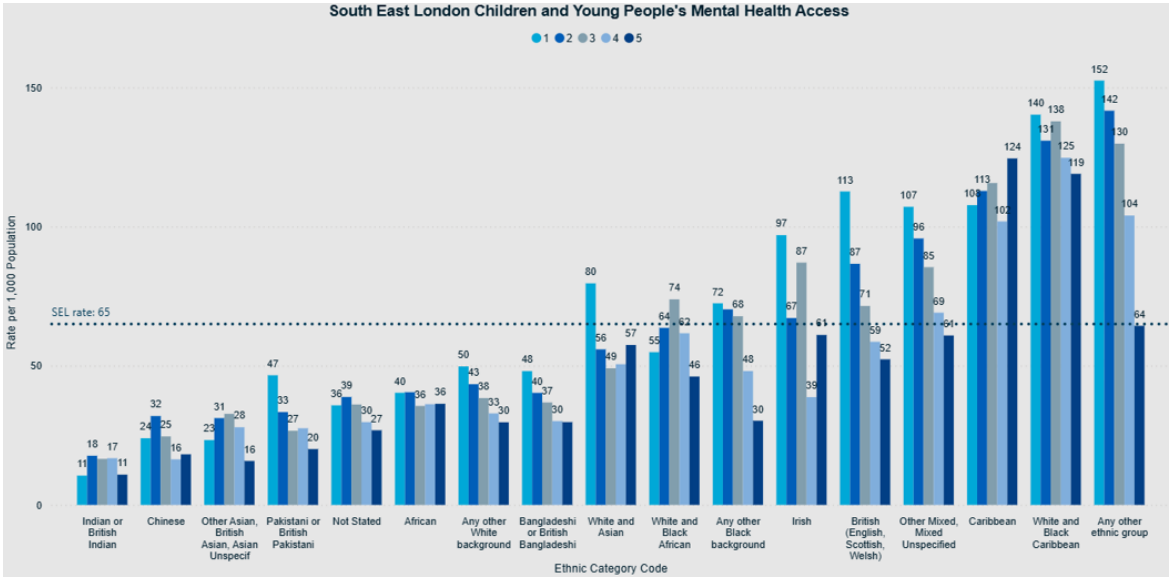


When looking at deprivation and ethnic profile, there is a clear correlation between access to mental health services and deprivation. Those in quintile 1 (most deprived) have an access rate of 71 per 1,000 population compared to those in quintile 5 (least deprived) of 41 per 1,000 population, which is well below the South East London average.

While the trend between access and deprivation is consistent across all ethnic groups i.e. higher rates of access in more deprived areas, the difference between the most and least deprived quintiles is largest for those of Other ethnicity. For those in quintiles 1,2 and 3 (most, next most and middle deprived) those of Other ethnicity have the highest access rate. Those of Mixed, White and Black ethnicity have higher access rates in quintile 5 (least deprived).



When the ethnic profile is broken down further by subgroups, access to mental health services by deprivation indicate slightly different trends. The difference between the most and least deprived quintiles is largest among those of Any other ethnicity. While most ethnic groups follow the trend of higher rates of access in more deprived areas, from the data observed this does not appear to be the same for all groups. Those of Caribbean descent show a different trend with the highest rate of access in quintile 5 (least deprived) 124 per 1,000 population.



8. Smoking Cessation

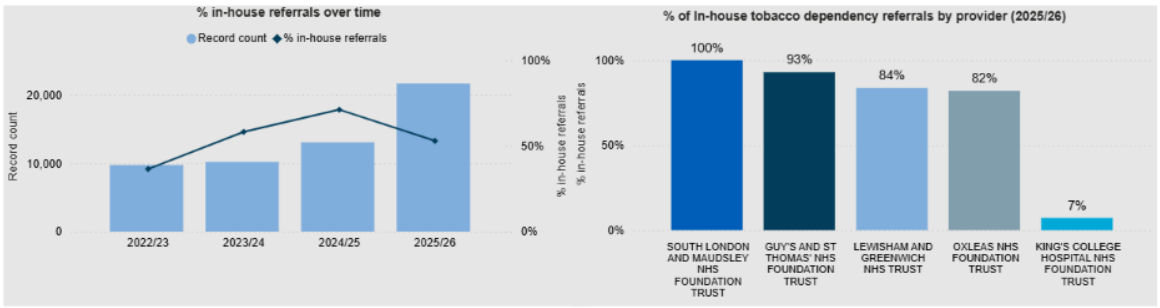
Overview: For those aged 45-84, females have a higher proportion of supported quit attempts, above the South East London average. More generally, those aged 55-74 have a higher proportion of supported quit attempts. Those within deciles 8, 9 and 10 (next least and least deprived) have a higher proportion of supported quit attempts which is above the South East London average. The percentage of supported quit attempts within deciles 1 to 5 (most, next most and middle deprived) varies, with some either slightly above or below the South East London average.

Activity Reporting Period: 2025 to 2026.
Data Source: Tobacco dependency dataset.

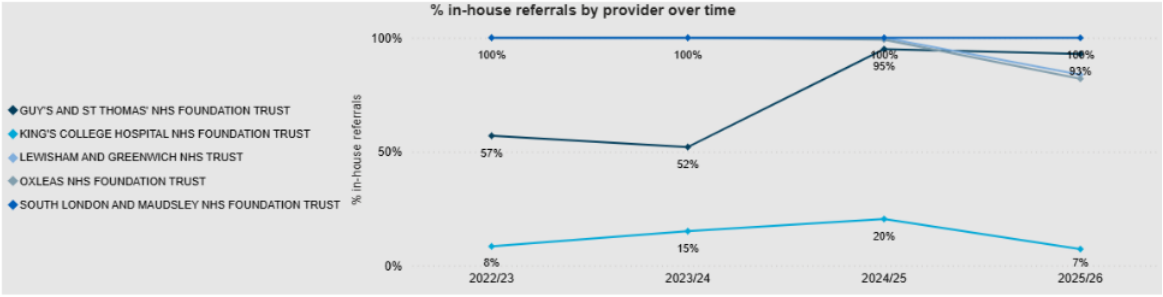
Referrals to in-house tobacco dependence treatment services made up 53% of referrals for South East London patients. This varies by provider, however, direct comparison should be approached with caution. The following should be considered as part of reviewing this data:

- The data reviewed looks at both mental and acute trusts which have different inpatient populations; different length of stay, smoking prevalence, and capacity to engage with a quit attempt.
- During the period this data covers, King's College Hospital NHS Foundation Trust experienced significantly reduced service (staffing) rather than a difference in referral practice or clinical need. This substantially reduced the number of patients the in-house service was able to see, which in turn limited the number of patients who could be referred and recorded as receiving an in-house referral.
- During this same period, at King's College Hospital NHS Foundation Trust, there were some EPIC-related reporting issues which affected the accuracy and completeness of referral data being captured.

Percentage of in-house referrals has fluctuated over the years. South London and Maudsley NHS Foundation Trust have a 100% referral rate. It is important to recognise the impact variation in tobacco dependence offering based on where a person has been admitted as an inpatient, can have on data analysis.



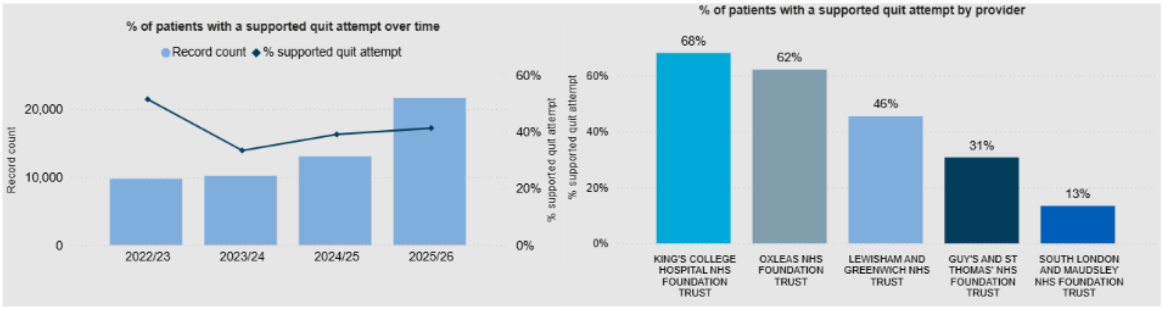
The number of records submitted to the tobacco dependency dataset have increased over time, this is to be expected as more tobacco dependency services have been established in recent years. South London and Maudsley have consistently had 100% in-house referrals over the last four year. There has been a significant improvement in the percentage of in-house referrals for Guy's and St Thomas' NHS Foundation Trust, with an increase of 40% since 2023/24. King's College Hospital NHS Foundation Trust remains the lowest.



A supported quit attempt is defined as a patient having one of the below care plans:

- Quit attempt with behavioural intervention and licensed medication.
- Quit attempt with behavioural intervention and nicotine containing vapes.
- Quit attempt with behavioural intervention and without pharmacotherapy.

41% of inpatients have a supported quit attempt with an in-house tobacco dependence treatment service in 2025/26. This varies significantly by provider, given King's College Hospital NHS Foundation Trust have the lowest percentage in-house referrals of 7%, their 68% of patients with a supported quit attempt is unsurprising. South London and Maudsley NHS Foundation Trust with in-house referrals of 100%, have 13% of patients with a supported quit attempt.



King's College Hospital NHS Foundation Trust and Oxleas NHS Foundation Trust have seen the greatest improvements in the percentage of patients with a supported quit attempt. Whilst King's College Hospital has the highest percentage of supported quit attempts, their in-house referral is very low due to the reasons detailed above

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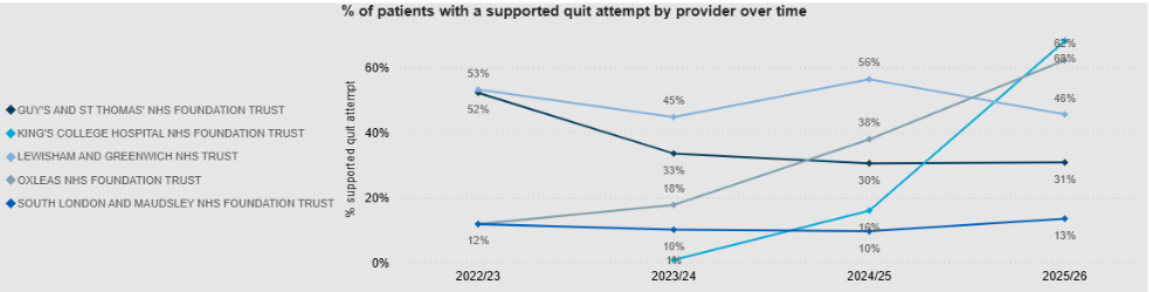
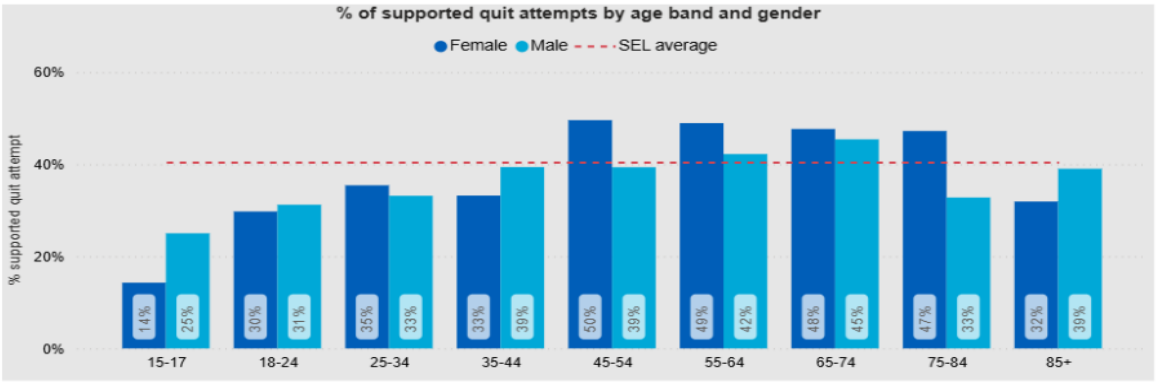
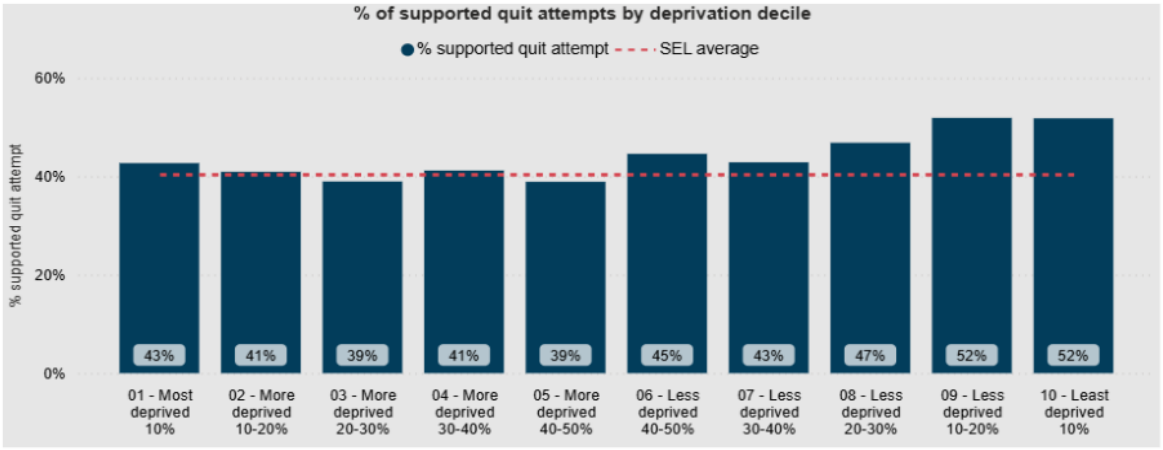


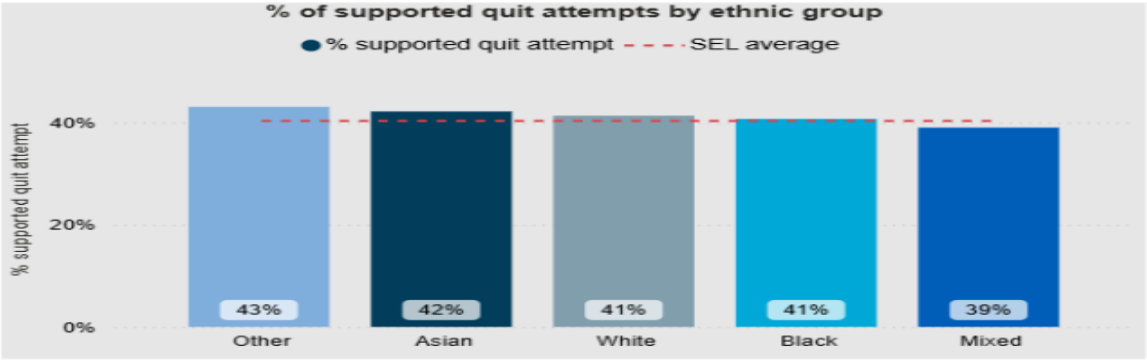
For those aged 45-84, females have a higher proportion of supported quit attempts, above the South East London average. More generally, those aged 55-74 have a higher proportion of supported quit attempts.



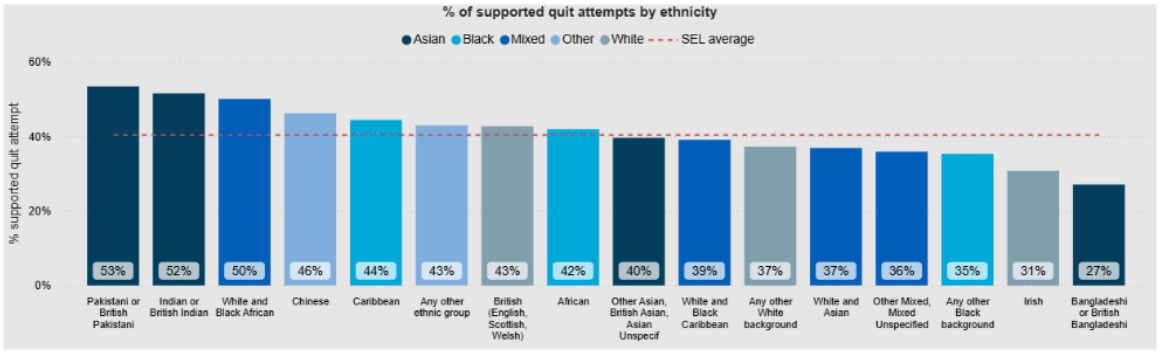
In general, those within deciles 8, 9 and 10 (next least and least deprived) have a higher proportion of supported quit attempts which is above the South East London average. The percentage of supported quit attempts within deciles 1 to 5 (most, next most and middle deprived) varies, with some either slightly above or below the South East London average.



Looking at the ethnic profile, there is little variation in the percentage of patients making a supported quit attempt.



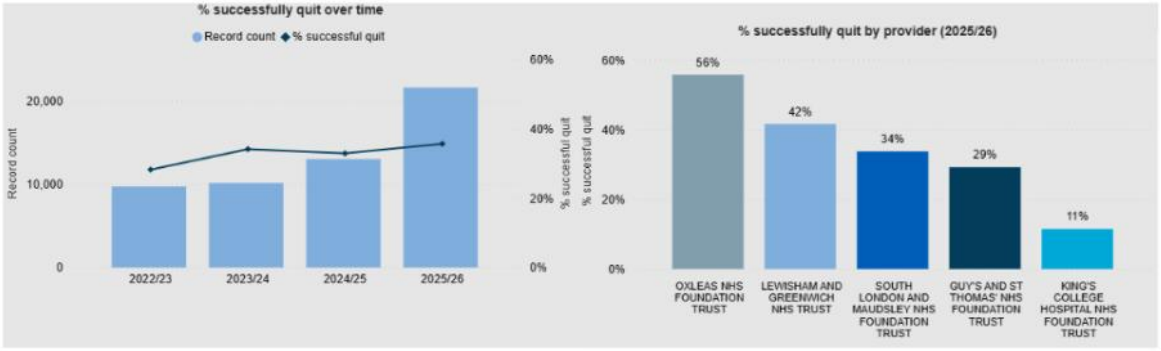
When the ethnic profile is broken down further into subgroups, a variance is observed. Within Asian ethnicity, those of Pakistani and Indian descent have the highest percentage of supported quit attempts, 53% and 52% respectively, this is nearly double that of those of Bangladeshi descent, with only 27% making a supported quit attempt. Similarly, within Mixed ethnicity, those of White and Black African descent have a higher supported quit attempt of 50%, in contrast all other Mixed ethnicities are below the South East London average. The only group that is above the South East London average is those of Other ethnicity.

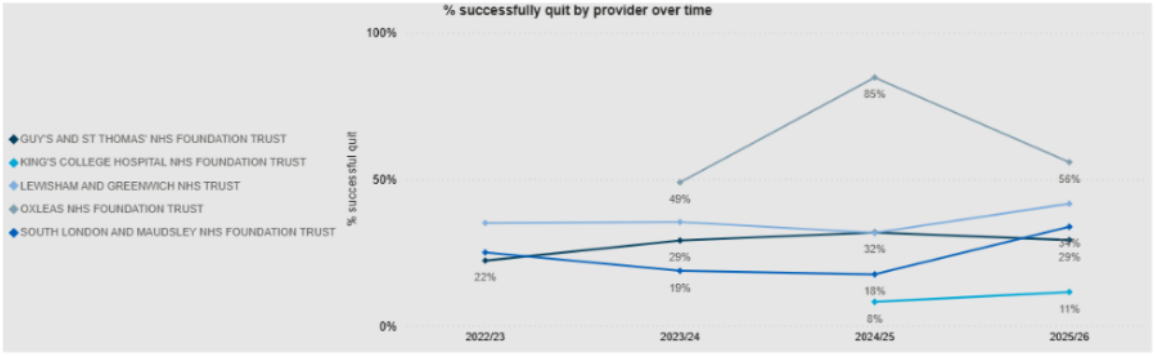


8.1 Inequalities in inpatients who successfully quit smoking as measured at 28 days after commencing a supported quit attempt

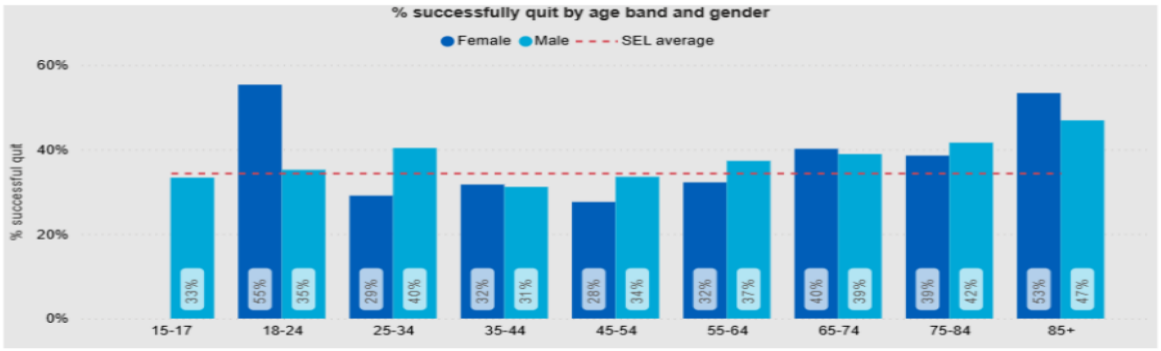
In 2025/26, of those patients seen by an in-house service with a supported quit attempt, 36% successfully quit. Success rate varies by provider, with Oxleas NHS Foundation Trust having the highest success rate of 56%. Oxleas NHS Foundation

Trust consistently has the highest percentage of successful quits in the last four years, although this figure fluctuates year on year.

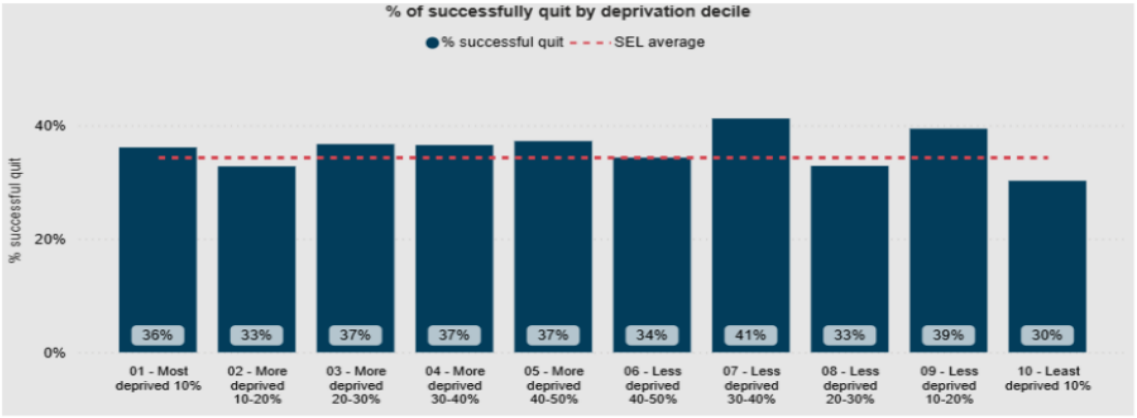




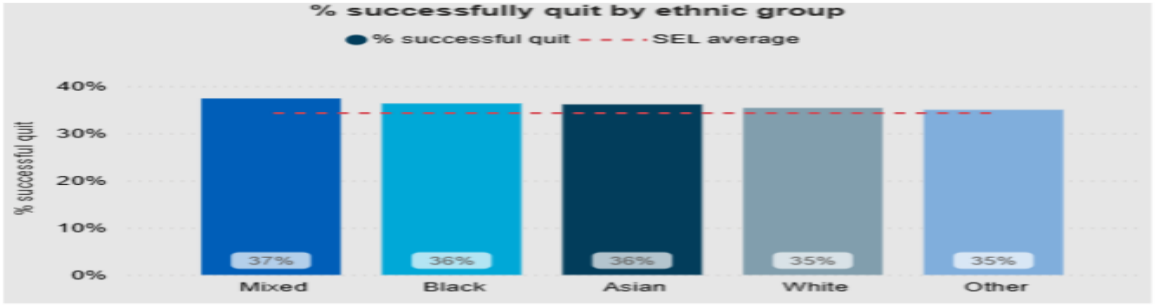
When compared to the rest of the population, females aged 18-24 and 85+ have a higher success rate. Some of the lowest success rates in both males and females are within those aged 35-54.



There is no clear correlation between deprivation and percentage of successful quits, with minimal variation observed in outcomes across all deciles.



Looking at the ethnic profile, there is minimal variation observed in outcomes across all deciles



When the ethnic profile is broken down further into subgroups, a variation is observed in success rates. It is important to note that the number of people with supported quit attempts in each ethnicity varies significantly, ethnicities with smaller population numbers should be interpreted with caution.

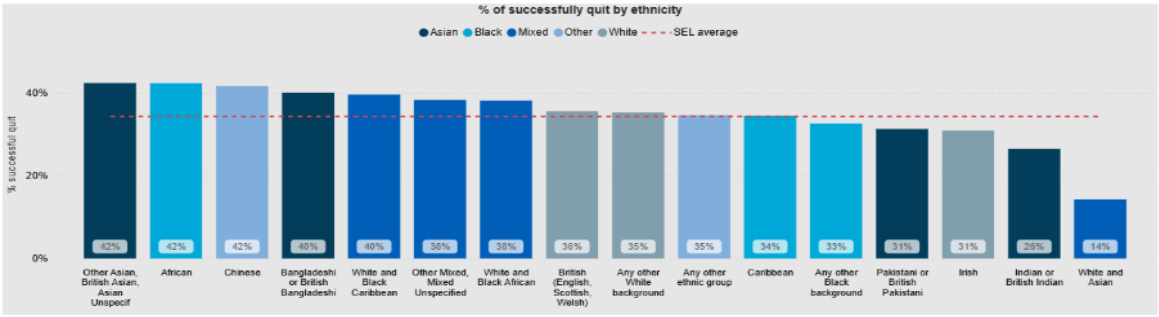
No ethnic group has a success rate above the South East London average. Within Asian ethnicity, those of Other Asian and Bangladeshi descent have some of the highest success rates, 42% and 40% respectively, compared to those of Pakistani and Indian descent who have some of lowest rates, 31% and 26% respectively. Those of Pakistani and Indian descent have the highest percentage of supported quit attempts, although collectively the total number of supported quit attempts is quite small. When looking at other possible outcomes, a large proportion of those of Indian and Pakistani descent are recorded as not quitting smoking.

UK research on smokers of Bangladeshi and Pakistani descent has consistently found that motivation to quit is often high, but attempts tend to rely on willpower alone rather than structured behavioural support or pharmacotherapy, with limited awareness of

how effective Nicotine replacement therapy (NRT) and other medications actually are (Bush et al., 2003[3]; White et al., 2006[4]).

A UK trial of community outreach workers for these groups found something very similar: outreach increased the number of Pakistani and Bangladeshi males taking up a quit attempt, but those who did try were somewhat less likely to succeed than people going through standard services (Begh et al., 2011a[5]). Hence, a higher attempt rate alongside a lower success rate is therefore not necessarily unsurprising.

The data shows those of Bangladeshi descent and those of White and Asian descent have a high percentage of lost to follow-up, this data should be treated with caution given the small numbers of total supported quit attempt (10 and 7 respectively).



	Total supported quit attempt	% successful quit	% not quit smoking	% lost to follow up
White and Asian	7	14.3%	42.9%	42.9%
Indian or British Indian	34	26.5%	41.2%	32.4%
Irish	55	30.9%	38.2%	30.9%
Pakistani or British Pakistani	16	31.3%	68.8%	
Any other Black background	172	32.6%	39.5%	27.9%
Caribbean	264	34.5%	39.8%	25.8%
Any other ethnic group	188	34.6%	35.6%	29.8%
Any other White background	352	35.2%	39.2%	25.6%
British (English, Scottish, Welsh)	1,994	35.6%	37.6%	26.9%
White and Black African	21	38.1%	38.1%	23.8%
Other Mixed, Mixed Unspecified	47	38.3%	38.3%	23.4%
White and Black Caribbean	48	39.6%	37.5%	22.9%
Bangladeshi or British Bangladeshi	10	40.0%	10.0%	50.0%
Chinese	12	41.7%	41.7%	16.7%
African	189	42.3%	33.3%	24.3%
Other Asian, British Asian, Asian Unspecif	59	42.4%	33.9%	23.7%

[3] Bush, J., White, M., Kai, J., Rankin, J. and Bhopal, R. (2003) Understanding influences on smoking in Bangladeshi and Pakistani adults: community based, qualitative study. *BMJ*, 326, pp.962–965.

[4] White, M., Bush, J., Kai, J., Bhopal, R. and Rankin, J. (2006) Quitting smoking and experience of smoking cessation interventions among UK Bangladeshi and Pakistani adults: the views of community members and health professionals. *Journal of Epidemiology and Community Health*, 60, pp.405–411.

[5] Begh, R.A., Aveyard, P., Upton, P., Bhopal, R.S., White, M., Amos, A., Prescott, R.J., Bedi, R., Barton, P., Fletcher, M., Gill, P., Zaidi, Q. and Sheikh, A. (2011a) Promoting smoking cessation in Pakistani and Bangladeshi men in the UK: pilot cluster randomised controlled trial of trained community outreach workers. *Trials*, 12, 197.

Improvement activity

• As part of the system sustainability funding, work is underway to expand the Ottawa Model (Ask, Advise, Act) across acute inpatient settings, in line with the NHS Long Term Plan commitment to offer tobacco dependence treatment to all inpatients who smoke. This means moving toward universal screening on admission, with every single patient screened and all patients identified as a smoker offered behavioural support from the in-house tobacco dependence team alongside pharmacotherapy. • Alongside this, the same funding stream has supported work to reduce variation in pharmacotherapy access across SEL, so that the treatment a patient receives no longer depends on which Trust or borough they attend. In practice, this means patients can expect to leave with up to six months of support which includes pharmacotherapy as a consistent offer across the system, rather than one that varies by location.	• To support continuity of care beyond discharge, patients are also referred to their local Stop Smoking Service (LSSS), so that behavioural support and access to pharmacotherapy continue in the community rather than ending when the inpatient episode does. • The inequality identified in the South East London data on the proportion of supported quit attempts being higher among least deprived patients (deciles 8-10), contrasts the general pattern seen nationally, where smoking cessation services tend to achieve greater reach among more deprived groups. This will inform more targeted Improvement activity to ensure that more deprived patients are being reached and supported.

9. Vaccinations

Overview: For both the two target groups for flu uptake and the three target group for COVID vaccination uptake, trends show a decline in uptake rates. Core20 (most deprived) population have a lower uptake rate compared to Non-Core20 population. Males generally have higher uptake rates across ethnic groups. Those of Black ethnicity consistently have lower uptake rates**.**

Activity Reporting Period: 2022 to 2026.
Data Source: Local - Primary Care Discovery, National - Fingertips | Public Health Profiles.

CEO: Andrew Bland
Chair: Sir Richard Douglas CB

9.1. Inequalities in uptake of COVID and flu vaccines

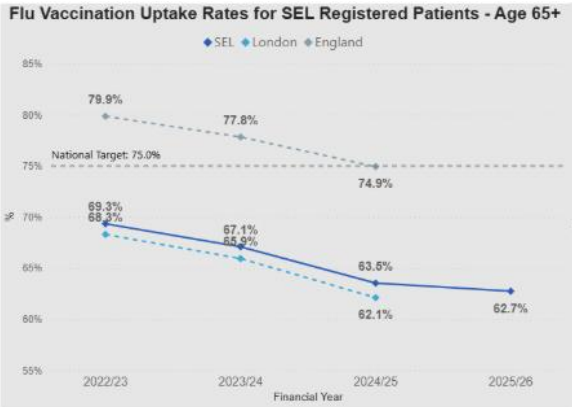
Flu Uptake Rates

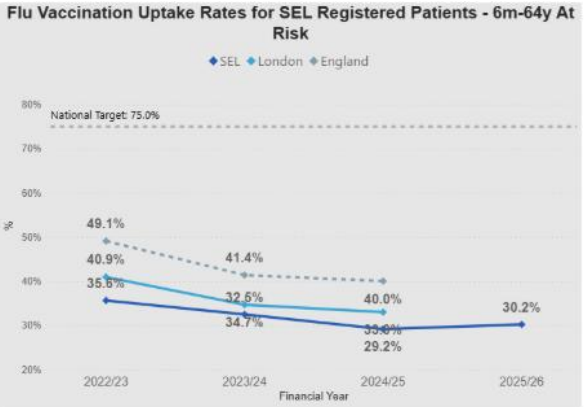
There are two target populations for flu vaccines:

1. 65+: all patients aged 65+.
2. 6m-64y At Risk: patients aged 6 months – 64 years old who meet one of the following at-risk criteria: chronic heart/kidney/liver/respiratory/ disease, asthma, diabetes and endocrine disorder, health and social care workers, asplenia of splenic dysfunction, CNS including significant learning disability, morbid obesity, severe mental illness, wider learning disability, living with immunosuppressed person, pregnancy, carer, homelessness.

For those aged 65+, flu vaccination rates have declined over the last four years in South East London, reaching a low of 62.7% in 2025/26. This decline in trend is also present at regional level, and London vaccination rates remain below the South East London average for this cohort. Although the latest national uptake rate is much closer to the NHS target of 75%, this has also declined over the years. This suggests that the reduction in vaccination rates in South East London is reflective of changing attitudes nationally.

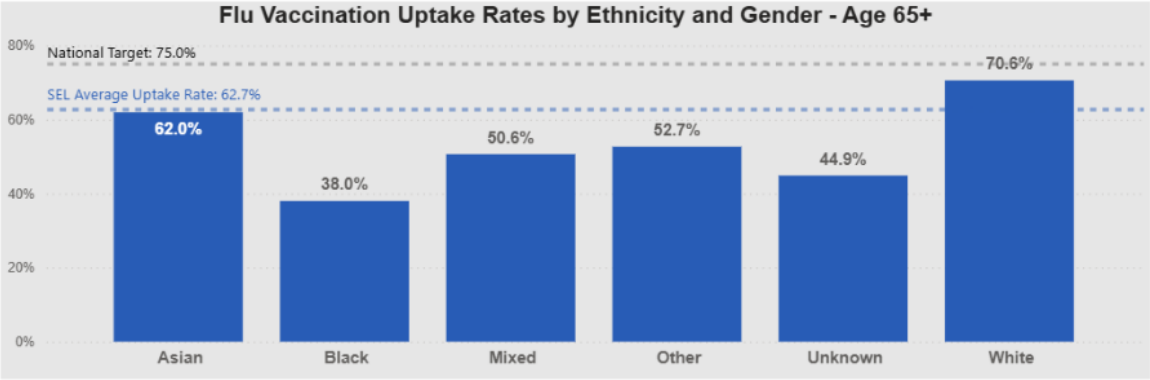
For those aged 6mth-64y at-risk, trends show a declining rate between 2022/23 and 2024/25 at South East London, London and national level. South East London rates remained below both London and national levels. However, there has been a slight increase in the 2025/26 figure for South East London registered patients. It should be noted that data for London and national levels is not available for this financial year, therefore, it is unclear whether this increase is also present at these levels.

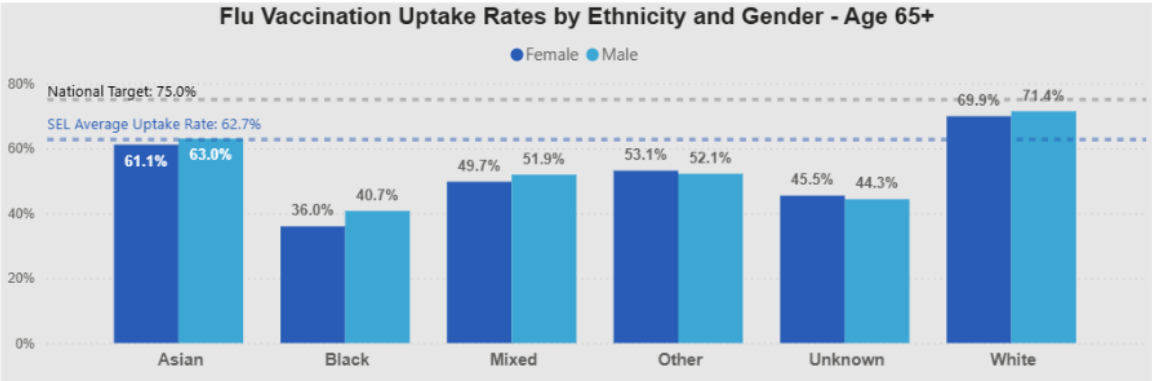




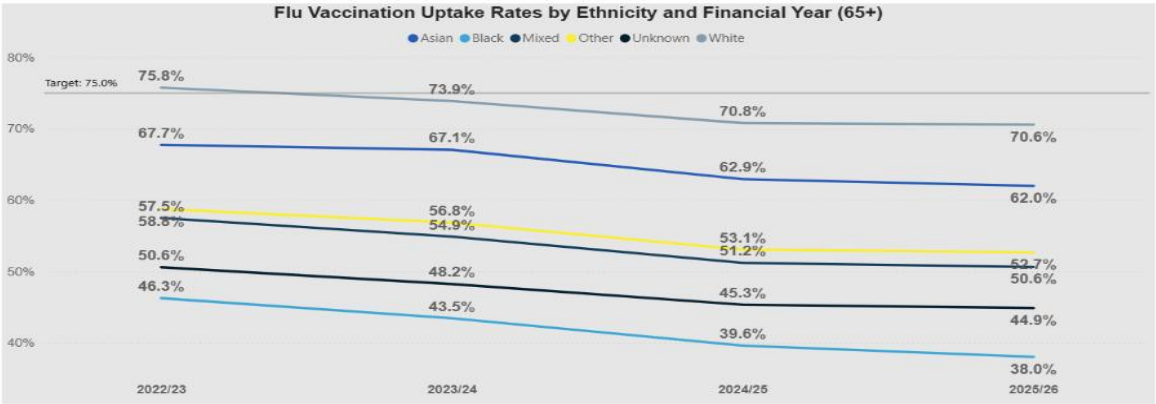
Looking at the ethnic and gender profile for the 65+ cohort, those of White ethnicity have the highest uptake rate of 71% which is 8% above the South East London average. Those of Asian ethnicity have the next highest rate of 62%, which is within 1% of the South East London average. Males generally have a higher uptake rate across ethnic groups. Those of Black ethnicity have a larger difference in uptake rate

between males and females of 4.7% and are the only ethnic group with the lowest overall rate.

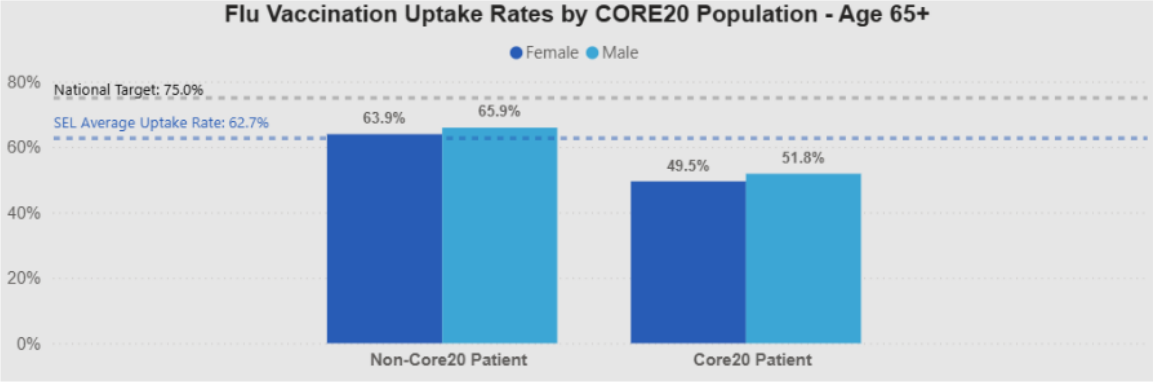




Looking at the ethnic profile over financial years, flu vaccination uptake rates have followed the same trend for the last four years. Despite the overall decline in trend, those of White ethnicity and Asian ethnicity consistently have the highest uptake rates, whilst those of Black ethnicity and Mixed ethnicity consistently have the lowest uptake rates. The rate of decline between ethnic groups is also relatively consistent, with a ~6% decline from the 2022/23 to 2025/26 rate observed in all ethnic groups except those of Black ethnicity and Mixed ethnicity which is slightly higher at 8%.



There is a clear correlation between uptake rates and deprivation. The uptake rate for Core20 (most deprived) population is 13.1% lower than Non-Core20 population and 10.4% lower than the South East London average. Looking at the gender prolife, a difference in uptake rates is observed for both Core20 and Non-Core20 population, with females having a lower uptake rate.

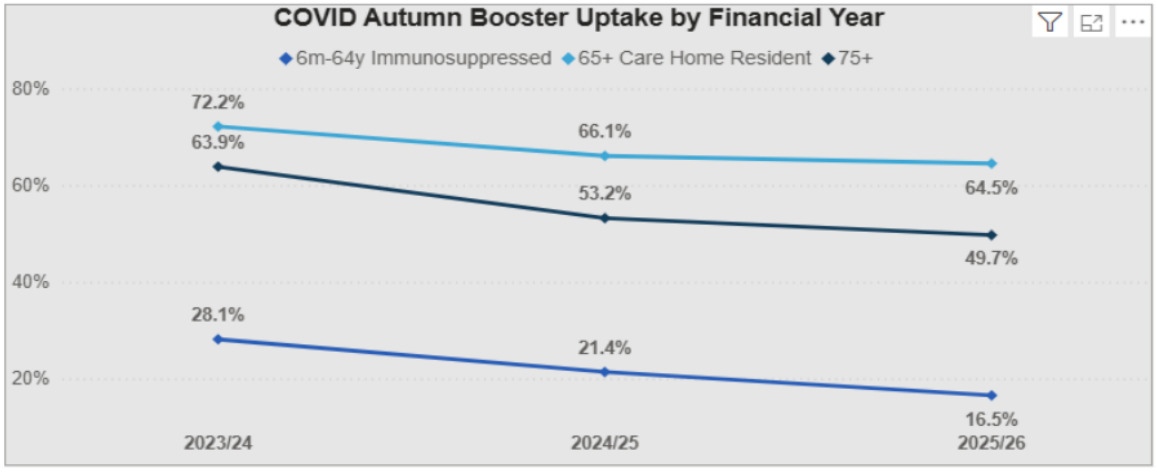


COVID Vaccination Uptake Rates

There are 3 target cohorts for COVID vaccinations:

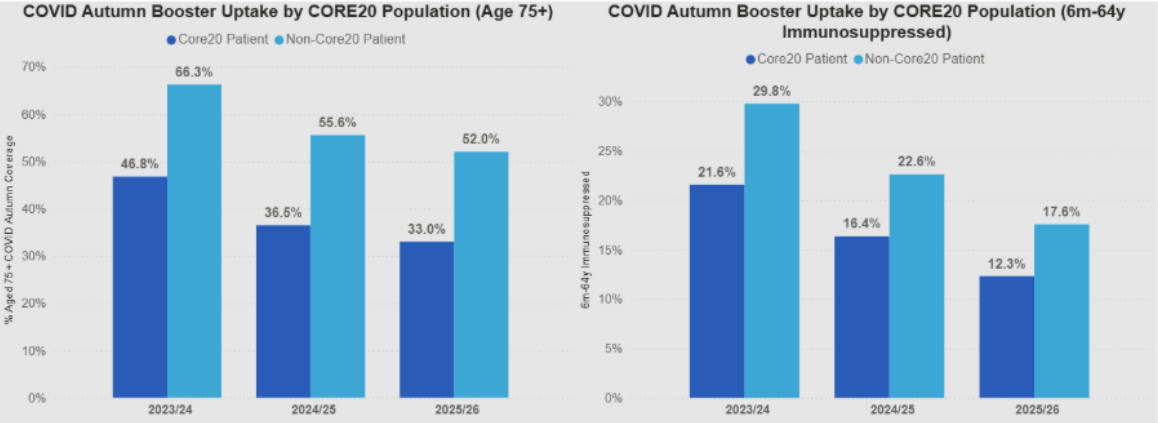
1. 6m-64y Immunosuppressed: patients aged 6 months - 64 years old and immunosuppressed.
2. Care Home Residents: patients aged 65 and above living in a care home.
3. 75+: all patients aged 75 and above.

Across all three target groups, a decline in trend is observed in uptake of COVID autumn boosters from financial years 2023/24 to 2025/26. For 2025/26, the uptake rate is as follows: 6m-64y immunosuppressed (17%), 75+ patients (50%) and care home residents aged 65+ (65%).



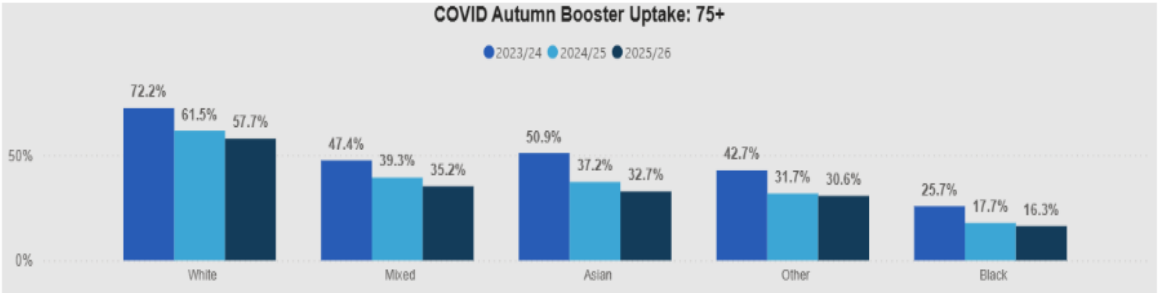
Across all years, Core20 (most deprived) population have a lower uptake rate compared to Non-Core20 population. For those aged 75+ there has been a year-on-year decline in rate, however, the difference between Core20 and Non-Core20 population has remained consistent around 19%. This indicates that whilst Core20 status impacts uptake rate, other factors contribute to the general reduction in overall uptake for both Core20 and Non-Core20 population.

A similar pattern is observed for those aged 6m-64y immunosuppressed. However, the rate difference between Core20 (most deprived) and Non-Core20 population has reduced over time. In 2023/24, uptake booster rate for Core20 population was 8.2% lower than Non-Core20 population. By 2025/26, this difference reduced to 5.3%. The data indicates a faster decline in uptake rate within Non-Core20 population, in comparison to Core20 population

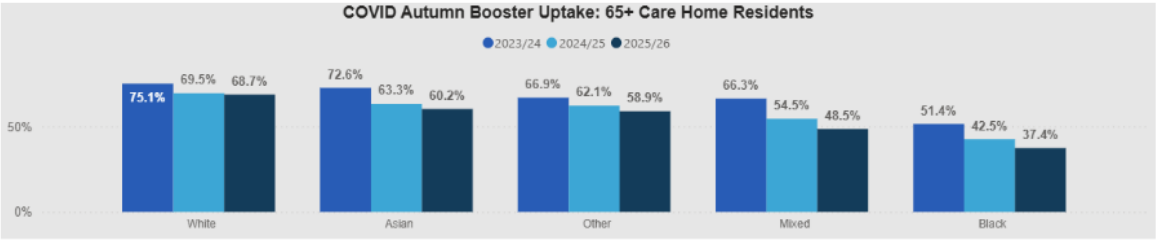


Looking at the ethnic profile for 75+, booster uptake rates differ significantly. In 2025/26, those of White ethnicity and Mixed ethnicity have the highest rates (57.7% and 35.2% respectively). Those of Black ethnicity have the lowest rate of 16%, this is less than half the rate of the next highest ethnic group and 41% below the rate for those of White ethnicity, the data indicates that uptake rate for those of Black ethnicity is significantly low.

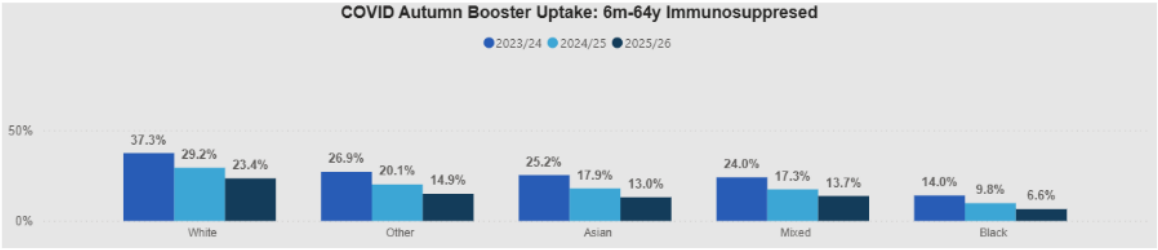
Though booster uptake rates have declined across the years for all ethnic groups, the degrees of decline differ. In 2023/24, those of Asian ethnicity had the second highest rate within all ethnic group of 50.9% and by 2025/26, this rate reduced by 18%, the highest reduction within all groups. Those of White ethnicity had the highest uptake rate of 72% in 2023/24 this rate reduced by 14% in 2025/26 but remains the highest uptake rate. Those of Black ethnicity have the smallest rate reduction between these years 9% which based on the data observed could be due to the small uptake rate to begin with.



Looking at the ethnic profile for 65+ care home residents, a decline in uptake rates is observed among all ethnic groups, although at varying degrees. In 2025/26, those of White ethnicity have the highest rate of 69% and the lowest reduction between the 2023/24 and 2025/26 of -6%. Those of Mixed ethnicity have the largest reduction of 18% among all ethnic groups. Similarly to the 75+ cohort, those of Black ethnicity have the lowest booster uptake rate of 37% in 2025/26, this is 27% below the South East London average for this cohort and 31% below those of White ethnicity.



Booster uptake rate for those aged 6m-64y immunosuppressed remains the lowest amongst the three groups. In comparison to the 75+ and 65+ care home residents, year-on-year reduction in uptake rate is less varied, reducing the likelihood of ethnicity being a driving factor in the trend over time.



Improvement activity

• **Bexley** targeted underserved communities and older adults through the Bexley Wellbeing Partnership and local engagement events. • **Bromley** focused on people with learning disabilities (LD), severe mental illness (SMI), people experiencing homelessness and pregnant women. • **Southwark** targeted refugees, asylum seekers, global majority community and residents in deprived areas. • **Lambeth** focused on deprived and ethnically diverse communities with lower uptake. • **Greenwich** and **Southwark** strengthened call/recall systems and used immunisation dashboards to identify and address uptake gaps. **Improving Access** • **Bexley, Lambeth** and **Lewisham** implemented measures to reduce barriers associated with digital exclusion, language and accessibility. • **Bromley** established local maternity vaccination clinics. • **Bromley** and **Greenwich** delivered targeted vaccination opportunities for people experiencing homelessness.	**Community Engagement** • **Lewisham** commissioned Voluntary, Community, Faith, and Social Enterprise (VCSFE) organisations to undertake culturally appropriate engagement with older adults experiencing health inequalities. • **Lambeth** partnered with faith groups, SEND forums and Black motherhood networks. • **Southwark** worked with community organisations and faith leaders to improve vaccine confidence. • **Bexley** utilised Community Champions and local networks to support campaign delivery.

10. Cancer

Overview: The proportion of cancers diagnosed at stage 1 and 2 (early) has steadily increased in the last four financial years – a trend which is also observed at a national level. In 2022/23, the proportion for South East London was slightly below the national level and recent figures for 2025/26 show that this is now 3% above. Data indicates significant inequalities associated with deprivation and ethnicity.

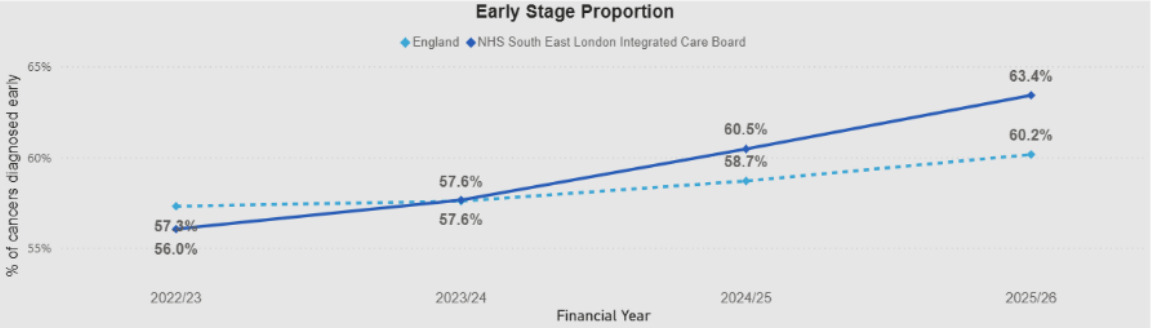
Activity Reporting Period: 2022 to 2026.
Data Source: Rapid Cancer Registration Data: Incidence and treatment dashboard, Local - Primary Care Discovery.

10.1. Inequalities in percentage of cancers diagnosed at stage 1 and 2

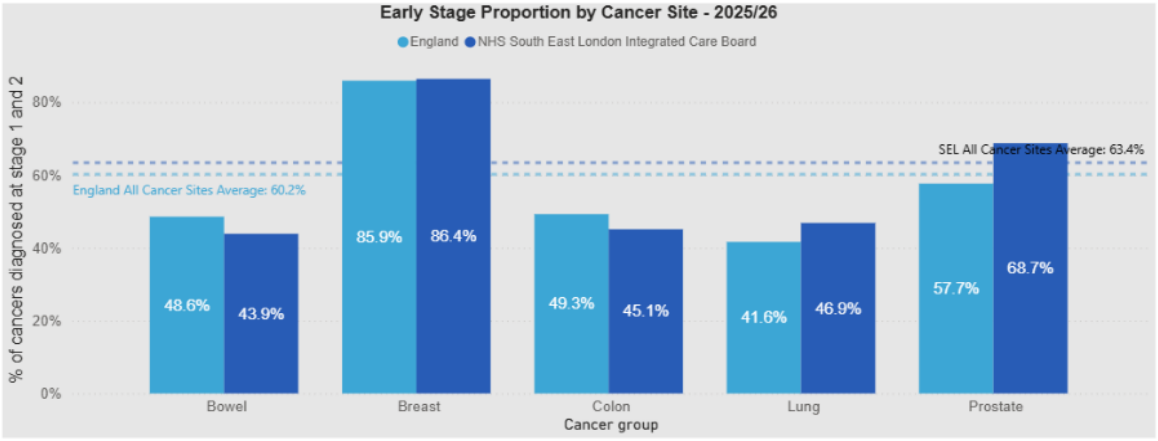
The cancer groups selected in this analysis were chosen because they are part of national screening programmes and/or have the highest prevalence rates.

Overview - Local and National Benchmarking

The proportion of cancers diagnosed at stage 1 and 2 (early) has steadily increased in the last four financial years – a trend which is also observed at a national level. In 2022/23, the proportion for South East London was slightly below the national level and recent figures for 2025/26 show that this is now 3% above.



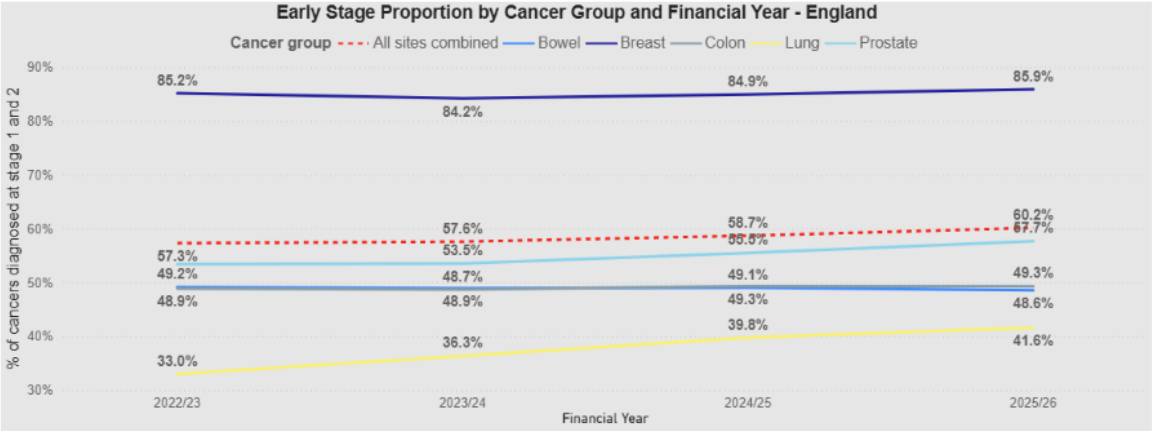
For 2025/26, the proportion of cancers diagnosed early differs by cancer site, as does the range between the national and South East London levels. For Breast cancer, the proportion is higher than all cancer-sites average at both South East London and national levels (86.4% and 85.9% respectively). For Prostate cancer, the proportion of 68.7% is higher than all cancer sites average for South East London only.



Bowel, Colon and Lung cancer, proportions remain below all cancer sites average at both South East London and national levels. South East London proportions for Bowel cancer of 43.9% and Colon cancer of 45.1% are below national levels by (4.7% and

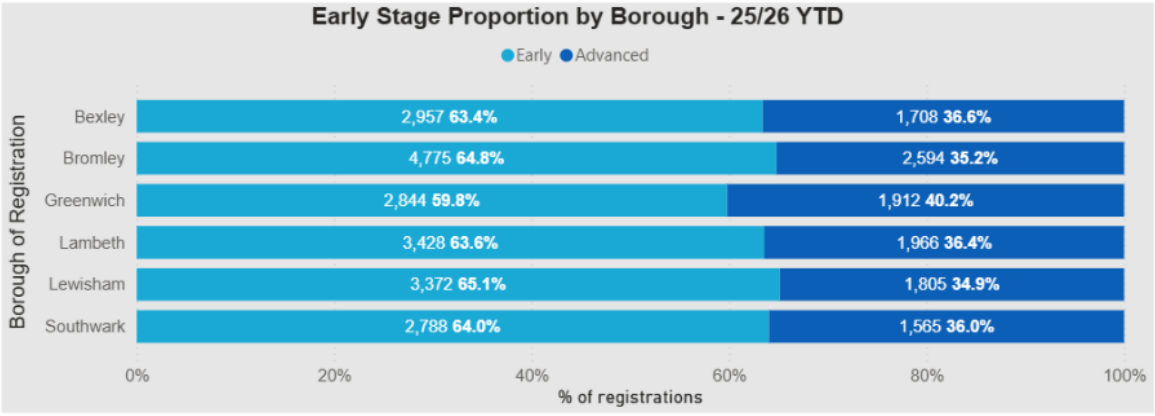
4.2%, respectively). The opposite is observed for Lung cancer of 46.9% which is 5.3% above the national level.

Early diagnosis rates for Breast and Prostate cancer remain above the South East London average for the last four years. Since 2022/23, early diagnosis rates have steadily increased for Breast cancer by 11% and Prostate cancer by 7%. Conversely, rates for Bowel and Colon cancer have not improved in the last four years, remaining below the South East London average. Despite early diagnosis rates for Lung cancer being the lowest of all cancer sites in 2022/23 of 33%, the 2025/26 rate is 13% higher, demonstrating a significant increase and improvement in early diagnosis.



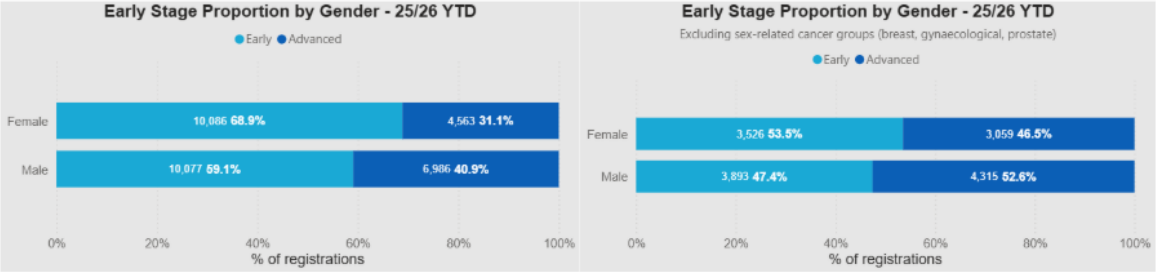
Demographic Comparison

The early-stage diagnosis proportion between South East London boroughs range by 5% with Lewisham and Bromley the highest at 65% and Greenwich the lowest at 60%.

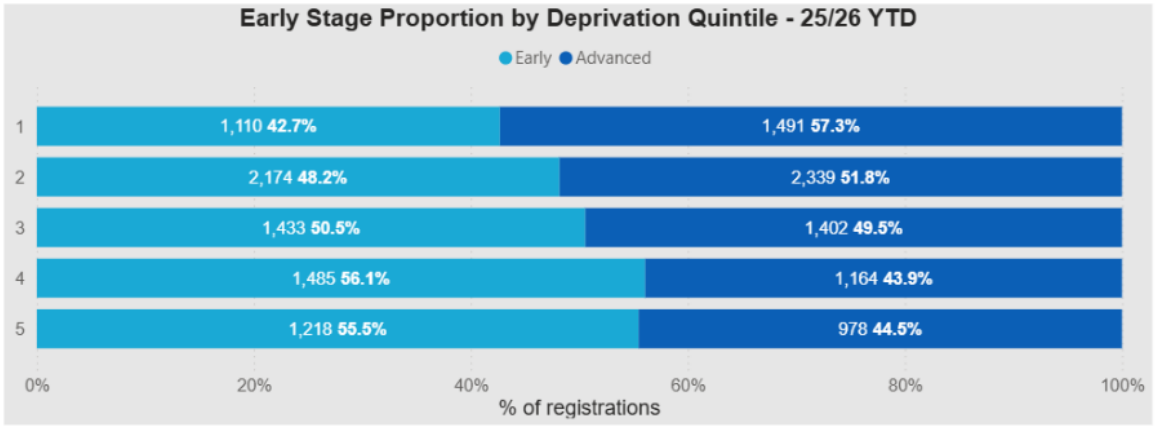


For all cancer groups, there is a large gender difference in the proportion of early cancer diagnoses, with 69% of females diagnosed earlier than 59% of males, a 10% difference. It is however observed that this difference is largely driven by sex-related

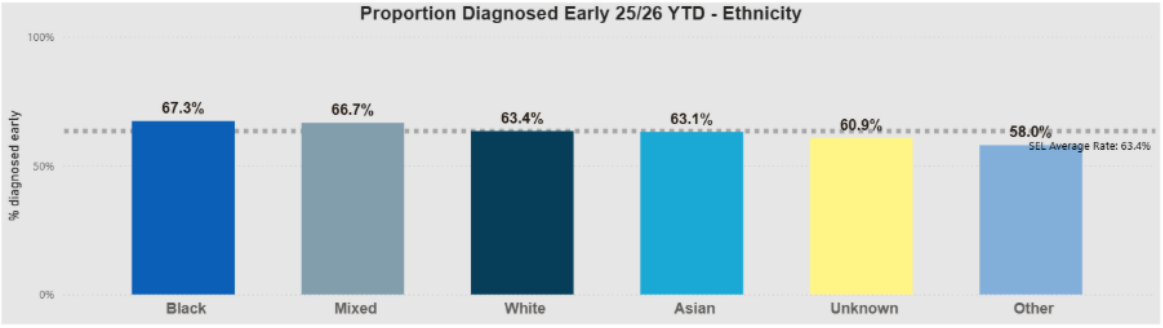
cancer sites such as prostate and breast. When these sex-related cancer sites are removed from analysis, the gender difference, though till present, is lower at 6%.



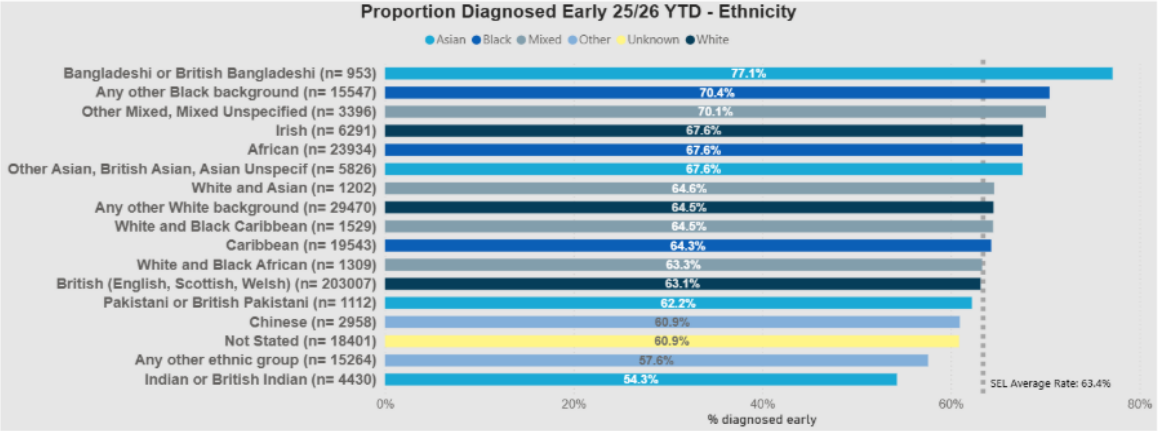
There is a clear correlation between early diagnosis rate and deprivation. Core20 population in quintile 1 (most deprived) have the lowest rate of early diagnosis of 42.4%. This is 14% below the rate of those in quintile 4 (second least deprived) and 12% below the South East London average.



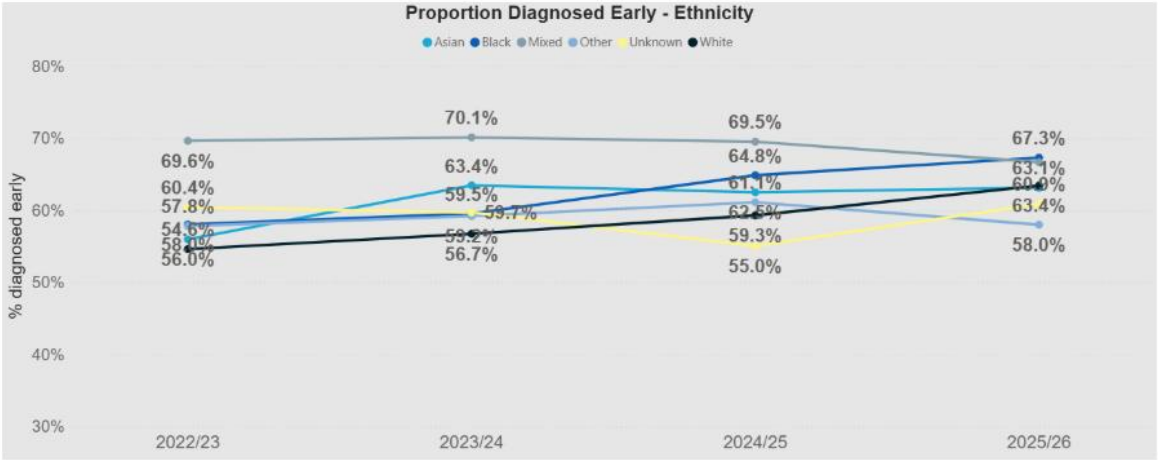
Looking at the ethnic profile, those of Black ethnicity have the highest rate of early diagnosis of 68%, followed by those of Mixed ethnicity of 66%, both above the South East London average. There is a large disparity between groups, with those of Other ethnicity having an early diagnosis rate of 58% a gap of around 9% compared to those of Black ethnicity.



When the ethnic profile is broken down further by subgroups, a variance is observed in early diagnosis rates. The high early diagnosis rates seen in those of Black ethnicity is mainly driven by those of Black Other descent at 71%, this rate is 6% higher than those of Black Caribbean descent. Similarly, for those of Asian ethnicity, those of Bangladeshi descent at 78% have the highest rate of all ethnic groups, and those of Indian descent at 54% have the lowest rate of all ethnic groups.



A shift in early diagnosis rates based on ethnic profile is observed. For those of Black ethnicity, the rate has steadily risen from 58% in 2022/23 to 68% in 2025/26. This 9% increase is the highest amongst all ethnic groups and is the same as those of White ethnicity. Despite having the highest early diagnosis rate in 2022/23 of 70%, those of Mixed ethnicity are the only group whose rates have declined over the years and is 3% lower in 2025/26. However, they remain the second highest amongst the groups. Overall, the gap in early diagnosis rates between ethnic groups has reduced over time, due to increases amongst most groups.



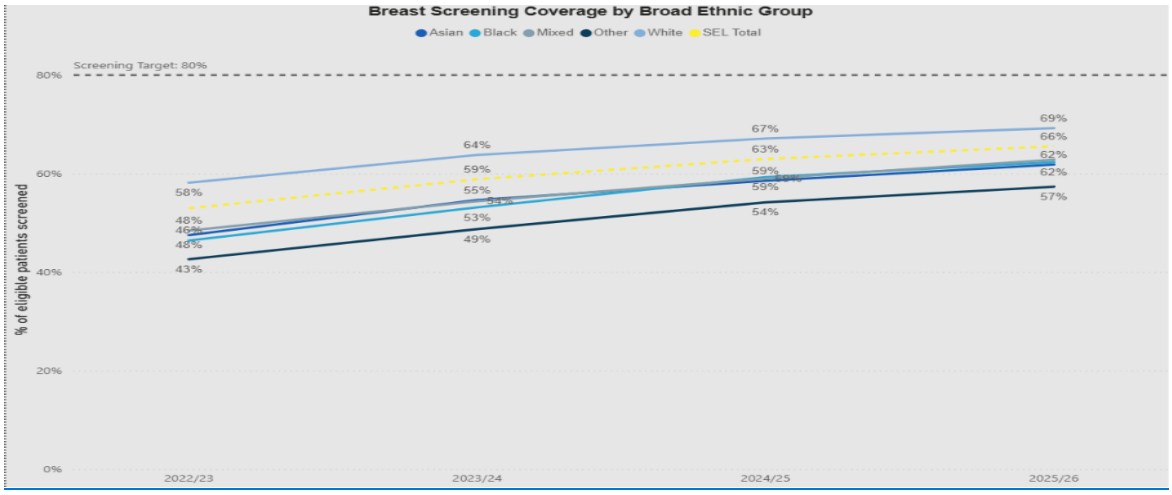
10.2. Inequalities in cancer screening coverage – including bowel cancer, breast cancer, cervical screening

Caveats:
The moving period for inclusion in the numerator means that historic data covers the COVID pandemic which will affect historic coverage rates. E.g., someone who is in the numerator of 2022/23 for breast screening, they may have been offered a cancer screening in 2020, as someone aged 50 to 70 should have a breast screening every three years, so we would expect coverage to be lower in 2022/23 compared to later years. The dataset uses the latest available month (March) for each financial year.

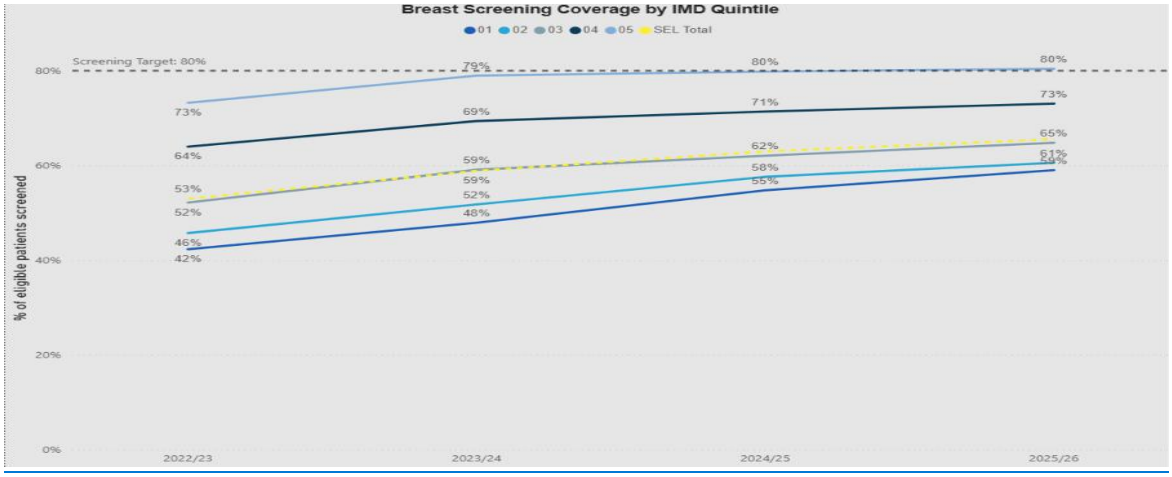
Breast Screening

Women aged 50-71 years old will be invited to a breast screening (mammogram). They can help identify cancers in the breast that are too small to feel or see.

Looking at the ethnic profile, breast screening coverage is increasing every year. Those of White ethnicity have the highest coverage in all financial years of 58% in 2022/23, an 11% increase to 69% in 2025/26. Those of Mixed, Asian and Black ethnicity are closely clustered throughout the four-year period. The national screening target of 80% has not been met within any of the ethnic groups in any years. The difference between the highest and lowest coverage rates in 2022/23 is 16%, and in 2025/26 is 12%, indicating a small narrowing of inequality in screening rates where ethnicity is considered.



There is a clear correlation between coverage rates and deprivation. Those in quintile 5 (least deprived) have the highest coverage of 80% in 2025/26 and those in quintile 1 (most deprived) have the lowest coverage of 59% in the same year. Although a gap remains between both groups, the range has decreased since 2022/23, from 31% to 21% in 2025/26.



When the ethnic profile is broken down further into subgroups and deprivation, a higher screening coverage is observed in quintiles 4 and 5 (next least and least deprived). Those of Bangladeshi descent have a lower than average coverage across all deprivation quintiles. The data indicates a strong correlation between deprivation and ethnicity and its impact on breast screening coverage.

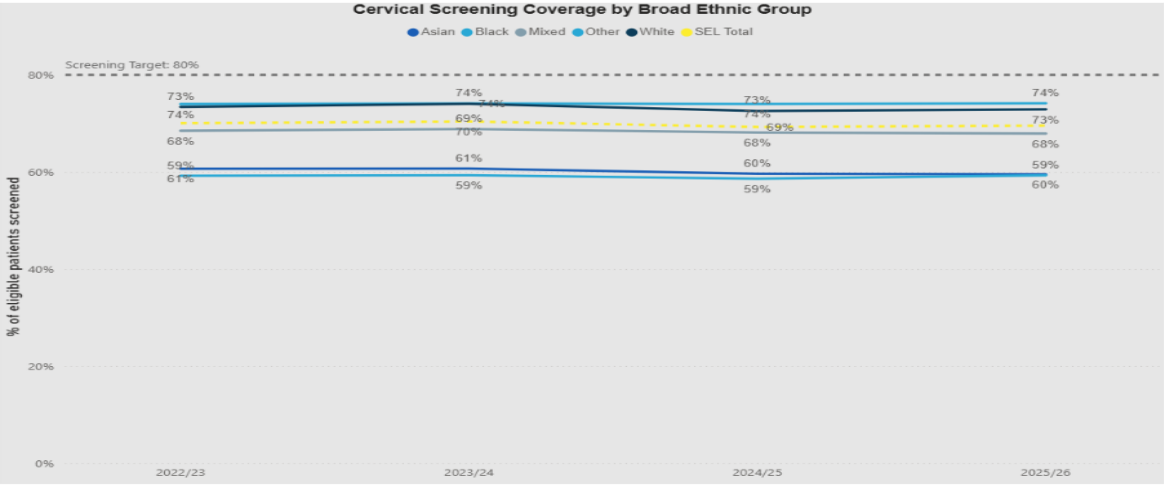
Ethnic Group & IMD Quintile	01	02	03	04	05
African	59.6%	60.2%	61.9%	65.9%	72.9%
Any other Asian background	59.2%	60.5%	59.0%	67.2%	73.1%
Any other Black background	60.0%	59.4%	63.6%	67.4%	73.6%
Any other ethnic group	52.7%	53.1%	55.2%	57.4%	70.6%
Any other mixed background	58.2%	56.0%	64.6%	68.6%	80.6%
Any other White background	54.3%	55.1%	57.7%	63.1%	70.7%
Bangladeshi	51.2%	53.1%	63.2%	62.2%	64.0%
Caribbean	63.8%	64.0%	64.7%	74.4%	79.8%
Chinese	59.2%	62.3%	58.1%	64.1%	73.0%
Indian	60.3%	56.8%	64.0%	68.0%	72.3%
Irish	60.6%	54.8%	66.1%	72.3%	81.1%
Pakistani	53.2%	48.7%	57.9%	54.1%	68.1%
White and Asian	53.1%	64.5%	61.4%	67.7%	80.5%
White and Black African	55.4%	59.9%	70.3%	73.8%	77.3%
White and Black Caribbean	60.5%	56.7%	62.5%	70.6%	77.3%
White British	61.6%	65.7%	70.7%	78.5%	83.8%

Cervical Screening

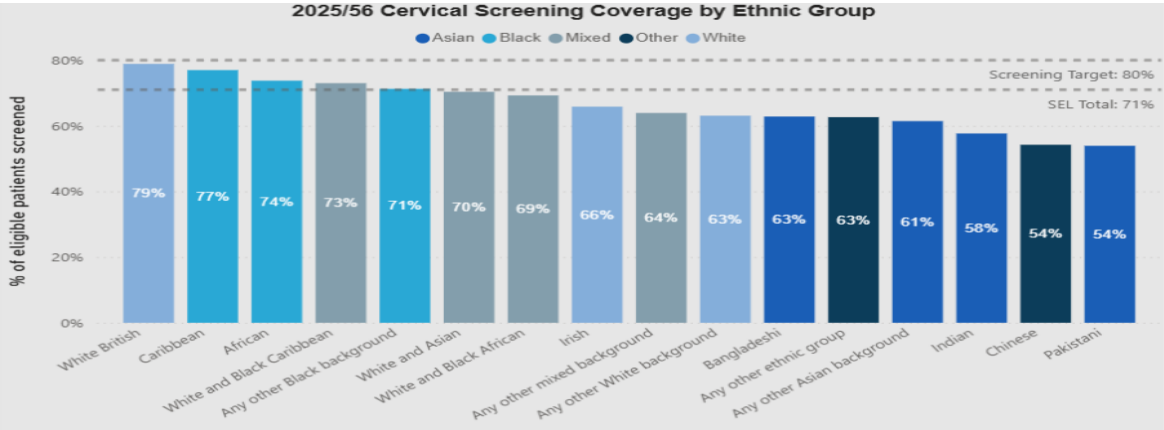
All women aged 25-64 years old are invited to cervical screening tests. The screening checks the health of the cervix and screens for HPV, as a means of preventing cancer, rather than detecting cancer.

Cervical screening coverage has remained stable over the last four financial years. Those of White and Black ethnicity are closely clustered as the two groups with the highest coverage. Those of Asian ethnicity have the lowest coverage in all financial years and have the most decrease in coverage, a relative decrease of 1.6%. The

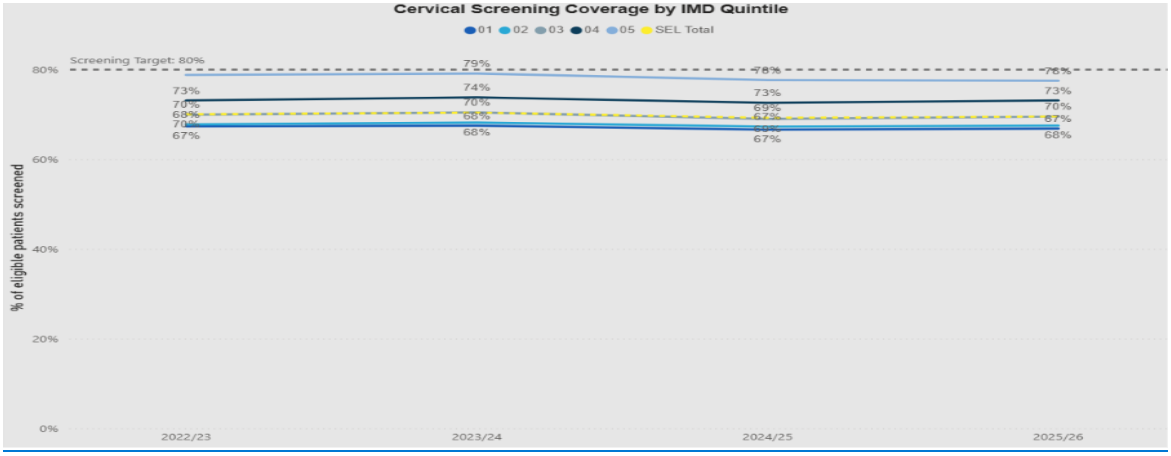
national screening target of 80% has not been met within any of the ethnic groups in any years.



Looking at the ethnic profile, those of White ethnicity have the highest coverage of 79%, although there is a large disparity within this group. Those of Irish and Any other White descent have a screening coverage over 10% lower than those of White British descent. Those of Black ethnicity are the only group who are either on or above the South East London average. In contrast, those of Asian and Other ethnicity are below the South East London average and have the lowest coverage.



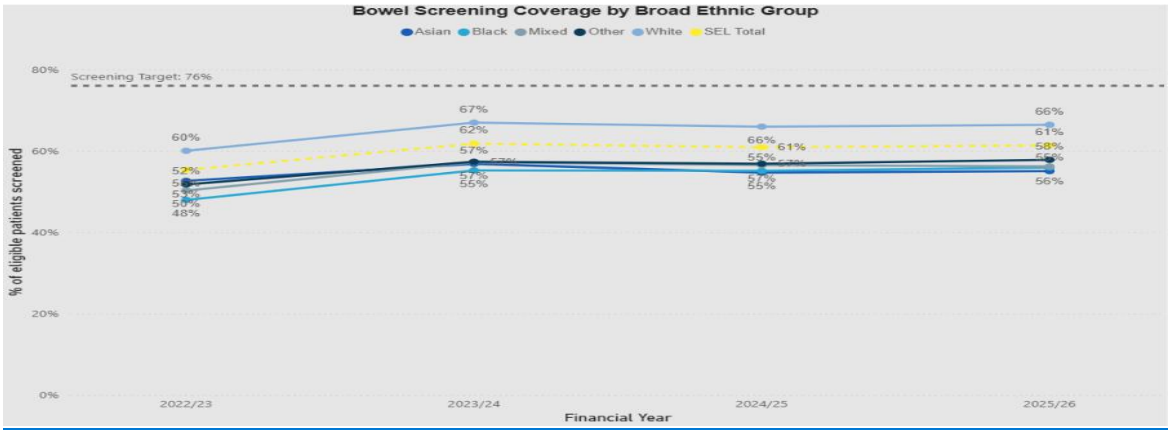
When the ethnic profile is broken down further by deprivation those in quintile 5 (least deprived) have a higher screening coverage of 78% in 2025/26 and those in quintile 1 (most deprived) have the lowest coverage of 67% for the same period. The disparity between the most and least deprived has decreased minimally over the four-year period from 12% to 11%.



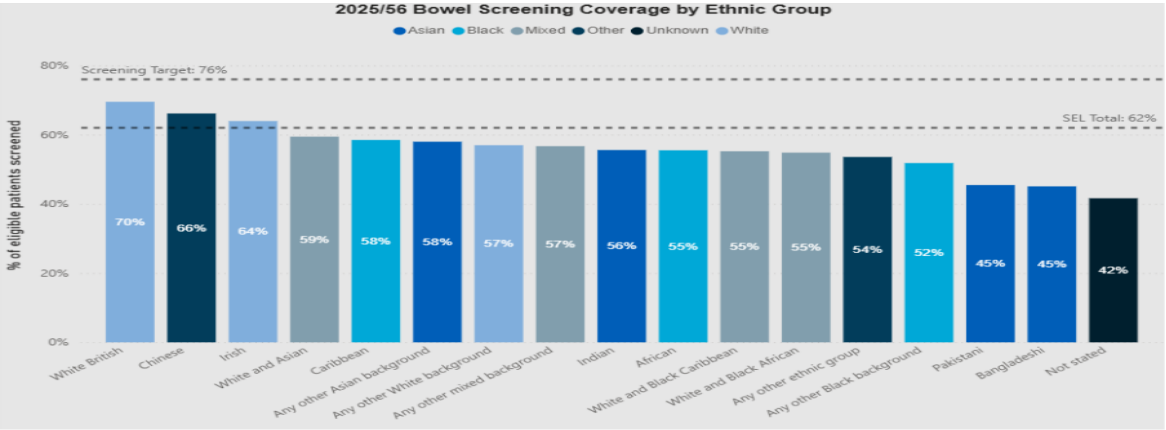
Bowel Screening

Those aged 50-74 years old will be invited to bowel cancer screening every two years. The screening uses a faecal immunochemical test to test for blood in your stool. This can help identify bowel cancer early and identify polyps that can develop into cancer.

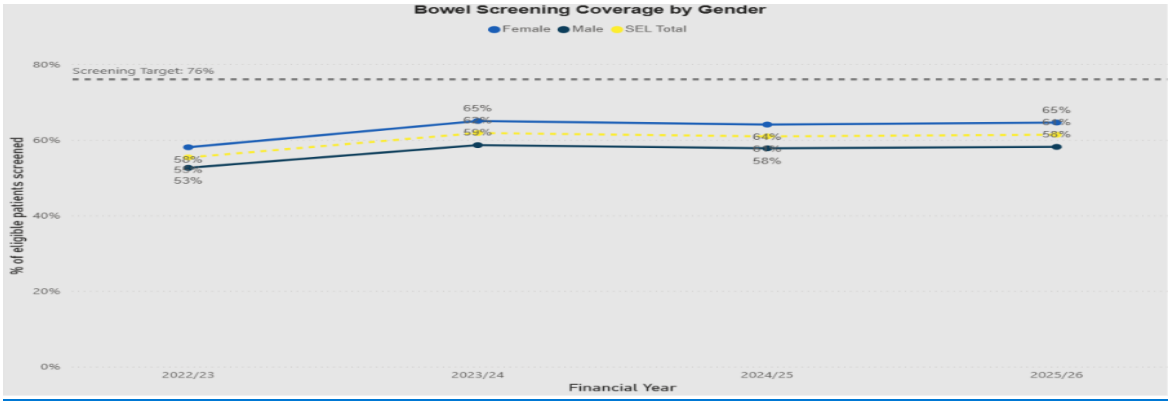
Overall bowel screening coverage has increased between 2022/23 and 2025/26, noted however within this period is a minimal decrease in coverage from 62% in 2023/24 to 61% in 2024/25 and 2025/26. Those of White ethnicity have the highest coverage in all years of 66%, which is 5% above the South East London average. All other ethnic groups have comparable coverage in 2025/26 at around 56%. The difference between the highest and lowest coverage rate is minimal, from 12% in 2023/24 to 11% in 2025/26, demonstrating rates improved at similar levels across all group.



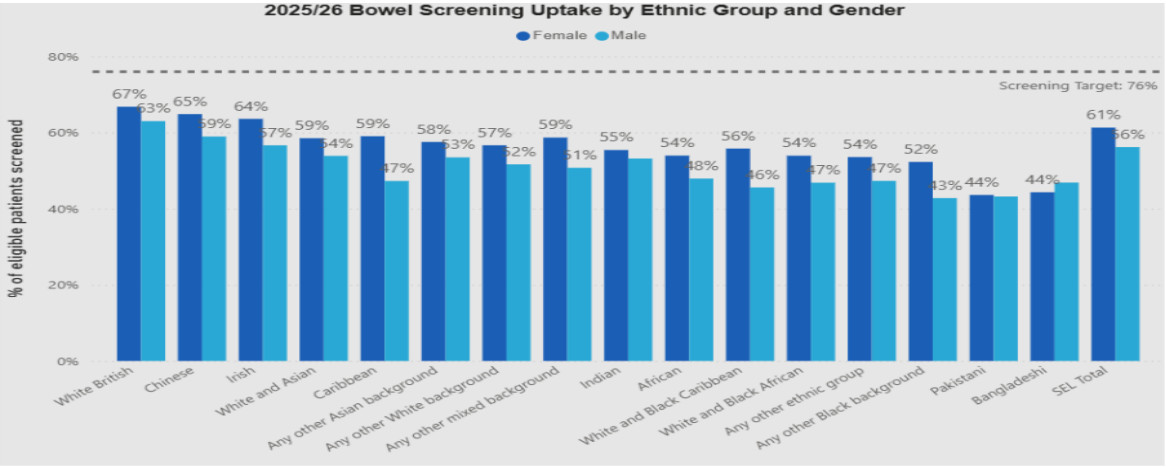
When the ethnic profile is broken down further by subgroups, a variance is observed. Those of Asian ethnicity are below the South East London average, with those of Pakistani and Bangladeshi descent having the lowest coverage of 45%. Those of White British Chinese and Irish descent have a higher than average coverage rate.



Looking at the gender profile in all years, coverage in the female population is higher than the male population of 65 and 58% respectively in 2025/26.



When the ethnic profile is broken further by gender, in 2025/26 a variance is observed. Females of Caribbean descent females have a coverage of 64% compared to males 51%. In all but one ethnic group, males have a lower coverage than females, those of Bangladeshi descent are the only group where males coverage of 48% is higher than females coverage of 42%.



When the ethnic profile is broken down further by deprivation, those in quintile 5 (least deprived) have a higher coverage of 74%% in 2025/26 and those in quintile 1 (most deprived) have the lowest coverage of 54% for the same period. The disparity between the most and least deprived has increased since 2022/23, with an 18% gap in screening coverage growing to 20% in subsequent years.

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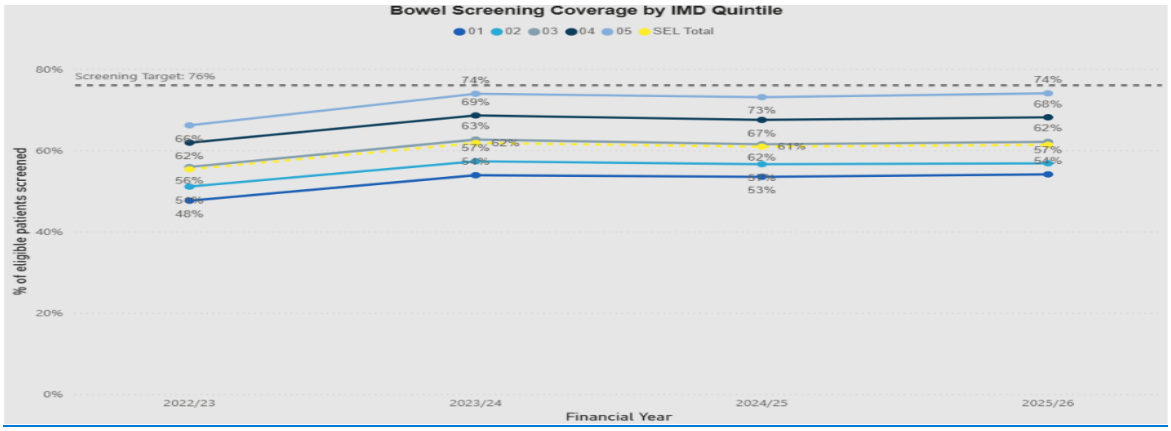


Improvement activity

Early Cancer Diagnosis	Cancer Screening
• Focus placed on cancer types where early diagnosis rates remain comparatively low, including lung, bowel, upper gastrointestinal, pancreatic and ovarian cancers, alongside population groups and communities experiencing poorer outcomes. **This includes combined:** • Public awareness activity (targeted awareness campaigns), primary care support (primary care education strengthened), improved access to diagnostics (local data used to identify variation in referral behaviour, screening participation and early diagnosis rates) and community engagement (partnership working with Voluntary, Community, Faith, and Social Enterprise (VCFSE) organisations, and neighbourhood-level initiatives).	• Bowel screening- targeted awareness activity, support for primary care to implement evidence-based interventions, strengthening reminder and safety-netting processes, and work to better understand barriers experienced by non-English-speaking communities and other underserved groups. • Cervical screening- action is being taken to improve participation among groups with lower coverage, including work to understand and address barriers experienced by some ethnic communities and vulnerable population groups. • Breast screening- activity focuses on increasing awareness and participation among communities with lower coverage rates, particularly where deprivation and ethnicity are contributing factors.

11. Cardiovascular Disease

Overview: Unsurprisingly, there is a clear relationship between age profile and emergency admissions for stroke and myocardial infarction, given increase in age is linked to the higher the rate of admissions. Across all age groups, males have a higher rate of admission than females. A higher proportion of female hypertension patients are treated to target in comparison to males, a trend that has remained consistent over the last three years. This gender difference is also present at both London and national levels, demonstrating a consistent trend of higher rates among females across England

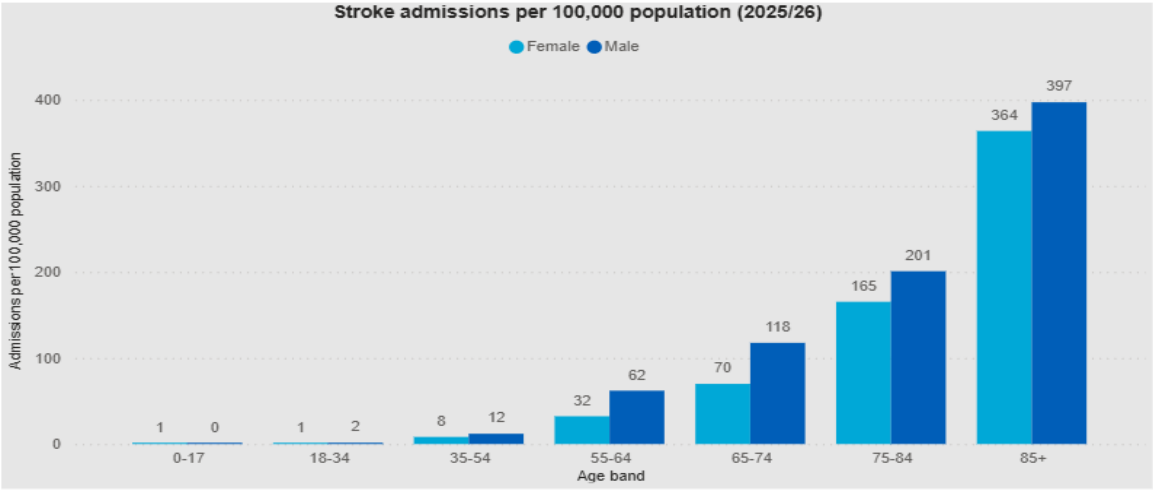
Activity Reporting Period: 2023 to 2026.
Data Source: Secondary Uses Service (SUS) and Primary Care, Cardiovascular Disease Prevention Audit (CVDPREVENT).

11.1. Inequalities in emergency admissions for stroke

In 2025/26, across South East London the rate of emergency admissions for stroke is 108 per 100,000 population, this has remained relatively stable over the past three years.

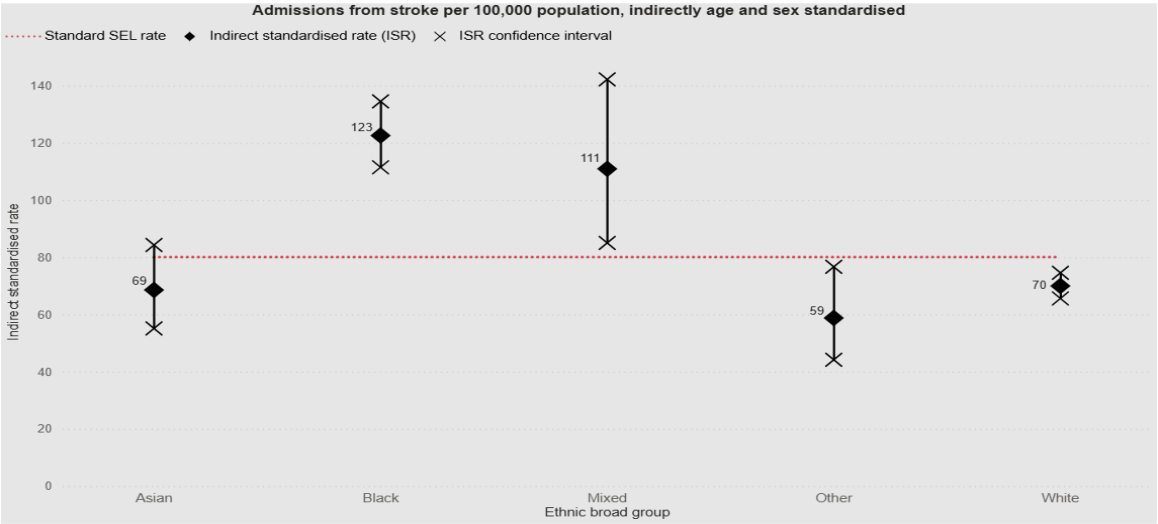


Unsurprisingly, there is a clear relationship between age profile and emergency admissions for stroke, given increase in age is linked to the higher the rate of admissions. Across all age groups, males have a higher rate of admission than females.

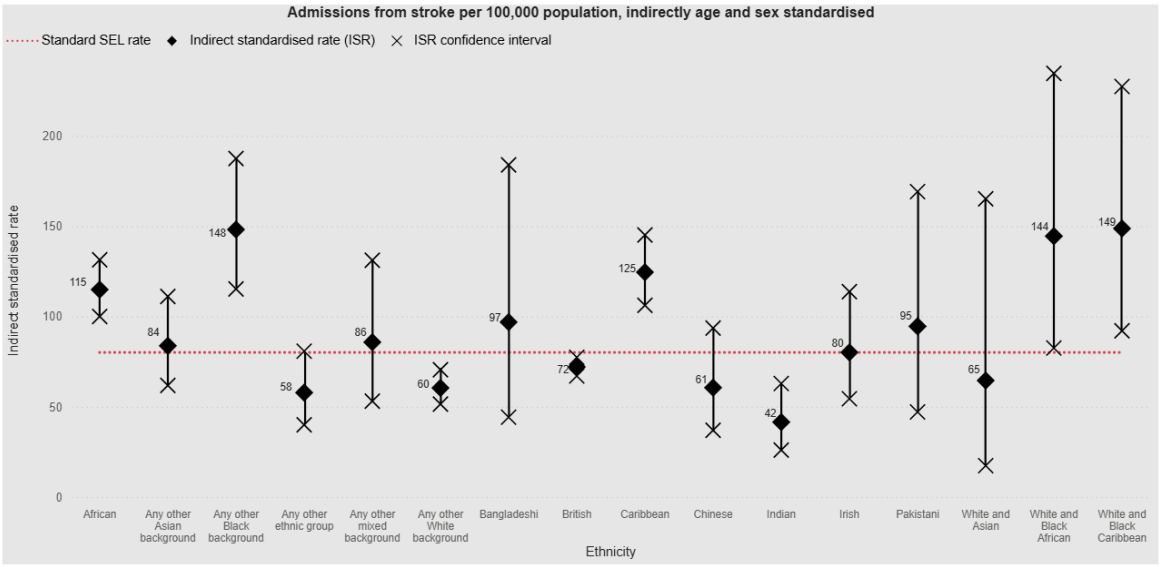


To draw any meaningful conclusions when looking at ethnic profile and deprivation, we need to standardise the age and sex metric, to account for the skew in admissions in both the older and male population.

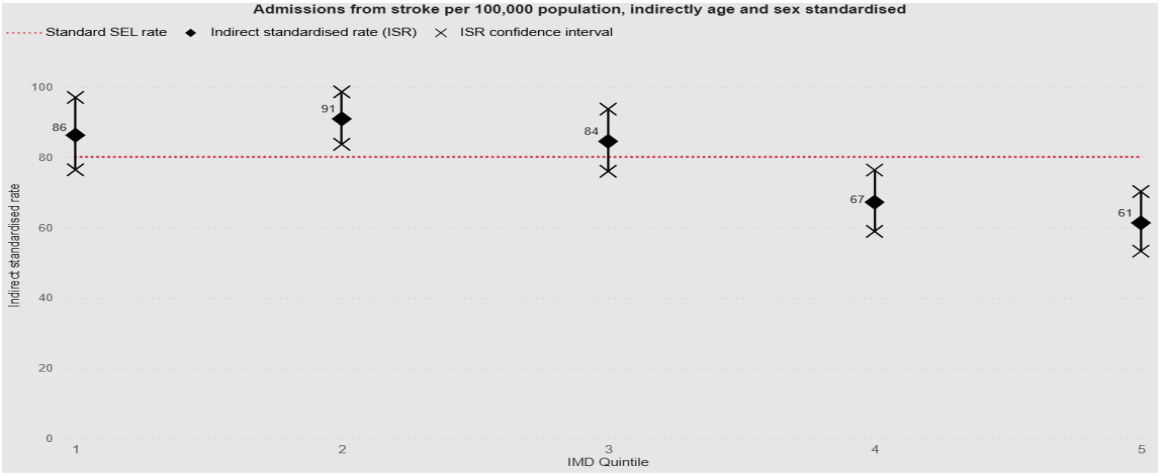
Looking at the ethnic profile, those of Black and Mixed ethnicity have a higher rate of emergency admission than the South East London standard rate of 80 per 100,000 population. There is a wider confidence interval for those of Mixed ethnicity, due to this group having a smaller overall number of admissions, although this remains above the South East London standard rate.



When the ethnic profile is broken down further by subgroups, those of African descent, Caribbean descent, White and Black Caribbean descent, Any other Black background descent and White and Black African descent all have emergency admission rates over 80% higher than the South East London standard rate.

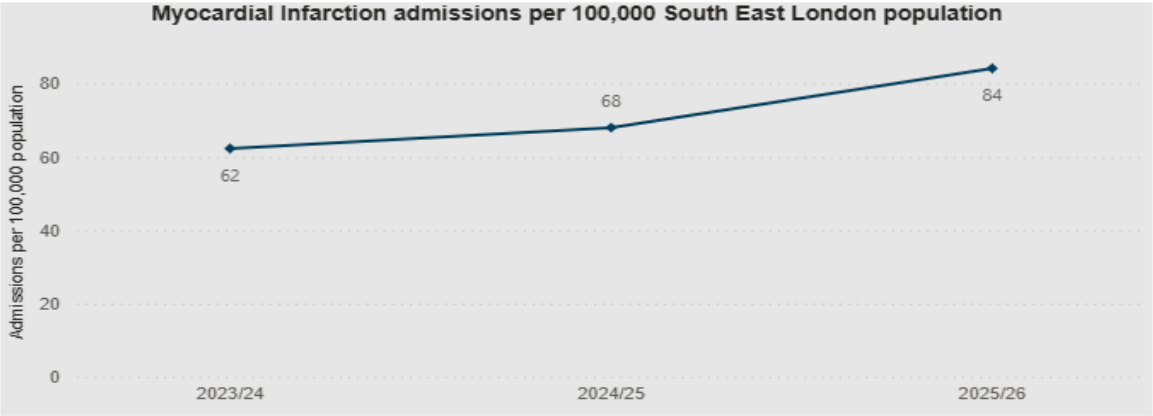


The data observed indicates that those in quintiles 1 to 3 (most, next most and middle deprived) have emergency admission rates higher than the South East London standard rate.



11.2. Inequalities in emergency admissions for myocardial infarction

In 2025/26, across South East London the rate of emergency admissions for myocardial infarction is 84 per 100,000 people, this increase in rate from 2024/25 is due to the number of admissions increasing by 23%, from 1,435 to 1,768.



Unsurprisingly, there is a clear relationship between age profile and emergency admissions for stroke, given increase in age is linked to the higher the rate of admissions. Across all age groups, males have a higher rate of admission than females.

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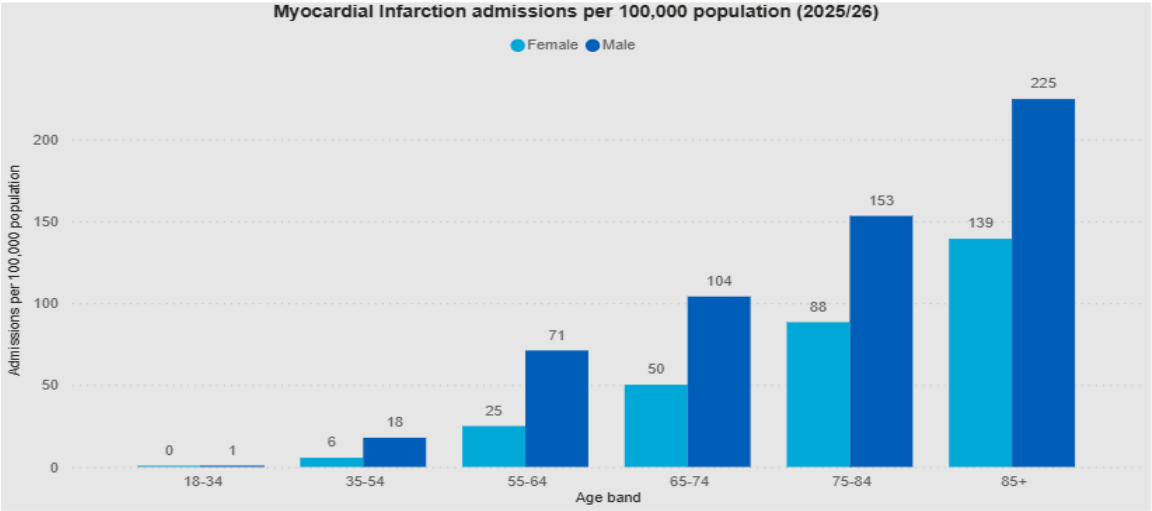
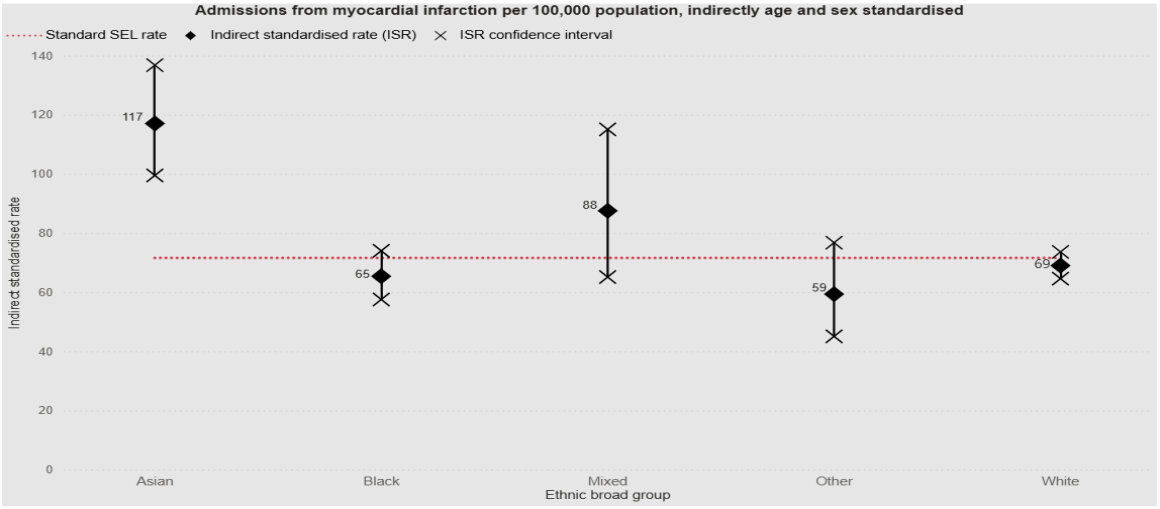
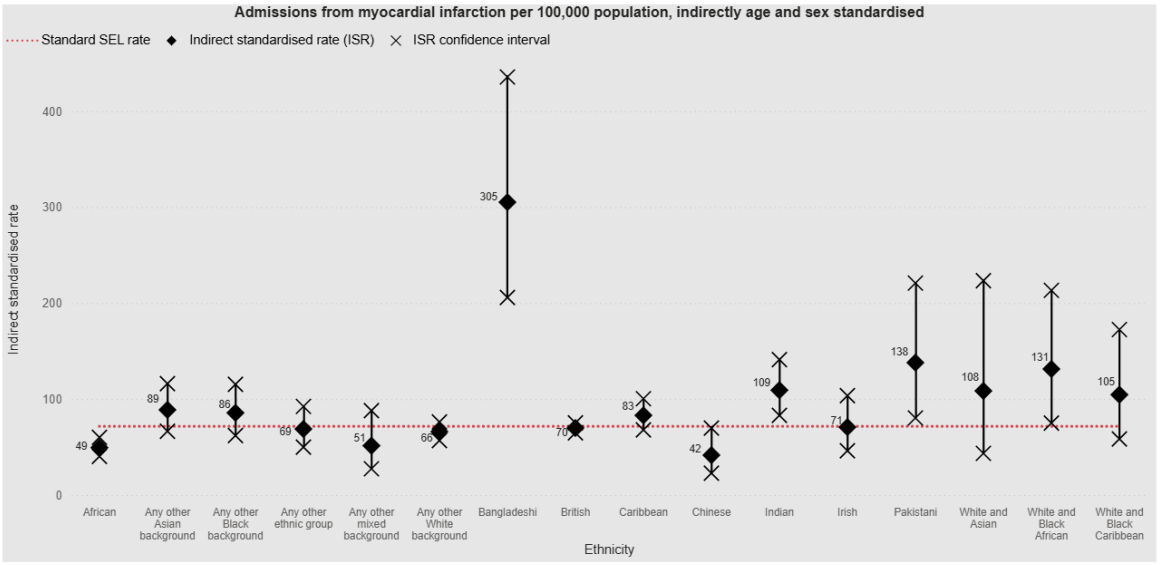


To draw any meaningful conclusions when looking at ethnic profile and deprivation, we need to standardise the age and sex metric, to account for the skew in admissions in both the older and male population.

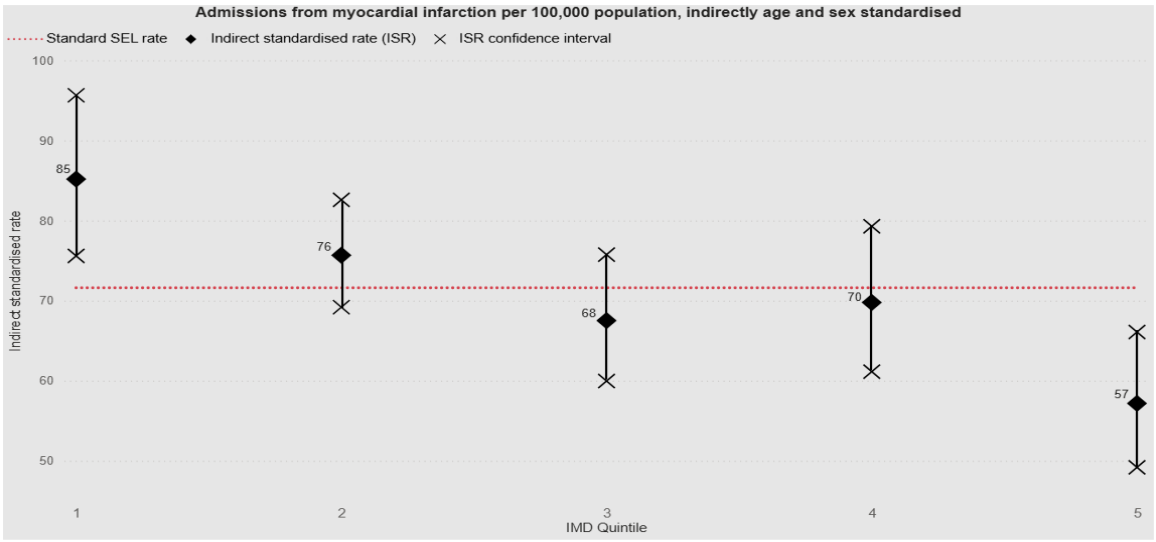
Looking at the ethnic profile, those of Asian and Mixed ethnicity have a higher rate of emergency admissions than the South East London standard rate of 72 per 100,000 population.



When the ethnic profile is broken down further by subgroups, those of Bangladeshi descent have a significantly higher rate of admission, four times higher than the South London standard rate. Whilst the confidence interval is quite wide 206 to 436 per 100,000 population, this remains above South East London standard rate.

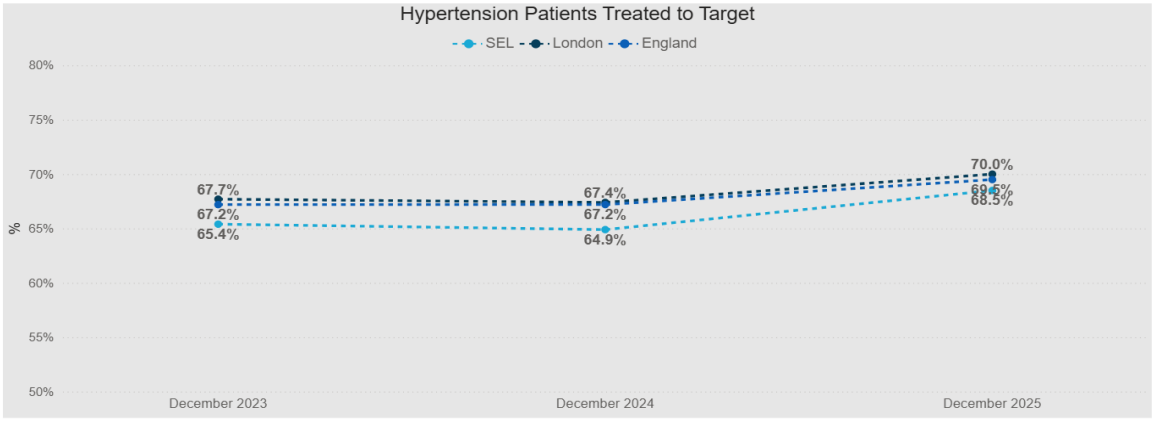


The data observed indicates that those in quintiles 1 to 2 (most and next most deprived) have emergency admission rates higher than the South East London standard rate.

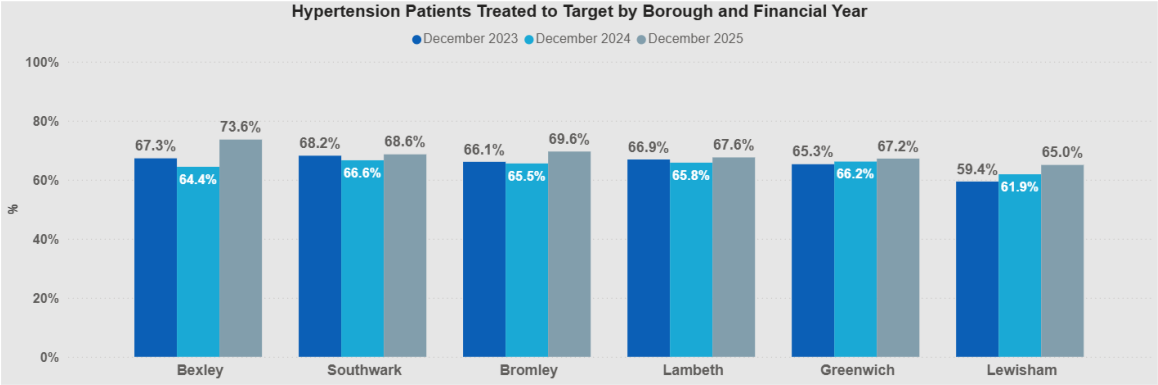


11.3. Inequalities in percentage of hypertension patients treated to target

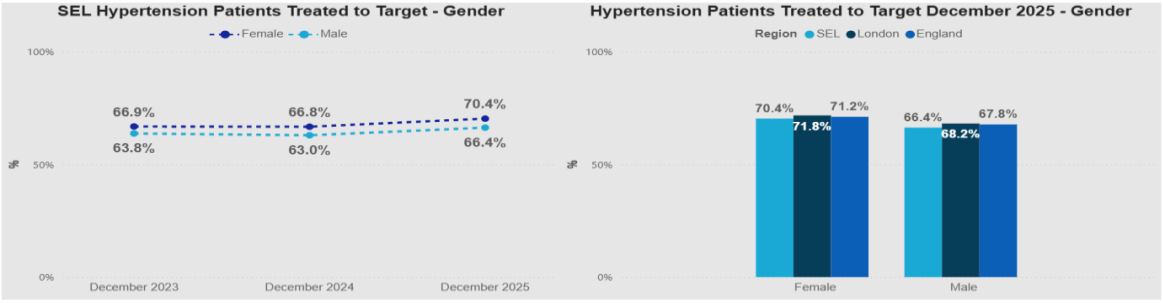
The graphs below show the proportion of hypertension patients with age-appropriate blood pressure readings in the preceding 12months, i.e. the proportion of patients treated to target (all-ages). Between December 2023 and December 2025, 68.6% of hypertension patients in South East London were treated to target, an average within 2% of both London and nation levels. In the last three years, the proportion of patients treated to target in South East London has increased by approximately 3%.



In the last three years, the proportion of hypertension patients treated differs by borough. In 2025, Bexley and Bromley have the highest proportion (73.6% and 69.6% respectively). Over the three-year period, Lewisham consistently has the lowest treated to target proportion and is the only borough with a below South East London average in 2025. Bexley has the highest proportion increase from 64.4% in 2024 to 73.6% in 2025.

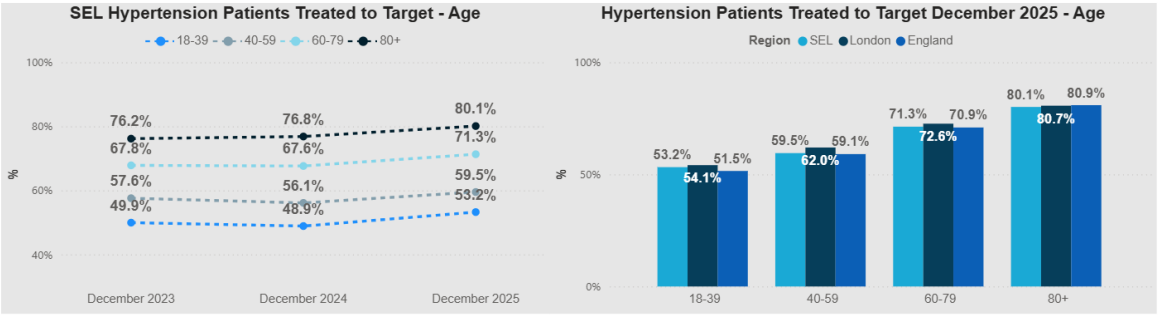


A higher proportion of females (70%) are treated to target in comparison to males (66%), a trend that has remained consistent over the last three years. This gender difference is also present at both London and national levels, demonstrating a consistent trend of higher rates among females across England.

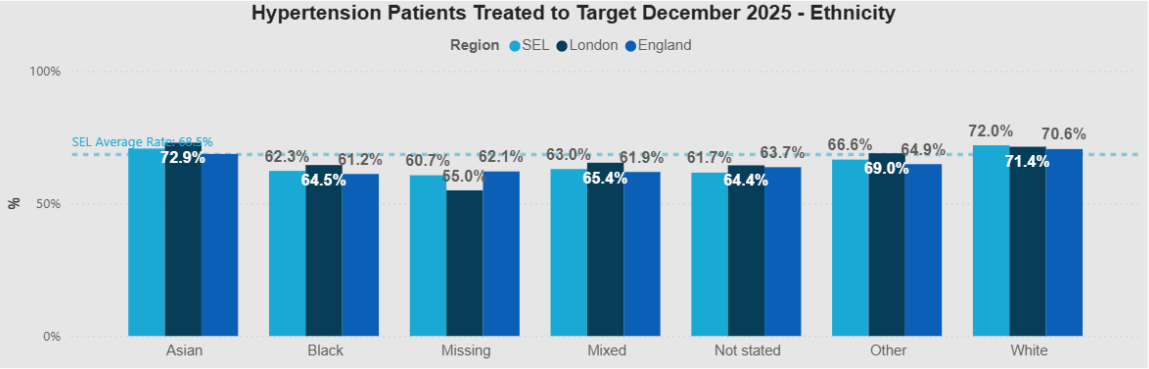


Looking at the age profile, a variance is observed. As age increases, the proportion of those treated to target also increases. In December 2025, 80% of those aged 80+ were treated to target in comparison to 53% of those aged 18-39. This 27%-29% gap is persistent across the last three years, indicating that those aged 80+ are 1.5 times more likely to be treated to target than those aged 18-39.

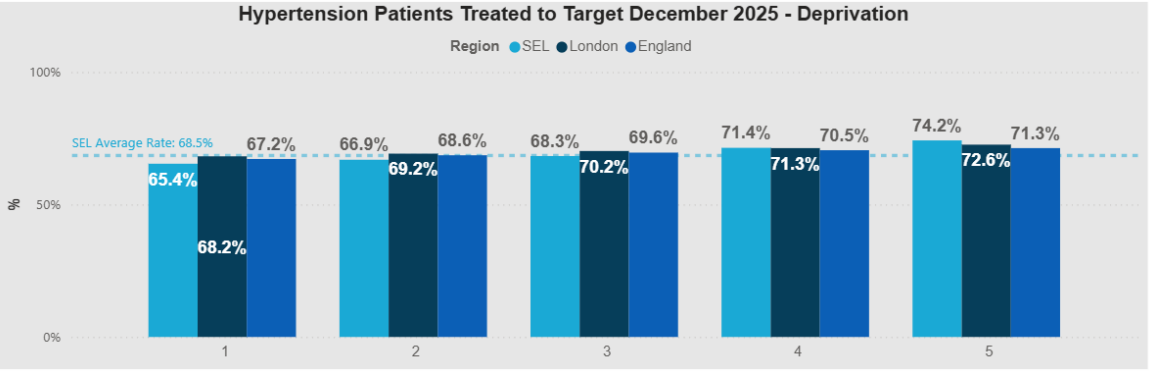
For those aged 18-79, a minimal difference is observed between South East London, London and national levels and the proportion treated to target. However, for patients 80+ there is no percentage difference between South East London, London and national levels and the proportion treated to target is the same.



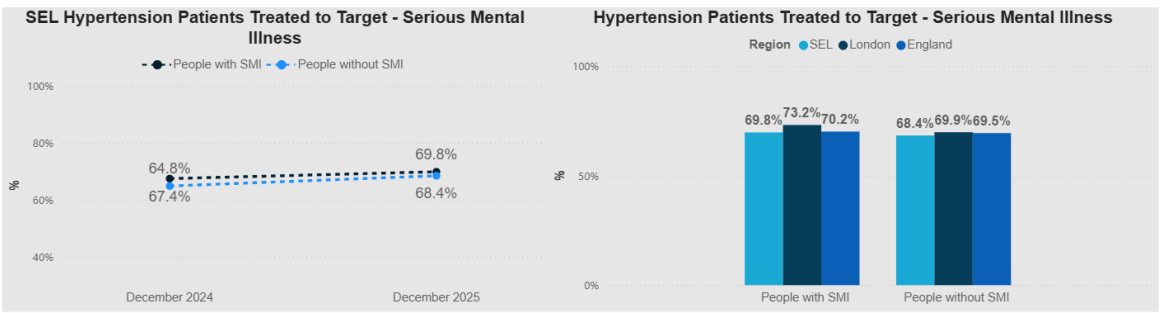
Looking at the ethnic profile, those of White and Asian ethnicity are the only group where the proportion of patients treated to target is higher than the South East London average by 8%. In contrast, those of Black ethnicity and Mixed ethnicity are the only group where the proportion of patients treated to target is below the South East London average by 6.2% and 7.2% respectively.

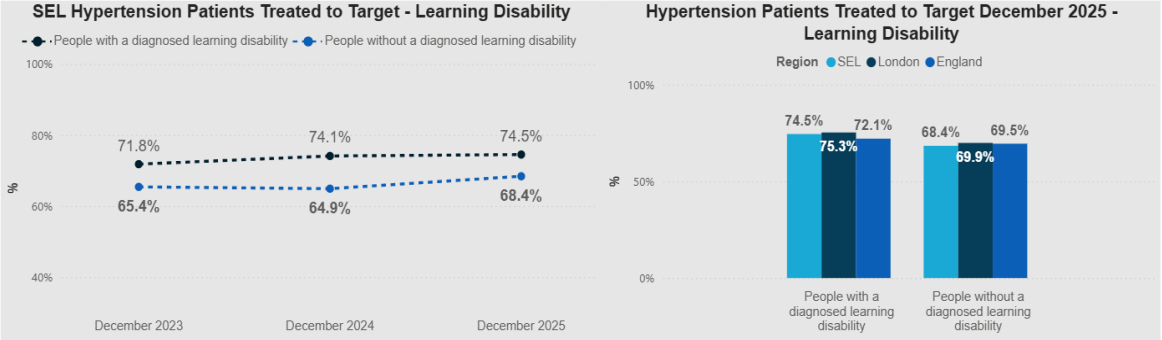


The data observed indicates a correlation between proportion of patient treated to target and deprivation. Those in quintiles 4 and 5 (next least and least deprived) have a higher proportion of patients treated to target than those in quintiles 1 and 2 (most and next most deprived). This trend is also present both at London and national levels.



Patients registered with a learning disability have a higher proportion of treated to target rate of 75% than patients without a registered learning disability of 68%. Similarly, patients with severe mental illness (SMI) have a slightly higher proportion of treated to target rate of 70% than patients without severe mental illness of 68%.





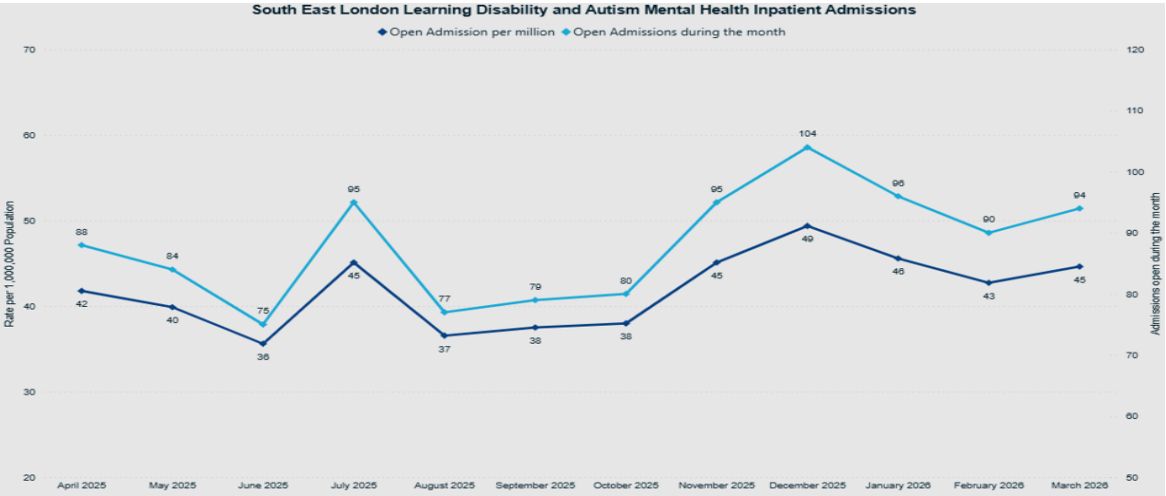
12. Learning Disability and Autism

Overview: The adult mental health inpatient admission rate for people who have a learning disability or are autistic varies by age, those aged 20-24 have the highest rate, followed closely by those aged 18-19, and those aged 75-84 have the lowest rate of admission. There is a clear correlation between deprivation and adult mental health inpatient admission rates for people who have a learning disability or are autistic. Those in quintile 1 (most deprived) have a rate of 370 per 1,000,000 population compared to those in quintile 5 (least deprived) with a rate of 133 per 1,000,000 population. Admission rates for those in quintiles 1, 2, and 3 (most, next most and middle derived) are all higher than the South East London adult rate.

Activity Reporting Period: 2023 to 2026.
Data Source: Mental Health Services Data Set (MHSDS) and Primary Quality and Outcomes Framework (QOF) register, Primary Care Data Set, Regional - Learning Disabilities Health Check Scheme - NHS England Digital.

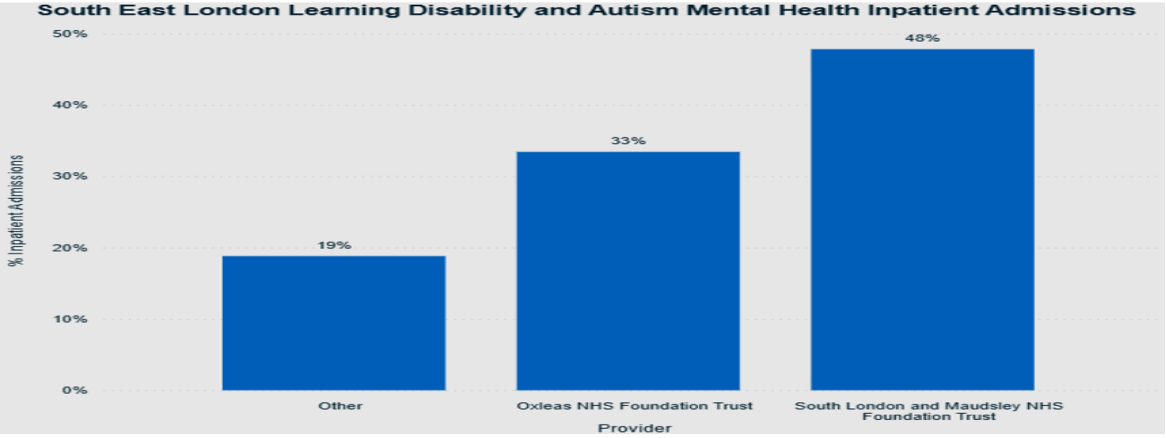
12.1. Number of people in a mental health inpatient setting who have a learning disability or are autistic – adults

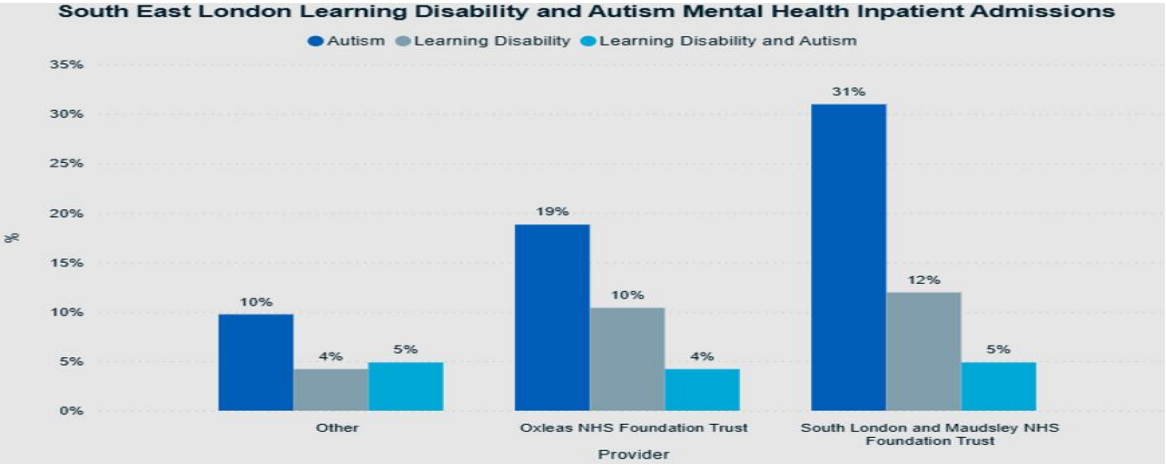
The average monthly rate of mental health inpatient admissions for South East London registered patients who have a learning disability or are autistic is 42 per 1,000,000 population (an average of 88 open admissions per month). For this report, open admissions are defined as any admission with no recorded discharge date as of the end of March 2026, or who are discharged within 2025/26. This also includes admissions from previous financial years.



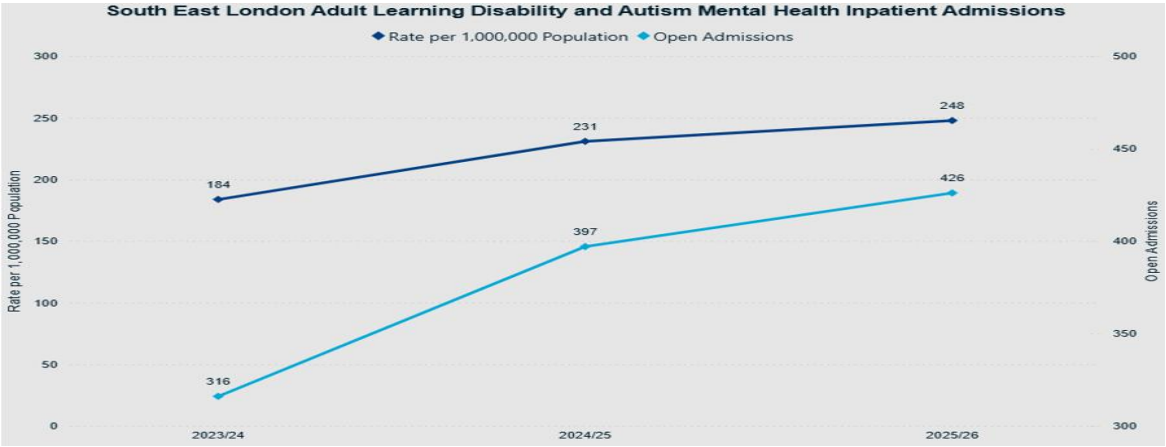
Please note this data shows distinct, open admissions within the financial year rather than distinct patients (i.e. a patient who is admitted twice within the year would be counted as two separate admissions). Data for mental health inpatient admissions is taken from MHSDS. Admissions specifically for South East London registered patients who have a learning disability and/or who are autistic are filtered using primary care records and QOF registers due to known data quality issues with recording learning disability in MHSDS. This may differ from data from other national datasets such as the Assuring Transformation dataset.

In 2025/26, there were a total of 452 open admissions for people in a mental health inpatient setting who have a learning disability or are autistic, a rate of 215 per 1,000,000 population, with 48% of admissions at South London and Maudsley NHS Foundation Trust and 33% at Oxleas NHS Foundation Trust. Of these mental health inpatient admissions, 60% are autistic patients, 26% have a learning disability and 14% are both autistic and have a learning disability. Adults aged 18+ are 94% of these admissions (452 total admissions, 426 adults) in 2025/26, with a rate of 248 per 1,000,000 population. The rest of this section will focus on adults (age 18+).

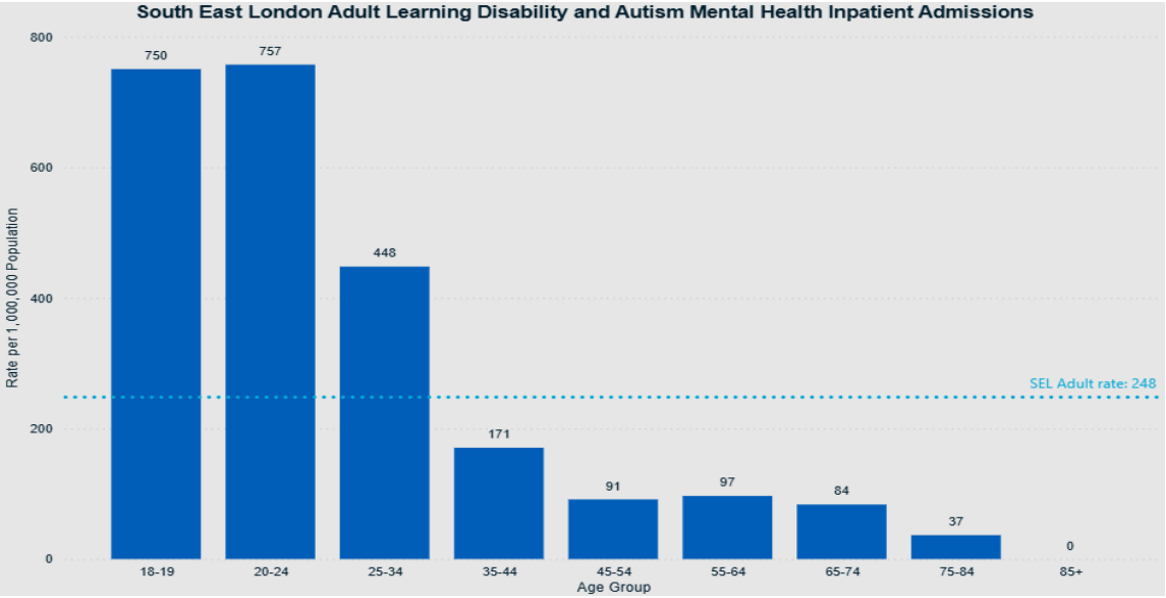




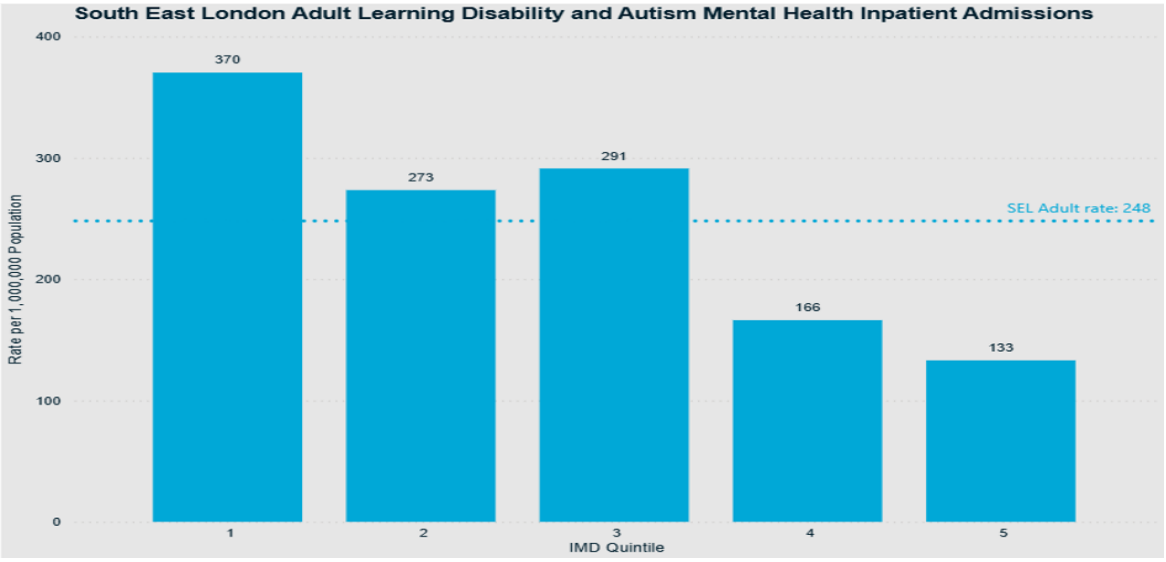
The adult mental health inpatient admission rate for people who have a learning disability or are autistic has increased slightly over the past few years from 184 per 1,000,000 population in 2023/24 to 248 per 1,000,000 population in 2025/26. Since 2023/24, the total number of open admissions has increased by 35% (from 316 open admissions to 426 open admissions).



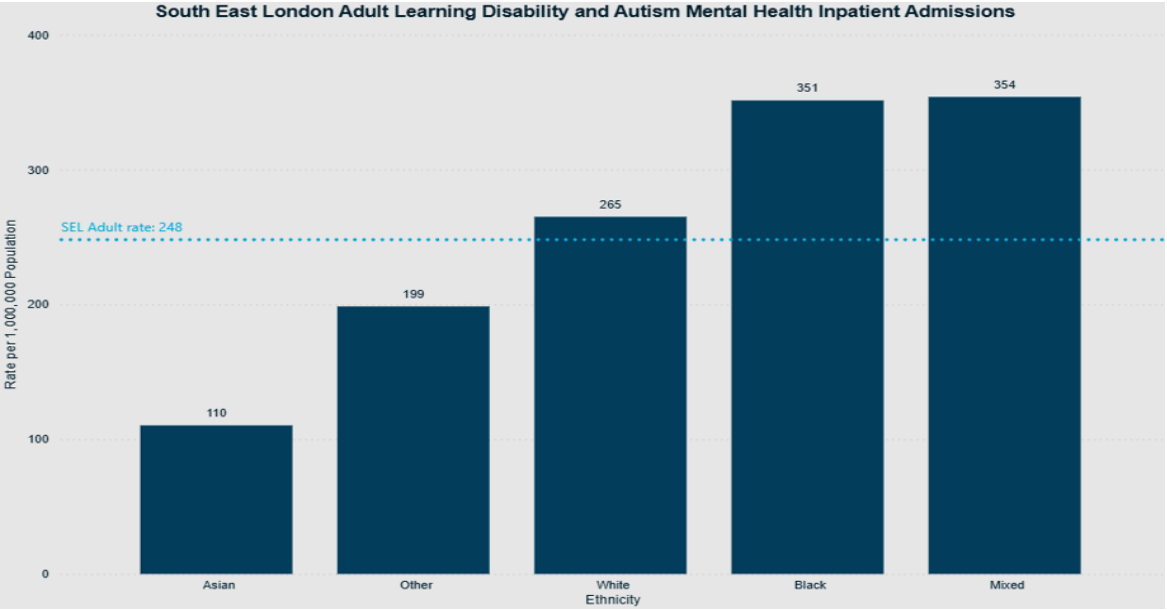
The adult mental health inpatient admission rate for people who have a learning disability or are autistic varies by age, those aged 20-24 have the highest rate of 757 per 1,000,000 population, followed closely by those aged 18-19 with a rate of 750 per 1,000,000 population. There are no open admissions in 2025/26 for those aged 85+. Of the age groups with at least one open admission, those aged 75-84 have the lowest rate of 37 per 1,000,000 population. Those aged 18-19, 20-24, and 25-34 have admission rates well above the South East London adult rate of 248 per 1,000,000 population, while admissions for those aged 35+ is below the South East London adult rate.



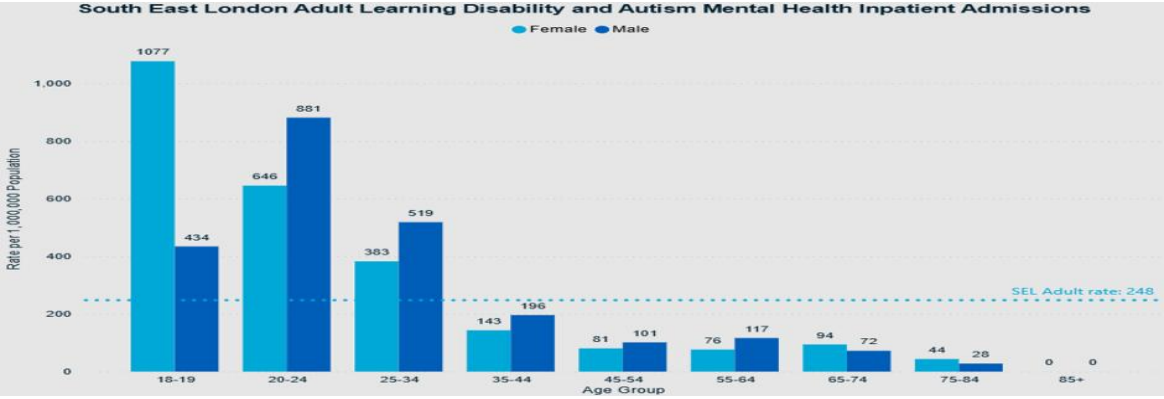
There is a clear correlation between deprivation and adult mental health inpatient admission rates for people who have a learning disability or are autistic. Those in quintile 1 (most deprived) have a rate of 370 per 1,000,000 population compared to those in quintile 5 (least deprived) with a rate of 133 per 1,000,000 population. Admission rates for those in quintiles 1, 2, and 3 (most, next most and middle derived) are all higher than the South East London average rate. A similar trend is observed for all adult mental health inpatient admissions, with the rate of admissions decreasing as deprivation decreases. However, the rate of mental health inpatient admissions for adults who have a learning disability or are autistic increases by 36% from quintile 2 to quintile 1 compared to an increase of only 10% for all mental health admissions. This indicates that inequalities in mental health inpatient admissions in least deprived areas are greater for people who have a learning disability or are autistic.



Looking at the ethnic profile, those of Black and Mixed ethnicity have the highest rate of adult mental health inpatient admissions for people who have a learning disability or are autistic of 351 and 354 per 1,000,000 population.



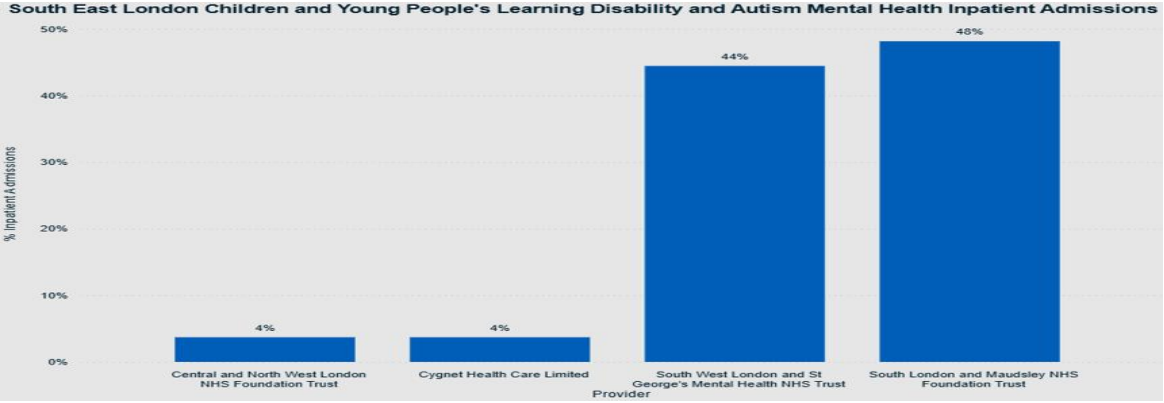
Adult mental health inpatient admission rate for people who have a learning disability or are autistic is highest for females aged 18-19 (1077 per 1,000,000 population), followed by males aged 20-24 (881 per 1,000,000 population). The majority of mental health admissions rate of 72% are for those aged 35 and under.

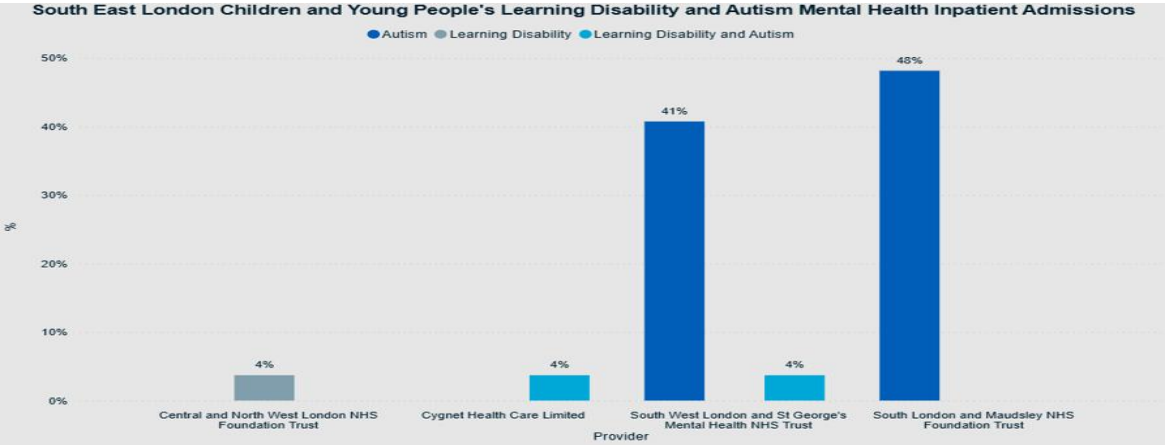


12.2. Number of under 18s with a learning disability or who are autistic in a mental health inpatient setting

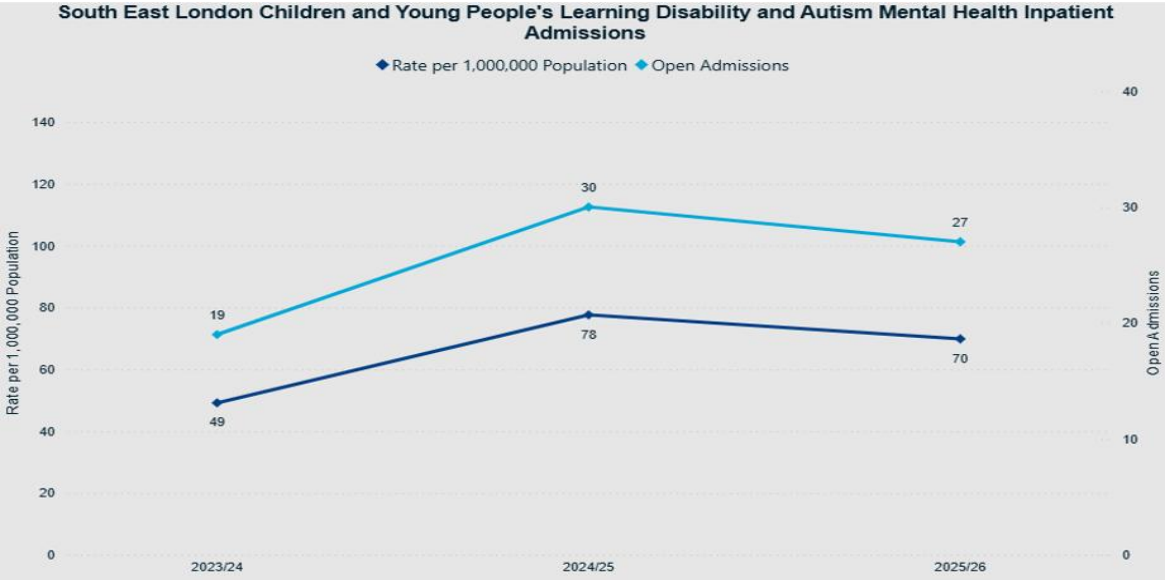
The total South East London Children and Young People (CYP) rate of people in a mental health inpatient setting who have a learning disability or are autistic in 2025/26 is 70 per 1,000,000 population. Patients with a learning disability and/or autism are identified using primary care records, which may result in underreporting.

It should be noted that the number of CYP with a learning disability or are autistic admitted to a mental health inpatient setting is very small, 27 in 2025/26. South London and Maudsley NHS Foundation Trust and South West London and St. George's have similar numbers of open CYP mental health inpatient admissions in 2025/26 (48% and 44% of all open admissions, respectively). Of these admissions, 89% are CYP who are autistic and 8% are CYP who have a learning disability and autism.

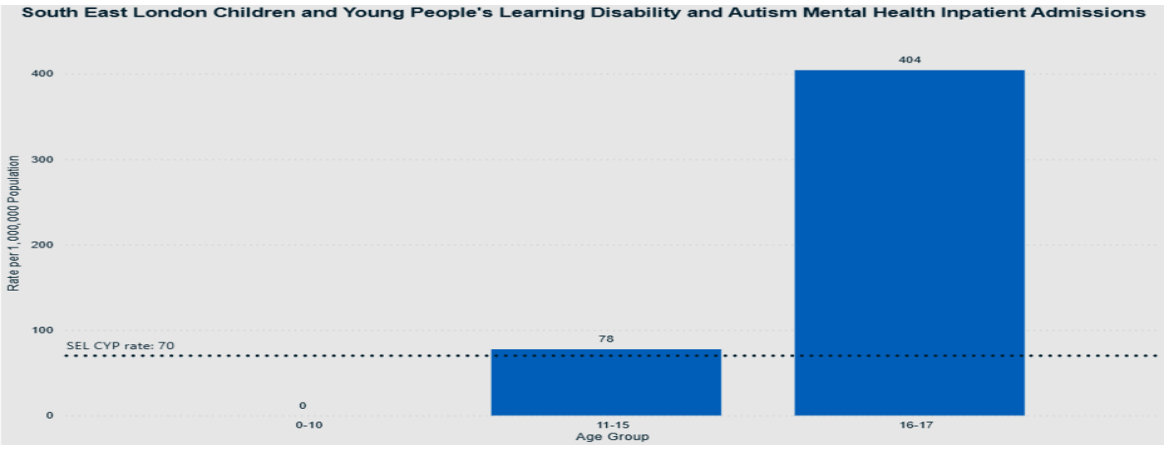




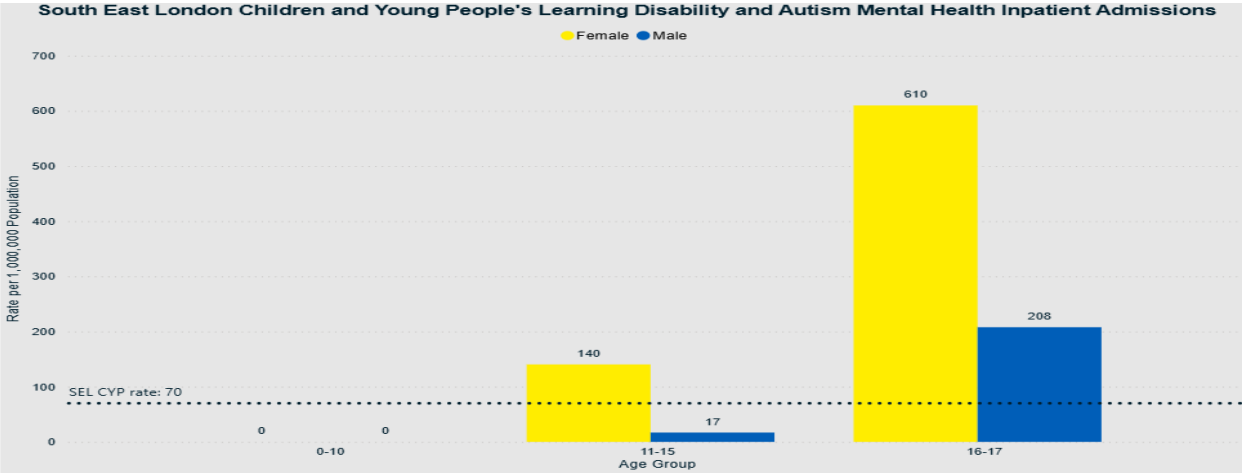
CYP mental health inpatient admissions for people who have a learning disability or are autistic have decreased by 10% from 2024/25 to 2025/26, again noting that these are small numbers. The rise and fall in rate from 2023/24 to 2025/26 is mainly due to changes in the number of 16-17 years old admissions. Some CYP acquire autism diagnoses during admissions for mental illness, so it is likely to rise and fall during the year and from year to year.



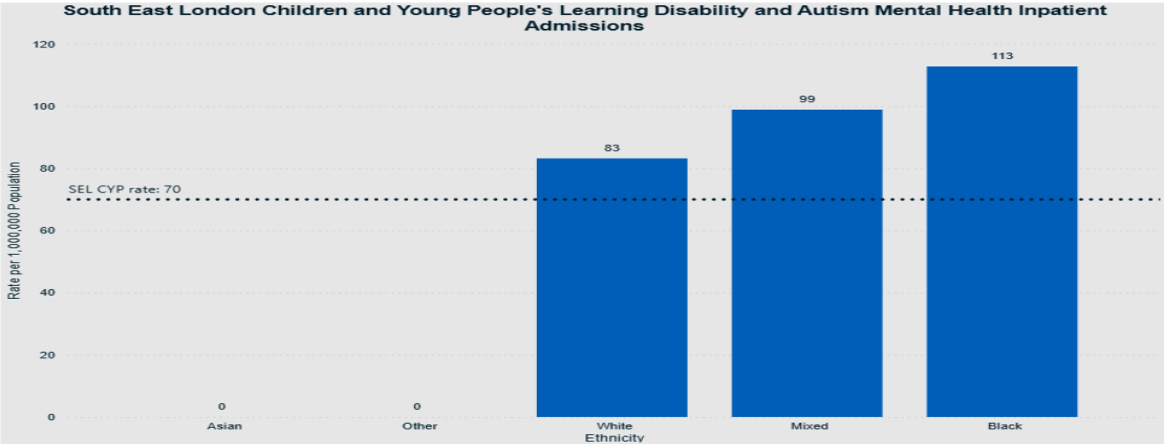
There are no mental health inpatient admissions for CYP who have a learning disability or who are autistic under the age of 11. For those aged, 16-17 the mental health inpatient admission rate is 404 per 1,000,000 population.



Females make-up the majority of CYP mental health inpatient admissions for CYP who have a learning disability or are autistic. Most male CYP admissions are for those aged 16-17 at a rate of 208 per 1,000,000 population compared to 17 per 1,000,000 population for males aged 11-15. However, the number of CYP with a learning disability or are autistic admitted to a mental health inpatient setting in 2025/26 are very small numbers (27 total open admissions).



Looking at the ethnic profile, those of Black ethnicity have the highest rate of mental health inpatient admissions for CYP with learning disability or autism of 113 per 1,000,000 population. Those of Asian and Other ethnicity have a rate of 0 for 2025/26. There is little data to draw insights from due to the very small numbers.



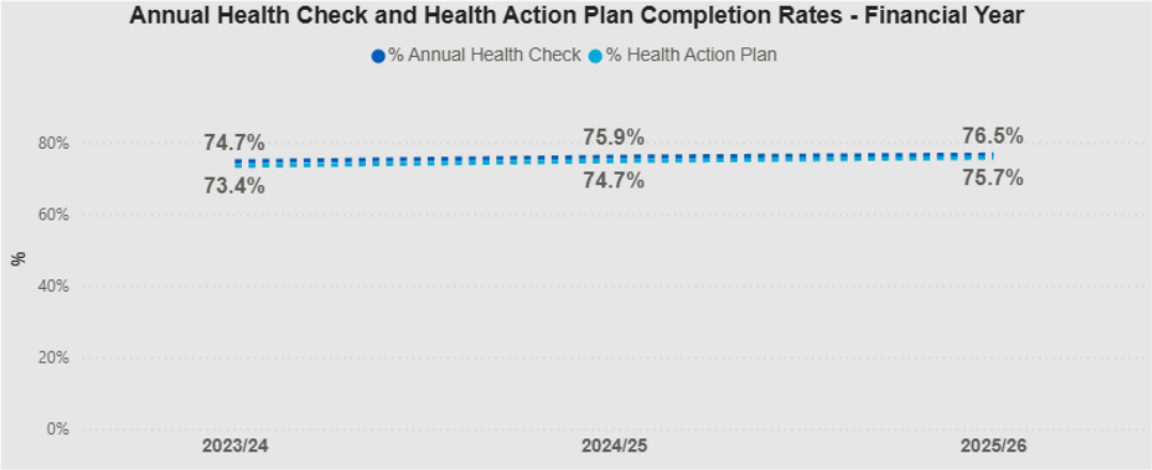
12.3. Percentage of patients aged 14+ on GP learning disability registers who have had an annual health check and action plan

Insights with demographic data are based on patients on the South East London Learning Disability register. This cohort may differ to populations reported in other sources, such as the operational plan.

People (aged 14+) on the learning disability register are entitled to a health check once a year. During this appointment, a doctor or nurse performs a physical health check-up, including weight, heart rate and blood pressure. People are sometimes given

support on how to stay well, spot symptoms of commonly occurring conditions and a medication review. At the end of the appointment, doctors and patients agree on a health action plan designed to help the patient manage their wellbeing by eating well, exercising and attending routine appointments and cancer screening as appropriate.

The data in the chart below is taken from the Learning Disabilities Health Check Scheme , provided by NHS digital. Due to differences in the underlying data sources, the South East London totals reported here differ slightly from those shown in other charts. The discrepancy is however within 1%.

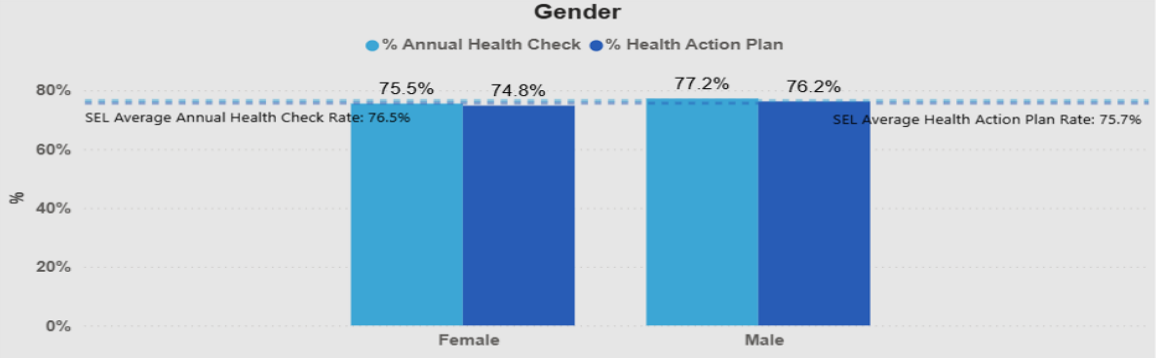


In South East London, annual health check and action plan completion rates have increased by approximately 2% from 2023/24 to 2025/26.

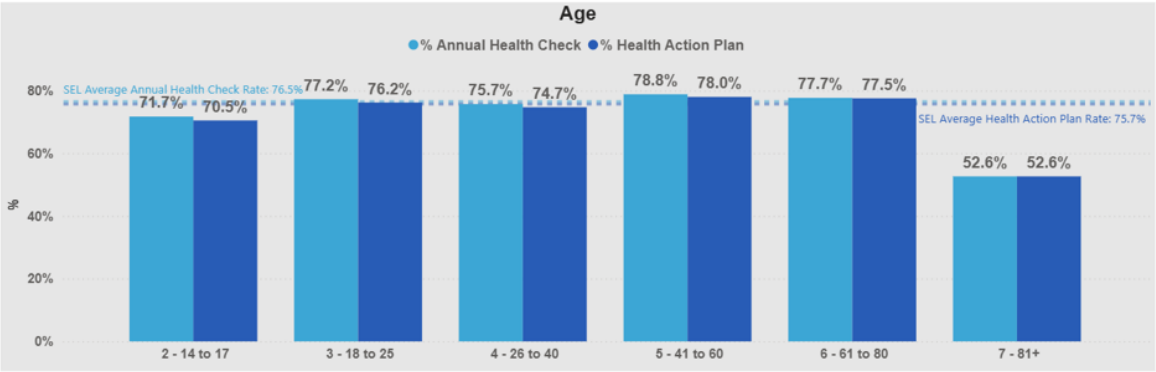
In 2025/26, 75% of South East London patients registered with a learning disability received both an annual health check and health action plan. This rate is higher than both the London (65%) and national (60%) levels, demonstrating that South East London patients receive checks 10% more than equivalent Londoners and 15% more than the rest of the country.



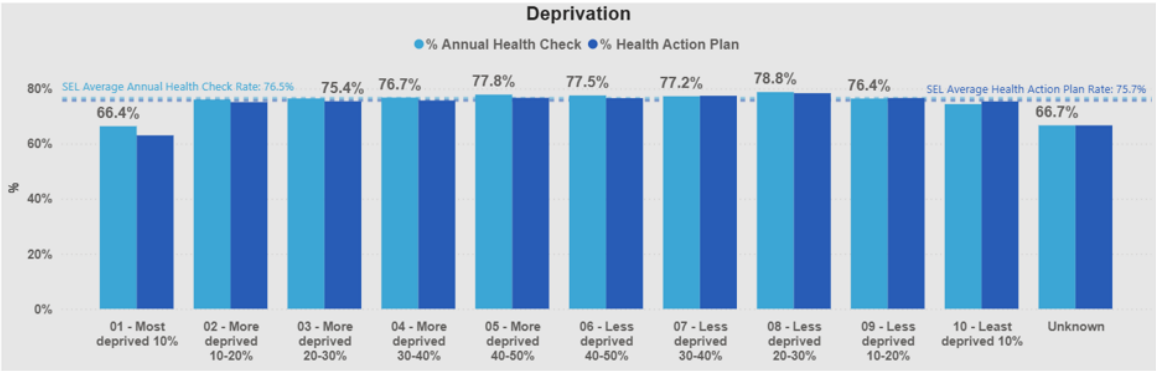
Across all categories, there is a minimal difference of around 1% completion rates between females and males.



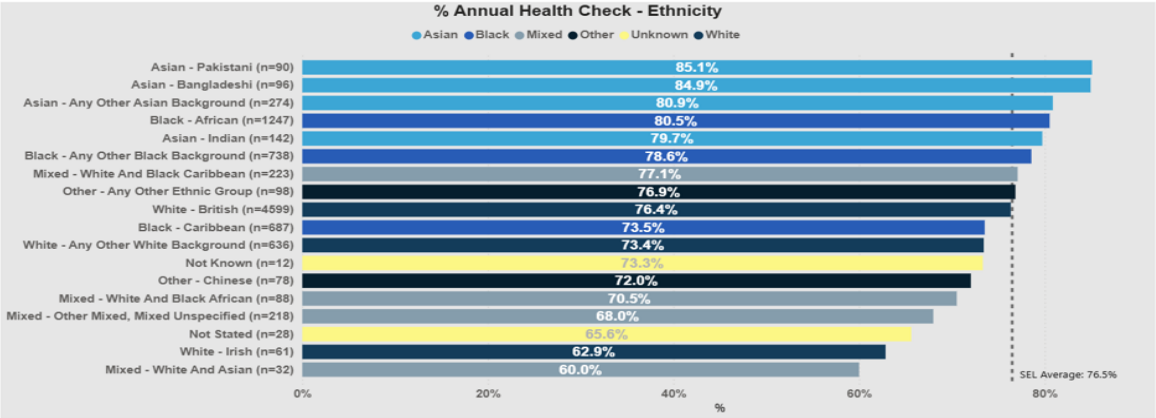
When the data is broken down by age profile, those aged 81+ have the lowest completion rate of all age groups. For annual health checks, this is 24% lower than the South East London average and for action plan this is 23% lower than the South East London average.



There is no clear correlation between completed annual health and action plan and deprivation. The data observed shows variation across all deciles.



Looking at the ethnic profile, those of Asian ethnicity have the highest annual health check rate of 82%, this is largely driven by those of Bangladeshi and Pakistani descent (85% respectively). Those of Black ethnicity have the second highest rate of 78%, driven by those of African and Black Other descent (81% and 79% respectively). Those of Mixed ethnicity have a lower completion rate overall, and in some instances, these are lower than the South East London average.



When the ethnic profile is broken down further by financial years, the annual health check rates fluctuate. Between 2023/24 and 2024/25, the rate increased for all groups on average by 1%. The biggest increase is observed among those of Mixed White and Asian descent +10%, Other descent +8% and White and Black Caribbean descent +4%. However, increases across ethnic group are not sustained the following year, with most groups experiencing a decrease in annual health checks completed, apart from those of Pakistani descent +7%, although they make-up a very small number of the overall Learning Disability population (90 people).

% Annual Health Check - Ethnicity and Financial Year

Ethnic Category	2023/24	2024/25	2025/26
Asian - Any Other Asian Background (n=274)	79.6%	82.1%	80.9%
Asian - Bangladeshi (n=96)	89.7%	87.4%	84.9%
Asian - Indian (n=142)	73.8%	73.3%	79.7%
Asian - Pakistani (n=90)	78.3%	77.8%	85.1%
Black - African (n=1247)	78.2%	79.5%	80.5%
Black - Any Other Black Background (n=738)	77.2%	79.1%	78.6%
Black - Caribbean (n=687)	73.7%	73.7%	73.5%
Mixed - Other Mixed, Mixed Unspecified (n=218)	72.7%	69.6%	68.0%
Mixed - White And Asian (n=32)	66.7%	76.9%	60.0%
Mixed - White And Black African (n=88)	70.2%	71.7%	70.5%
Mixed - White And Black Caribbean (n=223)	70.6%	74.9%	77.1%
Not Known (n=12)	33.3%	40.0%	73.3%
Not Stated (n=28)	69.0%	73.3%	65.6%
Other - Any Other Ethnic Group (n=98)	65.6%	73.6%	76.9%
Other - Chinese (n=78)	74.4%	77.1%	72.0%
White - Any Other White Background (n=636)	72.8%	72.4%	73.4%
White - British (n=4599)	74.1%	75.6%	76.3%
White - Irish (n=61)	68.1%	64.3%	62.9%
Total	**74.7%**	**75.9%**	**76.5%**

% Annual Health Check Difference from Previous Year - Ethnicity and Financial Year

Ethnic Category	2024	2025
Asian - Any Other Asian Background (n=274)	▲ +2.5%	▼ -1.2%
Asian - Bangladeshi (n=96)	▼ -2.4%	▼ -2.4%
Asian - Indian (n=142)	▼ -0.5%	▲ +6.4%
Asian - Pakistani (n=90)	▼ -0.5%	▲ +7.3%
Black - African (n=1247)	▲ +1.3%	▲ +1.0%
Black - Any Other Black Background (n=738)	▲ +1.9%	▼ -0.6%
Black - Caribbean (n=687)	▼ 0.0%	▼ -0.1%
Mixed - Other Mixed, Mixed Unspecified (n=218)	▼ -3.1%	▼ -1.6%
Mixed - White And Asian (n=32)	▲ +10.3%	▼ -16.9%
Mixed - White And Black African (n=88)	▲ +1.5%	▼ -1.2%
Mixed - White And Black Caribbean (n=223)	▲ +4.3%	▲ +2.2%
Not Known (n=12)	▲ +6.7%	▲ +33.3%
Not Stated (n=28)	▲ +4.4%	▼ -7.7%
Other - Any Other Ethnic Group (n=98)	▲ +8.1%	▲ +3.2%
Other - Chinese (n=78)	▲ +2.7%	▼ -5.1%
White - Any Other White Background (n=636)	▼ -0.4%	▲ +1.0%
White - British (n=4599)	▲ +1.4%	▲ +0.8%
White - Irish (n=61)	▼ -3.8%	▼ -1.4%
Total	**▲ +1.3%**	**▲ +0.6%**

Improvement activity

• Operational planning trajectories from 2025/26 onwards were set to consider the number of adults aged 18 and over from the ICB who have a learning disability (including those who may also be autistic) and the number of adults aged 18 and over from the ICB who are autistic (with no learning disability) who are in mental health inpatient care. • Intensive Support Teams (ISTs) for people with a learning disability secured and recruitment commenced in Q3 2025/26. New teams will ensure that there is IST coverage in all South East London boroughs to support discharge and prevent admissions. • Digital Dynamic Support Registers (DSRs) launched in August 2025 across South East London to support admission prevention and utilisation of Care Education Treatment Reviews (CETRs). The system is now being used to capture case notes for Key working and Case Management. • LDA specialist prescribing directly supports patients, primary care, annual health checks and the LeDeR Programme. The One Stop STOMP clinic is doing exceptional work in South East London.	• Community autism specialist services to support autistic only people developed to prevent admission and support community placements. Along with existing services commissioned from Mental Health providers, these services will support the continued reduction in admission rate. Providers are working to fully mobilise services during Q3 2026/27. • Housing, care and support work is in development to support discharge and prevent admissions. • The ICB is working with providers to develop an action plan to address the high numbers of people on waiting lists/long waiting times for autism assessment as well as requirements to meet demand in the longer term, includes work on Right to Choose and accreditation of services.

13. Asthma

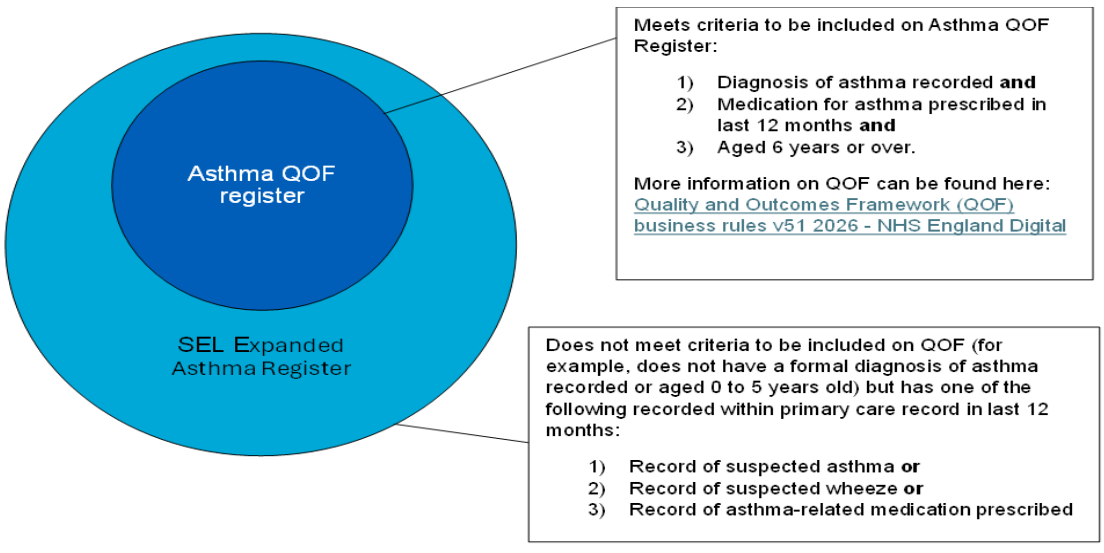
Overview: There are currently there are 17,834 CYP who are part of Quality Outcomes Framework (QOF) asthma register and 34,949 CYP who are part of the expanded asthma register (suspected and confirmed) aged between 0-24. Those aged 6-11 have a higher rate of asthma (suspected and confirmed) prevalence compared to any other age band, and those aged 18-24 have the lowest rate. Those of White and Black Caribbean descent have the highest rate of asthma (suspected and confirmed) prevalence, followed by those of Bangladeshi descent and Caribbean descent. Bexley, Greenwich and Bromley have the highest percentage (13%-14%) of patients on reliever only inhalers compared to their total asthma population.

Activity Reporting Period: 2023 to 2026.
Data Source: Primary care data via Discovery.

13.1. Children and Young People (CYP) Asthma Prevalence and Diagnosis

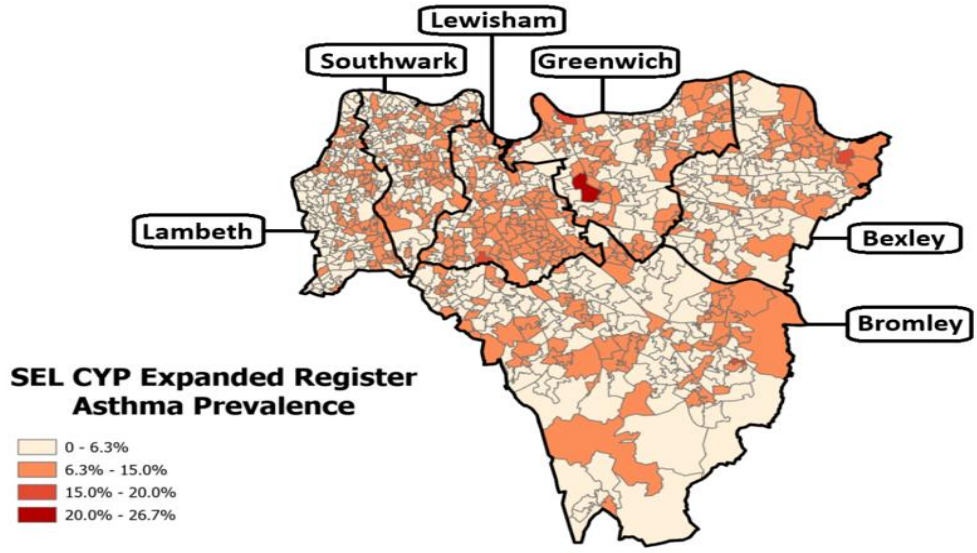
South East London have been utilising an "expanded" asthma register for reporting on Children and Young People (CYP) asthma which is used within this report. With thanks to the CHILDS team at the Evelina London Children's Hospital for creating and sharing this definition with the ICB, the South East London definition of expanded" asthma register includes:

- Any child or young person on the Quality Outcomes Framework (QOF) register for asthma (diagnosis of asthma, medication for asthma prescribed in last 12 months and aged 6 years or over)
- Any child or young person with a record of suspected asthma or wheeze in the last 12 months
- Any child or young person with a record of being prescribed asthma-related medication in the last 12 months without a diagnosis of asthma

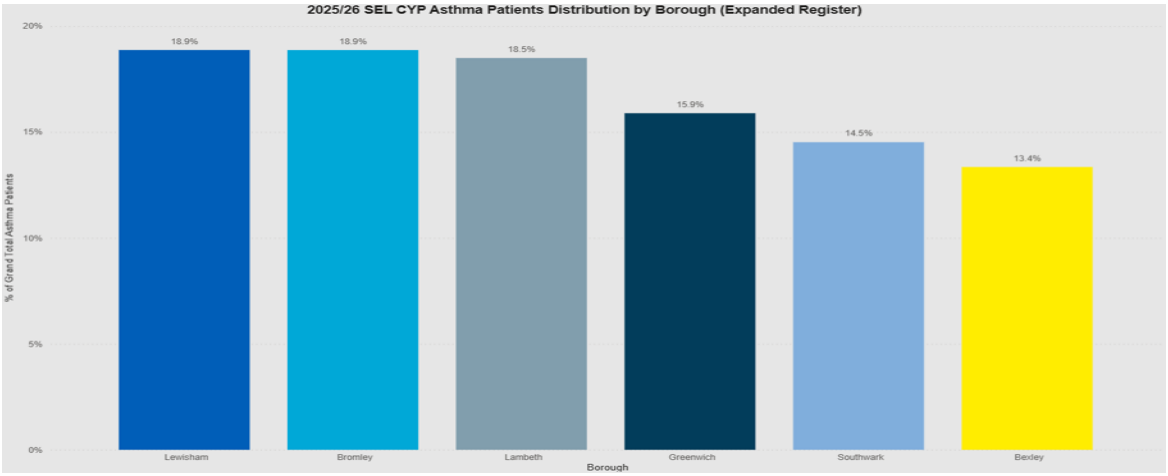


Currently there are 17,834 CYP who are part of Quality Outcomes Framework (QOF) asthma register and 34,949 CYP who are part of the expanded asthma register (suspected and confirmed) aged between 0-24 years old.

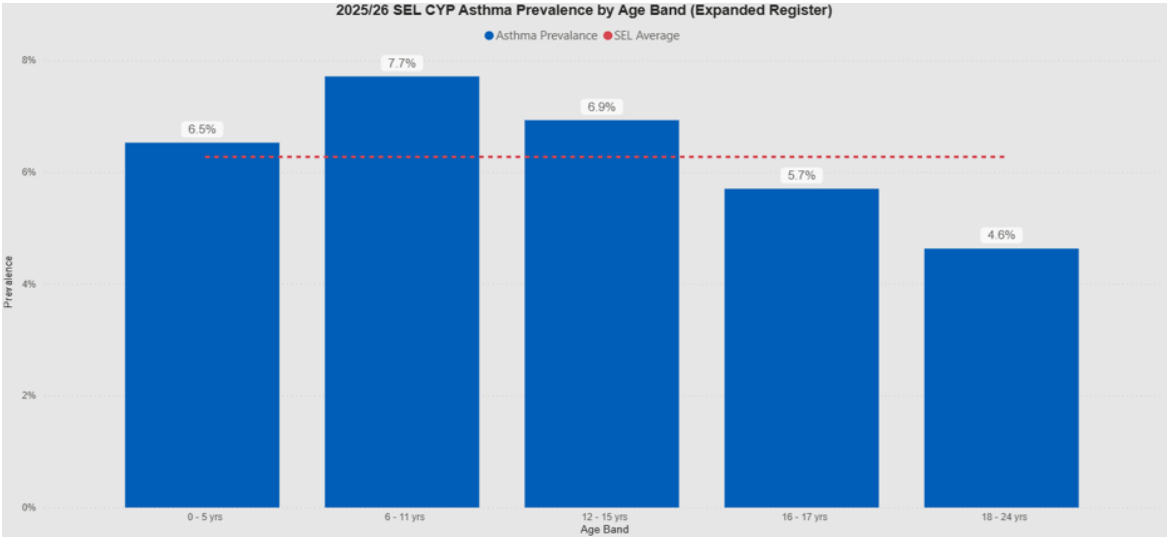
This map looks at the rate of CYP aged between 0-24 who are part of the expanded asthma register (suspected and confirmed) population. The darker colours represent the Lower Super Output Areas (LSOAs) which have a higher prevalence than the South East London average of 6.3%. Consideration should be given to higher rates possibly being due to some GP practices having better recording of asthma within patient records than others, rather than indicating a definite higher rate. It is worth noting that Lewisham appears to have a larger proportion of LSOAs with CYP asthma above the South East London average.



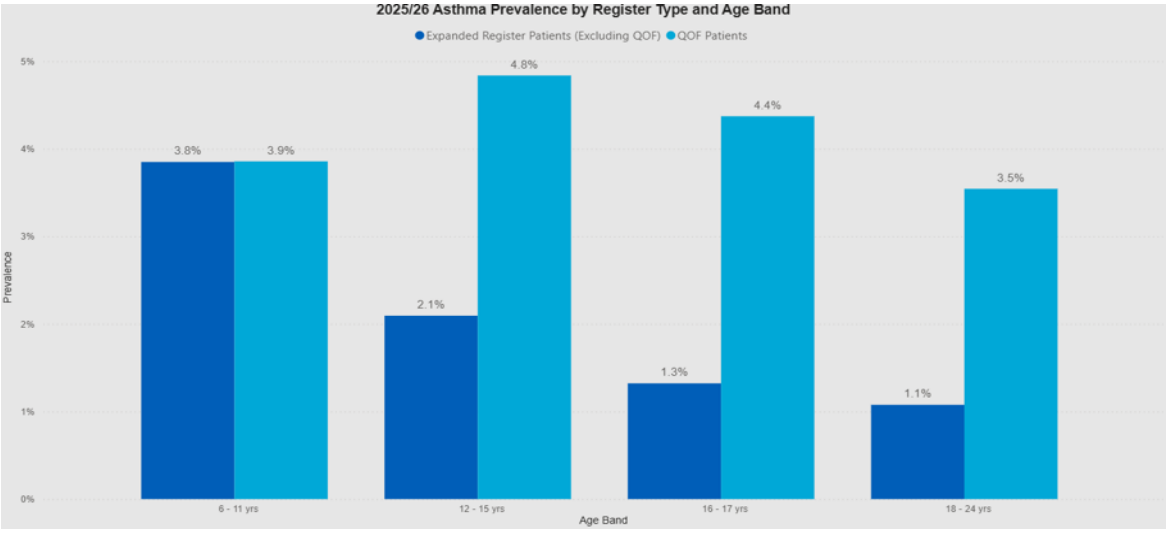
Looking at the distribution of asthma prevalence across boroughs, Lewisham, Bromley and Lambeth have the highest percentage of CYP with asthma.



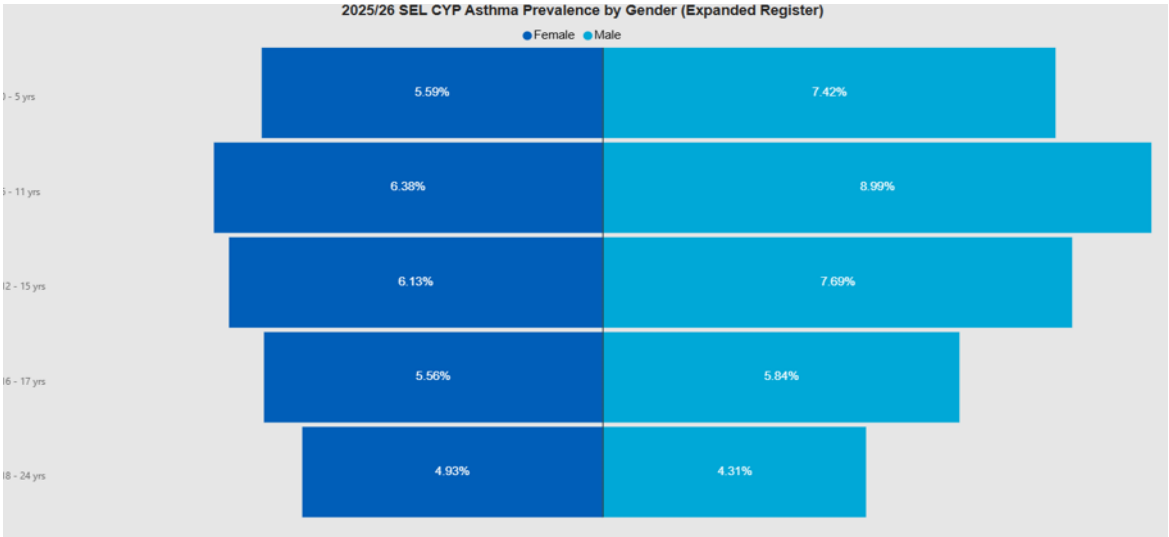
Looking at the age profile, those aged 6-11 have a higher rate of asthma (suspected and confirmed) prevalence compared to any other age band, and those aged 18-24 have the lowest rate. Those aged 0-5 whilst not on the QOF register, without intervention have the potential of being added to the QOF register once they turn 6 years old.



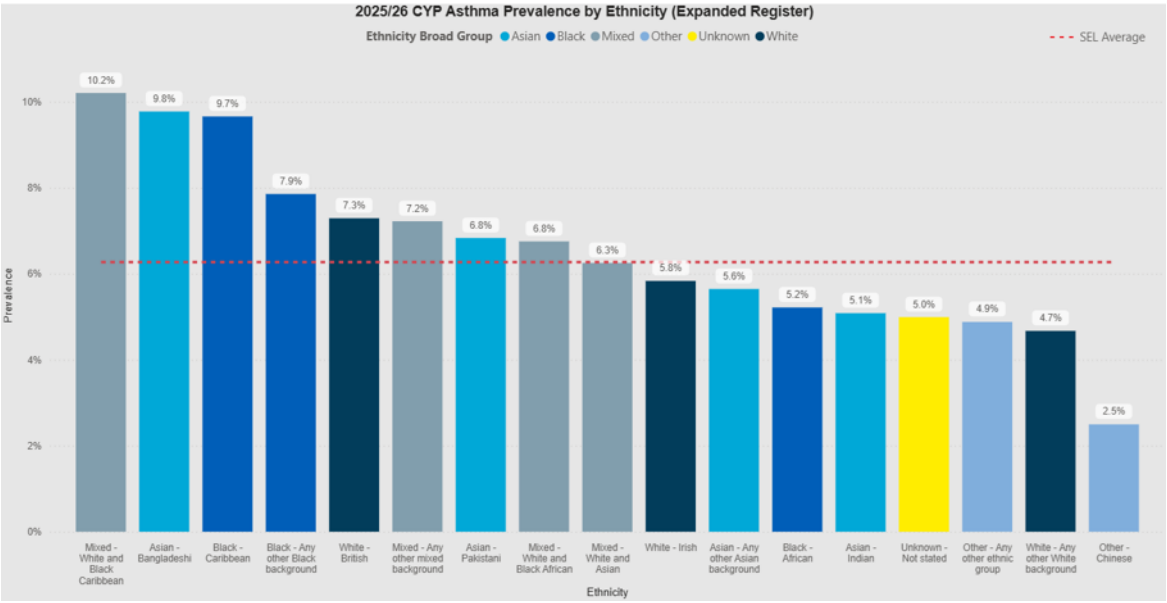
Given the high rate of suspected asthma within those aged 0-5, it is noteworthy to observe that those aged 6-11 have a comparable prevalence rate between those on QOF (confirmed asthma) and those on the expanded register (suspected asthma, once QOF is excluded), suggesting that there might be recording issues with QOF and that more CYP should be included on the QOF than are being captured.



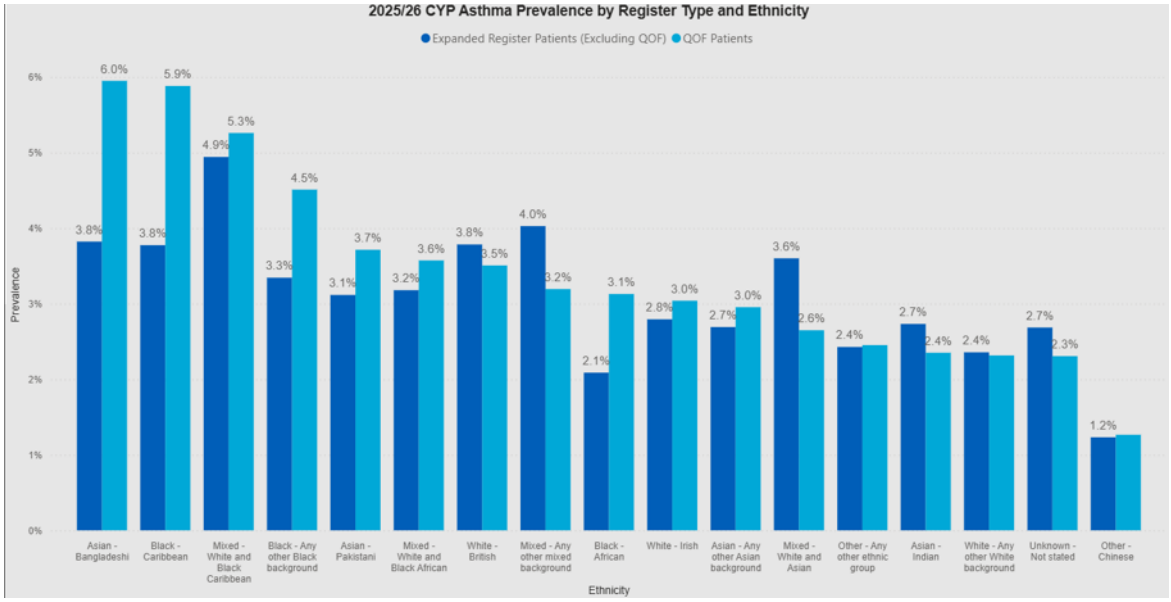
Looking at the gender profile males have a higher rate of asthma (suspected and confirmed) prevalence compared to females, with the largest difference observed within those aged 6-11.



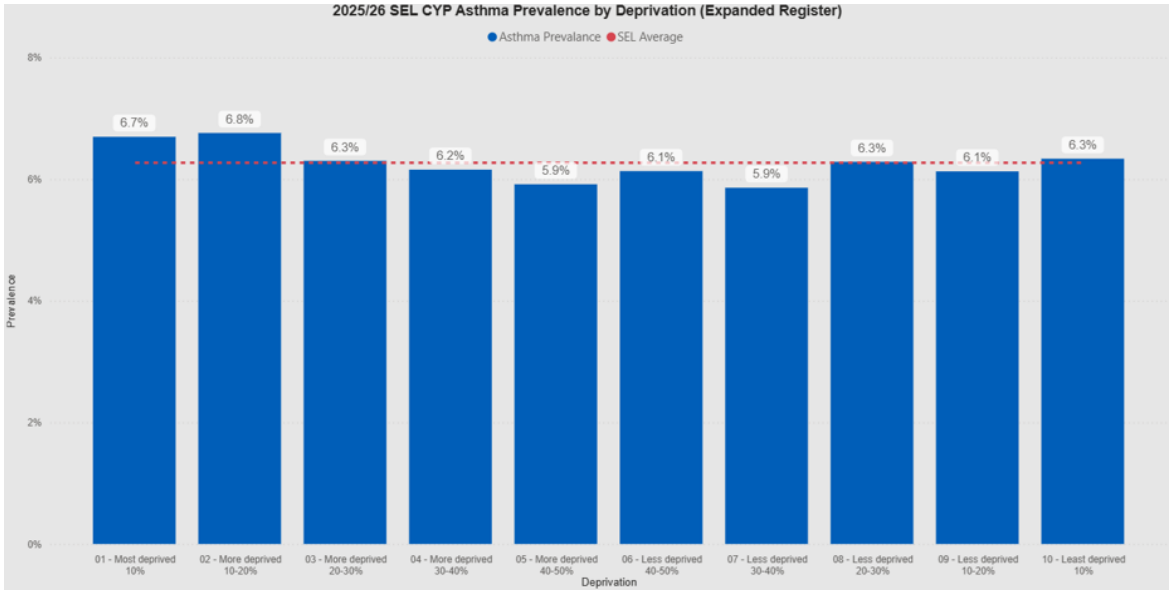
Looking at the ethnic profile, a variation is observed across all ethnic groups and when the data is broken down further by subgroups, the variation is clearer. Those of White and Black Caribbean descent have the highest rate of asthma (suspected and confirmed) prevalence, followed by those of Bangladeshi descent and Caribbean descent.



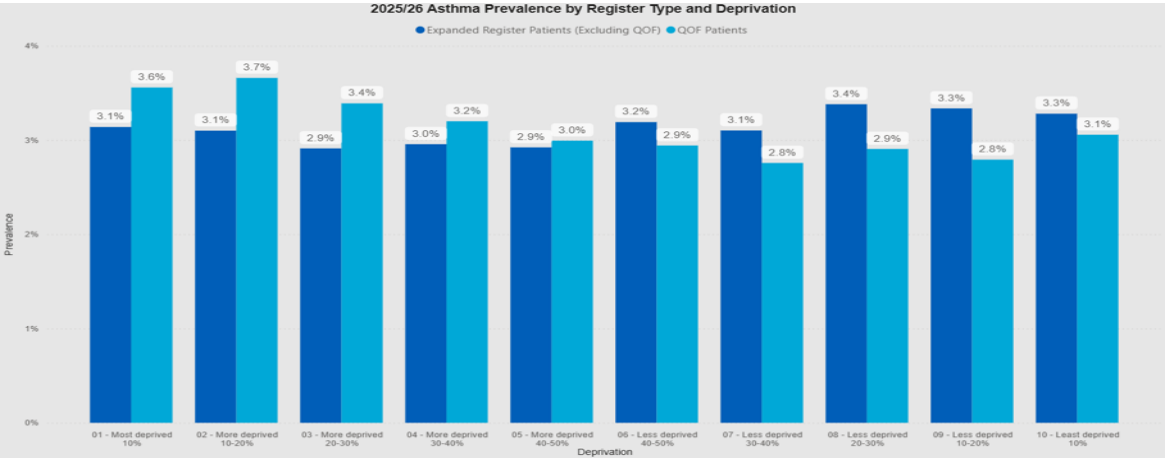
When the ethnic profile is broken down further by register type, a variance observed based on a single register type change slightly. Those of Bangladeshi descent have the highest rate of asthma prevalence, followed by those of White and Black Caribbean descent and Caribbean descent.



There is no clear corelation between asthma (suspected and confirmed) prevalence and deprivation, although those in deciles 1, 2 and 3 (most and next most deprived) have a higher rate, the difference across all deciles is minimal.



When the data is further broken by register type, the slight difference observed based on a single register remains the same. Suggesting no clear corelation between asthma prevalence and deprivation. It is important to note that national evidence demonstrates a clear association between deprivation and poorer childhood asthma outcomes, including higher rates of emergency attendance, hospital admission, intensive care admission and mortality. Local South East London data show a weaker relationship between deprivation and recorded asthma prevalence, with only modest differences across deprivation deciles. This suggests that, in South East London deprivation may be a stronger driver of asthma outcomes and control than of prevalence itself.



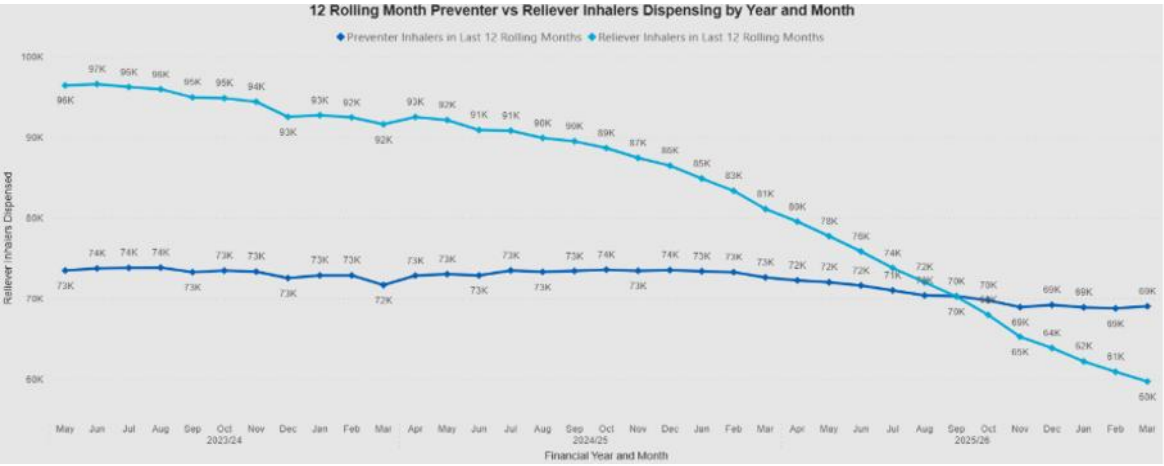
13.2. Inequalities in dispensing of reliever only inhalers for Children and Young People (CYP) with asthma

This reports notes that the terms for reliever and preventer inhalers have changed in line with the introduction of new NICE guidelines and acknowledges the following terms:

- Reliever inhalers are called Short-acting beta-2 agonists (SABAs)
- Preventer inhalers are called ICS/long-acting beta-2 agonist (LABA) inhalers

However, for the purpose of this report and for coding reasons we have maintained the name reliever and preventer inhalers. Any future reports will reflect this change.

Over the past three years the total number of reliever inhalers being prescribed has decreased significantly whilst preventer inhalers have remained relatively stable with a slight decrease. It is important to note that reliever inhalers act to quickly relieve symptoms and are only used when symptoms are felt or a person has an asthma attack, whereas preventer inhalers have a slow build-up and work over time to control asthma and are usually used more regularly.

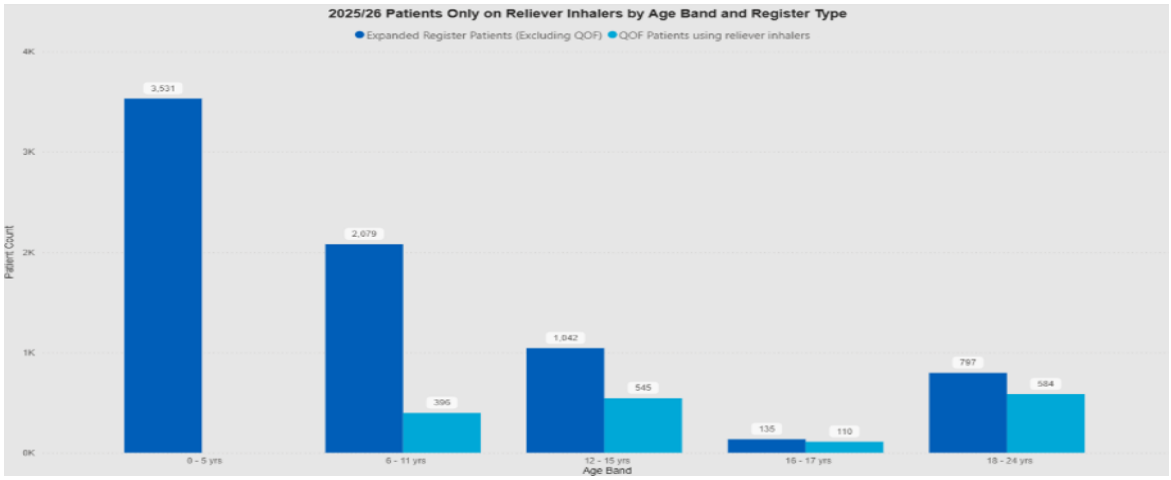


Reducing reliever-only inhaler use whilst increasing preventer inhaler use represents best practice asthma management and should be the goal. Evidence-based practice: Current asthma management guidelines (BTS / NICE) emphasise that:

- Reliever-only inhalers should NOT be the primary management strategy
- Children relying on reliever inhalers alone have poorly controlled asthma
- Preventer (controller) therapy is essential for all children with persistent asthma

The following data looks at patients who have been prescribed reliever only inhalers between April 2025 and March 2026.

Looking at the age profile and register type, 38% of those aged 0-5 (suspected asthma) are prescribed reliever inhalers, as are 23% of those aged 6-11. The data observed indicates that over 60% of children and young people on reliever only inhalers are aged between 0-11 and are not part of the QOF register. Across all age band more CYP on the expanded register (suspected asthma, once QOF is excluded) are prescribed reliever inhalers.



Looking at the gender profile, there are similar rates of reliever only inhalers prescribed per 1,000 population for both males and females. Females aged 0-5 on the expanded asthma register have the highest prescribing rate of 646 inhalers per 1,000 population.

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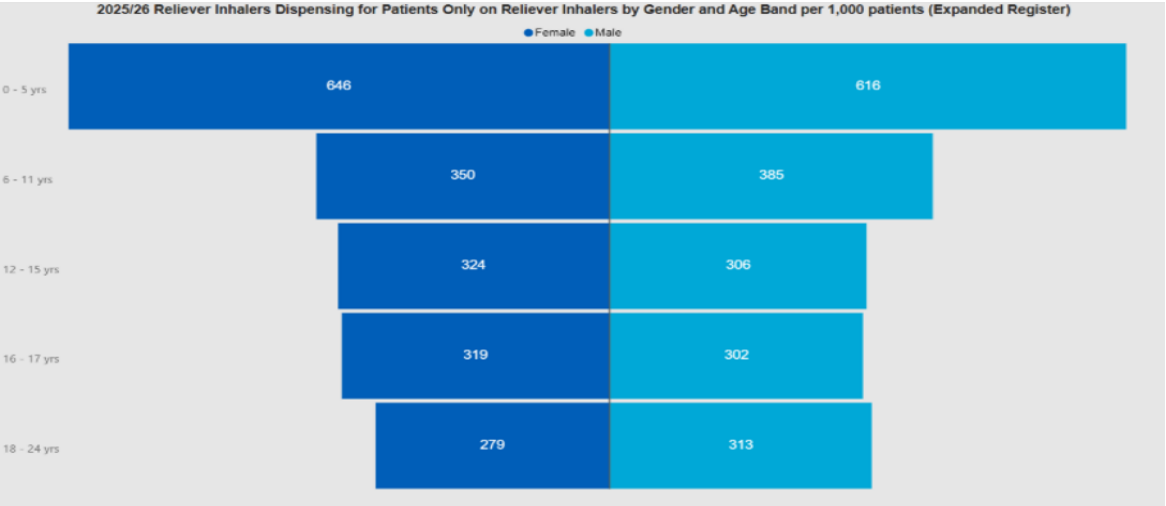
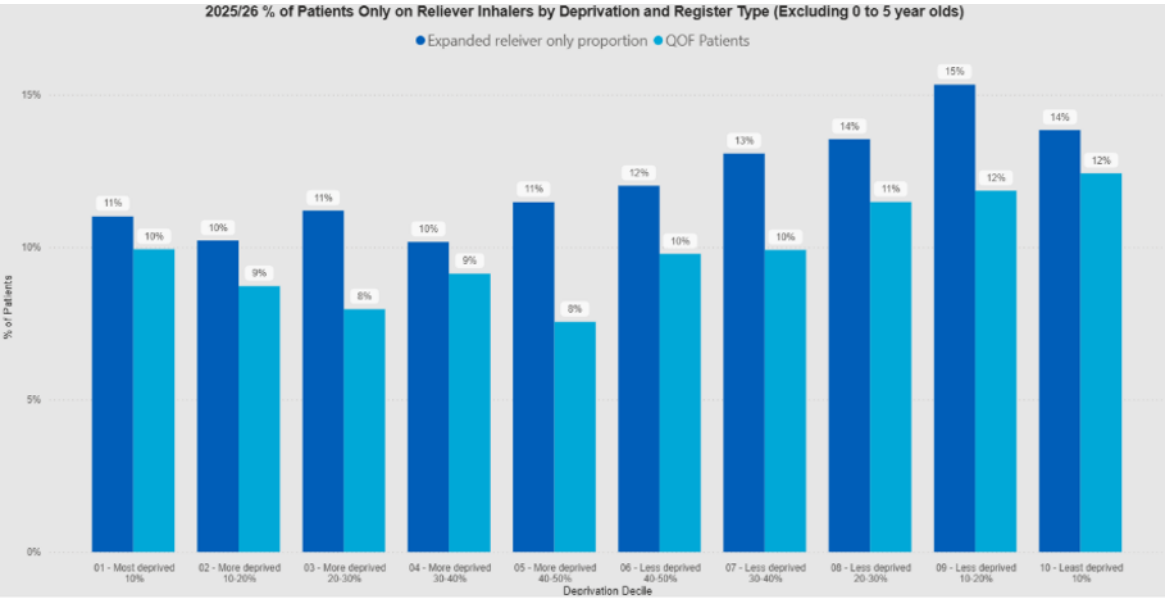
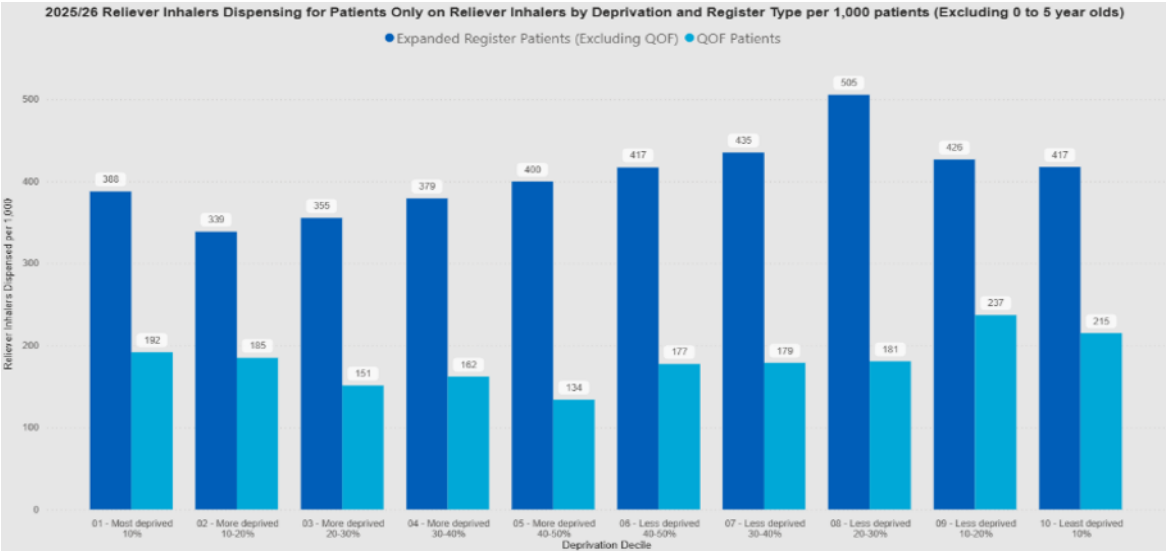


To compare inequalities within ethnicity and deprivation, those aged 0-5 have been excluded from the data, given this age group cannot be included on the QOF asthma register and therefore will only ever be in the expanded asthma register.

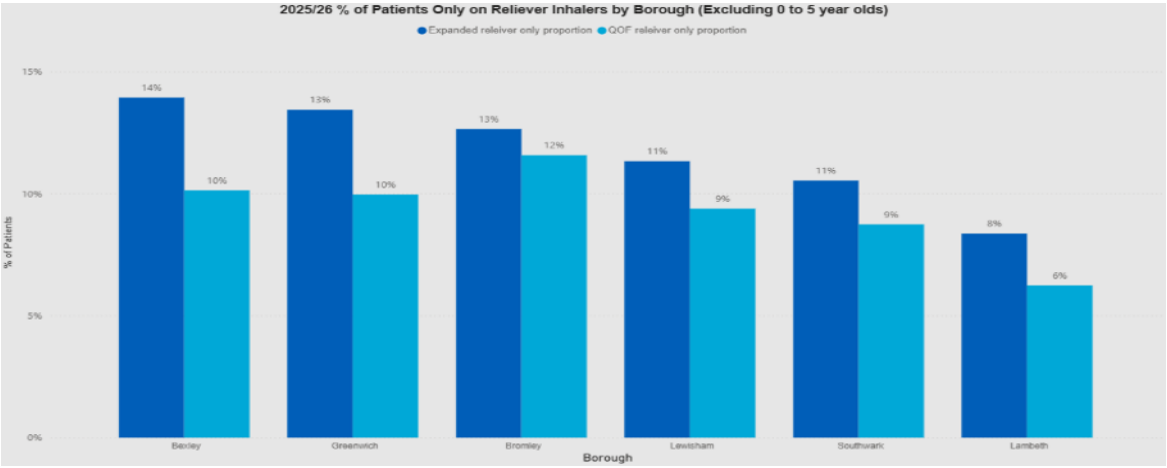
When the data is broken down further by deprivation, those within deciles 7-10 (next least and least deprived) have a slighter higher rate of prescribed reliever only inhalers irrespective of whether they are on the expanded register and QOF asthma register.



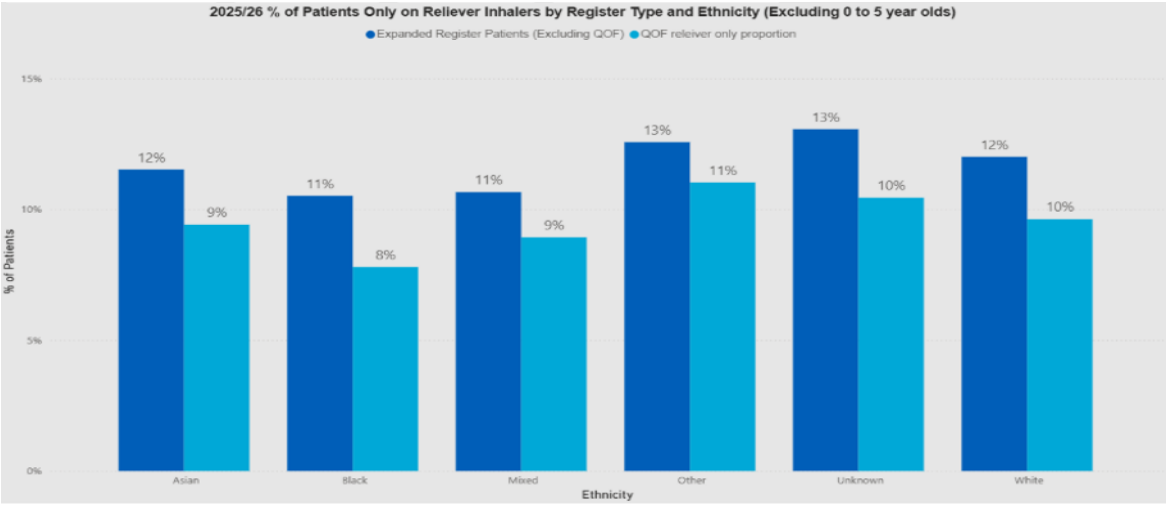
A similar trend is observed when the data is broken down further by the number of reliver only inhalers dispensed per 1,000 population, with those within deciles 7 to 10 (next least and least deprived) having a higher proportion of reliever inhalers prescribed per 1,000 patients, on the expanded register (suspected asthma, once QOF is excluded). When QOF is considered although rates fluctuate, higher rates are still observed within those in deciles 7 to 10.



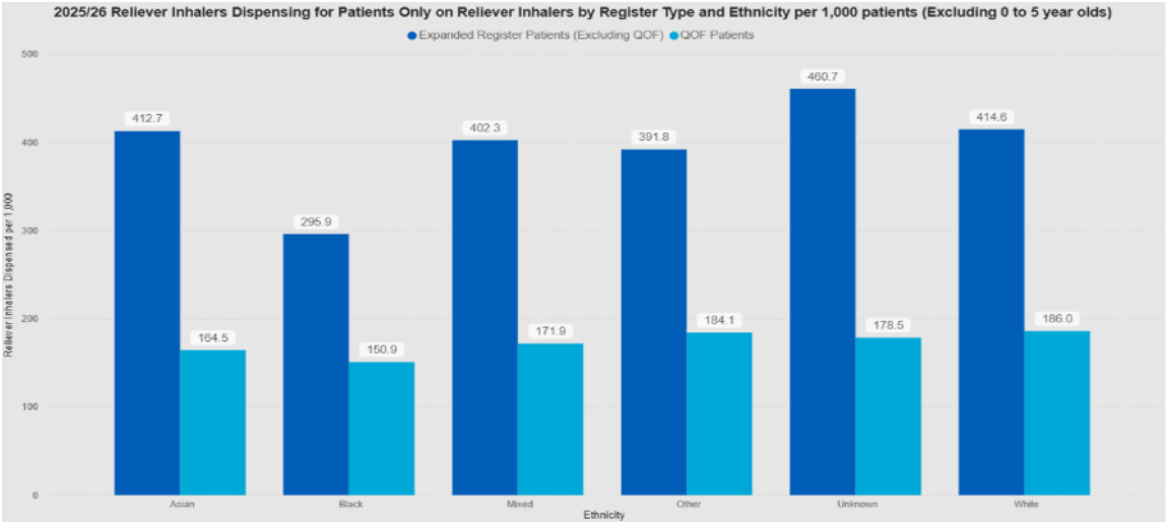
Bexley, Greenwich and Bromley have the highest percentage (13%-14%) of patients on reliever only inhalers compared to their total asthma population.



Looking at the ethnic profile by register type, the variance observed between group and register type is minimal.



When the ethnic profile is broken down further by reliver only inhalers dispensed per 1,000 asthma population by register type, a significant variance is observed between groups and register type.



Looking at the expanded asthma register for reliever only inhalers, for those aged 0-5, what is observed is that those within deciles 2 to 5 (next most deprived) have higher rates of prescribed reliever inhalers, accounting for a total of 62% of this cohort

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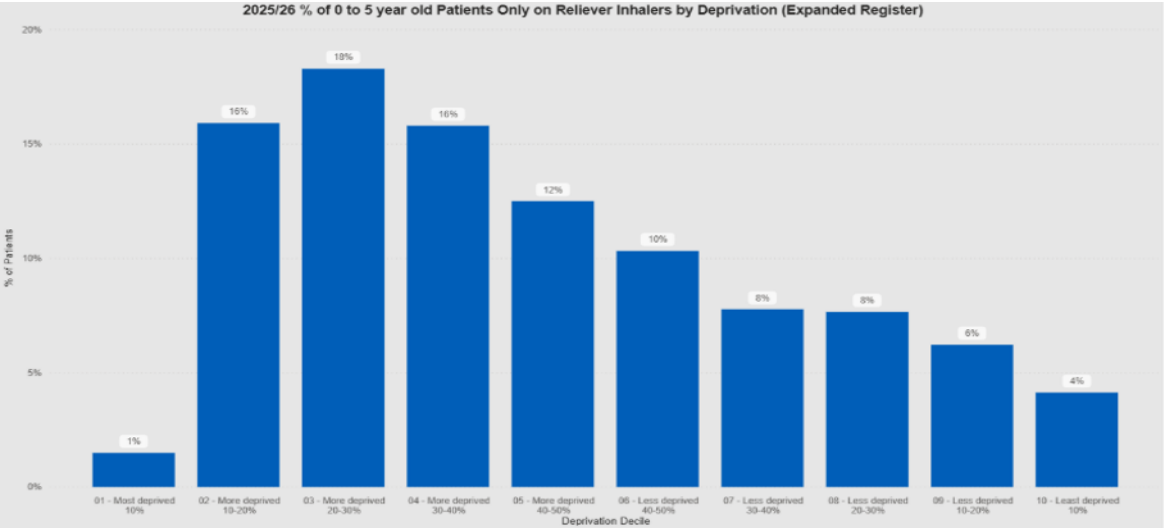
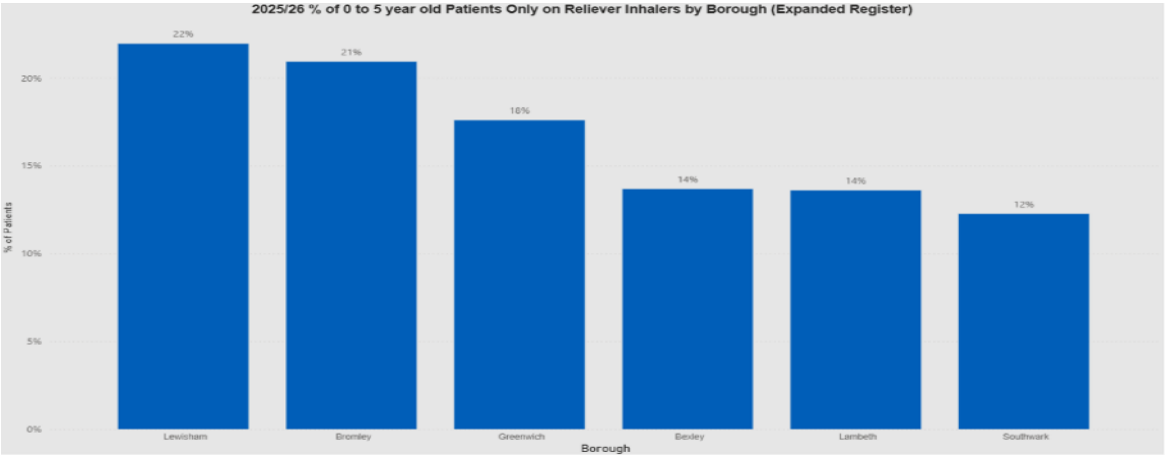


Looking at those aged 0-5 distribution by Borough, around 43% of patients prescribed reliever only inhalers are registered in Lewisham and Bromley. Given that the data indicates higher asthma prevalence within both boroughs, this finding might be unsurprising.



Improvement activity

• SEL ICB CYP asthma improvement programme is aligned to the National Bundle of Care for Children and Young People with Asthma and the CYP Core20PLUS5 priorities. The programme has focused on reducing variation, improving outcomes, and ensuring children and young people with asthma receive safer, more consistent, evidence-based care across South East London. **Some key areas of Improvement activity include**: • Development and oversight of SEL-wide CYP asthma governance, including the CYP Asthma Delivery Group and wider SEL CYP Asthma Network, to coordinate improvement activity across primary care, acute, community, pharmacy, medicines optimisation, public health, education and borough teams. • Use of population health management and primary care data to identify variation and inequalities, including use of an expanded CYP asthma register to better understand children and young people with suspected or confirmed asthma, reliever-only inhaler use, SABA overuse, oral corticosteroid use, admissions and A&E attendances. • Development of SEL asthma dashboards and reporting to support practices, boroughs and system partners to monitor improvement, understand variation, identify high-risk cohorts and evaluate the impact of interventions • Development and implementation of SEL ICB CYP asthma guidance, led through Clinical Effectiveness South East London (CESEL) and local clinical leads, including practical guidance for general practice on diagnosis, management, inhaler optimisation, and implementation of updated NICE/BTS guidance.	• Improvement activity has delivered measurable progress for CYP asthma in South East London, but there remains a significant amount further to go to ensure optimal asthma management and outcomes for children and young people. Continued improvement will require a multiagency approach across health, local authorities, schools, housing and wider partners, particularly where asthma outcomes are affected by wider determinants such as damp and mould, air quality, housing conditions, school support, health inequalities and timely access to reviews. • A key next step will be to align CYP asthma improvement with CYP Integrated Neighbourhood working, which is a major priority area for South East London ICB. Neighbourhood teams provide an opportunity to bring together primary care, community services, local authority partners, schools, housing and voluntary sector support around CYP and families, helping to identify risk earlier, coordinate proactive follow-up and strengthen local asthma management. • SEL ICB funded of a proactive case management pilot in Lambeth to identify CYP at higher risk of poor asthma outcomes and support more coordinated follow-up, including review of high-risk prescribing patterns, recent urgent and emergency care use, asthma action plans, inhaler technique, medicines optimisation, and links into wider primary, community and specialist support including pharmacy where needed. Learning from this pilot will be shared with other PCNs for potential inclusion in CYP Integrated Neighbourhood Teams.

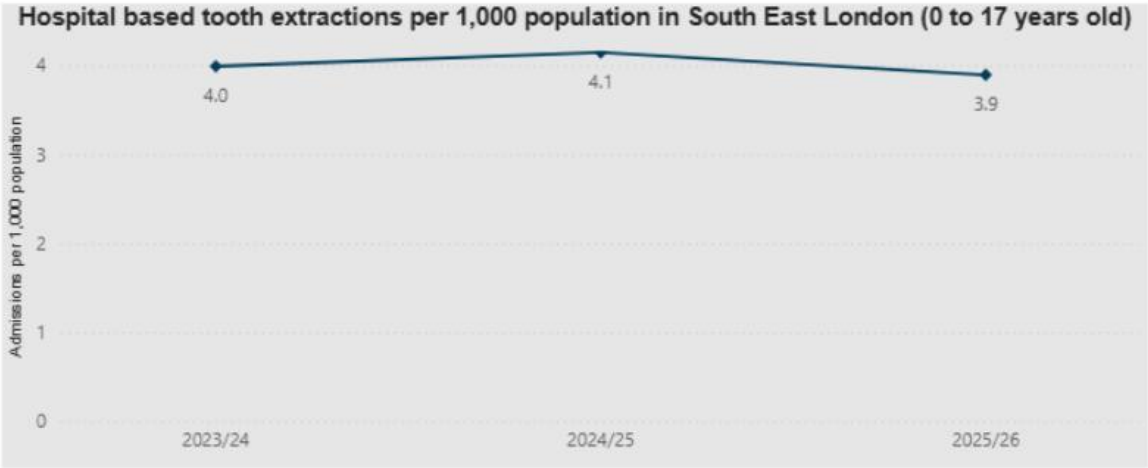
14. Oral Health

Overview: There were 1,504 hospital-based tooth extractions in 2025/26 for under 18s. Of those 1,504 South East London admissions, 962 of these were those aged 5-9 and make-up 64% of admissions compared to their population size for under 18s of 27%. This group have the highest rate of hospital-based extractions than any other age group. There is a clear correlation between hospital-based tooth extractions and deprivation, those in quintiles 1 and 2 (most and next most deprived) have higher admissions rate compared to those in quintiles 4 and 5 (next least and least deprived). This has been a consistent pattern over the past three years

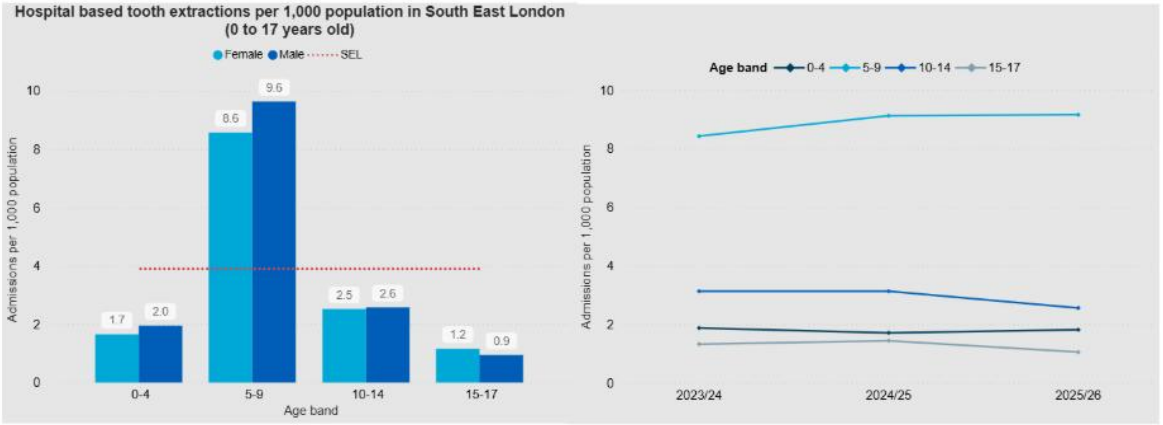
Activity Reporting Period: 2023 to 2026.
Data Source: Secondary Uses Service (SUS)

14.1. Inequalities in elective admissions of hospital-based tooth extractions due to dental caries

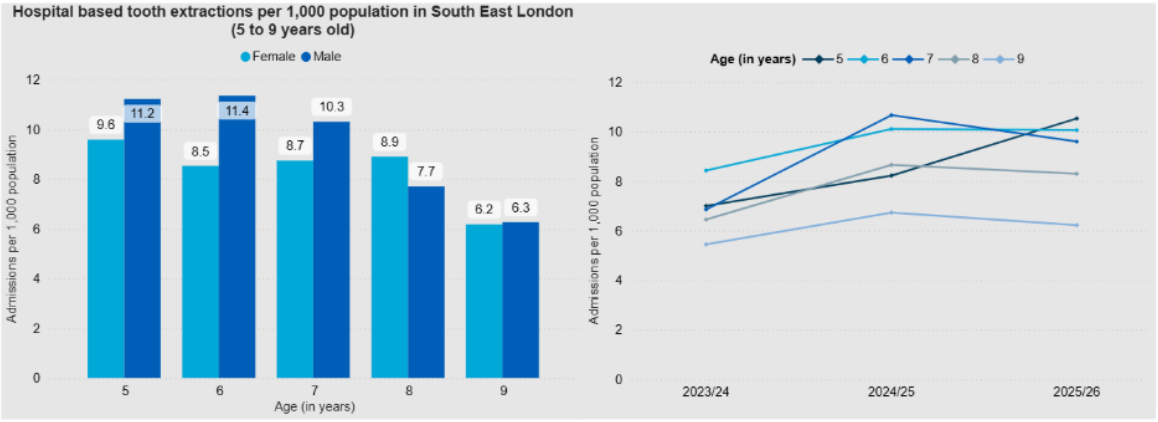
Admission for hospital-based tooth extractions for those aged 0-17 in South East London remains relatively stable in the past three years, with a rate of around 4 per 1,000 population. There were 1,504 hospital-based tooth extractions in 2025/26 for under 18s.



Looking at the age profile, of those 1,504 South East London admissions, 962 of these were those aged 5-9 and make-up 64% of admissions compared to their population size for under 18s of 27%. This group have the highest rate of hospital-based extractions than any other age group by far, 8.6 per 1,000 population for females and 9.6 per 1,000 population for males. This group equally has the largest variation in extraction between females and males.



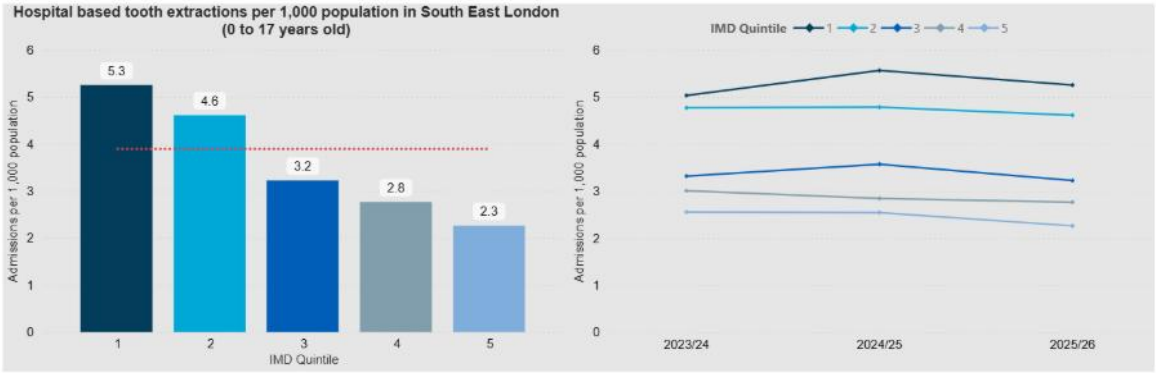
When the age profile is broken down further, the highest rate of admission is noted for those aged 5 and 6, (10.5 and 10.1 per 1,000 population respectively). An even further increase in rate is observed for males aged 5 and 6 (11 per 1,000 population). It is important to note that admissions for 5 year olds increased from 147 in 2023/24 to 200 in 2025/26, a 36% increase, however, the South East London population size for this age group decreased by nearly 10%.



There is a clear correlation between hospital-based tooth extractions and deprivation, those in quintiles 1 and 2 (most and next most deprived) have higher admissions rate compared to those in quintiles 4 and 5 (next least and least deprived). This has been a consistent pattern over the past three years.

IMD Quintile & Age Band	0-4	5-9	10-14	15-17
1	2.3	12.6	3.8	1.0
2	1.9	10.7	3.2	1.4
3	1.9	7.9	1.6	0.5
4	1.2	6.4	1.6	1.1
5	1.2	4.8	1.6	0.8

Looking at the age profile and deprivation, the highest rates of hospital-based extractions is observed in those aged 5-9 living in quintiles 1 and 2 (most and next most deprived) although it should be noted that across all quintiles, this age group has a higher extraction rate than the South East London average of 4 per 1,000 population.



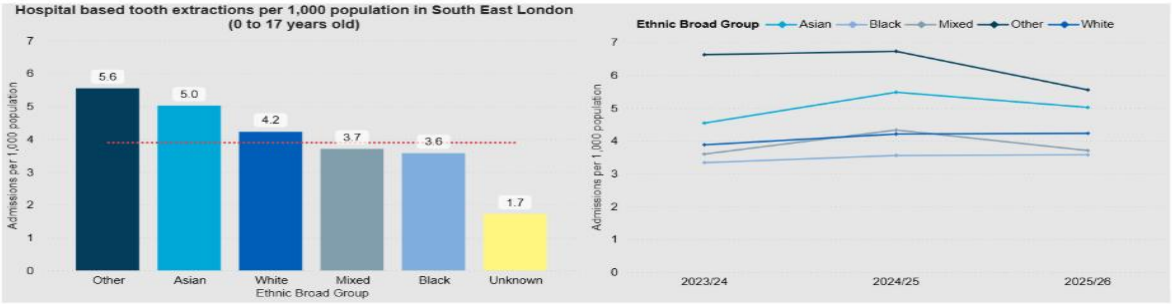
Looking at the ethnic profile, those of Other ethnicity has the highest rate of hospital-based extractions. This rate appears to have reduced in the last three years, from 6.6 per 1,000 population in 2023/24 to 5.6 per 1,000 in 2025/26. Given that recording of "Other" ethnicity within Secondary Uses Service (SUS) appears to be higher than what we would expect the ethnic make-up to be of the South East London population, it is difficult to determine if this reduced rate is a reduction in inequalities or an improvement in ethnicity recording. (**see Data Quality section for more information)**.

Ethnic group & IMD Quintile (ages 0 to 17 years)

Ethnic group & IMD Quintile	1	2	3	4	5
Asian	6.7	5.9	5.6	3.0	2.4
Black	3.9	3.9	2.7	3.0	1.0
Mixed	4.4	4.0	3.4	3.6	2.3
Other	7.8	6.5	4.4	2.9	2.2
White	7.4	5.5	3.1	2.8	2.7

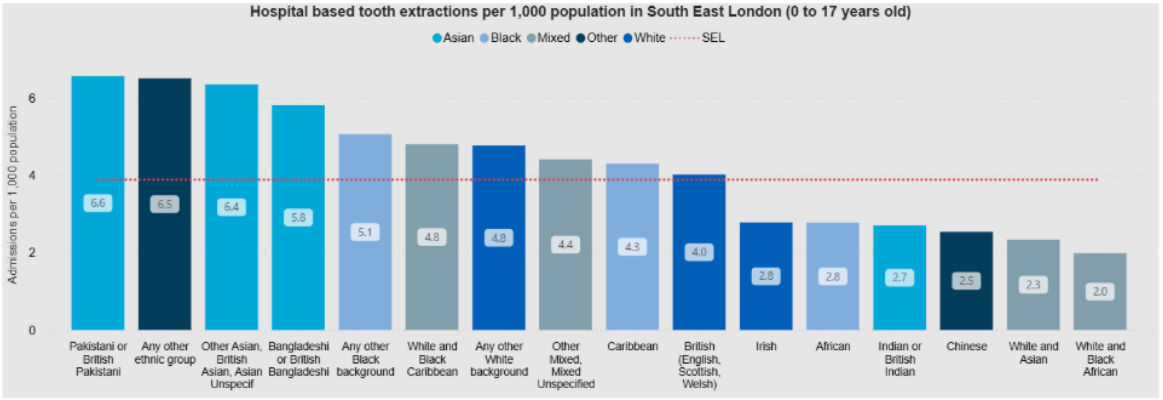
Ethnic group & IMD Quintile (ages 5 to 9 years)

Ethnic group & IMD Quintile	1	2	3	4	5
Asian	20.7	15.8	12.5	8.6	7.0
Black	8.6	8.3	7.3	7.6	
Mixed	10.5	10.9	8.1	9.1	7.2
Other	19.3	13.6	10.7	5.3	3.9
White	15.9	12.8	7.8	6.3	5.3



When the ethnic profile is broken down further by deprivation, for 0-17 years old, those of Asian, White and Other ethnicity living in more deprived areas have higher rates of hospital-based tooth extractions. Higher extraction rates are observed, when the data is broken down further focusing on those aged 5-9, rates roughly triple for those of Asian ethnicity and doubles for those of White and Other ethnicity across all quintiles.

When the ethnic profile is broken down further by subgroups, a greater inequality in hospital-based extractions within those of Asian ethnicity is observed. Those of Pakistan, Other Asian and Bangladeshi descent have some of the highest rates out of all ethnicities.



15. Data Quality

Overview: Ethnicity completeness in 2025/26 varies across datasets, although several common themes emerge. Primary Care (93%) and MSDS (98%) demonstrate the highest levels of completeness, providing a strong foundation for population health and maternity inequalities analysis. Across almost all datasets, 'Not Stated' ethnicity is the largest contributor to incomplete recording, suggesting that future improvements are likely to depend more on how ethnicity is requested, captured and recorded at the point of care than on technical data submission processes.

15.1. Quality of ethnicity coding across datasets received by the ICB Introduction

This analysis shows how ethnicity data are being recorded for completeness and accuracy within the Acute, Mental Health, Community and Maternity datasets for SEL registered patients.
The ICB receives data from national sources:

- Primary Care
- Secondary Uses Service (SUS) Unified:
  - Admitted Patient Care (APC)
  - Outpatients (OP)

    - Emergency Care Data Set (ECDS)
- Mental Health Services Data Set (MHSDS)
- Community Services Data Set (CSDS)
- Maternity Services Data Set (MSDS)

The ICB also receives local data flows:

- Service Line Agreement Monitoring (SLAM):
    - Patient Level Contract Monitoring (PLCM)
    - Drugs Patient Level Contract Monitoring (DrPLCM)
    - Devices Patient Level Contract Monitoring (DePLCM)

Period covered from 1st April 2022 to date.

Ethnicity coding completeness is reported under the following categories:

- **Non-Residual**: Valid ethnicity codes A-S submitted - ethnicity has been recorded using a valid, recognised National Ethnicity code.
- **Residual**: use of outdated, retired, invalid codes/ unknown values, this is possibly the result of bad coding practices or legacy mappings issues.
- **Not Stated:** patient choice in declining to provide ethnicity - this reflects how ethnicity is captured at the point of care/interactions.
- **Blank/Null**: this indicates missing data, i.e. the ethnicity field has not been population within the dataset, possibly a system or submission failure.

15.2. Ethnicity Data Quality Overview

Ethnicity completeness in 2025/26 varies across datasets, although several common themes emerge. Primary Care (93%) and MSDS (98%) demonstrate the highest levels of completeness, providing a strong foundation for population health and maternity inequalities analysis. Amongst the national datasets, APC (86%), OP (82%) and MHSDS (82%) perform at broadly similar levels, whilst ECDS (75%) and CSDS (68%) show lower completeness. Within local datasets, DrPLCM (87%) and DePLCM (86%) perform relatively well, whereas PLCM (76%) continues to show lower completeness.

Across almost all datasets, 'Not Stated' ethnicity is the largest contributor to incomplete recording, suggesting that future improvements are likely to depend more on how ethnicity is requested, captured and recorded at the point of care than on technical data submission processes. Residual coding continues to affect some datasets, particularly community and local contract monitoring datasets, while Null/Blank values are generally low and no longer represent a major system-wide issue.

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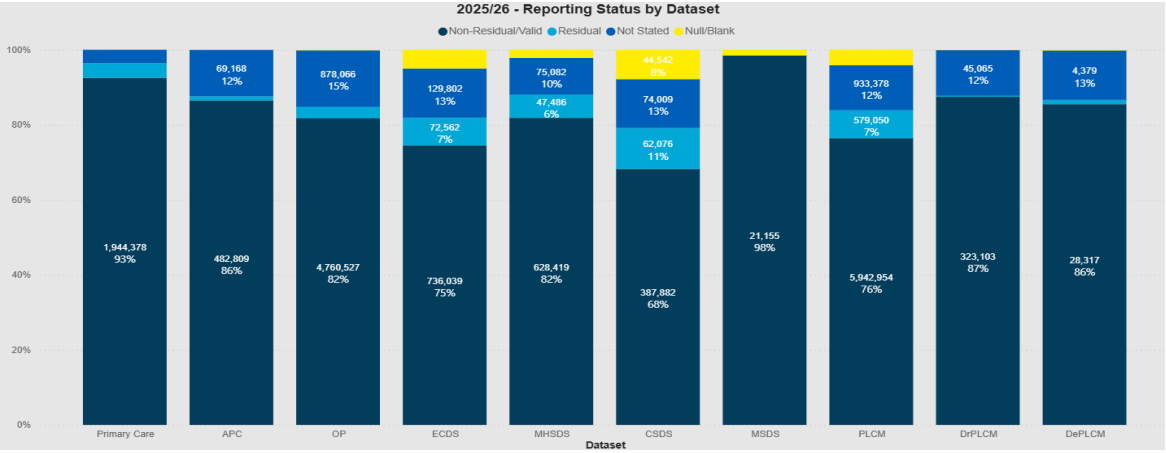


15.3. Provider overview

Looking across all datasets, overall ethnicity completeness has remained broadly stable over time, increasing from 85% valid coding in 2022/23 to 87% in 2025/26. The composition of incompleteness has also remained relatively consistent. The proportion of records recorded as 'Not Stated' has remained at around 7–8% across recent years and continues to represent the largest contributor to incomplete ethnicity recording. Residual coding has reduced slightly over time, while Null/Blank values remain low, suggesting that current levels of incompleteness are increasingly associated with recording practices and patient interaction rather than technical submission failures.

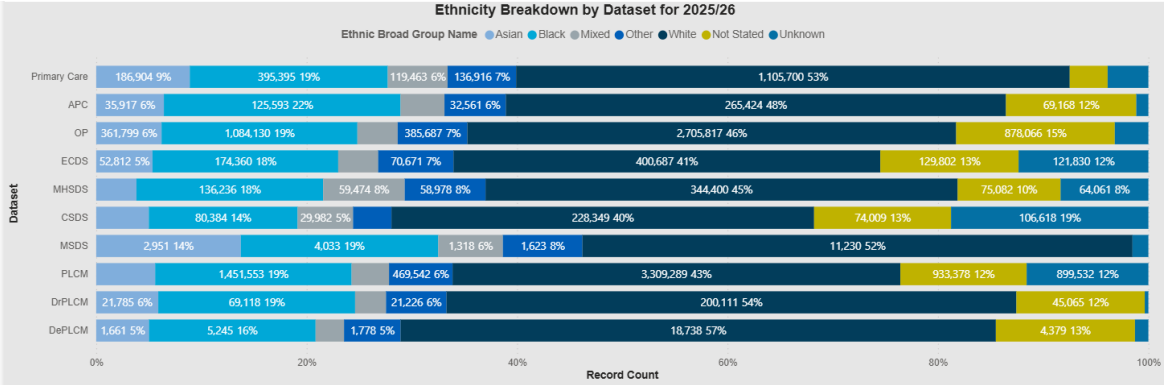
At provider level, ethnicity completeness varies, although the degree of variation differs by dataset. Across acute datasets, Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust generally demonstrate consistently high levels of completeness, while Lewisham and Greenwich NHS Trust tends to show lower completeness in several datasets, largely reflecting higher levels of 'Not Stated' ethnicity and, in some cases, residual coding. The greatest provider-level variation is seen within community and local contract monitoring datasets, where differences appear to be driven more by coding practices than missing data. In contrast, MSDS demonstrates consistently high completeness across all providers, with very little variation and near-complete ethnicity recording.

15.4. How the ICB can address ethnicity data quality issues

The ethnic composition of activity varies across datasets, reflecting differences in service use and population coverage. Whilst White ethnicity remains the largest recorded ethnic group across all datasets, the proportion varies considerably between services. Asian and Black ethnic groups together account for a substantial share of activity across most datasets. Higher levels of 'Unknown' and 'Not Stated' ethnicity are concentrated in ECDS, CSDS and some local contract monitoring datasets, reducing

confidence in the underlying ethnic profile and limiting the ability to interpret inequalities accurately.

Variation in 'Unknown' and 'Not Stated' remains a key factor affecting interpretability and reinforces the importance of continuing to improve ethnicity recording. However, completeness alone is not the only challenge, patients may have different ethnicities recorded across different datasets, creating additional inconsistency.



Improvement activity

Provider Overview:	South East London ICB:
• While some datasets demonstrate high levels of completeness, the variation observed over time and between providers highlights inconsistent ethnicity recording practices across services. This reinforces the need for ongoing system-wide and provider-level interventions to improve the quality and usability of ethnicity data. Within South East London, this is being addressed through annual Data Quality Improvement Plans (DQIPs) with providers, which identify specific data quality issues, set improvement thresholds, establish measurement approaches through contract review processes, and monitor progress against agreed actions throughout the year.	• To support more robust reporting, the South East London Ethnicity Register has been developed to bring together the most complete ethnicity information available from multiple data sources. The register provides an important supplementary source of ethnicity data, helping to address gaps and inconsistencies in individual datasets and supporting a more comprehensive understanding of health inequalities across South East London.

This report has been produced by South East London ICB. Should there be any questions that arise from reading this report, we ask that you direct them to the South East London contact us email address: contactus@selondonics.nhs.uk