

Addressing Health Inequalities in South West London 2025-2026

Table of Contents

1	Reducing health inequalities	5
2	Understanding population health needs	5
2.1	Measuring inequalities	7
2.1.1	Elective care	8
2.1.2	Urgent and emergency care.....	10
2.1.3	Maternity.....	11
2.1.4	Mental health	13
2.1.5	Respiratory	14
2.1.6	Cancer.....	16
2.1.7	Cardiovascular disease.....	17
2.1.8	Learning disability health checks	23
2.1.9	Inequalities in children’s emergency department attendances	25
2.1.10	Asthma - inequalities in asthma attendances	26
2.1.11	Oral health	27
2.1.12	Mental health-Children and young people.....	29
2.1.13	Ethnicity Coding	31
2.1.14	Limitations.....	32
2.2	Understanding intersectionality and risk factors.....	32
3	Acting on reducing health and healthcare inequalities.....	34
3.1	Community empowerment and outreach	34
3.2	Reducing digital exclusion	35
3.3	Reducing tobacco dependency.....	35
3.4	Growing inclusivity in research	36
3.5	Improving uptake and coverage of immunisations	36
4	Governance for health equity work.....	39

Table of Figures

Figure 1 18+ week wait by ethnicity	8
Figure 2 18+ week wait by age.....	8
Figure 3 18+ week wait by deprivation	9
Figure 4 Mean time waits in ED by ethnicity.....	10
Figure 5 Mean time waits in ED by age.....	10
Figure 6 Mean time waits in ED by deprivation.....	11
Figure 7 Mean time waits in ED by gender.....	11
Figure 8 Pre-term births by ethnicity.....	11
Figure 9 Pre-term births by age.....	12
Figure 10 Pre-term births by deprivation	12
Figure 11 Pre-term births by gender.....	12
Figure 12 Pre-term births by borough.....	12
Figure 13 Adult mental health patients by ethnicity	13
Figure 14 Adult mental health patients by age	13
Figure 15 Adult mental health patients by deprivation	14
Figure 16 Adult mental health patients by gender	14
Figure 17 Flu vaccinations by ethnicity.....	14
Figure 18 Flu vaccinations by age.....	15
Figure 19 Flu vaccinations by deprivation	15
Figure 20 Flu vaccinations by gender.....	15
Figure 21 Percentage of cancer diagnoses by stage and ethnicity	16
Figure 22 Percentage of cancer diagnoses by stage and deprivation.....	16
Figure 23 Percentage of cancer diagnoses by stage and gender	17
Figure 24 MI admissions by ethnicity	17
Figure 25 MI admissions by age	17
Figure 26 MI admissions by deprivation	18
Figure 27 MI admissions by gender	18
Figure 28 MI admissions by borough	18
Figure 29 Stroke admissions by ethnicity	18
Figure 30 Stroke admissions by age	19
Figure 31 Stroke admissions by deprivation.....	19
Figure 32 Stroke admissions by gender	19
Figure 33 Stroke admissions by borough	20
Figure 34 Hypertension management by ethnicity.....	20
Figure 35 Hypertension management by age.....	20
Figure 36 Hypertension management by deprivation	21
Figure 37 Hypertension management by gender.....	21
Figure 38 Hypertension management by borough.....	21
Figure 39 Anticoagulation drug therapy by ethnicity	22
Figure 40 Anticoagulation drug therapy by age	22
Figure 41 Anticoagulation drug therapy by deprivation.....	22
Figure 42 Anticoagulation drug therapy by gender	22
Figure 43 Anticoagulation drug therapy by borough	23
Figure 44 LD health checks by ethnicity	23
Figure 45 LD health checks by age	23
Figure 46 LD health checks by deprivation.....	24

Figure 47 LD health checks by gender	24
Figure 48 LD health checks by borough	24
Figure 49 CYP ED attendance by ethnicity	25
Figure 50 CYP ED attendance by deprivation	25
Figure 51 CYP ED attendance by gender	26
Figure 52 CYP ED attendances for asthma by ethnicity	26
Figure 53 CYP ED attendances for asthma by deprivation.....	26
Figure 54 CYP ED attendances for asthma by age	27
Figure 55 CYP mental health patients by ethnicity	29
Figure 56 CYP mental health patients by age	29
Figure 57 CYP mental health patients by deprivation	30
Figure 58 CYP mental health patients by gender	30
Figure 59 Ethnicity coding by acute provider.....	31
Figure 60 Ethnicity coding by mental health provider	31
Figure 61 Ethnicity coding by community provider	32
Figure 62 Insights gained from communities as part of the KREC report.....	33

1 Reducing health inequalities

Moving towards health equity is a key priority nationally, regionally and locally. Reducing health inequalities is a central goal in the treatment-to-prevention shift set out in the [NHS 10 Year Plan](#), fundamental to ICBs as outlined in the [Model ICB guidance](#), and central across all stages of strategic commissioning. We have prioritised reducing health inequalities in both our South West London Integrated Care Partnership's [Strategic Plan](#) and [Joint Forward Plan](#).

Health inequalities refers to the differences in health outcomes between population subgroups, including differences in how long we live or healthy lifespan. Inequalities in health are largely due to inequalities in society, and the unequal distribution of the social determinants of health. These occur across several demographics including gender, age, ethnicity, socio-economic group, geography, religion and sexual preference. There are also inequalities in the use of healthcare relating to education, income and occupation.

Healthcare is also a determinant of health inequalities, so addressing differences in access to and use of services between population groups will help in reducing overall health inequalities. In South West London, we are doing this by working towards equitable distribution of our services and embedding in them prevention, community empowerment and self-care.

Since 2024, the Health Equity Partnership Group in South West London has focused on a range of collaborative efforts aimed at reducing health inequalities across our six boroughs. The group consists of representatives from local authorities, NHS trusts and community organisations working together to address social determinants of health, such as housing, employment and access to healthcare services.

Initiatives have included expanding outreach programmes for underserved communities, improving access to mental health support and promoting culturally tailored health education campaigns. Additionally, the Health Equity Partnership Group has championed the collection and use of data to better identify health inequalities and monitor progress, ensuring that resources are allocated where they are most needed to make a tangible impact on health outcomes.

2 Understanding population health needs

NHS South West London has spent considerable time improving its health intelligence on health and healthcare inequalities. During the 2024/25 annual assessment of ICBs, NHS England noted the development of the Health Inequalities Explorer Dashboard to identify potential areas of inequality.

Throughout 2025/26, we have continued to improve this dashboard, as well as other tools on our internal Health Insights platform. This platform brings together real-time data from health and care organisations across our integrated care system, creating an integrated health and care record for each patient. These are used to create dashboards on different topics, for example, long term conditions and vaccination uptake.

We use the dashboards to monitor inequalities in health outcomes across a range of clinical domains by deprivation, ethnicity, gender and age, allowing us to identify where the Core20 and other population groups may have health needs which are not being addressed.

For example, the vaccinations team has carried out detailed analysis of health inequalities to inform the targeting of pop-up clinics, identifying strong links between uptake and factors such as ethnicity and deprivation.

NHS South West London's Inequality Explorer is available to acute programmes to assess inequalities in service use and access, split by the patient demographics available to us from primary care records. The data are refreshed regularly so that we can start to account for changes over time, person, and place and to detect any emerging patterns.

We have acted in specific clinical areas to improve completeness and accuracy of coding and recording practices, especially for ethnicity characteristics, reflecting our commitment to implementing the [Ethnicity Recording Improvement Plan](#).

For example, in maternity services, all South West London trusts are compliant with Maternity Services Dataset submissions. Ethnicity is captured on the Local Maternity and Neonatal Services (LMNS) dashboard, including stillbirths and maternal deaths. This data is presented at Board meetings. Other reports which report on ethnicity include High-Intensity A&E User report and Post-Partum Haemorrhage reports.

This data is presented at patient level to programme teams and primary care users. Overall numbers are compared to nationally published aggregate numbers to ensure integrity in datasets, and confidence in the results presented back to clinicians. New programmes have coding checked and validated by clinicians so that our patient identification reflects local coding practices.

This year, we undertook a separate analysis of population needs for our Clinically-Led Strategic Plan, where we focused on differences between Core20 and non-Core20 populations by age cohorts and stratification including 'generally healthy', 'single long-term condition', 'multi-morbidity' in relation to service access and use. This revealed that people from the most deprived backgrounds (Core20) have a higher level of healthcare resource use, particularly for those in the severe mental illness, cancer and end-stage disease segments.

For example, Core20 populations in the cancer segment use 17% more resource than the rest of the population. This can be because people from more deprived communities access services later, when their disease is more developed, and therefore requiring more intensive support (including higher levels of A&E use).

These findings have been picked up within the various workstreams of our Clinically-Led Strategic Plan, and evidence-based interventions to reduce the inequalities will be put into place over the next three years. We have also started work on embedding population health management in the development of our integrated neighbourhood teams, helping them to use local data to identify specific groups experiencing poorer health outcomes or barriers to accessing care, such as those from deprived backgrounds, ethnic minorities and individuals with complex needs. We are encouraging regular reviews of local health data to ensure that

emerging inequalities are quickly identified and responded to, allowing resources to be targeted where they will have the greatest impact.

During 2025/26, we undertook projections of healthy life expectancy across Core20PLUS groups in South West London. We found that healthy life expectancy had regressed to 2012 levels due primarily to the impact of the Covid-19 pandemic. Prevalence of mental ill-health has increased most. The borough projected to have the most significant improvement in healthy life expectancy is Merton, with expectations to overtake the current highest performer which is Richmond.

Medical and physiological treatments, alongside social prescribing, can improve self-reported disability-related quality of life, and there is strong evidence that physical activity helps manage many long-term conditions.

During 2025/26 we worked with local authorities and general practices to improve the use of physical activity in primary care both for staff and patients.

2.1 Measuring inequalities

In this section, we provide an overview of inequalities across eight operational and Core20PLUS5 priorities for adults:

- Elective care
- Urgent and emergency care
- Maternity
- Mental Health
- Respiratory
- Cancer
- Cardiovascular disease

For children:

- Admissions to emergency departments
- Asthma
- Oral health
- Mental health

We assess inequality in these domains by looking at the three factors which we know contribute to inequality in South West London:

- deprivation
- ethnicity
- gender

We have also, where appropriate, included data on representation by age and borough.

Comparing this year's data with last year's indicates that there have been no significant changes and levels of inequality have remained stable.

Deprivation figures are presented either by quintiles or by deciles depending on the population size.

2.1.1 Elective care

The below tables show the proportion of the waiting list that has been waiting longer than the 18-week target. [Data as of 1st Feb 2026]

Figure 1 18+ week wait by ethnicity

Ethnicity	>18 Weeks	>52 Weeks	>65 Weeks	>104 Weeks
Asian	11,643 (39%)	382 (1%)	4 (0%)	0
Black	8,868 (38%)	372 (2%)	7 (0%)	0
Mixed	3,618 (39%)	139 (2%)	2 (0%)	0
Other	4,219 (40%)	156 (1%)	3 (0%)	0
White	49,258 (39%)	1,755 (1%)	36 (0%)	1 (0.0%)
Total	77,606 (39%)	2,804 (1%)	52 (0%)	1 (0.0%)

Figure 2 18+ week wait by age

Age Band	>18 Weeks	>52 Weeks	>65 Weeks	>104 Weeks
0–4	1,334 (30%)	17 (0%)	0	0
05–18	5,134 (35%)	132 (1%)	3 (0%)	0
19–49	30,200 (42%)	1,285 (2%)	22 (0%)	1 (0.0%)
50–64	18,442 (39%)	744 (2%)	15 (0%)	0
65+	22,779 (37%)	637 (1%)	12 (0%)	0
Total	77,889 (39%)	2,815 (1%)	52 (0%)	1 (0.0%)

Figure 3 18+ week wait by deprivation

Deprivation Quintile	>18 Weeks	>52 Weeks	>65 Weeks	>104 Weeks
(Unlabelled)	9,911 (40%)	398 (2%)	7 (0%)	0
1	5,319 (39%)	238 (2%)	5 (0%)	0
2	13,372 (39%)	562 (2%)	16 (0%)	0
3	14,258 (39%)	515 (1%)	3 (0%)	0
4	16,983 (39%)	583 (1%)	13 (0%)	1 (0.0%)
5	18,045 (39%)	543 (1%)	8 (0%)	0
Total	77,889 (39%)	2,815 (1%)	52 (0%)	1 (0.0%)

Figure 4 18+ week wait by gender

Gender	>18 Weeks	>52 Weeks	>65 Weeks	>104 Weeks
Female	46,042 (40%)	1,729 (1%)	33 (0%)	1 (0.0%)
Male	30,047 (38%)	1,086 (1%)	19 (0%)	0
Total	77,889 (39%)	2,815 (1%)	52 (0%)	1 (0.0%)

Figure 5 18+ week wait by borough

Borough	>18 Weeks	>52 Weeks	>65 Weeks	>104 Weeks
Croydon	17,067 (37%)	803 (2%)	13 (0%)	0

Kingston	10,268 (41%)	228 (1%)	0	0
Merton	10,414 (38%)	370 (1%)	10 (0%)	0
Richmond	11,282 (41%)	318 (1%)	3 (0%)	0
Sutton	12,113 (41%)	549 (2%)	20 (0.1%)	1 (0.0%)
Wandsworth	16,747 (38%)	547 (1%)	6 (0%)	0
Total	77,889 (39%)	2,815 (1%)	52 (0%)	1 (0.0%)

The proportion of individuals waiting more than 18 weeks for elective care appears similar across the ethnicity, deprivation and gender dimensions; however, working age adults appears to have a higher proportion of long waits than children or the elderly.

2.1.2 Urgent and emergency care

The below tables show the inequalities in mean time waits in emergency departments. [Data as of 16 February 2026]

Figure 4 Mean time waits in ED by ethnicity

Ethnicity	Wait time in minutes
Null	180
Asian	224
Black	224
Mixed	204
Other	221
White	251

Figure 5 Mean time waits in ED by age

Age Band	Wait time in minutes
0–4	159
5–14	157
15–44	206
45–64	242

65–74	295
75–84	358
85+	445

Figure 6 Mean time waits in ED by deprivation

Deprivation Quintile	Wait time in minutes
NULL	233
1	220
2	230
3	240
4	250
5	244

Figure 7 Mean time waits in ED by gender

Gender	Wait time in minutes
Female	239
Male	236
Not Known	179
Not Specified	285

Older individuals appear to have longer waits in emergency departments.

2.1.3 Maternity

The below tables show the rates of pre-term (under 37 weeks) births. [Data from 2nd Jan 2025-2nd Jan 2026]

Figure 8 Pre-term births by ethnicity

Ethnicity	Births	Pre-Term Births	Pre-Term
(Blank)	10	–	–
Asian	4,160	208	5.00%
Black	2,293	145	6.30%
Mixed	1,092	67	6.10%
Other	1,130	61	5.40%
White	10,284	444	4.30%
Total	18,969	925	4.90%

Figure 9 Pre-term births by age

Age Band	Births	Pre-Term Births	Pre-Term
15–19	65	1	1.50%
20–24	847	40	4.70%
25–29	2,810	115	4.10%
30–34	5,985	292	4.90%
35–39	6,845	330	4.80%
40–44	2,139	128	6.00%
45–49	243	14	5.80%
50–54	22	4	18.20%
55–59	3	1	33.30%
Total	18,969	925	4.90%

Figure 10 Pre-term births by deprivation

Deprivation Quintile	Births	Pre-Term Births	Pre-Term
(Unlabelled)	4,044	212	5.20%
1	1,321	65	4.90%
2	3,545	180	5.10%
3	3,685	188	5.10%
4	3,660	171	4.70%
5	2,734	109	4.00%
Total	18,969	925	4.90%

Figure 11 Pre-term births by gender

Gender	Births	Pre-Term Births	Pre-Term
Female	18,969	925	4.90%
Total	18,969	925	4.90%

Figure 12 Pre-term births by borough

Borough	Births	Pre-Term Births	Pre-Term
Croydon	5,348	239	4.50%
Kingston	1,862	96	5.20%
Merton	3,199	138	4.30%
Richmond	1,554	81	5.20%
Sutton	1,801	96	5.30%
Wandsworth	5,205	275	5.30%
Total	18,969	925	4.90%

Individuals from areas in the 2nd and 3rd most deprived quintiles, non-white ethnic groups and older mothers appear to have higher rates of pre-term birth.

2.1.4 Mental health

The below tables show the proportion of adult patients in mental health services versus the South West London population. [Data represents patients referred to MH services in the 12 months March 2025 to Feb 2026 inclusive]

Figure 13 Adult mental health patients by ethnicity

Ethnicity Group	% MH Patients	% SWL Population
British	49.84%	37.66%
Any other White background	11.91%	19.55%
African	5.38%	5.52%
Caribbean	5.48%	3.17%
Any other Asian background	4.83%	6.48%
Any other ethnic group	4.17%	4.56%
Indian	3.29%	5.69%
Pakistani	2.62%	2.94%
Other Mixed, Mixed Unspecified	2.59%	1.61%
Any other Black background	2.49%	1.58%
White and Black Caribbean	2.21%	0.89%
Irish	1.38%	1.60%
White and Black African	1.08%	0.71%
White and Asian	0.93%	0.80%
Chinese	0.84%	2.06%
Bangladeshi	0.66%	0.62%

Figure 14 Adult mental health patients by age

Age Band (MH)	% MH Patients	% SWL Population
18-21	7.08%	3.58%
21-25	7.67%	5.41%
25-30	9.93%	9.92%
30-35	10.17%	10.79%
35-40	9.04%	10.85%
40-45	7.43%	10.46%
45-50	6.11%	9.66%
50-55	5.50%	8.28%

55-60	5.32%	7.39%
60-65	4.73%	6.40%
65-70	3.45%	4.89%
70-75	3.41%	3.69%
75+	15.44%	7.27%

Figure 15 Adult mental health patients by deprivation

IMD Decile	% MH Patients	% SWL Population
Unknown	14.80%	13.99%
1	1.05%	0.62%
2	7.59%	5.47%
3	10.36%	8.55%
4	8.96%	8.26%
5	9.54%	8.34%
7	9.50%	9.86%
6	11.34%	11.66%
8	8.46%	9.96%
9	10.99%	13.60%
10	0.0739	0.097

Figure 16 Adult mental health patients by gender

Gender	% MH Patients	% SWL Population
Female	58.79%	50.23%
Male	41.11%	49.75%

Females, individuals from more deprived areas, children and young people and those from Caribbean and 'any other Black background' were over-represented in general mental health services vs in the general population.

2.1.5 Respiratory

The below tables show the eligible patients vaccinated for Flu within Flu season. [Winter 2025-2026]

Figure 17 Flu vaccinations by ethnicity

Ethnicity	Flu Vax	Flu Population	Flu Vax Rate
Asian	13,710	32,826	417.68
Black	9,324	23,850	390.94

Mixed	2,192	5,484	398.98
Other	4,023	11,587	347.8
White	78,539	178,385	440.33
Total	108,534	259,356	418.47

Figure 18 Flu vaccinations by age

Age Band	Flu Vax	Flu Population	Flu Vax Rate
0–4	3	11	272.73
05–18	62	112	553.57
19–49	83	373	222.52
50–64	82	232	353.45
65+	108,304	258,628	418.76
Total	108,534	259,356	418.47

Figure 19 Flu vaccinations by deprivation

Deprivation Quintile	Flu Vax	Flu Population	Flu Vax Rate
1	7,523	18,485	406.98
2	5,665	13,637	415.41
3	15,444	38,063	405.75
4	18,652	46,413	401.87
5	26,517	62,713	422.83
(Unlabelled)	34,733	80,045	433.92
Total	108,534	259,356	418.47

Figure 20 Flu vaccinations by gender

Gender	Flu Vax	Flu Population	Flu Vax Rate
Female	59,051	139,630	422.91
Male	49,483	119,726	413.3
Total	108,534	259,356	418.47

Borough	Flu Vax	Flu Population	Flu Vax Rate
---------	---------	----------------	--------------

Croydon	31,791	68,231	465.93
Kingston	15,118	34,698	435.7
Merton	11,752	34,635	339.31
Richmond	18,380	40,272	456.4
Sutton	13,707	35,692	384.04
Wandsworth	17,786	45,828	388.1
Total	108,534	259,356	418.47

There were lower rates of vaccination of eligible patients for flu among the 2nd and 3rd most deprived quintiles, individuals of Black, mixed or 'other' ethnicity and among working age adults.

2.1.6 Cancer

The below tables show inequalities in percentage of cancers diagnosed at stage 1& 2. [Data from 2024-2025]

Figure 21 Percentage of cancer diagnoses by stage and ethnicity

Ethnicity	1–2	3–4	Total
Asian	59%	41%	100%
Black	63%	37%	100%
Mixed	61%	39%	100%
Other	58%	42%	100%
White	57%	43%	100%
(blank)	60%	40%	100%

Figure 22 Percentage of cancer diagnoses by stage and deprivation

Index of Multiple Deprivation Decile	1–2	3–4	Total
1	52%	48%	100%
2	55%	45%	100%
3	56%	44%	100%
4	56%	44%	100%
5	56%	44%	100%
6	58%	42%	100%

7	57%	43%	100%
8	59%	41%	100%
9	61%	39%	100%
10	61%	39%	100%

Figure 23 Percentage of cancer diagnoses by stage and gender

Gender	1–2	3–4	Total
Female	61%	39%	100%
Male	57%	43%	100%

A lower proportion of cancers were diagnosed at stage 1-2 for individuals from more deprived deciles.

2.1.7 Cardiovascular disease

2.1.7.1 MI admissions

The below tables show the rates of myocardial infarction (MI) admissions. [Data from 31st Dec 2024- 31st Dec 2025]

Figure 24 MI admissions by ethnicity

Ethnicity	Admissions	Population	Admission Rate
Asian	96	295,783	32.46
Black	39	194,894	20.01
Mixed	13	98,543	13.47
Other	20	122,314	16.35
White	295	1,063,819	27.73
Total	463	1,840,355	25.16

Figure 25 MI admissions by age

Age Band	Admissions	Population	Admission Rate
0–4	–	66,340	–
05–14	–	199,891	–
15–44	15	825,317	1.82
45–64	125	490,179	25.5
65–74	104	136,444	76.22
75–84	111	86,163	128.83
85+	108	36,021	299.83

Total	463	1,840,355	25.16
--------------	------------	------------------	--------------

Figure 26 MI admissions by deprivation

Deprivation Quintile	Admissions	Population	Admission Rate
1	41	258,263	16
2	29	116,260	24.94
3	75	311,580	24.07
4	74	332,348	22.27
5	110	395,565	27.81
(Unlabelled)	134	428,339	31.28
Total	463	1,840,355	25.16

Figure 27 MI admissions by gender

Gender	Admissions	Population	Admission Rate
Female	185	922,805	20.05
Male	278	917,550	30.3
Total	463	1,840,355	25.16

Figure 28 MI admissions by borough

Borough	Admissions	Population	Admission Rate
Croydon	94	461,181	20.38
Kingston	85	236,928	35.88
Merton	68	245,314	28.9
Richmond	59	235,681	25.04
Sutton	105	216,314	48.54
Wandsworth	54	444,957	12.14
Total	463	1,840,355	25.16

Individuals from the Asian ethnic group have a higher admission rate for heart attacks than other ethnic groups.

2.1.7.2 Stroke admissions

The below tables show the rates of admission for stroke. [Data from 31st Dec 2024- 31st Dec 2025]

Figure 29 Stroke admissions by ethnicity

Ethnicity	Admissions	Population	Admission Rate
-----------	------------	------------	----------------

Asian	196	295,783	66.26
Black	212	194,894	108.78
Mixed	39	98,543	40.4
Other	59	122,314	48.24
White	850	1,063,819	79.9
Total	1,356	1,840,355	73.68

Figure 30 Stroke admissions by age

Age Band	Admissions	Population	Admission Rate
0–4	–	66,340	–
05–14	–	199,891	–
15–44	49	825,317	5.94
45–64	346	490,179	70.59
65–74	309	136,444	226.47
75–84	371	86,163	430.58
85+	281	36,021	780.1
Total	1,356	1,840,355	73.68

Figure 31 Stroke admissions by deprivation

Deprivation Quintile	Admissions	Population	Admission Rate
1	94	258,263	36.68
2	137	116,260	117.84
3	260	311,580	83.45
4	239	332,348	71.91
5	290	395,565	73.31
(Unlabelled)	336	428,339	78.44
Total	1,356	1,840,355	73.68

Figure 32 Stroke admissions by gender

Gender	Admissions	Population	Admission Rate
Female	582	922,805	63.07

Male	774	917,550	84.36
Total	1,356	1,840,355	73.68

Figure 33 Stroke admissions by borough

Borough	Admissions	Population	Admission Rate
Croydon	411	461,181	89.12
Kingston	171	236,928	72.17
Merton	190	245,314	77.45
Richmond	182	235,681	77.23
Sutton	208	216,314	96.18
Wandsworth	194	444,957	43.6
Total	1,356	1,840,355	73.68

Individuals in the Black ethnic group and those from the most deprived quintile have much higher admission rates for stroke than other groups.

2.1.7.3 Hypertension management

The below tables show the percentage of patients aged 18 and over, with GP recorded hypertension, for whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment. [Data from 10th Feb 2025- 10th Feb 2026]

Figure 34 Hypertension management by ethnicity

Ethnicity	Hypertension Patients	BP Test Pass	BP Test Pass Rate
Asian	1,245	484	40%
Black	30,203	19,400	64%
Mixed	28,255	16,310	58%
Other	7,950	4,765	60%
White	109,683	69,856	64%
Total	182,732	113,971	62%

Figure 35 Hypertension management by age

Age Band	Hypertension Patients	BP Test Pass	BP Test Pass Rate
15–44	9,061	4,279	47%
45–64	66,913	36,980	55%
65–74	46,036	29,474	64%
75–84	40,157	28,350	71%
85+	20,565	14,878	72%

Total	182,732	113,971	62%
--------------	----------------	----------------	------------

Figure 36 Hypertension management by deprivation

Deprivation Quintile	Hypertension Patients	BP Test Pass	BP Test Pass Rate
1	14,781	8,619	58%
2	13,240	8,128	61%
3	33,522	20,559	61%
4	34,651	21,884	63%
5	41,895	26,070	64%
(Unlabelled)	44,643	28,111	63%
Total	182,732	113,971	62%

Figure 37 Hypertension management by gender

Gender	Hypertension Patients	BP Test Pass	BP Test Pass Rate
Female	91,645	58,717	64%
Male	91,087	55,254	61%
Total	182,732	113,971	62%

Figure 38 Hypertension management by borough

Borough	Hypertension Patients	BP Test Pass	BP Test Pass Rate
Croydon	52,927	32,402	61%
Kingston	24,884	16,259	65%
Merton	24,082	15,823	63%
Richmond	21,781	12,467	57%
Sutton	25,622	16,387	64%
Wandsworth	32,536	20,653	63%
Total	182,732	113,971	62%

Those in the most deprived two quintiles appear to be slightly less likely to have optimally managed hypertension.

2.1.7.4 Atrial fibrillation management

The below tables show the percentage of patients aged 18 and over, with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy. [Data from 10th Feb 2025- 10th Feb 2026]

Figure 39 Anticoagulation drug therapy by ethnicity

Ethnicity	AF Patients	Anticoagulation Drugs	AF Drug Therapy Rate
Asian	7	5	71%
Black	317	277	87%
Mixed	237	202	85%
Other	58	47	81%
White	3,557	3,208	90%
Total	4,303	3,854	90%

Figure 40 Anticoagulation drug therapy by age

Age Band	AF Patients	Anticoagulation Drugs	AF Drug Therapy Rate
15–44	16	13	81%
45–64	340	279	82%
65–74	999	870	87%
75–84	1,741	1,597	92%
85+	1,207	1,095	91%
Total	4,303	3,854	90%

Figure 41 Anticoagulation drug therapy by deprivation

Deprivation Quintile	AF Patients	Anticoagulation Drugs	AF Drug Therapy Rate
1	294	253	86%
2	200	176	88%
3	500	453	90%
4	821	739	90%
5	1,192	1,088	91%
(Unlabelled)	1,296	1,145	88%
Total	4,303	3,854	90%

Figure 42 Anticoagulation drug therapy by gender

Gender	AF Patients	Anticoagulation Drugs	AF Drug Therapy Rate
Male	2,365	2,161	91%
Female	1,938	1,693	87%
Total	4,303	3,854	90%

Figure 43 Anticoagulation drug therapy by borough

Borough	AF Patients	Anticoagulation Drugs	AF Drug Therapy Rate
Croydon	800	707	88%
Kingston	1,144	1,064	93%
Merton	391	332	85%
Richmond	662	586	89%
Sutton	504	454	90%
Wandsworth	802	711	89%
Total	4,303	3,854	90%

Individuals from Black and mixed ethnic groups appear to have slightly lower rates of appropriate therapeutic management of atrial fibrillation.

2.1.8 Learning disability health checks

The below tables show the population age 15+ on a QCF Learning Disabilities register. Performance is calculated as those with a health check compared to all Learning Disability patients (excluding those who declined a health check), across the last 12 months of data. [Data from 10th Feb 2025- 10th Feb 2026]

Figure 44 LD health checks by ethnicity

Ethnicity	Population	AHC	AHC Declined	AHC%
(Blank)	28	8	3	32%
Asian	1,035	551	33	55%
Black	1,540	800	55	54%
Mixed	563	234	22	43%
Other	279	152	11	57%
White	6,252	3,175	227	53%
Total	9,697	4,920	351	53%

Figure 45 LD health checks by age

Age Band	Population	AHC	AHC Declined	AHC%
15–44	6,207	2,983	248	50%

45–64	2,275	1,337	77	61%
65–74	765	421	16	58%
75–84	347	175	8	52%
85+	103	24	2	24%
Total	9,697	4,920	351	53%

Figure 46 LD health checks by deprivation

Deprivation Quintile	Population	AHC	AHC Declined	AHC%
(Unlabelled)	934	388	29	43%
1	1,090	520	49	50%
2	2,258	1,135	78	52%
3	1,889	1,042	71	54%
4	1,817	946	71	54%
5	1,609	889	53	57%
Total	9,697	4,920	351	53%

Figure 47 LD health checks by gender

Gender	Population	AHC	AHC Declined	AHC%
Male	5,600	3,002	213	56%
Female	4,097	1,918	138	48%
Total	9,697	4,920	351	53%

Figure 48 LD health checks by borough

Borough	Population	AHC	AHC Declined	AHC%
Croydon	3,139	1,588	176	54%
Kingston	1,072	516	24	50%
Merton	1,139	657	35	58%
Richmond	867	382	21	45%

Sutton	1,612	814	40	52%
Wandsworth	1,838	963	55	54%
Total	9,697	4,920	351	53%

Those from more deprived quintiles and from mixed ethnic groups are slightly less likely to have had a learning disability health check in the last 12 months.

2.1.9 Inequalities in children’s emergency department attendances

The below tables show children and young people (CYP) emergency department attendances. The data refers to attendances for under-18 year olds. [Data from 2024/25]

Figure 49 CYP ED attendance by ethnicity

Ethnicity	Attendance rate per 10,000 population
Null	656.43
Asian	3883.42
Black	4349.3
Mixed	4297.86
Other	3533.45
White	3781.01

Figure 50 CYP ED attendance by deprivation

Deprivation Quintile	Attendance rate per 10,000 population
NULL	1149.89
1	5989.44
2	5106.72
3	4424.26
4	3686.21
5	3215.97

Figure 51 CYP ED attendance by gender

Gender	Attendance rate per 10,000 population
Female	3578.79
Male	4098.16
Not Known	6521.74
Not Specified	3157.89

There appear to be higher rates of ED attendances among Black and mixed ethnic group children and those from more deprived quintiles, and among male children. Where gender is not known or specified, figures might be misleading due to very small numbers.

2.1.10 Asthma - inequalities in asthma attendances

The below tables show CYP emergency attendances for asthma specifically. The data refers to attendances for under-18 year olds. [Data from 2024/25]

Figure 52 CYP ED attendances for asthma by ethnicity

Ethnicity	Attendance rate per 10,000 population
NULL	10.59
Asian	190.52
Black	174.27
Mixed	156.89
Other	126.54
White	143.42

Figure 53 CYP ED attendances for asthma by deprivation

Deprivation Quintile	Attendance rate per 10,000 population
NULL	50.71
1	205.44
2	203.65
3	175.16

4	152.09
5	130.24

Figure 54 CYP ED attendances for asthma by age

Gender	Attendance rate per 10,000 population
Female	121.33
Male	183.05

There appear to be higher rates of asthma A&E attendances among Asian and Black children and among children from more deprived quintiles, as well as among male children

2.1.11 Oral health

The below tables show tooth extractions for children admitted as inpatients to hospital, aged 10 years and under. Note, the data covers the number of admissions, not the number of teeth extracted. The teeth extraction rate refers to the number of teeth extractions in the context of related population figures. [Data from 31st Dec 2024-31st Dec 2025]

Ethnicity	Teeth Extractions	Teeth Extraction Rate
Asian	169	550
Black	83	429
Mixed	78	368
Other	66	513
White	339	361
Total	738	408

Age	Teeth Extractions	Teeth Extraction Rate
3	22	135
4	35	212
5	73	405
6	100	558

7	126	676
8	139	721
9	118	586
10	125	604
Total	738	408

Deprivation Quintile	Teeth Extractions	Teeth Extraction Rate
(Unlabelled)	81	374
1	71	551
2	159	480
3	174	515
4	151	392
5	102	249
Total	738	408

Gender	Teeth Extractions	Teeth Extraction Rate
Female	324	368
Male	414	447
Total	738	408

Borough	Teeth Extractions	Teeth Extraction Rate
Croydon	109	394
Kingston	111	488
Merton	88	370
Richmond	74	327
Sutton	129	564
Wandsworth	137	358
Total	738	408

The rate of tooth extractions for children admitted as inpatients appears to be higher for males, those in the 3 most deprived quintiles, and for Asian, Black and ‘other’ race children.

2.1.12 Mental health-Children and young people

The below tables show the proportion of CYP (under-18 year old) patients in mental health services versus the South West London population. [Data represents patients referred to MH services in the 12 months March 2025 to Feb 2026 inclusive]

Figure 55 CYP mental health patients by ethnicity

Ethnicity Group	MH Patients	SWL Population
British	49.03%	34.56%
Any other White background	11.85%	17.04%
Other Mixed, Mixed Unspecified	5.21%	4.44%
Any other ethnic group	4.33%	5.49%
White and Black Caribbean	4.26%	2.10%
African	4.23%	6.30%
Any other Asian background	3.76%	6.92%
Caribbean	3.56%	2.27%
Any other Black background	2.90%	2.35%
Pakistani	2.54%	3.98%
White and Asian	2.25%	2.51%
Indian	2.12%	5.49%
White and Black African	1.83%	1.54%
Chinese	0.93%	1.88%
Bangladeshi	0.50%	0.76%
Irish	0.46%	0.60%

Figure 56 CYP mental health patients by age

Age Band	MH Patients	SWL Population
-----------------	--------------------	-----------------------

0–5	3.32%	25.19%
5–8	15.88%	17.03%
8–11	24.35%	18.77%
11–15	35.78%	25.88%
15–18	20.66%	13.14%

Figure 57 CYP mental health patients by deprivation

IMD Decile	MH Patients	SWL Population
Unknown	10.80%	11.33%
1	0.85%	0.75%
2	7.78%	6.41%
3	11.33%	9.50%
4	8.85%	8.41%
5	8.98%	8.38%
6	10.14%	9.56%
7	12.06%	11.76%
8	8.96%	9.57%
9	11.77%	13.76%
10	8.49%	0.1057

Figure 58 CYP mental health patients by gender

Gender	MH Patients	SWL Population
Female	50.02%	48.99%

Male	49.97%	51.00%
------	--------	--------

Children from Caribbean and mixed white and Black African ethnic groups, those from more deprived deciles and females are overrepresented in mental health services.

2.1.13 Ethnicity Coding

Hospitals are encouraged to record the ethnicity of their patients. The below tables show the percentage of hospital records, by South West London Trust, that have a valid ethnicity recorded. [Reporting period Nov 2025]

Figure 59 Ethnicity coding by acute provider

Acute Provider	Ethnic category data item score	National average data item score
Croydon Health Services NHS Trust	99	86.6
Epsom and St Helier University Hospitals NHS Trust	99.2	86.6
Kingston Hospital NHS Foundation Trust	99.2	86.6
St George's University Hospitals NHS Trust	98.4	86.6

Figure 60 Ethnicity coding by mental health provider

Mental Health Provider	Ethnic category data item score	National average data item score
Oxleas NHS Foundation Trust	86.1	68.9
South London and Maudsley NHS Foundation Trust	99.2	68.9

South West London and St George's Mental Health NHS Trust	91.5	68.9
-----------------------------------------------------------	------	------

Figure 61 Ethnicity coding by community provider

Community Provider	Ethnic category data item score	National average data item score
Central London Community Healthcare NHS Trust	82.7	71.6
Your Healthcare	81.6	71.6

South West London providers score highly on completeness of ethnicity coding compared to national averages.

2.1.14 Limitations

This method is helping us to develop our understanding of inequalities in South West London, however, results can be affected by low population numbers. As inequality does not always mean inequity, we are using these insights alongside our understanding of population need when considering service design. However, we continually refine health insights dashboards to comply with guidance in the new NHS Statement of Information on Health Inequality. In the future we hope to also integrate trend information to monitor how interventions impact on health inequalities.

2.2 Understanding intersectionality and risk factors

Alongside routine quantitative data, we gained qualitative insights from specific PLUS groups, providing nuanced understanding of intersectionality's impact on experience. For example, in 2023, Kingston Race and Equalities Council (KREC) was commissioned by NHS South West London to help understand racism and inequalities in health care services, publishing their [report](#) in 2025.

This explored how specific risk factors and barriers, such as transport, language and digital skills, affect different groups. The report found that the key barriers to accessing healthcare services were experiences of bias, discrimination and racism, intersectionality, lack of access to language and interpretation services, financial challenges, digital exclusion and feelings of being misunderstood (see Figure 62). Several recommendations were made, which are being picked up by the Health Equity Partnership Group.

Figure 62 Insights gained from communities as part of the KREC report¹

<p>1. Experience of bias, discrimination, and racism</p> <p>Frequently caused difficulty in accessing timely appointments and led to symptoms being overlooked. People felt rushed, dismissed, stereotyped and talked down to, with a perception that staff lack time or empathy.</p>	<p>2. Intersectionality and complex barriers shape peoples' experiences</p> <p>Multiple identities including race, refugee status, disability, and being a carer disproportionately impacted people in navigating services. Intersectionality places additional pressure on mental and emotional wellbeing.</p>
<p>3. Cultural competence and sensitivity</p> <p>Healthcare professionals need to genuinely listen instead of making assumptions based on stereotypes. There was a strong call for improved cultural competence. Little awareness of cultural needs meant people were often misunderstood or ignored.</p>	<p>4. Lack of access to language and interpretation services</p> <p>Significant barriers exist in the lack of access to interpretation services or information in other languages. This often led to a breakdown in communication and trust. Reliance on family members to translate leaves many feeling unheard, vulnerable and misdiagnosed.</p>
<p>5. Cost of living</p> <p>High costs of prescriptions, treatments and transport were frequently mentioned. High parking costs are a significant deterrent alongside the unreliability of community transport.</p>	<p>6. Digital exclusion and barriers to access</p> <p>Older adults, disabled people, and refugees and asylum seekers reported major difficulties navigating appointment systems. People felt pushed online with few offline alternatives.</p>

Another PLUS group, where in-depth work has been carried out, is the homeless population. There is a pan-London [co-occurring conditions programme](#) led by Transformation Partners in Health and Care and overseen by the Office for Health Improvement and Disparities. It focusses on improving coordination between mental health and substance misuse for homeless populations. NHS South West London works with inclusion health leads from other ICBs on this programme.

In 2025, South West London ICB, with the GLA, undertook an exercise to assess how services and pathways meet the needs of people experiencing multiple disadvantages, especially those with co-occurring mental health and substance use issues. The outputs are currently being worked on with local authority public health teams. They include establishing a South West London good practice network, workforce development guidance, a community of practice for palliative care and increasing the number of accredited [safe surgeries](#). To date, 80% of general practices are committed to removing barriers to GP

¹ [SWL-Anti-Racism-report v4-FINAL.pdf](#)

registration and care for people who are excluded, marginalised or in vulnerable circumstances.

3 Acting on reducing health and healthcare inequalities

Throughout 2025/26, we continued to embed NHS England's Core20PLUS approach for healthcare and worked through our South West London Health Equity Partnership Group and Place level Prevention and Health Inequalities Boards, which execute local strategies for reducing health inequalities. We supported the evaluations of South West London and Place based projects that had been funded by the South West London Health Inequalities Investment Fund, disseminating learning where possible. We continued to deliver outreach immunisations and interventions to increase vaccine acceptancy and worked with partners across the system to improve access to health checks. Further details are provided below under 'Improving uptake and coverage of immunisation

3.1 Community empowerment and outreach

Community empowerment is the process of enabling communities to increase control over their lives. South West London has many different types of community link worker including social prescribers. We also deliver health and wellbeing checks in the community and are working on developing integrated neighbourhood teams.

One of our well-known models is community health and wellbeing workers. Based on a model successfully implemented in Brazil, and mentioned in the NHS 10 Year Plan, they are considered a best practice example of neighbourhood working. The model consists of individuals from a neighbourhood, trained in a wide range of health and social care issues, who visit households in their own community. During 2025/26, we undertook evaluations of the projects.

The model was first introduced in Battersea, Wandsworth in 2023 and extended in 2024 to the remaining five boroughs with funding from the South West London Health Inequalities Investment Fund. Each programme had two full-time community health and wellbeing workers, part-time service management and clinical supervision through the participating general practices.

The programme reached between 20-30% of target households (approximately 500 to 1,400). Clinical records showed an increased uptake of preventative opportunities such as breast cancer screening and flu vaccinations. Strong pathways were developed at neighbourhood and borough level, including with local housing associations and teams, welfare advice, mental health services and local community groups and activities.

Community health and wellbeing workers were able to build trust, find hidden needs, give a voice to people often overlooked, reduce inappropriate GP use and improve uptake of preventative opportunities.

Residents demonstrated improved wellbeing and greater confidence managing their own health. The programme has continued in three boroughs with funding secured locally. We

are now working on how to embed and scale the model, including developing a framework for community health and wellbeing workers, with best practice examples.

We use our population health data and community insights to target specific groups and ensure their voices are heard in the design and development of services, for example in the rollout of the weight loss medication Tirzepatide to priority groups in primary care.

There has been a particular focus on understanding service user experiences across the maternity and neonatal system. We have carried out ongoing engagement and outreach on inequalities in gestational age at booking. A significant emphasis has been placed on engaging with CORE20PLUS communities and recognising that targeted outreach is essential for improving inclusion, access, and equity in maternity and neonatal care.

South West London providers also offer parental craft classes in different languages to ensure women are informed about their maternity care and there are forums to support targeted populations. As part of this work, we have scheduled coffee mornings at the Croydon Family Hub for women from CORE20PLUS populations. This provides a supportive space to discuss their maternity journeys, including topics such as booking and self-referrals, birth choices, pre-conception support, pain relief used in labour, six-week postnatal checks, and signposting to relevant services.

3.2 Reducing digital exclusion

South West London previously published a [Digital Inclusion Toolkit](#) informed by the NHS Digital Inclusion Framework. The toolkit identifies wards at risk of digital exclusion using the Digital Exclusion Risk Index (DERI). All digital projects are required to assess their impact on patient usage and, in particular, how patients unable to use digital tools are supported. Recently, a digital exclusion evaluation was conducted for South West London's digital health self-management app (GetUBetter). The app complies with W3C's web content accessibility guidelines, has features in multiple languages and was co-designed with users, leading to more video-based and less text-based content, to improve inclusivity. The ICB employs practice co-ordinators who provide face to face support within primary care, aimed at increasing use of digital tools.

3.3 Reducing tobacco dependency

In 2024/25, we implemented a tobacco dependency programme across all our hospitals. This hospital-based prevention programme delivers advice and personalised stop smoking services to inpatients, and maternity and mental health patients who want to quit smoking.

In 2025/26, we continued to commission a maternity tobacco dependence treatment service in our four maternity units (Croydon, Epsom & St Helier, Kingston & Richmond and St George's). Smoking prevalence is higher among lower-income groups and people in deprived areas. In collaboration with the ICB's maternity team, trusts provide safe treatment and support to all pregnant women identified as current smokers. This programme helps implement the national priorities of universal smoking monitoring for pregnant women under the NHS Long Term Plan and reducing smoking in pregnancy as part of the [Saving Babies' Lives Care Bundle](#).

Provisional data for 25/26 (up to 30 September 2025) showed that 2.5% of pregnant women in South West London were known smokers at time of delivery, below the national Smokefree 2020 target of 4%.

3.4 Growing inclusivity in research

Improving inclusivity in research is a priority in South West London. Throughout 2025/26, we worked through our South West London Health Research Collaborative and NHS England/National Institute of Health Research's Research Engagement Network-funded initiatives to build trust with communities who are often underserved or excluded.

For three years, we have received NIHR funding to grow inclusivity in research. We do this in several ways but primarily through funding 'research cafes' and the [South West London Research Support Network](#). Researchers in South West London NHS Trusts and universities partner with local voluntary sector organisations and community groups to raise awareness about research practices and encourage participation in locally relevant studies. This year we have run eight research cafes, meeting a diverse range of individuals with over 60% of attendees coming from Black communities.

The South West London Research Support Network has played a vital role in enhancing community engagement with research initiatives. Through the monthly cafes, the network has provided opportunities for individuals to share experiences, learn more about research processes and develop the skills needed to become active contributors or even leaders in research projects.

These efforts have helped foster trust, build capacity and ensure that the voices of underrepresented communities are included in shaping the research landscape in South West London. To date, the network has reached over 1,000 people.

We continue to support our evaluation ambassadors, most of whom come from grassroots VCSE organisations. Their leadership in mentoring others, supporting evaluation planning and promoting inclusive approaches has strengthened local research capacity.

This year we undertook a Regional Research Delivery Network-funded study to explore how to increase GP engagement in research. Through this, we furthered our learning in how to develop long-term inclusion models by training peer researchers from underserved communities. We also learned how to co-ordinate inclusion efforts and ensure culturally appropriate settings and materials.

3.5 Improving uptake and coverage of immunisations

Coverage of immunisations varies greatly across South West London. The lowest coverage across all age ranges can be seen in Croydon (north and central), east Merton, areas across Wandsworth and some immunisation programmes in Richmond. The ICB participates in all borough-led immunisation steering groups to support public health initiatives and is undertaking several projects with the aim of increasing coverage across all age ranges.

Health Visitor Pathfinder Programme

The ICB, in collaboration with Croydon Council and Croydon Health Services NHS Trust, was successful in bidding for funds to participate in the national Health Visitor Pathfinder

Programme, alongside two other London boroughs. This pilot is part of government's manifesto commitment to 'enable vaccinations for babies and children as part of health visits'. The service will identify and contact parents of partially or unvaccinated children under five and offer scheduled and opportunistic immunisations including home visits where necessary. The pilot programme runs from mid-February until November 2026. Croydon Health Services will concentrate on north Croydon practices, rolling out more widely if capacity allows.

MMR community pharmacy project

This is an ICB-led project with the aim of improving MMR coverage in patients aged five to 19 by offering vaccination at pharmacies. It also aims to help us understand whether pharmacies can help increase uptake rates in hard to engage cohorts.

The project has partnered GP practices in low uptake areas with a pharmacy contracted to provide MMR. The practice provides information on patients who have missed their MMR to allow the pharmacist to operate a call and recall service alongside the offer of vaccination. The pharmacist is also able to assist the practice if immunisation data is missing, by supporting the patient to provide vaccination evidence. The project ran from 13 January until 31st March 2026.

Community engagement

Our outreach team held 315 pop-up clinics and engagement events across South West London, providing Covid and flu vaccinations (including for children aged two to three years old). The team works with community groups such as Age UK, family hubs, children's centres and libraries to arrange clinics and attend meetings to talk about immunisation.

The ICB has funded a programme of work led by Croydon BME forum to increase uptake of Covid and flu vaccinations, particularly among Black heritage populations and those who are immunosuppressed. The programme focussed on collaborating with influential faith and community leaders to engage in conversation about vaccination.

Leaders hosted events aimed at sharing accurate information with their communities, primarily in churches and community centres. Covid and flu vaccinations for those eligible were provided where appropriate. Resources including webinars and YouTube videos were created and circulated to contacts and partners. This work is being extended to include areas in north and east Merton for 2026/27.

Staff training

The ICB has hosted several training sessions during 2025/26 to give staff the confidence to initiate discussions about immunisations and explain the benefits. Attendees have come from GP, community pharmacies, the health visitor service and the voluntary sector.

Training has included:

- Delivery of Two Jitsuvax (Empathetic Refutational Interview) in person training sessions to address vaccine hesitancy and increase vaccine acceptance

- Four in person HPV training provided by MDS at different locations across SLW attended by Healthy Schools Coordinators, Practice immunisation leads, practice nurses, South West London outreach team
- Six training sessions covering the changes to the childhood immunisation schedule attended by practice immunisation leads, practice nurses, community pharmacy MMR sites and health visitors selected representation from the voluntary sector.

Communication

We have created new digital content to help people understand the importance of being vaccinated. For autumn 2025 this was extended to specific content on the importance of being vaccinated if you are immunosuppressed, including videos featuring local respiratory clinicians highlighting the impact of rising flu rates in our hospitals. Targeted digital advertising was used to reach low uptake areas and translated materials and leaflets were shared via the voluntary sector. Campaign materials were seen over 12 million times – this includes billboards and advertising in Core20PLUS5 areas across all six boroughs and via the Croydon Tram network. Additional support was provided with specific patient leaflets for people living with sickle cell and HIV.

Call and recall initiative for shingles and pneumococcal

This programme is funded by GSK and uses a third-party provider (Chase People) to give practices extra capacity for call and recall. It is an opt-in programme that provides administrative support.

Respiratory Syncytial Virus (RSV) in community pharmacies

The ICB has worked with NHS England to commission RSV vaccinations in community pharmacies in low uptake areas across London, including 10 pharmacies across Croydon, Wandsworth, Merton and Sutton. Of these, six are now live and vaccinating. Routine and catch up vaccinations are available to older adults and pregnant women.

RSV Making Every Contact Count (MECC) – opportunistic vaccination of housebound patients

We are worked with providers vaccinating housebound residents in older adult care homes during the spring Covid season to opportunistically offer the RSV vaccination to those who had missed a dose.

HPV – working with RM Partners and school age vaccination providers.

RM Partners are working in partnership with the South London Children & Young People Community Immunisation Services team (CYCIS) to increase the uptake of the HPV vaccination to 73% of students in years 8 to 10 by the end of the summer 2027 - with no school to have an uptake of less than 50% at the end of the summer term 2026. The programme will be delivered through communication and awareness in communities along with school-based interventions to amplify work already being undertaken by vaccine partners.

Immunisation coordinators

South West London has three full-time immunisation coordinators, funded by NHS England, who work with practices to improve uptake. The coordinators arrange frequent visits to low-uptake practices and regular visits to those with moderate uptake to review processes and data. Their work is data-led using analysis to understand where vaccination rates are low.

They provide additional training and support to practices around child immunisation schedule changes and present the latest vaccination uptake data and work being done at a practice level at monthly borough meetings. The coordinators also support many of the other uptake improvement projects listed above.

4 Governance for health equity work

A Health Equity Partnership Group was established in 2024. This group reports to the ICP and the ICB Board as well as the London Prevention and Health Equity Board. South West London ICB's chief executive is the SRO for prevention and health equity for London, along with Professor Kevin Fenton, Regional Director of Public Health.

During 2025/26, the Health Equity Partnership Group was involved in testing the [National Health Inequality Assurance Framework](#), designed to support integrated care boards to assess progress on tackling health inequalities against strategic objectives and commissioning plans.

We also reviewed the impact of the group using a Delphi methodology to build consensus around what is working well and areas for improvement. This review was timely, given the significant system changes, such as the evolving ICB role and ICP dissolution. It highlighted challenges in aligning governance among partners to address health inequalities and where collective efforts were best placed. It also found areas to focus on within our system and make practical steps to reducing inequalities. These are being picked up in our workplan going forward.

Throughout the work of the Health Equity Partnership Group and other boards, the ICB remains committed to the view that the NHS can affect health inequalities through equitable access, addressing the social determinants of health and by being an anchor institution and employer while contributing to multi-agency action.