Lewisham Local Care Partners Strategic Board
Date: 29 September 2022, 14.30-16.40 hrs
Venue: MS Teams (meeting to be held in public)
Chair: Dr Pinaki Ghoshal

AGENDA

No	Item	Paper	Presenter	Action	Timing
1.	**Welcome, introductions, declarations of interest, apologies for absence & Minutes of the previous LCP meeting held on 28 July 2022 (for approval)**	Verbal/ Enc 1	Chair		14.30-14.35 5 mins
2.	**PEL (Place Executive Lead) update**	Enc 2	Ceri Jacob		14.35-14.40 5 mins
	Delivery				
3.	**Enhanced Access**	Enc 3	Ashley O'Shaughnessy		14.40-14.55 15 mins
4.	**Digital Exclusion update**	Enc 4	Ceri Jacob/Michael Kerin		14.55-15.10 15 mins
5.	**Winter Plan**	Enc 5	Sarah Wainer/Amanda Lloyd		15.10-15.25 15 mins
6.	**People's Partnership Committee proposals**	PRES	Charles Malcolm-Smith-Anne Hooper/PPL		15.25-15.40 15 mins
7.	**In Place Integrated Development framework (5 P's)**	PRES	Ceri Jacob/Charles Malcolm-Smith/PPL		15.40-16.00 20 mins
8.	**Practice merger – Downham Family Medical Practice & Burnt Ash Surgery**	Enc 6	Ashley O'Shaughnessy/ Chima Olugh	For approval	16.00-16.15 15 mins
	Governance				
9.	**Finance update**	Enc 7	Michael Cunningham		16.15-16.25 10 mins
	Place Based Leadership				

10.	**Any questions from members of the public**				16.25-16.35 10 mins
11.	**Any Other Business**				16.35-16.40 5 mins
	Papers for information				
	• **Safeguarding Children report** • **Place Executive Group Draft Minutes**				

Lewisham Local Care Partners Strategic Board

Minutes of the meeting held in public on 28 July 2022 at 16.00 hrs

Via MS Teams

Present:

Dr Jacky McLeod (JMc) (Chair)	Clinical & Care Professional Lead
Ceri Jacob (CJ)	Place Executive Lead, Lewisham
Michael Kerin (MK)	Healthwatch representative
Ross Diamond (RD)	Age UK
Fiona Derbyshire (FD)	Citizens Advice Bureau, Lewisham
Sam Hawksley (SH)	Voluntary sector, Lewisham Local
Anne Hooper (AH)	Community Representative
Tom Brown (TB)	Executive Director for Community Services (DASS)
Dr Helen Tattersfield (HT)	Primary Care representative
Prad Velayuthan (PV)	One Health Lewisham (OHL)

In attendance:

Lizzie Howe (LH)	Corporate Governance Lead, Lewisham (Minutes)
Steve James (SJ)	Communications & Engagement team
Michael Cunningham (MC)	Associate Director Finance
Tatianna Wanyanga (TW)	Borough Business Support Lead, Lewisham

Dr Naheed Rana (NR)	Public Health representative
Helen Eldridge (HE)	Head of Communications & Engagement, Lewisham
Andrew Bland (AB)	Chief Executive Officer (SEL ICS)
Ashley O'Shaughnessy (AOS)	Associate Director Primary Care
Fiona Leacock (FL)	Quality team
Sam Gray (SG)	South London and Maudsley (SLaM)
Robert Gamage (RG)	One Health Lewisham (OHL)
Sarah Lang (SL)	London Borough of Lewisham

Apologies:

Pinaki Ghoshal, Director of CYP
Sarah Wainer, Director of System Transformation
Sandra Iskander, LGT
Vanessa Smith, SLaM
Dr Catherine Mbema, Director of Public Health
Abdul Kayoum, LBL Finance

		Actioned by
1.	**Welcome, introductions, declarations of interest, apologies for absence & Minutes from the previous meeting held on7 June 2022** Dr McLeod (Chair) welcomed everyone to the first meeting of the new Lewisham Local Care Partners Strategic Board. Housekeeping matters were given by the Chair. There were no questions submitted in advance from members of the public. Members of the public were advised they were welcome to ask any questions at the end of the meting under "AOB".	

	Apologies for absence were noted. JMc introduced Andrew Bland, Chief Executive Officer, South East London Integrated Care System. Andrew had been invited to address the first Lewisham LCP meeting and say a few words about the new organisation. AB thanked JMc for the introduction and advised he had attended two other LCP meetings. He was delighted to attend Lewisham and was happy to attend again if required. AB updated regarding the SEL ICS and Lewisham LCP interface. Have established a statutory body, the ICB, with a shift in tone and culture and of the way we do things. Focus is on our population with institutions working together collaboratively to secure the best provision for our residents, taking a population health management approach and tackling health inequalities for Lewisham residents. Noted not a huge structural change but now have a legal footing. AB advised he had never established a public body in middle of a financial year before. The plans for 2022/23 were devised by the CCG and these will continue alongside planning for next year. Currently 50% of ICB spend is out of hospital spend. Delegation must be meaningful and drive locally responsive services. The national review led by Dr Fuller focuses on prevention work, integrated neighbourhood teams and a different offer in the unscheduled care pathway. This review will be a key focus for the future work of the LCP The HWB strategy is also very important. AB noted the LCP will be the engine room for these areas of work. Delegation to the LCP must go beyond the NHS and support integration of services and decision making. It is a journey of discovery for each borough and AB is looking for full integration of responsibilities in each borough. The community focus in Lewisham is undoubted. The population health and wellbeing challenges are enormous and they were before the pandemic. Financial challenges also need to be managed There are opportunities but significant challenges too. JMc thanked AB for his words and noted the challenges. This had been a clear steer from the centre.	

	Declaration of Interests – JMc noted this was a new organisation. There were no new or amended declarations of interest. LH reminded attendees to complete their online declaration for the SEL ICS. Minutes of the BBB/LHCP meeting held on 7 June 2022 – these were agreed as a correct record. **The Board approved the Minutes of the BBB/LHCP meeting held on 7 June 2022.**	
2.	**Terms of Reference (LCP & Primary Care)** JMc introduced the agenda item and advised the Board were being asked to approve two Terms of Reference (ToR) at this meeting. One for the Lewisham Local Care Partnership and one for Primary Care. For the LCP ToR's CJ gave the background. This is a new organisation and the ToR will be reviewed in six months. No questions or queries were raised. **The Board approved the LCP Terms of Refence.** AOS presented the agenda item for the Primary Care Group ToR, noting the group would be accountable to the LCP. It was not a new group, so have refreshed the ToR to be fit for LCP. The ToR will also be subject to a six month review as well. No questions or queries were raised. **The Board approved the Primary Care Group Terms of Refence.** Both ToR will be added to the LCP forward planner LH also advised will be reviewed by SMT as well if required. **Action: LH**	
3.	**Fuller review: implications for Lewisham** CJ and AOS presented the agenda item. CJ noted there would be further, more detailed information at future meetings, but wanted the Board to be sighted on it at this point.	

	AOS noted it provides a fresh impetus with sensible recommendations. Would recommend reading full document. Noted at place level some work undertaken already and that it is not just about primary care but the whole system. Some work already underway is aligned to the Fuller Review and there is a need to keep that going as implementation plans are developed. Progress will be reported back to the Board. Same day urgent care and access, need to address integration and MDT working to maximise impact. CJ commented that primary care and community services are fully delegated to the local systems but we may also want to work with other SEL boroughs on some areas however, core outcomes and standards will need to be standard across SEL. AH said this was an excellent start; a strategic focus for Lewisham working with local communities and it dovetails with PPL work. Need to consider how we will harness those skills that are critical to reaching all parts of our communities. It aligns with work tackling inequalities set out in the BLACHIR report. HT commented on urgent care concerns as significant changes are happening. Needs to be real and working on the issues, not just working on paper. Fuller recommendations on workforce and estates, are critical. JMc said HT raised good points. AB stated the Fuller review was not just primary care. What can we wrap around PCNs to make them multi-disciplinary? JMc agreed. TB said we were concerned with thinking about hospital but work with colleagues to keep people out of hospital is key underpinned by the principle of working in neighbourhoods and communities to achieve this. Lewisham is not one homogenous group of people; it is a vibrant place and TB welcomed it from a social care perspective. Wants the best outcomes for our residents, to address inequalities and a commitment from the council. CJ noted UC (Urgent Care) work will be on-going, a big focus on that, need to look at how we measure impact, not just primary care, will be engaging widely to shape our response.	

	A member of the public raised a question around support for autistic patients. JMc and LH advised questions would be taken at the end of the meeting and they would also be able to discuss any concerns after the main meeting. JMc reiterated this work is important to us and have a new clinical lead, keen to progress this work. Great opportunity to work together for more robust community care. JMc and AOS acknowledged conversations would also continue at Primary Care Operational Group	
4.	**Developing the Lewisham LCP Plan** CJ presented the agenda item. The Board were being asked to just reach agreement for the proposed approach. The plan, once agreed, would guide the work that we do as a system. This plan will need to reflect local priorities and the ICS Strategy as it is finalised through this year. The Board were advised this would need to link and respond to the JNSA, the Health & Wellbeing Strategy, the Fuller review and service sustainability in terms of local priorities, some background work on bench marking initiatives, mapping initiatives is being completed ahead of a planned workshop to agree our local priorities. Voluntary Services and community voices need to help shape the plan and key principles include, Co-production, quality and safety as core and outcomes focussed. The slides would be circulated. JMc queried timeline for the workshop? CJ advised late August or first week in September. MK commented on mental health work and strategy, future for Ladywell and services to be delivered on Lewisham hospital site not necessarily acute. CJ advised community is delegated to us but not the acute. The interface with SEL wide teams will be very important matrix working. The local plan will detail what we need to do at a Lewisham level.	

	AB said for Ladywell; capital spend is a national challenge, forums are needed where all partners can interface, pathways are overlapping, we are not starting from scratch.	
5.	**Finance & Efficiencies** MC presented the agenda item. The finance report is for the period to Month 2 2022/23. It includes key messages for Lewisham and also for the whole of the CCG as well. Lewisham for Month 2 is at a break even position the same as for other CCG boroughs. There are relatively small overspends on CHC (continuing health care) and prescribing, balanced out by other underspends. For efficiencies, Lewisham target for the year is £2.6m, which is identified now. However in order to achieve there needs to be a focus on delivery. Prescribing in particular requires focus, as this accounts for £0.9m of the total £2.6m savings plan. Incentives to deliver are reflected in the Medicines Optimisation Plan. A programme of visits has been arranged to GP practices to support delivery., The breakdown of the efficiencies is shown in the report. Future reports will feature efficiencies updates from Month 4. Challenges include planning early for future years. This will be guided by the planning guidance. Pending receipt of guidance, it would be reasonable to assume 2.5-3%, similar to £2.6m requirement this year. For future years, 2023/24 onwards, it is expected to have a system approach to identifying and delivering savings, and these will be linked to development of agreed service priorities. The early autumn workshop on planning of priorities for future years will provide an initial opportunity to consider approach to system savings, and really working across the system to do things in different ways, not comprising service quality, clear priorities and a shared view, funding and money needs to dovetail, doing things in the most efficient way as we can. The borough should continue to pursue non system savings against the delegated budget in addition to this system work.	

	JMc thanked MC for the introduction to finance and efficiencies for the Board. CJ commented on the opportunity as an LCP, we can work across the system, and think differently as to how we approach things. A member of the public raised a question, JMc reiterated questions would be considered under "AOB".	
6.	**LBL Finance Report** JMc noted Abdul Kayoum had offered apologies for absence due to A/L. The Board noted the report.	
7.	**Risk Register** Tatianna Wanyanga presented the agenda item. JMc noted the risk register contained mostly legacy risks from the CCG and the local team would be reviewing risks, both content and format for future meetings. TW advised there were currently 30 risks on the register, some are legacy risks as mentioned. We will work to have these risks reflect new organisations. Looking at them on monthly basis at Place Executive Group which CJ chairs. The Board are being asked today to note the risks detailed. JMc noted the format would also be discussed at PEG. The Board noted the Lewisham Risk Register.	
8.	**Any other business** - Any questions from the public Olivia, member of the public and a member of the Save Lewisham Hospital campaign queried the efficiencies of £2.6m and £2.3m reduction "which is obviously cuts in funding". She noted, the effect on patients and communities and staff on ever increasing efficiencies.	

	Can it be escalated upwards with regards to dissatisfaction with the system. People are also working longer. The whole health and care system is working extremely hard and partners in the voluntary sector, try to work together for health and wellbeing for Lewisham. CJ responded that these were good points and mentioned sustainability, not necessarily about funding but making sure people are seen and have their needs met. It is better for patients and residents to manage their needs in a planned care way rather than an urgent care route. This creates efficiencies and better outcomes for the people. We will engage with local people to ensure our plans are properly understood. - Voluntary sector involvement FD commented on being part of the right meeting along with RD. CJ, advised yes, it is a partnership board, you work with the local community and will shape what we do. - SEL HI Funding (Dr Naheed Rana) Dr Rana, Public Health consultant, updated on Health Inequalities funding. Slides were shared on screen. Noted there had been a submission for £912k which the previous Board had agreed. In total £764k awarded against the original bid of just over £912k. A proportionate, reduction across all programmes was being proposed. Once agreed, the team would draw down the funding. JMc queried the proportionate reduction rather than a set %, method? Dr Rana stated each proposal had its own amount, to be fair it was decided on the same proportion of the original bid. RD queried the * asterisk next to two funds? D Rana advised it denoted requirements for the posts, if there was a reduction in deliverables of that WTE (whole time equivalent), would look to resource elsewhere. - Future meeting dates for 2022/23 Proposed dates would be circulated by LH to the Board as soon as possible.	

	Action: LH - Draft Agenda for next meeting in August 2022 (seminar session) Board members noted they would be advised of details once available. JMc gave closing comments to the Board and noted future LCP Board meetings would be longer. Also thanks to members of the public for attending and thank you for your contributions. Meeting closed 17.10 hrs.	

South East London Integrated Care System

NHS South East London

Lewisham Local Care Partners Strategic Board

Item 2
Enclosure 2

Title:	**PEL Update Report**
Meeting Date:	**29 September 2022**
Author:	Ceri Jacob
Executive Lead:	Ceri Jacob

Purpose of paper:	**To provide a general update to the Lewisham Care Partnership Strategic Board**	Update / Information	*x*
		Discussion	
		Decision	

Summary of main points:

This report provides a brief summary of areas of interest to the LCPSB which are not covered within the main agenda.

Unplanned Care Board:
During the winter of 2021/22 the Lewisham Unplanned Care Board was stood down to create capacity to manage the immediate operational issues. A decision has been taken by the Place Executive Group to re-establish the UC Board. This is to create space for partners to come together to plan and deliver an optimised non-elective pathway for Lewisham which leads to improved patient experience and outcomes and achievement of statutory performance targets.

The first meeting was held on 22 September with representatives from across health partners and the Local Authority. It was agreed to develop a Lewisham unplanned care plan that encompasses the following four areas:

- Attendance and admission avoidance
- Front door and ED
- Flow through the hospital
- Discharge

The requirement for an integrated same day care pathway, as set out in the Fuller Review, will be taken forward as part of work on attendance and admission avoidance.

It was also agreed that Terms of Rerference would be developed for an operational group to manage system pressures on a day-to-day basis. This group will be stood up if required through winter.

Fuller Review:
Work continues to put in place arrangements to take forward the Fuller Review recommendations as part of our existing work on community-based care. A co-

	ordination group will be established to ensure progress and to assess impacts. It will report into the Place Executive Group. The work is expected to be taken forward in detail through the: • Primary Care Group • Unplanned Care Board • Care at Home Alliance An initial gap analysis has been developed and will underpin a high level implementation plan. This plan will remain iterative as the detail is developed. The initial plan is required to be submitted by 21 October 2022.				
APotential Conflicts of Interest	**Nil**				
Relevant to the following Boroughs	**Bexley**		**Bromley**		
	Greenwich		**Lambeth**		
	Lewisham	**x**	**Southwark**		
	Equality Impact	Nil			
	Financial Impact	Nil			
Other Engagement	Public Engagement	**Not required for this paper**			
	Other Committee Discussion/ Engagement	**NA**			
Recommendation:	**To note the update**				

Lewisham Local Care Partnership Strategic Board
Cover Sheet

Item 3
Enclosure 3

Title:	Network Contract Directed Enhanced Service (DES) - Enhanced Access
Meeting Date:	29 September 2022
Author:	Ashley O'Shaughnessy, Associate Director of Primary Care
Executive Lead:	Ceri Jacob, Lewisham Place Executive Lead

Purpose of paper:	The purpose of this paper is to update the Lewisham Local Care Partnership Strategic Board in regard to the development and mobilisation of the Primary Care Network (PCN) Enhanced Access plans and to confirm support for these plans	Update / Information	
		Discussion	
		Decision	X

Summary of main points:

- From 1 October 2022, PCNs are required to offer patients a new 'enhanced access' model of care in accordance with the requirements as set out in the national DES.
- PCNs need to ensure their Enhanced Access is provided between 6:30 pm and 8:00 pm Mondays to Fridays and between 9:00 am and 5:00 pm on Saturdays. This is referred to in the DES as the Network Standard Hours.
- In preparation for the implementation of Enhanced Access, PCNs have worked collaboratively with the Lewisham Local Care Partnership (LCP) primary care team and developed Enhanced Access Plans.
- All 6 Lewisham PCNs submitted initial draft plans to the Lewisham LCP primary care team for review and comment by the 31st July 2022 deadline.
- Following review, all 6 Lewisham PCNs submitted final iterations of their plans by the 31st August 2022 deadline.
- Assurance that all 6 plans met the requirements of the DES has been given to the South East London ICB Primary Care contracting team and onwards to NHSE/I.
- The Lewisham LCP primary care team are now working with each PCN to support mobilisation of their Enhanced Access services for go-live on the 1st October 2022.
- Although providing the same level of capacity (i.e. minutes per 1000 patients), the new 'enhanced access' model of care does not provide the same level of coverage across the week as the existing GP Extended

	Access service, specifically in regard to Saturday early mornings and evenings, Sundays, Bank Holidays and additional in- hours (Monday - Friday, 8am – 6.30pm) capacity. • The existing GP Extended Access service is also co-located with the Urgent Care Centre at Lewisham Hospital which has supported the management of same day, urgent primary care needs. • The LCP is actively exploring approaches to mitigate any potential negative impacts from these changes.			
Potential Conflicts of Interest	There is a direct conflict of interest for Dr Helen Tattersfield, Sevenfields PCN Clinical Director who is the PCN Clinical Representative on the Lewisham Care Partnership Strategic Board. Any conflict of interest should be managed according to the ICBs Standards of Business Conduct and Conflict of Interest Management Policy.			
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	**X**	**Southwark**	
	Equality Impact	PCNs were asked to consider equality impacts as part of their plans.		
	Financial Impact	There is no direct financial impact of these plans to the ICB as costs are fully funded by NHSE as part of the Network Contract Directed Enhanced Service. There may be an indirect financial impact associated with mitigations put in place to manage any potential negative impacts from the changes.		
Other Engagement	Public Engagement	All PCNs undertook patient engagement to support the development of their enhanced access plans including via online survey, PPGs and patient focus groups. The borough primary care team also undertook patient engagement at the existing GP Extended Access Service which was shared with PCNs to further inform their plans.		
	Other Committee Discussion/ Engagement	Regular updates have been shared with the Lewisham Primary Care Group, the Lewisham Place Executive Group and the Lewisham Local Medical Committee. The Lewisham Healthier Communities Select Committee were briefed on developments at their meeting on the 7th September 2022		

Recommendation:	**The Lewisham Local Care Partnership Strategic Board is asked to note this update and confirm their support for the Primary Care Network (PCN) Enhanced Access plans**

Network Contract Directed Enhanced Service (DES) - Enhanced Access

Update to the Lewisham Local Care Partnership Strategic Board

29th September 2022

Background

In Investment and Evolution (2019), BMA General Practitioners Committee (GPC) England and NHS England agreed to bring together the existing extended access services and funding streams as part of one, single funding stream under the Network Contract DES, to support delivery of a new model of "Enhanced Access". This incorporates the Primary Care Network (PCN) delivered extended hours access service under the Network Contract DES and the CCG commissioned extended access service.

Initially this service was intended to commence in April 2021, but it was agreed with GPC England in Supporting General Practice in 2021/22 that this would be delayed until April 2022 due to the pandemic. It was further delayed until October 2022 to support core general practice capacity and to avoid any disruption over the 2021/22 Winter period.

On 31 March 2022, the Enhanced Access (EA) service specification was published as part of the Network Contract DES and supporting guidance. The specification requires PCNs to provide this service from 1st October 2022.

Summary of key requirements of the DES:

From 1 October 2022 a PCN must provide enhanced access between the hours of 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays (which are referred to as "Network Standard Hours")

A PCN must provide bookable clinical appointments during the Network Standard Hours that satisfy all of the requirements set out below:

a) are available to all PCN Patients;

b) are for any general practice services and services pursuant to the Network Contract DES that are provided to patients;

c) are for bookable appointments, that may be made in advance or on the same day, by the PCN's Core Network Practices, regardless of the access route via which patients contact their practice, and the PCN must:
   i. make the appointments available a minimum of two weeks in advance, with the PCN's Core Network Practices utilising appropriate triage and/or navigation as required to book and/or offer patients available appointments;
   ii. make the Network Standard Hours appointment book accessible to the Core Network Practices to enable efficient patient bookings into slots following patient contact;
   iii. make same day online booking for available routine appointments where no triage is required up until as close to the slot time as possible;
   iv. operate a system of enhanced access appointment reminders;
   v. provide patients with a simple way of cancelling enhanced access appointments at all times;

vi. in line with published guidance, make available to NHS111 any unused on the day slots during the Network Standard Hours from 6.30pm on weekday evenings and between 9am-5pm on Saturdays, unless it is agreed with the commissioner that the timing for when these unused slots are made available is outside of these hours; and

vii. have in place appropriate data sharing and, where required data processing arrangements to support the delivery of Enhanced Access between the PCN's Core Network Practices and where applicable a sub-contractor.

d) are delivered by a multi-disciplinary team of healthcare professionals employed or engaged by the PCN's Core Network Practices, including GPs, nurses and Additional Roles and other persons employed or engaged by the PCN to assist the healthcare professional in the provision of health services;

e) are within Network Standard Hours:
   i. a mixture of in person face to face and remote (telephone, video or online) appointments, provided that the PCN ensures a reasonable number of appointments are available for in person face-to-face consultations to meet the needs of their patient population, ensuring that the mixture of appointments seeks to minimises inequalities in access across the patient population;
   ii. in locations that are convenient for the PCN's patients to access in person face-to-face services;
   iii. ensuring that the premises from which Enhanced Access is delivered is as a minimum equivalent to the number of sites within the PCN's geographical area from which the CCG Extended Access Service was delivered;

f) are providing a minimum of 60 minutes of appointments per 1,000 PCN adjusted patients per week during the Network Standard Hours,

Full details of the DES can be found at: https://www.england.nhs.uk/wp-content/uploads/2022/03/B1357-Network-Contract-Directed-Enhanced-Service-contract-specification-2022-23-primary-care-network-requireme.pdf

Plan development

PCNs worked collaboratively with the Lewisham LCP primary care team, with each other and with One Health Lewisham (as the current provider of the GP Extended Access service) to develop their Enhanced Access Plans.

As per the requirements of the DES, PCNs undertook patient engagement to support the development of their plans specifically in regard to the mix of services that would be available, when they would be available across the Network Standard Hours and how they will be accessed by patients including the locations from where in person face-to-face services will be delivered.

The LCP primary care team supported PCNs in their engagement by:

- Drafting a template patient survey
- Providing the offer of facilitation for public and patient virtual focus groups
- Carrying out direct engagement with patients using the existing GP Extended Access service

PCNs were asked to submit their plans using a template developed across London.

Assurance process

All 6 Lewisham PCNs submitted initial draft plans to the Lewisham LCP primary care team for review and comment by the national deadline of the 31st July 2022.

Plans went through an initial desktop assessment to review compliance with the national DES requirements.

Panel sessions with each PCN (led by the Place Executive Lead) were then held to further scrutinise plans.

Taking into account feedback given and clarifications requested, all 6 Lewisham PCNs submitted final iterations of their plans to the Lewisham LCP primary care team by the national deadline of the 31st August 2022.

Based on these final plans, assurance was formally given to the South East London ICB Primary Care contracting team and onwards to NHSE/I that all 6 PCN plans had met the requirements of the DES.

Mobilisation

The LCP primary care team are now working with each PCN to support mobilisation through weekly touchpoint meetings – these are focussing on key areas such as workforce, estates, IT, communications (both internal and external to patients), sub-contracting arrangements (where relevant) etc. Scenarios are also being used to test the resilience/contingency arrangements within PCNs.

In specific regard to patient communications, we are awaiting release of a national/London PCN toolkit to support PCNs and the SEL central communications team are also supporting.

Based on conversations to date, at this stage there are no immediate concerns to go-live on the 1st October 2022 for any of our 6 PCNs.

Potential system impacts and mitigations

Although providing the same level of capacity (i.e. minutes per 1000 patients), the new 'enhanced access' model of care does not provide the same level of coverage across the week as the existing GP Extended Access service, specifically in regard to Saturday early mornings and evenings, Sundays, Bank Holidays and additional in- hours (Monday - Friday, 8am – 6.30pm) capacity.

The existing GP Extended Access service is also co-located with the Urgent Care Centre at Lewisham Hospital which has supported the management of same day, urgent primary care needs (none of the new 'enhanced access' models of care include delivery on the hospital site).

The LCP is actively exploring approaches to mitigate any potential negative impacts from these changes including specific work with One Health Lewisham and Lewisham Hospital focussed on the Urgent Care Centre.

Summary of PCN plans

PCN	Patient engagement	Location	Skill mix/appointment types	Mode of consultation
Aplos	Online survey (over 1700 responses) PPGs Focus group	Rotating across all 4 PCN practice sites through the week Saturday clinic at Sydenham Green Group Practice	GP Nurse HCA Dietician Health & Wellbeing Coach Pharmacist Phlebotomist Health Checks	Face-to-face Telephone Video Online
Modality	Online survey (over 900 responses) PPG	Rotating across all 3 PCN sites	GP Nurse Physio Health & Wellbeing Coach	Face-to-face Telephone Video
Sevenfields	Online survey (over 2800 responses) PPGs Focus group	Rotating across Novum (Rushey Green and Baring Road sites), Parkview and Downham Health and Leisure Centre	GP Nurse Health & Wellbeing Coach Health Checks Physio	Face-to-face Telephone Video Online
North Lewisham	Online survey (over 2600 responses) PPGs Focus group	Waldron Health Centre	GP Nurse HCA Health & Wellbeing Coach Pharmacist Physio	Face-to-face Telephone Video Online
The Lewisham Care Partnership	Online survey (over 2500 responses) PPG	Rotating across all 5 PCN sites	GP Nurse HCA Pharmacist	Face-to-face Telephone Video Online
Lewisham Alliance	Online survey (over 3500 responses) PPGs	Rotating across all 5 PCN practice sites through the week Saturday clinic at Woodlands Health Centre	GP Nurse Health Checks	Face-to-face Telephone Video Online

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 4
Enclosure 4

Title:	**Addressing Digital Exclusion**
Meeting Date:	**29 September 2022**
Author:	Michael Kerin/Sarah Wainer
Executive Lead:	Ceri Jacob

Purpose of paper:	To recommend to Lewisham Health and Care Partners the action that needs to be taken to respond to the recommendations set out in Healthwatch Lewisham's Digital Exclusion report (as attached)  HWL Digital Exclusion report.pdf	Update / Information	
		Discussion	x
		Decision	
Summary of main points:	Healthwatch Lewisham's report was sent to local partners for consideration and organisations were asked to respond to the recommendations made in the report. The response was delayed initially due to some confusion with whether a joint LHCP or individual organisation response was required. The latter was confirmed. Since being distributed to health and care partners, only SLaM submitted a response. It has been recognised that this could be partially due to the complex nature of the recommendations and difficulty in identifying which partner or partners were expected to respond to individual recommendations. To address this, a template has been produced which will be circulated to all members of the LCPSB to gather responses to the recommendations. Members are also asked to nominate a contact within their organisation who can help to develop an associated action plan to address the recommendations.		
Potential Conflicts of Interest			

Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	

	Equality Impact	Digital exclusion limits or prevents access to services.
	Financial Impact	
Other Engagement	Public Engagement	The Healthwatch report is based on engagement with local people.
	Other Committee Discussion/ Engagement	The Healthwatch report has been considered by the Lewisham Health and Wellbeing Board and passed to this committee for action.
Recommendation:	Members of the Board are asked to approve the following recommendations: 1. Agree to receive the attached template which provides a clear structure to respond to each recommendation or to add N/A where it is not applicable to the organisation; 2. Agree a deadline of end of October for responses to be returned, with a contact name for follow up action, to Deborah Harry, System Transformation Business Support; 3. Agree that the collated responses will be presented to HWL; 4. Agree that an action plan to address digital exclusion be developed by Healthwatch and the System Transformation Team to be presented back to LCP later in the year.  (PCN)%20HWP%20Recommendation%20C  HWP%20Recommendation%20response Ps. 2 templates provided for 6 partners (4 on one, 2 on one)

Digital exclusion and access to health services

2021

healthwatch Lewisham

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Your Voice in Health and Social Care is an independent organisation that gives people a voice to improve and shape services and help them get the best out of health and social care provisions. YVHSC holds the contracts for running the Healthwatch services for Healthwatch Hounslow, Healthwatch Ealing, Healthwatch Waltham Forest and Healthwatch Bromley. HW staff members and volunteers speak to local people about their experiences of health and social care services. Healthwatch is to engage and involve members of the public in the commissioning of Health and social care services. Through extensive community engagement and continuous consultation with local people, health services and the local authority.

Contents

Executive Summary

For this research project, we wanted to engage with people who are more likely to be digitally excluded and gain a better understanding of how this might impact their experience with health and care services. We focused on primary care as this is the first point of contact for people accessing services. However, our findings will be relevant to all services which are moving towards digital delivery. We partnered with North Lewisham Primary Care Network (NLPCN), who have a shared interest in using patient experience to improve the offer and health of the community they serve.

We paid particular attention to people's experience of accessing services during the COVID-19 pandemic. In total, we carried out interviews with 45 residents as part of the project. Those we spoke with included older people, people with English as their second language, and people with disabilities. The reason why we chose these groups is because they traditionally experienced barriers before the pandemic, and we wanted to understand whether this had exacerbated as a result of the lockdowns.

Digital exclusion can be the result of a variety of factors, including affordability and limited accessibility because of disabilities, lack of support and language barriers. The stories we heard about people's access to health and social care were mixed. Some people found remote GP consultations to be beneficial and were understanding of the need to shift to these digital care methods whilst the pandemic spread rapidly. Others were unhappy with the quality of care and treatment received using remote consultations and didn't feel confident with the diagnosis and/or the treatment plan. Both groups advocated for a return to face-to-face appointments.

Feedback also suggests that many participants were disappointed with the level of service received, especially when it came to administration. Numerous participants highlighted the challenges they faced when trying to get through on the telephone. Waiting times for appointments were undesirable with some people not being able to receive appointments for over two weeks, which echoes similar experiences prior to the pandemic.

Some residents experienced multiple barriers when trying to access health care support (affordability, lack of IT skills, and language barriers) which caused high levels of stress and anxiety.

Primary Care professionals we engaged with as part of this project discussed the benefits of remote care but also acknowledged that a shift to remote consultations risked excluding a significant proportion of service users from health and social care services. As the NHS supports primary care to move towards a digital first approach it is essential that the needs of digitally excluded residents are embedded within delivery plans.

There is the danger that the drive for greater digital access leaves behind those who are unable to engage with technology and therefore deepens existing health inequalities. Through our engagement, it is evident that the majority of participants would prefer face-to-face appointments as they value them more than the digital approach. Services must ensure that they deliver a hybrid approach of in-person and remote consultations which meets the needs of the local population and which takes account of their access needs.

About Healthwatch

Our organisation is an independent champion for people who use health and social care services. We exist to ensure that people are at the heart of care. We listen to what people like about services, and what could be improved, and we share their views with those with the power to make change happen. Under the General Data Protection Regulations (GDPR) and the Data Protection Act 2018, we have a lawful basis to process information that is shared with us by services and service users. Confidentiality is important to us, and we will only keep data for as long as is necessary. If you would like to know more about how we use the data we collect, our privacy statement is available on our website, www.healthwatchlewisham.co.uk

Introduction

The unprecedented COVID-19 pandemic forced services to adapt their service strategies in order to protect staff and patients as well as mitigate the risk of the virus spreading. As a result, services had to adapt quickly and introduced new models of access, which included remote access and a total triage system*.

The rapid changes meant that there was little time to research the possible impact on health outcomes, patient experience, or health-related inequalities when using digital platforms. There is a legitimate fear, that as a result, a 'one size fits all' approach may further widen local health inequalities. Twenty months on and digital exclusion remains a great concern and raises multiple challenges that need to be addressed urgently.

To help understand the impact of the changes, we carried out a research project looking to better understand the impact of a 'virtual by default' access model (with focus on primary care) implemented by health and social care services in response to the COVID-19 pandemic on a socially deprived and vulnerable population.

The aim of the research project was to deliver targeted engagement with residents who have limited access to or don't use digital technology to address the gap in local knowledge. The project aimed to understand how the change to a digital model has impacted on this cohort's experiences of accessing health and care services. Intelligence gathered has been used to help support the development of alternative methods and pathways for those who are digitally excluded to have equity of access to the care and treatment they need. The project helped us:

1. To gain an understanding of the needs and potential barriers people who do not use/or have limited access to technology when engaging with services, with a focus on GP practices.

2. To produce a series of recommendations to help address the needs of people who are digitally 'excluded' based on the feedback received.

The findings from our report will not only highlight issues residents have had with new remote models in primary care but will be applicable to all local health and care services which provide a digital offer. We want to work closely with partners to address the issue of digital exclusion and the challenges residents face.

* Total digital triage uses an online consultation system to gather information and support the triage of patient contacts, enabling care to then be provided by the right person, at the right time, using a modality that meets the patient's needs.' 15 September 2020. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0098-total-triage-blueprint-september-2020-v3.pdf

Background

The COVID-19 pandemic forced health and care services to make changes to their models of care and how they support residents. There has been a shift towards a digital model of telephone and online appointment systems. The Covid-19: Lewisham system recovery plan shows that between March and June 2020, 85% of primary care appointments were delivered virtually. New precautionary measures were established to keep vulnerable people and staff safe during the pandemic, however these methods of delivering primary care may become the new normal.

We conducted research with over 1000 residents on their experiences of remote consultations and accessing health services as part of our 'Impact of COVID-19 on Lewisham' [1] report during the first lockdown with the aim to understand how this rapid shift was received in the borough. Many residents highlighted the benefits of the digital shift, such as greater ease in securing appointments. However, there were also concerns raised about the exclusion of residents who cannot use or afford digital technology to access primary care. It was evident that there was a gap in local information regarding the experiences of residents that are digitally excluded and a need for research to be carried out to understand the views of those that have limited or no access to digital devices.

The London Borough of Lewisham is extremely diverse with 46% of the population being from a Black, Asian and minority ethnic background and residents representing over 75 nationalities. It is the 10th most deprived borough within London and ranked in the top 20% most deprived Local Authorities in England [2]. Vulnerable people already experienced barriers to primary care pre-COVID-19, including poverty, language barriers and mistrust of the system, amongst others. Research that was conducted with GPs and support services for vulnerable patients indicates that these issues have likely worsened because of the pandemic [3]. Furthermore, new pandemic-related barriers have formed, which include issues around quality of information about changes to local service delivery, a hesitancy to share personal information via a triage system, removal of walk-in services and digital exclusion [4].

The NHS Long Term Plan outlines how the model of care found across the NHS will change over 10 years through the introduction of digital health technologies (DHTs).

Primary care services will adopt a 'digital first' system in which most patients are assessed through healthcare apps, telephone consultations, or through web-based platforms. This system would give GPs more time to have longer consultations with those in need [5]. The steady introduction of digital services enables feedback by patients and healthcare professionals to be incorporated, such that these services meet the demands of the communities that they serve.

COVID-19 resulted in the Total Triage (TT) model being implemented in a matter of days in March 2020 [6]. How each service incorporated the policy changes into their practice is still being examined, as is the impact of these changes on vulnerable groups [7&8]. The government planned for the changes enacted over the pandemic, such as TT to be embedded into services permanently [9]. However, the TT model ended in May 2021 as 'GPs were told the use of telephone and online consultations

can remain where patients benefit from them, but physical appointments must also be available' [10]. This report understands the experiences of digitally excluded residents and how they found these new systems. We have primarily focused on groups that historically have issues accessing healthcare, and those that could be at risk of digital services impeding their access.

Over the course of 2020 there has been a substantial increase in users of the NHS app [11], and the number of consultations conducted remotely in February 2021 was 40.9% [12]. Over the first lockdown positive reviews of GP consultations were reported, with people feeling that remote consultations fit more conveniently with their schedules [13]. However, reports also found that most participants highlighted a need for the availability of face-to-face appointments to support those who have issues accessing digital services.

According to the Consumer Digital Index Report, approximately 9 million people across the UK struggle to get online without assistance (16%), and 11.7 million (22%) lack the skills for everyday life. These values are compounded by factors such as age, disability, and ethnic minority, with elderly individuals, and those who are most disadvantaged, having higher levels of digital disengagement [14]. These findings draw concern as digital exclusion could worsen already existing health inequalities, and risk some people being left behind in a 'one size fits all' system.

Currently, studies have documented how those from deprived areas receive poorer access to primary care [15], and how marginalised groups, such as sex workers, homeless individuals, drug-users, and prisoners have poor health outcomes [16]. This risks the NHS mandate of everyone having equal and fair access to care not being met. While the national Healthwatch report 'GP access during COVID-19' highlights some positive experiences of service users, it found ongoing issues within health services that need to be addressed, and the need for a more detailed assessment of the aforementioned groups experience of digital healthcare at local level [17].

The Healthwatch Lewisham study and resulting report supports many of the Healthwatch England key findings and addresses areas that need to be improved when accessing health and social care services.

Methodology

Our engagement was delivered across the London Borough of Lewisham from March – July 2021. Research suggests that residents with language barriers and disabilities experience difficulties accessing services. We wanted to hear from residents that do not use or have limited access to digital devices and the internet. Our primary focus was engaging with residents who are at risk of being digitally excluded and whether the shift to remote access has exacerbated existing issues.

We focused our engagement on people who were likely to have no access or limited access to digital technology. This included:

1. Residents who do not speak English as a first language
2. Older residents
3. Residents with disabilities or sensory loss

We partnered with North Lewisham Primary Care Network (NLPCN) who share interest in reducing health inequalities exacerbated by the recent COVID-19 pandemic.

We developed accessible leaflets to promote the project and encourage participation. We worked with local organisations and food banks to help distribute the leaflets to residents from targeted groups. Examples of methods of distribution included local newsletters, community mailing lists, leaflets, and attending online engagement forums.

To engage with this cohort of people and reach residents who would not normally use digital devices, we aimed to carry out face-to-face and telephone interviews. To recruit suitable participants, and to encourage participation, we worked with community organisations, such as Lewisham Refugee and Migrant Network (LRMN), Age UK, Voluntary Services Lewisham, Lewisham Homes and Phoenix Housing. This required a lot of assistance from partners who actively recruited participants for the project and we would like to thank them all for their continuous support (Thank you, pg.31). On certain occasions, interviews and recruitment were conducted directly by partner organisations. This was the case where ethical considerations had to be considered. Some participants were reluctant to speak to external organisations. However, they felt comfortable sharing their experiences with organisations who supported them.

The Lewisham Refugee and Migrant Network (LRMN) empowers 'people and families who are destitute, homeless or have No Recourse to Public Funds (NRPF), from refugee, asylum seeker and migrant communities' [18]. Their team received consent and conducted interviews with 11 participants. We were also supported by Lewisham Council in identifying and facilitating conversations with Deaf residents.

Although our initial intention was to carry out face-to-face engagement, national lockdown measures meant that most interviews were carried out remotely to reduce the risk of spreading the virus and ensure the safety of staff, volunteers and residents. The interview questions were developed in partnership with the NLPCN using Healthwatch England's template from a similar study.

Participants were predominantly interviewed over the telephone. Zoom calls were also used in a small number of cases when requested by professionals and participants who felt it was more appropriate for residents that experience learning disabilities, language barriers and/or have long term health conditions. We also delivered several paper copies of the questionnaire to residents who preferred to fill it in by hand. This was mostly due to hearing difficulties when initially contacting them over the telephone.

The feedback collated consisted of both qualitative and quantitative data which was analysed to identify themes and trends. To mitigate bias, two members of the Healthwatch team (a Project Officer and Research Volunteer) analysed the data separately. We carried out two online engagement sessions that we promoted with the help of NLPCN to local primary care professionals. The sessions were attended by 10 participants. The aim of the first session was to better understand the impact of the new access models on patient experience from the perspective of primary care professionals, particularly hearing from GPs. A second session was set up to present the initial findings of this project and assist with co-designing the recommendations for this report.

Participant Profiles

Healthwatch Lewisham spoke to 45 residents between April – July 2021. In addition, we engaged with 10 primary care professionals to understand their perspective on this issue. These sessions took place in April and August 2021.

We gathered a substantial amount of monitoring information, and it is evident there is intersectionality. For example, several residents we engaged with would fall under the three traditionally disadvantaged groups we wanted to focus on: English as a second language, older residents, and people with disabilities.

People over the age of 55

25 people were over 55 years old (see Appendix 3). This group included:

- 65% women and 35% men
- 83% confirmed that they are 'Not in Employment/ not actively seeking work (Retired)'
- Several people had age-related conditions such as hearing or sight impairment

Disabled People

21 people identified themselves as disabled. This group included:

- 76% Women and 24% men
- People with physical disabilities, mental health issues, mobility and sensory impairment, long-term conditions, and learning disabilities
- Those that were happy to share their ethnicity identified as White British (38%), Black British (African/Caribbean) (38%), White Other (10%) and Asian British (Bangladeshi/Indian) (1%)

Primary care professionals

With the support of the North Lewisham Primary Care Network, we organised two engagement sessions open to all primary care professionals. The participants mostly consisted of GPs.

English is their second language

Of the 45 participants engaged with the research project, 16 people confirmed that English is their second language. This group included:

- People with varying levels of English proficiency. In some cases, we provided an interpreter to assist with carrying out interviews
- One Deaf person who uses Portuguese and British Sign Language (BSL). We organised an interview with the resident through Zoom with the support of a BSL interpreter.
- People who spoke Arabic, Igbo (also known as Ibo), Romanian, Maltese, Tamil, Twi (also known as Akan Kasa), and Spanish.

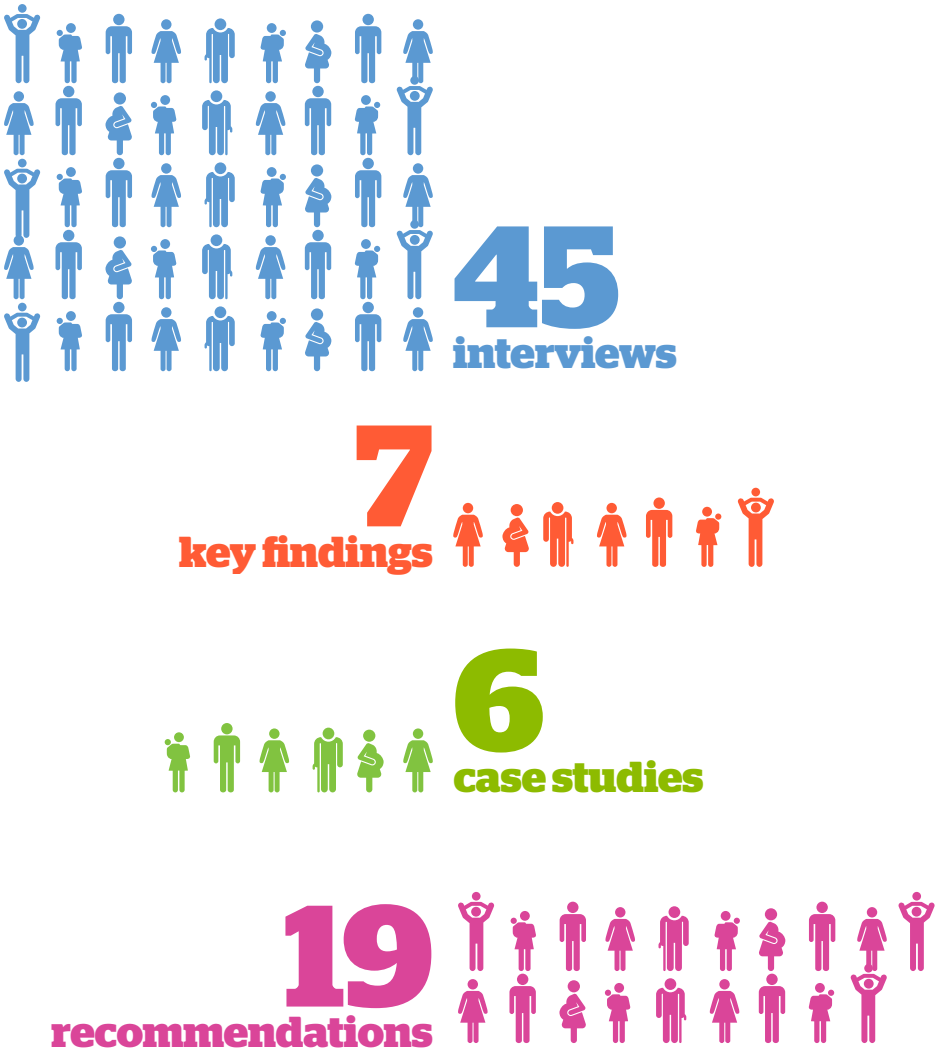
Ethnicity

Studying the monitoring information shared by most participants, we identified the following ethnic groups (see Appendix 4):

- 33% Black British (African/Black Caribbean)
- 31% White British (English/Welsh / Scottish / Northern Irish/ British)
- 9% White Other
- 5% Arab
- 2% Asian British (Bangladeshi/Indian)
- 2% Mixed Multiple (White & Asian)

Report Layout

The following chapters focus on analysis of the 45 interviews. We have highlighted the key issues which emerged through the conversations and have included several case studies which showcase the different experiences for participants when accessing services.



Key Findings: Limited or lack of Technology & IT Skills

Online appointments have created barriers for some of the residents we interviewed many of whom do not have adequate IT skills to access their GPs this way. This left them feeling unable to use the service after the introduction of new remote access methods because of the pandemic. The new model of access exacerbated by difficulties in contacting the practice via telephone, has led to some people giving up trying to seek help from their GP.

A participant explained that they can't get through when ringing their practice and due to poor health rarely feel able to attempt a call again. Another participant felt the new system was not inclusive as they were unable to access their GP because they didn't possess digital devices. When they called their practice, they were consistently advised to book appointments through the online system which they felt was discriminatory. They tried to get an appointment for months over the telephone and had no success, which caused a huge level of stress.

Feedback suggests that some respondents relied on family members to help with digital access and/or making steps to improve their IT skills by attending classes. Whilst some residents have had family members support them with digital issues, services should not rely on this support. They should take the necessary steps to empower all residents to have privacy for confidential discussions if necessary, and parity of access to their services.

The lack of digital skills has made it harder for some participants to access health information or know what services are available to them. This could be particularly challenging for those that are socially excluded for multiple reasons, such as learning difficulties or language barriers. During a NLPCN discussion, a primary care professional spoke about how "Our digital triage system has shifted the demographic of patients at the surgery. We have a university population close by so the demographic is young students. ...There is a shift away from patients who probably need services, because they can't use e-consult as well as younger professionals."

CatBytes is a non-profit organisation that support residents in developing their IT skills. We attended one of their technology workshops to get a better understanding of the work that they do and hear about their first-hand experience of working with individuals that want to develop their IT skills. Catbytes' Damian Griffiths said "I think the experience of helping people use digital devices has taught me that there are far more ways of getting things wrong than there are getting things right. They don't explain that in the instruction manuals. This is why person-to-person support will always be part of keeping people in the digital loop."

The above feedback suggests that change to new digital models may have had a negative impact on people who are used to accessing services in the traditional way. The difficulties in getting through on the telephone add further barriers for those who are unable to use digital technologies to access services.

"The advancement of technology makes you feel a bit alienated..."

".... I feel so restricted. I don't have a computer and they have an online app that is not working during the pandemic. There are no appointments available."

"I don't have access to online. There must be many in the same position as me."

Key Findings: Digital Poverty

Our aim was to engage with residents that are more likely to be digitally excluded. Whilst most participants we spoke with have access to a digital device (computer or smart phone), a few participants said that they don't have a computer or internet connection at home. 11% of participants confirmed they had used e-consult or had a video consultation with their GP practice (See Appendix 5). The findings suggest that some of the participants experienced significant barriers in accessing care remotely as a result of the lack of affordability. Some of the examples are outlined below:

- During an interview, a participant on low income asked if we could find them "a cheap computer" as they weren't sure how to locate one themselves and their financial situation has impacted access to technology.

- Several participants commented on phone bills being more expensive because of long waiting times when trying to get through to a GP practice. One participant doesn't own a landline or mobile phone. They had to use a phone box which they found exceptionally difficult as it costs more money. Although they eventually got through and had a positive experience getting a referral, they found accessing the service extremely frustrating and felt it was an overly complicated process. It took up a lot of their time, was more expensive and they would have preferred walking into their GP practice to book an appointment.

- Similarly, a participant highlighted the challenges they faced when trying to register at a GP practice. When engaging with a receptionist, they informed them that they didn't have access to a laptop and only have a telephone. The receptionist couldn't believe this and advised they go to a friend's house for digital support. The participant felt they were treated without empathy, and that their individual needs were ignored, which left them facing additional barriers registering with their GP.

Dr Al Mathers at Good Things Foundation says there has been a rise in data poverty during the COVID-19 pandemic. Approximately 10% of internet users have a smartphone to get online and 6% (down from 11% in 2020) of households were without access to internet and devices in March 2021 [19]. 55% of those that are offline earn under £20,000 [20].

"It also costs a lot.... you have to hold onto the line, and you are in a list of people. Then something goes wrong, and you go right back to the start again."

"You are made to feel like a second-class citizen if you don't use the internet."

Key Findings: Appointment availability & booking system

Prior to the pandemic, our organisation regularly found through our intelligence reports that access to GP appointments was the biggest issue for Lewisham residents in relation to health and care services. Overall, the findings from our digital exclusion project show that 90% of participants were able to access help from a primary care professional at least once during the pandemic. 59% confirmed they had managed to get a telephone consultation and 30% had received a face-to-face consultation. In most cases participants received face-to-face appointments if they were being seen by a nurse, having a blood test, or required urgent physical examination. This particular cohort of residents were grateful to receive their preferred type of appointment.

18 participants, however, highlighted that waiting times on the GP practice's telephone was the biggest barrier faced when trying to book an appointment. Other technical barriers were flagged such as people finding it difficult to use apps to book appointments, extensive phone queues and unreliable phone connections which would cause people to be cut off and must start the process again. The new remote system has not improved access to appointments for many residents. Difficulty engaging with services means that patients can choose to give up contacting the service and this could result in them interacting with services at a point of crisis.

Despite having access to a smartphone or the internet, the majority of participants rang their GP practice to get appointments. One person shared their story of being unable to get hold of their doctor and ringing NHS 111 for support. They were referred to a walk-in clinic in a neighbouring borough who managed to speak to their GP practice and arrange an appointment. It has been extremely difficult for them to get through to a person on the phone and they wished for better communication and more support.

Red Ribbon is a volunteer-led community organisation supporting people affected by HIV in the London Borough of Lewisham and surrounding areas. Most of the people they support are migrants, on low income and have no recourse to public funds. We attended a Zoom workshop with the organisation where participants shared their experience of healthcare access over the past 18 months. One of the key issues for Red Ribbon service users was the long waiting time trying to get through to a GP practice on the telephone. One participant said they tried calling and their GP practice was fully booked for the whole week. This is a concern for many Red Ribbon service users as they have a long-term health condition which can require regular medical attention but aren't always able to reach their GP when they need support.

The implementation of remote booking systems has also resulted in residents being unable to book appointments in-person within their GP practice. This provides an additional barrier for residents who either do not have access to technology or cannot afford to incur increased phone bills due to long waits on the telephone.

"They don't answer the phone and when you get through, they don't pay attention to you ..."

"You are fifteenth in line and there is so much jargon."

Key Findings: Communication

Several participants told us that a lack of communication from services during the pandemic meant they weren't aware of the access arrangements prior to engaging with the service. In some severe cases this led to hospital visits or a participant not addressing their health issues immediately causing further complications.

Internal communication between health and care services was also highlighted as an area for improvement. During an interview, a participant said that their prescriptions were delayed due to miscommunication between their GP practice and the pharmacy. This was an immediate concern as they have long term health conditions, which require regular medication. Another participant, that has Chronic Obstructive Pulmonary Disease (COPD), spoke about an issue concerning their repeat prescriptions. When they spoke to a GP at their practice, the doctor was unaware of their medical history and not a chest specialist.

The feedback we received shows that 33% of participants found out about changes to their GP's booking system when they rang the practice themselves. Whilst 20% of participants received a letter in the post and 11% received a telephone call from their practice to inform them of the changes being made. The other methods of communication, which received less than 10%, were email, leaflets, text, GP website and word of mouth (see Appendix 7).

A participant said that they have been registered for more than 8 years with their GP practice. They never received any correspondence related to changes at their surgery and only discovered the new triage system when calling the practice directly.

Another participant also was unaware of the changes accessing their GP until an LRMN advisor rang the practice on their behalf. Prior to this, the participant had made several attempts to call their GP and the line kept going to voicemail. Eventually they had to ring 111, which then led to them ringing 999 and being taken to a hospital.

Residents with sensory disabilities further highlighted challenges they faced including confidentiality, communication barriers and concerns around data protection.

A Deaf participant highlighted the barriers of accessing their GP as a result of interpreting services provided by the Council being paused. Prior to the pandemic they used the same interpreter at healthcare appointments which meant the professional was familiar with their issues and could communicate their concerns. During the pandemic, interpreter provision has been provided nationally which has prevented continuity and the resident found that some interpreters did not have the required skills to communicate their specific health issues with the doctor. Virtual appointments also meant that they couldn't meet with the interpreter beforehand to build a rapport.

Residents that access their GP practice regularly expressed their frustration in the lack of communication about changes in access during the COVID-19 pandemic. One patient, that has multiple health issues as well as being unemployed, described their current situation as "living through hell".

Key Findings: Communication (continued)

The lack of access to their GP has impacted their health and well-being because they have serious health issues that haven't been addressed. Due to not having a computer and limited technology skills, the patient has struggled to see a doctor over the past 18 months and resulted to visiting A&E when their health condition deteriorated.

During a NLPCN discussion, a primary care professional said that "Running a total triage system has given us increased capacity. But not having an open-door policy as well as poor messaging, makes some people think that our service is closed. Primary Care communication across multiple platforms is an issue." This finding was also identified in our 'Impact of COVID-19 on Lewisham Residents' report [21].

"My own GP would know me, and I have ended up in hospital when I don't need to go."

".... government needs to give more money to GPs so they can take longer to listen to people, especially now after we have the problems of Covid."

Key Findings: Face-to-face vs. remote appointments

The majority of participants said that their GP practice has been operating remotely since the start of the COVID-19 pandemic. 44% of participants felt the shift to phone, video or e-consultations had impacted their ability to access GP services in a negative way, with many expressing concerns that their health issues could not be addressed properly if they weren't physically seen by a doctor. 33% of participants expressed neutral sentiment, and felt their health needs were met, and 23% had a positive experience with remote consultations.

The majority of participants said that they weren't given a choice to choose between remote or face-to-face appointments. If given the option, most service users would choose face-to-face (See Appendix 6).

One of the reasons for preferring face-to-face appointments was the concern of being misdiagnosed, or the wrong medication being prescribed. People felt this was more likely to happen without a thorough examination in person. This indicates that the remote model reduces people's trust in the diagnosis and treatment plan.

Many participants felt that the face-to-face appointment was of better quality as it was 'easier' to communicate, especially for patients with multiple and/or complex conditions. The discussion with the primary care staff as well as feedback from participants suggests that face-to-face appointments creates a rapport between the patient and doctor and allows for more meaningful interactions.

One participant said they have multiple medical issues where it's only appropriate to talk to someone in person. They sometimes find it difficult to remember everything they wanted to say over the telephone. During a NLPCN discussion, a primary care professional spoke about the issues they had faced with remote consulting from a clinical perspective; "There are very few set things that remote consulting are good for, i.e., contraceptive pill. For the vast majority of problems, it is very difficult to do it in a satisfactory way for both a GP and a patient."

Similarly, a GP in Lewisham that attended one of our NLPCN discussion groups, told us that some asylum seekers have access to a telephone via their home office accommodation. However, language is often an issue, and they feel dissatisfied with the appointments they are receiving remotely. A telephone appointment, rather than face-to-face, is not valued and "acts as a deterrent to them booking appointments".

"You can't give a thorough examination without being in person."

"I would like to be able to have face-to-face....I can use Google translate on my phone to speak in person, I can't use this when I am on a phone."

Key Findings: Confidentiality

The issue of confidentiality was raised by several participants. People expressed their concerns around having to share personal information over the phone with a receptionist. They didn't want to be discussing private health matters with anyone other than their doctor. People also expressed concern around the use of personal data.

> **"I would prefer to have face to face ... You can sit down and tell them your griefs and it is confidential."**

One participant, who is visually impaired, spoke about the challenges they faced when accessing appointments. They don't have an internet connection at home and booking an appointment requires a support worker, which they were unable to get over the past 18 months. Therefore, accessing health services during the pandemic was exceptionally difficult for them. Out of good will, a neighbour stepped in to help read letters sent from their GP practice. However, this has resulted in them no longer having privacy or confidentiality.

Key Findings: Continuity of care

Several participants expressed their concern about how the new access models impacted on continuity of care and being able to book appointments and interact with the same health professional. A Red Ribbon service user said that sometimes they are afraid of trying to access a health care service because they can't guarantee they will see their GP. They commented that members of Black communities tend to rely on people they know and connect with and that there is a lot of action to be done to ensure continuity of care and avoid a lack of trust in health care services.

> **"If you live alone, it is hard. I have my daughter and a carer for support."**

Key Findings: Impact on mental health

Several participants said they felt incredibly anxious as a result of not being able to speak to a GP in person about their health conditions over the past 18 months. One participant commented that they found it difficult to trust what a GP said to them over the telephone and stressed how much more relaxed they would feel if they could be seen in person by a doctor.

"Last year I gave up contacting the GP for anything.... it was causing me more anxiety than usual. My advocate stepped in ..... and only then did I get an appointment."

On the other hand, another person said they felt safer speaking over the phone during the COVID – 19 pandemic. They thought it was better to only see a doctor in person if it was an emergency because they were worried about contracting the virus when visiting a practice.

"One is inclined to worry more about their ailments."

Another participant said they had a 'fear of germs' in the small waiting rooms with chairs that faced each other. They felt more wary and at risk of getting COVID-19 in their GP practice. The participant also felt there was a lack of mental health and wellbeing support for people that are digitally excluded. Whilst they had been made aware of online resources, they preferred to have in-person counselling and couldn't access this over the past 18 months.

During a NLPCN discussion, a primary care professional discussed their first-hand experience with healthcare access for refugees and asylum seekers; "I had a patient who was coming to see me, on the same day he completed an e-consult... He submitted it because he got really anxious.... it meant that someone else has got to look at that through a triage system. But he also had booked to see me face-to-face at the same time."

Positive Experiences and Good Practice

The key findings from our engagement highlighted a variety of different issues that digitally excluded residents faced when trying to access their GP practice during the pandemic. However, as previously mentioned within the report, 23% of participants commented on how much they valued the support they received from their health services during the COVID-19 pandemic. Their experiences incorporated themes such as good communication, convenient access arrangement and excellent service.

For example, a participant spoke about the positive experience they had had with their GP practice's triage system. They received a mixture of telephone and face-to-face appointments which they said were equally satisfactory. They thought the quality of care received over the telephone was good and they felt safe going into the GP practice when the surgery required an in-person examination. The participant had found access to primary care during the pandemic to be easy. However, they also said they were not attempting to get same day appointments, which meant they weren't attempting to call their GP when the service opens at 8am.

Another participant commented that their GP practice "understands my limitations and they have known me for years. They always support me, so when I call, I don't have to go online." This shows how some services understand the needs of their patients and ensure they have a good experience when accessing health services.

Finally, another participant said their practice gave them the option to choose between remote consultation or face-to-face appointments. At the height of the pandemic, their experience with a telephone consultation was comprehensive and effective, and they were happy with the quality of care they received from their GP.

A NLPCN discussion group identified that some health services have adopted strategies to better support those that are digitally excluded. These include:

- A direct phone line that is given out to vulnerable clients.
- Front of House Champions who support service users that need additional support i.e., online registration for a GP practice.

"They got in touch with me to let me know their telephone number has changed."

"The GP is round the corner from me so it was easy to commute."

"I have had both vaccines. The GP came to where I live and did them at my home. We had letters to inform us about it."

"I was quite happy speaking to the doctor over the phone."

Case Studies

For this report, we carried out extensive interviews with local residents. This enabled us to gain a greater understanding of people's experiences during the pandemic. We have collated a series of case studies, which showcase both positive and negative experiences.

Case Study: Participant A

Participant A is deaf and gave birth in late 2020. They primarily communicate in either Portuguese or British Sign language. Their experience of giving birth was complicated due to the number of people talking in the hospital and having no interpreter to translate for them. There have been multiple barriers, mainly due to poor communication, which has made accessing primary care more difficult for them over the past 18 months.

Participant A said that trying to access information remotely "has been quite upsetting at times". When they attended a remote consultation, technology wasn't always reliable; "...the picture kept freezing. They were wearing masks which made it harder to communicate. Those were the two main issues that were big for me".

They also told us that the interpreters provided by the GP practice had only basic British Sign Language (BSL) Level 1 or 2, which made it difficult to explain health issues.

Prior to the pandemic, Participant A had used an interpreting service provided by Lewisham Council to call a GP practice on their behalf and book a consultation with a BSL interpreter present. They also have experience using Sign Live, a service provider of online video interpreting services through its Video Relay Service (VRS) and Video Remote Interpreting (VRI). However, they explained that most council services supporting deaf people stopped when the COVID-19 pandemic spread rapidly. This lack of interpreting support created a substantial barrier to accessing healthcare services. Pre-COVID-19, it was easier to use GP services but since interpreting services have changed, face-to-face interpreting stopped. Participant A's GP practice made face masks mandatory which added additional stress as communication became more challenging. Participant A said that they would like face-to-face appointments to go back to how they were pre-COVID-19 as you could "meet with the interpreter beforehand and discuss my situation... and appraise them. Having an interpreter physically with you and accompanying you through the whole process is much easier."

Participant A felt that doctors had not taken responsibility and reception staff hadn't taken into consideration how to get an interpreter that's suitable for discussing primary care needs of a deaf person. Communication needs to improve dramatically so that information is passed on correctly between staff to ensure support from BSL services improve within health and social care services.

Case Study: Participant B

Participant B, a Spanish national, had only positive things to say about the treatment he has received over the past 18 months. Whilst English is not his first language, a relative was able to act as a translator and has helped arrange remote consultations as well as being seen in person for ongoing treatment. Participant B said the only issue he faced when visiting a hospital was that he had requested a Spanish speaking nurse beforehand. Unfortunately, this hadn't been organised, but staff managed to find someone to act as a translator very quickly and the participant felt well looked after.

Participant B said he was very satisfied with his GP practice; "I have been here since 2002 and had no problems at all." He received his COVID-19 vaccines in January and March 2021 and the appointments were conveniently arranged by telephone.

Case Study: Participant C

Participant C commented on the positive experience she has had with her GP practice since the start of the COVID-19 pandemic; "I would say I always thought they were pretty bad, but they were excellent over the past year from the beginning of COVID."

When asked if their practice was using a triage system, Participant C said that she was able to book an appointment over the phone and would receive a call back from a doctor the same day. Pre-COVID-19, Participant C said that sometimes she would wait on the phone up to 30 minutes to get through to someone, and that things had significantly changed over the past 18 months. Participant C did say that she was fortunate not to have to ring her GP for anything seriously wrong. It was typically smaller problems that could be dealt with over the phone. In the past, she had to visit her practice often and it was unpleasant sitting in the surgery's reception. She said that a telephone call with her GP practice was more suitable, and less time is wasted.

Case Study: Participant D

Participant D is partially sighted. They said that their GP practice has been okay' during the pandemic. They mostly spoke with their surgery over the phone but saw a doctor when it was necessary, and fortunately the practice is walking distance from their home.

Participant D said that their GP predominantly offers telephone consultations and has introduced Personal Protective Equipment (PPE) for patients visiting the practice. The practice didn't contact them directly to communicate the changes to their system. Participant D found out through exchanges with close friends.

Participant D doesn't have access to a smartphone as they are unable to use one due to their visual impairment. They have a mobile but can't see texts therefore cannot engage with health services via this method. They also don't have access to internet at home. The GP practice's reception staff have a good rapport with service users and Participant D said they had had a positive experience with telephone calls and that remote consultations had not affected the quality of care. They have also been able to walk-in and book appointments in person provided they are wearing PPE.

The patient said that if they had a health concern that was treatable using remote consultations, this wouldn't have been a problem. However, due to their health condition, it is necessary to have face-to-face consultations when the matter is serious.

Conducting an appointment over the phone would not be beneficial for them if they needed a thorough examination and their condition was causing distress.

Participant D's only negative comments referred to the hospital. Last year they had 6 appointments cancelled for tests to examine their eyes as well as waiting 3 months for an ultrasound. When their last appointment was cancelled, they received no letters or correspondence from the hospital about rescheduling a visit.

Case Study: Participant E

Participant E has diabetes, mobility, and mental health issues. Their main experience has been a lack of accessing health and social care services since the start of the pandemic. One of the main issues for them is difficulty in getting through on the telephone. The shift to remote consultations has impacted their ability to access GP services. An increase in the number of people trying to call the surgery makes it very difficult for them to speak to anyone. They said that they call their practice at 07:00, wait in a queue, and then get told by reception staff to call back another time. Due to their health issues, they don't always feel up to calling back and waiting again in another queue hoping to get through to a doctor.

Participant E said that they are unemployed and on benefits, which has impacted their access to technology and made it difficult to access a GP practice during the pandemic. They don't own a computer and struggle to use a mobile phone, which has made it more stressful trying to contact a doctor. They hate using a mobile phone because their eyesight is poor. On several occasions they have had to ring 111 to get antibiotics because it has been so challenging trying to get through to their GP and request a prescription.

Participant E received a letter inviting them to get a COVID-19 vaccine. However, they haven't been able to leave the house stating that they have been isolating "even long before the pandemic...because of family history issues". In addition to not having the vaccine, they haven't been to a diabetes eye clinic or had their flu jab.

When asked what they felt a GP could have done differently to help them access care, Participant E said that if the doctor would call and check on them, on a semi-regular basis, they would really appreciate this. Pre-COVID-19 they had monthly check-ups, but this stopped when the pandemic rapidly spread. They said more support in the form of communication from a doctor was needed to help vulnerable people access services.

Case Study: Participant F

Participant F, has chronic obstructive pulmonary disease (COPD). They said their main issue with health and social services is the negative experience they have had trying to access their GP practice; "you just get in a loop of recordings that go on and on repeating itself".

Since the start of the COVID-19 pandemic, Patient F said that their GP practice has changed their automated phone recording several times. Previously, it would inform you of your position in the queue. Currently, it lets you know your position when you first connect but then never updates your progress, which has led to them being on hold for 30 minutes not knowing where they are in the queue; "when do you give up cause you can't stand it any longer.... there are quite a few occasions where I have given up entirely."

Participant F also commented on the automated phone system continuously informing patients that online consultations are available. They found this very frustrating as they don't use a computer. When their GP text to let them know their first COVID-19 vaccination was ready to book, they were given the option to telephone or use the practice's website to arrange an appointment. With their second vaccination, the text message only gave them a website option. They had to ring the practice multiple times to try and book an appointment. After several failed attempts, they eventually spoke to a kind receptionist who managed to book their second vaccine over the telephone; "it did work beautifully after a hiccup."

When we asked Participant F what has changed in the way their GP operates since the start of COVID-19, they said "it had gone very impersonal even before the pandemic. It was difficult to get appointments anyway." Their practice had written to say that changes would be made, and leaflets were also distributed locally informing residents that they would be using an online system; "there were fewer appointments available over the phone."

Because of their health condition, Participant F said they normally would have an annual review. In 2020, their review was carried out over the telephone. However, they were not given the option to get tested. Their GP practice also doesn't appear to have a primary care professional with COPD expertise since one of their nurses retired; "I don't know if I am getting the best possible treatment." They believe their condition has deteriorated because they have been unable to do as much exercise as they normally would over the past 18 months.

Participant F said that they would not be happy if the changes to the system stayed the same after the pandemic. They would like to be treated like a "human being... we are patients and not customers. The current system turns you into a customer, like phoning an energy company."

Conclusion

Through our engagement, we found that digitally excluded participants had mixed experiences when accessing and using GP services. 27% felt that their experiences had been positive during the pandemic (Appendix 1) and were supportive of the changes brought by the total triage model. However, 47% felt that the new systems either exacerbated or created new barriers which impacted on their access to services. It is vital that local systems learn from these experiences and address the challenges highlighted by disadvantaged residents to ensure they are not excluded from accessing basic health and care services.

Services would benefit from improving communication around access arrangements with patients, especially those who are most vulnerable and do not have easy access to the internet. People should be given a choice on the type of appointment available to them which meets their accessibility needs.

Practices must take into consideration that not everyone is confident with digital technology or has access to the necessary devices. There is a need for services to identify those users who are/ are at risk of being digitally excluded to ensure that all patients can access care when they need it.

During our interviews, we spoke with several people that had sensory disabilities, including sight and hearing loss. These interviews further highlighted challenges these residents faced including confidentiality, communication barriers and concerns around data protection.

The majority of participants would prefer face-to-face appointments when accessing their GP practice. Whilst some participants valued remote consultations and, in some cases, thought it improved patient access, other participants felt that a high level of care and treatment could only be delivered in person. Participants shared their experiences of unsuccessful remote consultations leading to misdiagnosis and felt a physical examination would have been more effective. Lewisham Speaking Up, a local charity supporting people with learning disabilities outline in their 'Research on Digital Exclusion since the Covid-19 pandemic 2020' report, that "Digital technology should be available, but as one element of a range of options for people to choose from" [22] and this is similarly echoed by our findings.

Residents who had positive experiences with their GP practices during the pandemic were pleased at having a mixture of remote and in-person consultations depending on the severity of the issue. A primary care professional said they had "found a combination of different things in communication with the patient quite useful...from an IT perspective, offering different routes (languages) and a variety of access through the platform as well as different services.... allows them the choice."

Several participants highlighted the stark reality of digital poverty and the impact total triage and remote booking systems had on their access to care. Some were unable to easily engage because they couldn't afford digital technology. Others highlighted the increasing cost of phone bills due to long waits in telephone queues or faults with telephony systems which cut them off.

Conclusion (continued)

Being unable to book appointments in person meant that residents had to incur charges if they wanted to have an appointment. Services must ensure that their access models enable equity of access or otherwise they could discourage people seeking support for their health and care.

The NHS Long Term Plan outlined the intention for more appointments to be made available via digital methods and the increased delivery of remote consultations. However, the outbreak of the pandemic has seen rapid digital developments within primary care. Our digitally excluded participants felt that the changes had had a negative impact on their experience of GP services.

Feedback of service users must be taken into account as we move out of lockdown and systems are reviewed to ensure adequate service and parity of access. For the implementation to be ultimately successful, services must bring residents along with them by empowering them to use digital methods and most importantly providing alternative access options for those who cannot afford or cannot use digital solutions.

"I am really happy that I have had the opportunity to be interviewed and shared my concerns. There are people in the system who are responsible to check on the vulnerable and ensure they aren't left out."

Lewisham Resident

Recommendations

The feedback received from patients who participated in our research further endorses the idea that there is not a 'one size fits all' model for access to services. Based on our data analysis, we have made the following recommendations, with support from primary care professionals that attended our NLPCN discussion groups, on digital isolation.

Appointment availability & booking system

Finding:

Getting through on the telephone to a GP practice was the biggest barrier for digitally excluded residents when accessing services. In extreme cases, people chose to no longer access the service due to frustrations in getting through to their practice.

Recommendation:

1. Investment in improved telephone systems which are fit for purpose.

2. The adoption of telephone systems which can gather data on the number of people accessing the services would enable local services to have a greater understanding of the true demand on services and help them to monitor the issue.

3. Developing solutions to help reduce waiting times when residents are trying to access appointments through the telephone. One Lewisham practice has adopted a call back system which gives residents the opportunity to receive a call from the service rather than waiting on the telephone.

Finding:

The implementation of remote booking systems has meant that residents are unable to book appointments in-person within their GP practice. This provides an additional barrier for residents who either do not have access to technology or cannot afford to incur increased phone bills due to long waits on the telephone.

Recommendation:

1. Services must look to re-establish the option of booking appointments in-person to ensure residents who cannot afford to engage with the digital systems are able to access care.

Limited Technology & IT Skills and Digital Poverty

Finding:

For some of our participants, affordability and limited access to digital devices created significant barriers when trying to book appointments at health and social care services. Primary care professionals explained that they need to take into consideration that a certain cohort of patients may need different methods of access than others.

Recommendation:

1. Services to clearly outline and communicate to their patients all the appointment types available to them and how to access them. Additional efforts should be put in place to communicate the above with the most vulnerable patients.

2. Services to review telephone systems in place to ensure they are fit for purpose and do not disadvantage those that only have this access route as an option. For example, a Lewisham GP practice has set up a separate direct phone line that is given out to vulnerable patients. This has helped reduce the waiting times on their main service phone line and helped minimise the cost of some patient's phone bills. This model could be adopted by other services.

3. Services to ensure appointment systems allow for patient choice.

4. Healthwatch England (HWE) carried out a national research project 'Locked Out' which focused on people's experiences with remote GP appointments. Within their report they highlighted the need to further develop digital support on a national and local level to ensure everyone has access to public services. This is a key finding which was also evident from our engagement with Lewisham residents and therefore we would support the following HWE recommendations:
   I. Ensuring all GP practices are reachable by a freephone number
   II. Arrangements with telecom firms that no data charges will incur when accessing any NHS services.
   III. Including access to the internet in social prescribing schemes, funded by the NHS for those whose health may benefit from it.

Finding:

We found that the majority of residents we interviewed did have access to a digital device. However, most people used a telephone as the main method of accessing health services.

Recommendation:

1. With the expansion of digital services, local systems should look at supporting residents by providing a clear support and digital training offer for using their service.

Communication

Finding:

Several participants highlighted challenges communicating with front line staff when trying to access services. They told us that a default approach for certain services was to direct patients to book appointments through online systems such as Patient Access. On one occasion, a resident was advised to ask their family to help them book online appointments when they explained they couldn't do it themselves.

Recommendation:

1. Training for front line staff on digital isolation and how to sensitively support people to access GP appointments. This report and associated case studies could form a basis for this training.
   For example, a GP practice within North Lewisham has established Front of House Champions which support patients with registration and being able to identify people that might need further assistance when booking appointments. This is an example of good practice which could be rolled out across the borough.

2. Services should look to capture information on whether a resident is digitally excluded or has a basic level of IT skills, or their preferred appointment type, in order to better understand if they have additional communication or access needs.
   Research carried out by Healthwatch England found that patients and primary care professionals 'suggested that it would be helpful for practices to code patient records with information regarding a patient's language and communication needs or level of digital skills, so that staff can be proactive about offering people an appropriate consultation type or pre-empt requests for adjustments in future' [23].

3. Services should ensure that staff are aware and able to signpost service users to local digital support groups.

4 Many health and care organisations are increasingly using their websites and social media as their primary approach to communication with their clients or the wider public.
   We would encourage organisations to engage with people who may have difficulty accessing such digital media to identify alternative communication methods to reach people who may not have easy access to the internet.

Finding:

Participants had varying levels of awareness around current GP access arrangements. Some residents had been directly contacted by their practice (11%) whilst others had received no communication during the pandemic (Appendix 7).

Communication (continued)

Recommendation:

1. The COVID-19 pandemic has seen rapid developments with digital access. Services should actively communicate with patients, via texts, calls, or follow up letters, about changes to appointment and access systems. There should be additional focus on vulnerable groups who have barriers in engaging with online information. This will enable residents to be better informed when seeking to access treatment and care.

Finding:

A Deaf participant highlighted the barriers of accessing healthcare services as a result of interpreting services provided by the Council being paused. There were also challenges with interpreters provided not having the required skills to communicate the specific health issues or having the opportunity to discuss issues prior to the appointment.

Recommendation:

1. Services should look to reinstate interpreting services which enable deaf residents to have access to a designated interpreter. The automatic provision of face-to-face appointments for patients which need translation support would improve patient experience by reducing communication issues.

Choice

Finding:

The majority of participants explained that their GP practice has been operating remotely since the start of the COVID-19 pandemic and that they weren't given a choice between remote or face-to-face appointments. If given the option, most people would choose physical appointments. Several residents had positive experiences with accessing services as they were able to have a mixture of remote and face-to-face consultations.

Recommendation:

1. Services to offer a hybrid consultation system which embeds patient choice.

2. When services are developing new appointment models, they should always seek to capture feedback to help shape services that meet the needs of digitally excluded and vulnerable people.

Wider system recommendations

Finding:

Multiple participants told us that a lack of communication from services during the pandemic meant they weren't aware of the access arrangements prior to engaging with the service.

Recommendation

1. There is a need for a communication plan at national, regional and local levels to provide residents and professionals with clear and consistent information about changes to the health care system. Residents need to be informed about changes to access arrangements and the benefits of the different types of consultations.

Finding:

Primary care professionals informed us that there is a lack of data available indicating whether there has been increased demand on other services because of people being unable to access a GP.

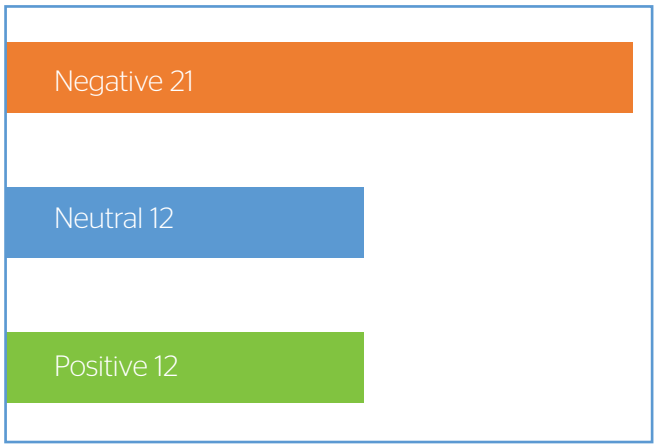
Recommendation

1. Local health and care systems should collate the different access data from GP services, GPEA, 111 and A&E departments to understand the current access demand on primary care services and impact on the rest of the system. The data can be used to identify where resources would be best used within the system to tackle the issue of demand on primary care services.

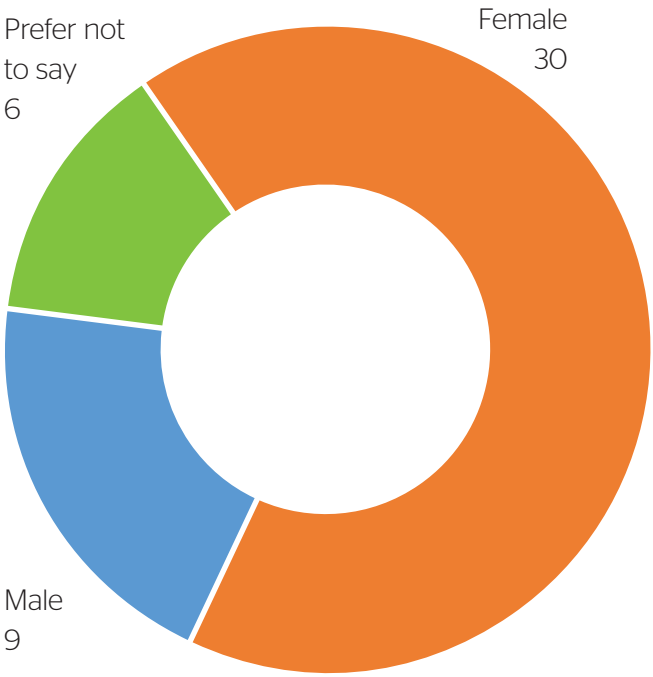
2. A&E departments should look to capture information from patients on whether issues accessing primary care services had led to them attending hospital.

Appendix

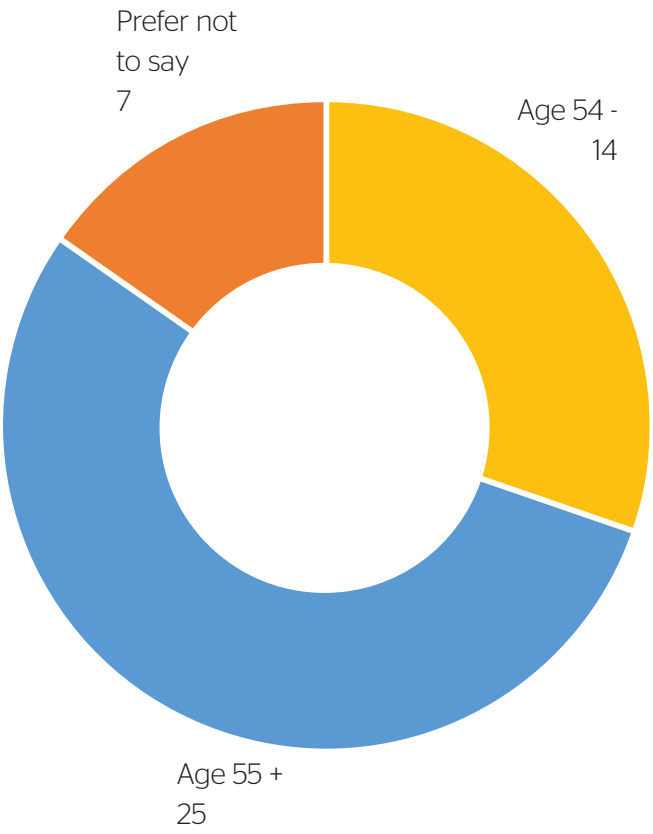
Appendix 1: What was your experience of trying to access primary care during the pandemic?



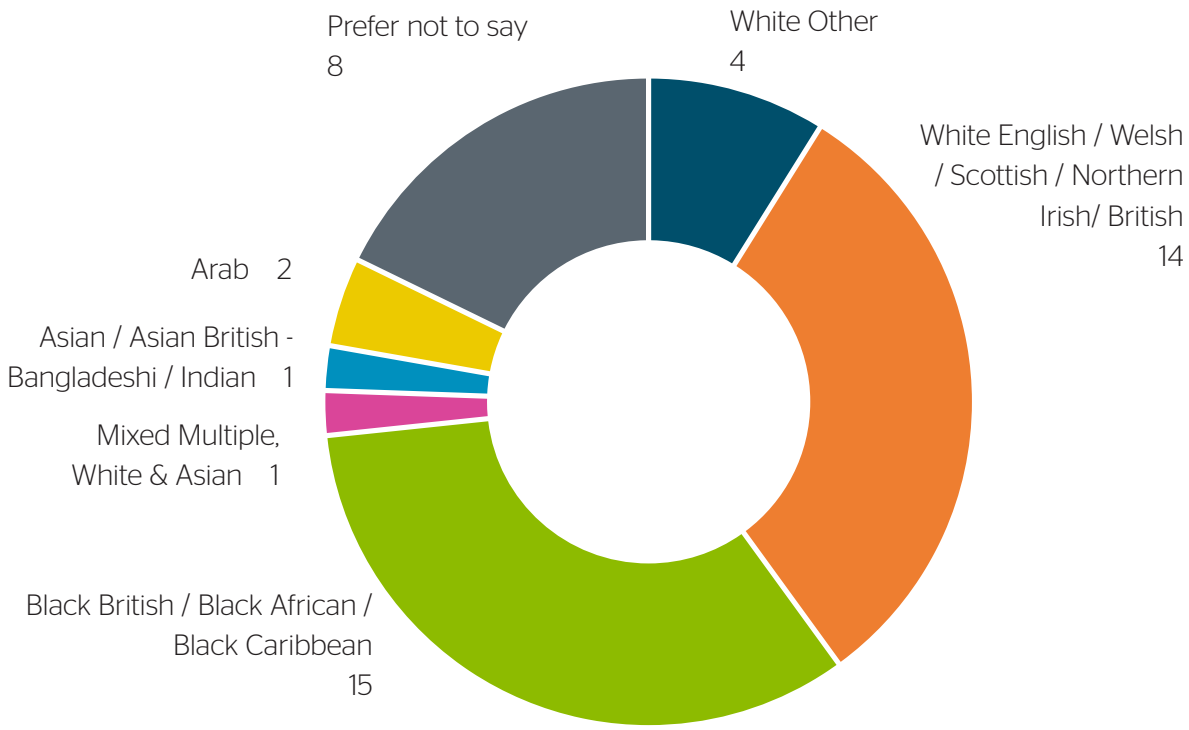
Appendix 2: Monitoring Information, Gender



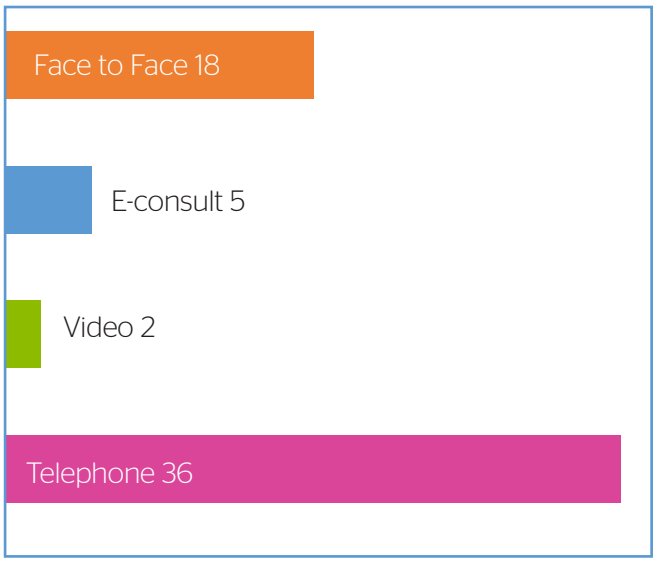
Appendix 3: Monitoring Information, Age



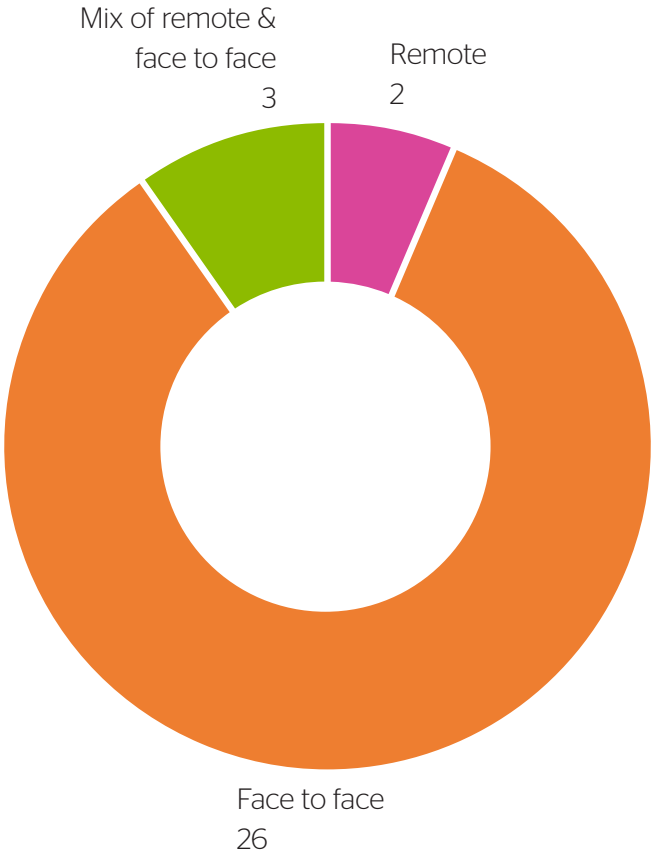
Appendix 4: Monitoring Information, Ethnicity



Appendix 5: What type of appointment did you have?



Appendix 6: If given a choice, would you have wanted a remote consultation or face-to-face appointment?



Appendix 7: How did you find out about changes to the system?

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Thank you

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- Good Gym
- King's Church London
- Phoenix Housing
- Lewisham Homes
- Lewisham Local
- Lewisham Refugee & Migrant Network
- Lewisham Speaking Up
- Lewisham Visual Impairment Team, London borough of Lewisham
- Metro Charity
- London Borough of Lewisham, Senior Specialist Advice & Information Officer D/deaf and Deaf/ Blind
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- North Lewisham Primary Care Network (NLPCN)
- Red Ribbon Foundation
- Sign Language Interactions
- SLAM
- St Peter's Church, Brockley
- Table Talks
- Voluntary Services Lewisham

Digital exclusion and access to health services

Summer 2021

This report is available to the public and is shared with our statutory and community partners. Accessible formats are available. If you have any comments on this report or wish to share your views and experiences, please contact us.

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Your Voice in Health and Social Care is an independent organisation that gives people a voice to improve and shape services and help them get the best out of health and social care provisions. YVHSC holds the contracts for running the Healthwatch services for Healthwatch Hounslow, Healthwatch Ealing, Healthwatch Waltham Forest and Healthwatch Bromley. HW staff members and volunteers speak to local people about their experiences of health and social care services. Healthwatch is to engage and involve members of the public in the commissioning of Health and social care services. Through extensive community engagement and continuous consultation with local people, health services and the local authority.

yvhsc
Engaging communities, shaping services

healthwatch
Lewisham

HWP RESPONSE TEMPLATE

"Findings"

Recommendations

Appointment availability & booking system					
"Getting through on the telephone to a GP practice was the biggest barrier for digitally excluded residents when accessing services. In extreme cases, people chose to no longer access the service due to frustrations in getting through to their practice"					
1.Investment in improved telephone systems which are fit for purpose					
PCN			**CCG**		
Current	Future		Current	Future	
2.The adoption of telephone systems which can gather data on the number of people accessing the services would enable local services to have a greater understanding of the true demand on services and help them to monitor the issue					
PCN			**CCG**		
Current	Future		Current	Future	
3.Developing solutions to help reduce waiting times when residents are trying to access appointments through the telephone. One Lewisham practice has adopted a call back system which gives residents the opportunity to receive a call from the service rather than waiting on the telephone.					
PCN			**CCG**		
Current	Future		Current	Future	
"The implementation of remote booking systems has meant that residents are unable to book appointments in-person within their GP practice. This provides an additional barrier for residents who either do not have access to technology or cannot afford to incur increased phone bills due to long waits on the telephone"					
4.Services must look to re-establish the option of booking appointments in-person to ensure residents who cannot afford to engage with the digital systems are able to access care					
PCN			**CCG**		
Current	Future		Current	Future	
Limited Technology & IT Skills and Digital Poverty					
"For some of our participants, affordability and limited access to digital devices created significant barriers when trying to book appointments at health and social care services. Primary care professionals explained that they need to take into consideration that a certain cohort of patients may need different methods of access than others"					

5.Services to clearly outline and communicate to their patients all the appointment types available to them and how to access them. Additional efforts should be put in place to communicate the above with the most vulnerable patients			
PCN		**CCG**	
Current	Future	Current	Future

6. Services to review telephone systems in place to ensure they are fit for purpose and do not disadvantage those that only have this access route as an option. For example, a Lewisham GP practice has set up a separate direct phone line that is given out to vulnerable patients. This has helped reduce the waiting times on their main service phone line and helped minimise the cost of some patient's phone bills. This model could be adopted by other services			
PCN		**CCG**	
Current	Future	Current	Future

7.Services to ensure appointment systems allow for patient choice.			
PCN		**CCG**	
Current	Future	Current	Future

8.Healthwatch England (HWE) carried out a national research project 'Locked Out' which focused on people's experiences with remote GP appointments. Within their report they highlighted the need to further develop digital support on a national and local level to ensure everyone has access to public services. This is a key finding which was also evident from our engagement with Lewisham residents and therefore we would support the following HWE recommendations: I. Ensuring all GP practices are reachable by a freephone number II. Arrangements with telecom firms that no data charges will incur when accessing any NHS services. III. Including access to the internet in social prescribing schemes, funded by the NHS for those whose health may benefit from it			
PCN		**CCG**	
Current	Future	Current	Future

"We found that the majority of residents we interviewed did have access to a digital device. However, most people used a telephone as the main method of accessing health services"

9.With the expansion of digital services, local systems should look at supporting residents by providing a clear support and digital training offer for using their service.			
PCN		**CCG**	
Current	Future	Current	Future

Communication

"Several participants highlighted challenges communicating with front line staff when trying to access services. They told us that a default approach for certain services was to direct patients to book appointments through online systems such as Patient Access. On one occasion, a resident was advised to ask their family to help them book online appointments when they explained they couldn't do it themselves".

10.Training for front line staff on digital isolation and how to sensitively support people to access GP appointments. This report and associated case studies could form a basis for this training. For example, a GP practice within North Lewisham has established Front of House Champions which support patients with registration and being able to identify people that might need further assistance when booking appointments. This is an example of good practice which could be rolled out across the borough

PCN		CCG	
Current	Future	Current	Future

11.Services should look to capture information on whether a resident is digitally excluded or has a basic level of IT skills, or their preferred appointment type, in order to better understand if they have additional communication or access needs. Research carried out by Healthwatch England found that patients and primary care professionals 'suggested that it would be helpful for practices to code patient records with information regarding a patient's language and communication needs or level of digital skills, so that staff can be proactive about offering people an appropriate consultation type or pre-empt requests for adjustments in future'

PCN		CCG	
Current	Future	Current	Future

12.Services should ensure that staff are aware and able to signpost service users to local digital support groups.

PCN		CCG	
Current	Future	Current	Future

13.Many health and care organisations are increasingly using their websites and social media as their primary approach to communication with their clients or the wider public. We would encourage organisations to engage with people who may have difficulty accessing such digital media to identify alternative communication methods to reach people who may not have easy access to the internet.

PCN		CCG	
Current	Future	Current	Future

"Participants had varying levels of awareness around current GP access arrangements. Some residents had been directly contacted by their practice (11%) whilst others had received no communication during the pandemic"

14.The COVID-19 pandemic has seen rapid developments with digital access. Services should actively communicate with patients, via texts, calls, or follow up letters, about changes to appointment and access systems. There should be additional focus on vulnerable groups who have barriers in engaging with online information. This will enable residents to be better informed when seeking to access treatment and care

PCN		CCG	
Current	Future	Current	Future

"A Deaf participant highlighted the barriers of accessing healthcare services as a result of interpreting services provided by the Council being paused. There were also challenges with interpreters provided not having the required skills to communicate the specific health issues or having the opportunity to discuss issues prior to the appointment"

15.Services should look to reinstate interpreting services which enable deaf residents to have access to a designated interpreter. The automatic provision of face-to-face appointments for patients which need translation support would improve patient experience by reducing communication issues.

PCN		CCG	
Current	Future	Current	Future

"The majority of participants explained that their GP practice has been operating remotely since the start of the COVID-19 pandemic and that they weren't given a choice between remote or face-to-face appointments. If given the option, most people would choose physical appointments. Several residents had positive experiences with accessing services as they were able to have a mixture of remote and face-to-face consultations."

16.Services to offer a hybrid consultation system which embeds patient choice.

PCN		**CCG**	
Current	Future	Current	Future

17.When services are developing new appointment models, they should always seek to capture feedback to help shape services that meet the needs of digitally excluded and vulnerable people

PCN		**CCG**	
Current	Future	Current	Future

Wider system recommendations

"Multiple participants told us that a lack of communication from services during the pandemic meant they weren't aware of the access arrangements prior to engaging with the service"

18.There is a need for a communication plan at national, regional and local levels to provide residents and professionals with clear and consistent information about changes to the health care system. Residents need to be informed about changes to access arrangements and the benefits of the different types of consultations.

PCN		**CCG**	
Current	Future	Current	Future

"Primary care professionals informed us that there is a lack of data available indicating whether there has been increased demand on other services because of people being unable to access a GP"

19.Local health and care systems should collate the different access data from GP services, GPEA, 111 and A&E departments to understand the current access demand on primary care services and impact on the rest of the system. The data can be used to identify where resources would be best used within the system to tackle the issue of demand on primary care services.

PCN		**CCG**	
Current	Future	Current	Future

20.A&E departments should look to capture information from patients on whether issues accessing primary care services had led to them attending hospital.

PCN		**CCG**	
Current	Future	Current	Future

HWL Digital Exclusion report.pdf

HWP RESPONSE TEMPLATE

"Findings"

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Appointment availability & booking system

"Getting through on the telephone to a GP practice was the biggest barrier for digitally excluded residents when accessing services. In extreme cases, people chose to no longer access the service due to frustrations in getting through to their practice"

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ONE HEALTH LEWISHAM		PUBLIC HEALTH		LBL		LGT	
Current	Future	Current	Future	Current	Future	Current	Future

2.The adoption of telephone systems which can gather data on the number of people accessing the services would enable local services to have a greater understanding of the true demand on services and help them to monitor the issue

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4.Services must look to re-establish the option of booking appointments in-person to ensure residents who cannot afford to engage with the digital systems are able to access care

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5.Services to clearly outline and communicate to their patients all the appointment types available to them and how to access them. Additional efforts should be put in place to communicate the above with the most vulnerable patients

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Current	Future	Current	Future	Current	Future	Current	Future

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Current	Future	Current	Future	Current	Future	Current	Future

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ONE HEALTH LEWISHAM		PUBLIC HEALTH		LBL		LGT	
Current	Future	Current	Future	Current	Future	Current	Future

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ONE HEALTH LEWISHAM		PUBLIC HEALTH		LBL		LGT	
Current	Future	Current	Future	Current	Future	Current	Future

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 5
Enclosure 5

Title:	**Winter Plan**
Meeting Date:	**29 September 2022**
Author:	Amanda Lloyd, System Transformation & Change Lead
Executive Lead:	Sarah Wainer, System Transformation & Change Director

Purpose of paper:	**To provide information on the Winter Plan for Lewisham**	Update / Information	*X*
		Discussion	
		Decision	
Summary of main points:	A Lewisham system Winter Plan is in development. Winter Funding allocations will support the delivery of the Winter Plan. Funding allocations are being aligned across Lewisham system partners to ensure best use of available funding.		
Potential Conflicts of Interest	**None**		

Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	**X**	**Southwark**	

	Equality Impact	N/a
	Financial Impact	the cost of winter plans will be contained within allocated financial resources.
Other Engagement	Public Engagement	
	Other Committee Discussion/ Engagement	**Place Executive Group, 15/9/22** **Unplanned Care Board, 22/9/22**
Recommendation:	**To note the approach set out**	

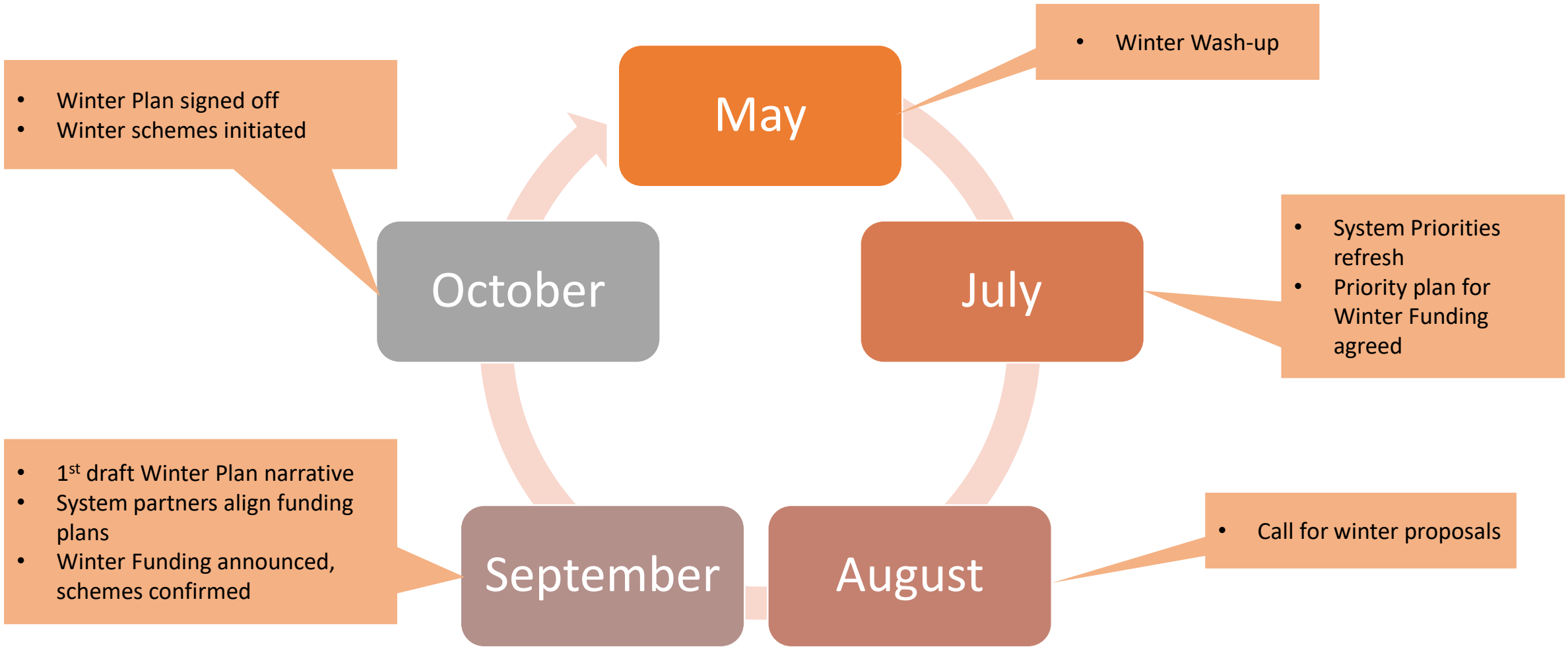
South East London Integrated Care System

Winter Planning 22/23

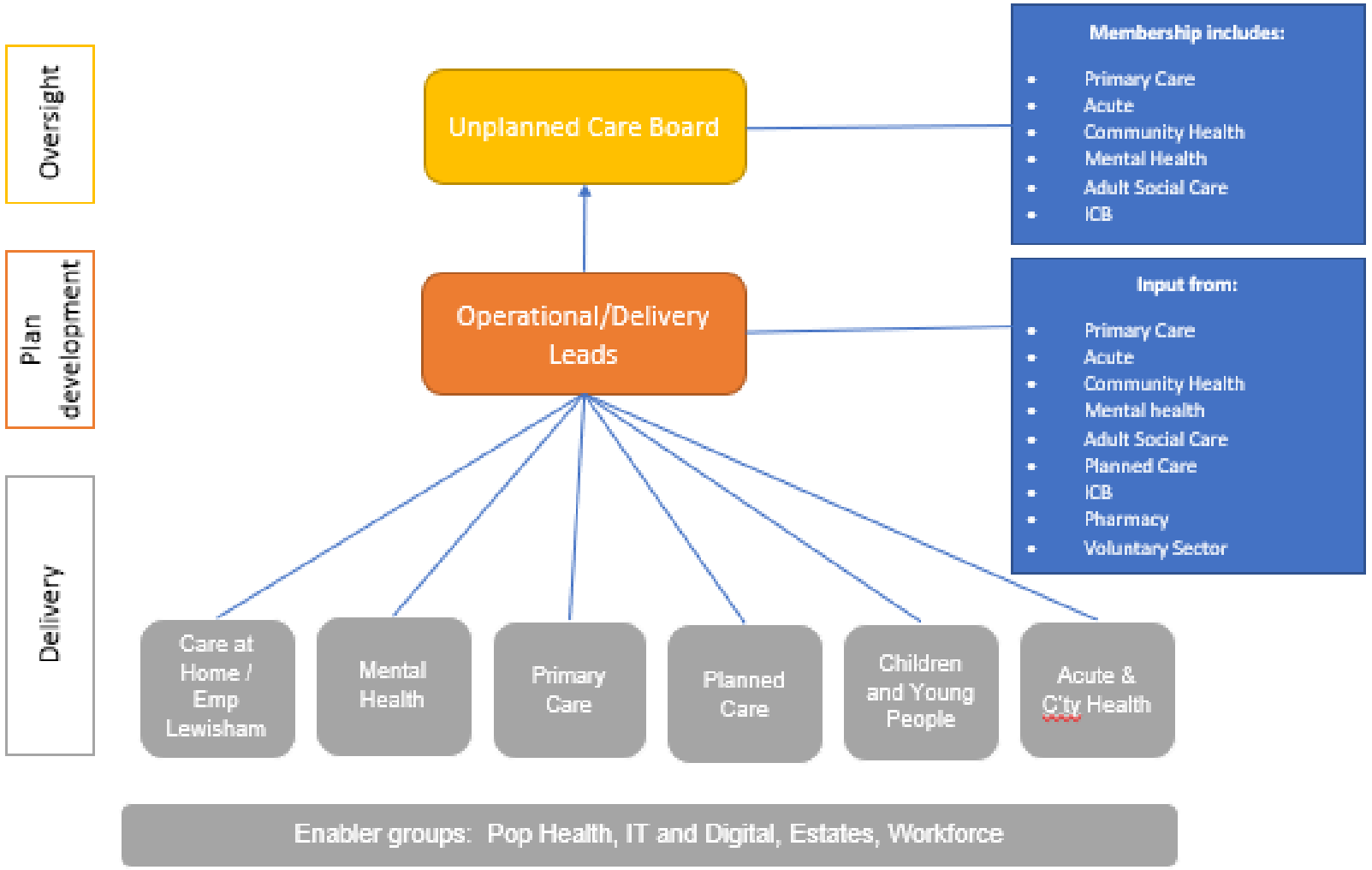
Report to Lewisham Care Partner Board

29th September 2022

Winter Planning – cyclical timeline



Winter Plan – governance & approach



Membership

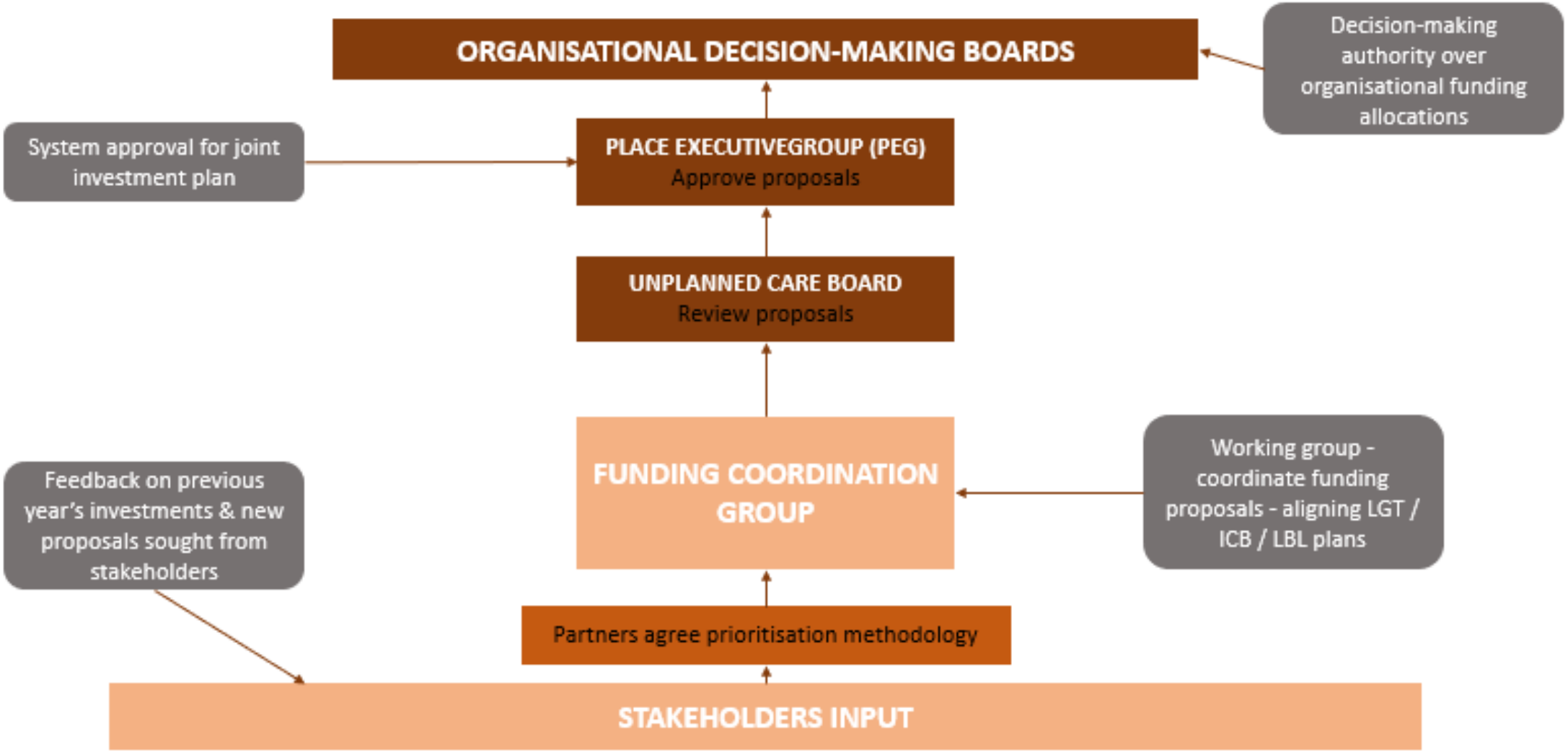
South East London Integrated Care System

- Representation to ensure operational delivery & commissioning expertise:

  - SLaM – Mental Health Trust
  - LGT – Acute & Hospital Discharge
  - LGT – Community Health Services & Allied Health Services
  - ICB/LBL joint commissioning representing community providers – Care Homes, Home Care, Unpaid Carers, LD/Autism, Homeless/Rough Sleepers, MH
  - LBL – Adult Social Care, Children's Services
  - LBL – Transport, Housing
  - ICB – Community Pharmacy, Primary Care, Planned Care
  - LBL/ICB – Voluntary sector services & Community-based care

Those on the group are responsible for providing the narrative input from each delivery area pulling together provider and commissioner plans, and ensuring alignment of the joint system plan for Lewisham across all delivery areas.

Winter Funds – governance & approach



Membership

- Representation to ensure finance and operational oversight:

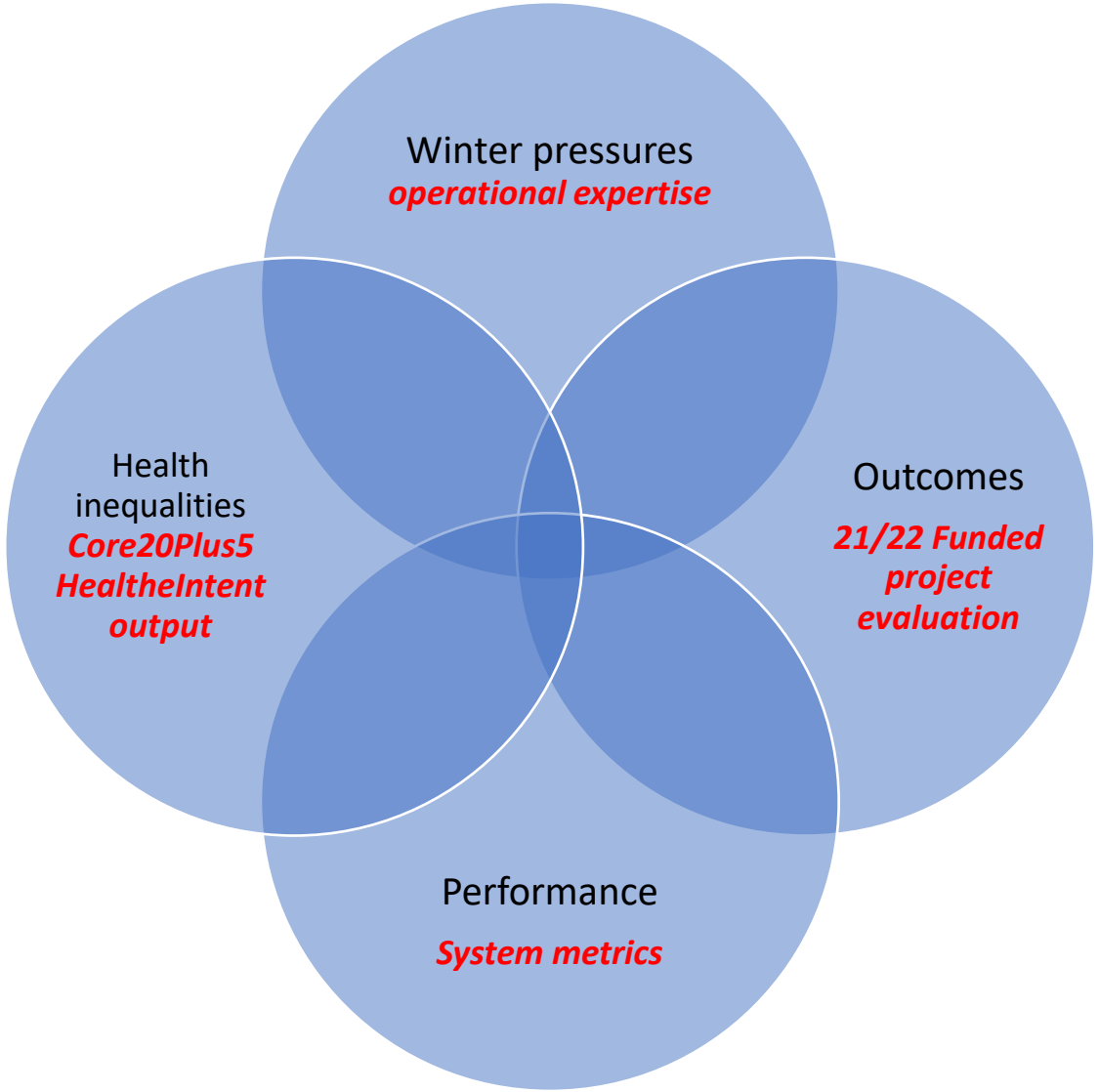
  - SLaM – Mental Health Trust
  - LGT – Acute & Hospital Discharge
  - LGT – Community Health Services & Allied Health Services
  - ICB/LBL - Joint commissioning
  - LBL – Adult Social Care
  - ICB – Community Pharmacy, Primary Care
  - LBL/ICB – Voluntary Sector services & community-based care

Those on the group are responsible for sharing information to facilitate joint planning on use of Winter Pressures funding.

Prioritising investment – Winter 22/23

PRIORITISING
1. Operational pressures
2. Health Inequalities
3. Area of highest overlap between 4 areas

CONDITIONS
1. Must be deliverable



Current status

Winter Plan

- Weekly Checkpoint meetings in place to review & update plan, using 21/22 as template.

Winter Funding allocations

- 23/9 – review of Winter Funding bids from all partners to agree prioritisation
- Bids significantly exceed expected allocations

South East London
Integrated Care System

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 8
Enclosure 6

Title:	Proposed Merger between Burnt Ash Surgery (G85027) and Downham Family Medical Practice (G85057)
Meeting Date:	29 September 2022
Author:	Chima Olugh, Primary Care Commissioning Manager
Executive Lead:	Ceri Jacob, Lewisham Place Executive Lead

Purpose of paper:	This paper outlines the proposal from Burnt Ash Surgery and Downham Family Medical Practice to merge their PMS contracts to form a single contract and GP practice.	Update / Information	
		Discussion	
		Decision	**X**

Summary of main points:

- Burnt Ash Surgery and Downham Family Medical Practice both hold individual PMS contracts.
- The practices have submitted a business case proposal to merge the two contracts to form a single PMS contract and a single GP practice.
- The merger will also include the integration of the two clinical systems which will enable efficiencies in the delivery of services.
- The expected date of system integration will be confirmed after the merger proposal is approved.
- There will be no site closures as a result of the merger.
- The benefits to patients would be to secure a sustainable and resilient service with the ability to extend service provision.
- The merged practice will have a registered patient list of c13,000, it will retain the ODS code G85057, and will be known as Ashdown Medical Group.
- The merger will result in a change to Sevenfields and Lewisham Alliance PCN Core Network Practice membership and their financial baseline allocations.

	▪ The proposal fits strategically with the NHS Long Term plan in that it delivers primary care at scale, and the model supports sustainability of provision.			
Potential Conflicts of Interest	▪ There is a direct conflict of interest for Dr Helen Tattersfield, Sevenfields Primary Care Network Clinical Director who is the PCN Clinical Representative on the Lewisham Care Partnership Board. ▪ The merged practice will result in a change to Sevenfields Core Network Practice membership. ▪ Any conflict of interest should be managed according to the ICBs Standards of Business Conduct and Conflict of Interest Management Policy.			
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	**X**	**Southwark**	
	Equality Impact	An Equality Impact Assessment was undertaken. It is attached as part of the business case and confirms there will be no adverse equality impact on the protected characteristic groups.		
	Financial Impact	The estimated cost of the clinical system mergers is approximately £9,000.00, which will be funded by commissioners. The merger will not make financial savings for the Integrated Care Board in relation to the premises budget as there are no site closures, it will however improve the long-term viability of the merged practice and ensure financial stability. There is likely to be some financial impact on the baseline allocations of Lewisham Alliance and Sevenfields PCN due to the change in PCN Core Network Practice membership.		
Other Engagement	Public Engagement	Both practices have involved their Patient Participation Groups and conducted an online survey.		
	Other Committee Discussion/ Engagement	▪ The merger proposal was formally discussed and endorsed at the September Lewisham Primary Care Group meeting. ▪ The Lewisham Local Medical Committee support the merger proposal.		

		▪ Healthwatch Lewisham also support the merger proposal.
Recommendation:	**The Lewisham Care Partnership Strategic Board is asked to approve:** a. The merger of the contracts and the patient lists of Burnt Ash Surgery and Downham Family Medical Practice. **b.** The change to Sevenfields and Lewisham Alliance PCN Core Network Practice membership as a result of the merger.	

Burnt Ash Surgery and Downham Family Medical Practice Proposed Merger Business Case

June 2022

Ashdown Medical Group

Putting your healthcare first. Making healthcare better together. A healthier you a healthier community.

Background (1/3)

- In May 2021, Dr Leonardo Antony, Senior Partner, Burnt Ash Surgery gave notice of his plan to retire in September 2021 after over 20 years of service.
- In June 2021, it was agreed that both Burnt Ash Surgery (G85027) and Downham Family Medical Practice (G85057) would share Practice Manager services provided by Louise Hassan after a vacancy became available at Downham.
- In July 2021, both practices employed an Operations Lead to support the Practice Manager.
- On 1st September 2021, Dr Antony retired from Burnt Ash Surgery.

Background (2/3)

- At the end of April 2021 Burnt Ash Surgery and Downham Family Medical Practice had preliminary discussions regarding the proposed merger and it was agreed by all that it should proceed.
- Following these discussions, the proposal was raised with Ashley O'Shaughnessy, Associate Director of Primary Care in Lewisham who was supportive subject to the correct route being followed. It was also suggested that Nightingale Surgery, also based within the Lee Health Centre, should be offered the opportunity join the merger. This offer was made but has since been turned down by Nightingale Surgery.

Background (3/3)

- Partners of the two practices have been meeting regularly as part of the merger process planning since April 2021.
- Both Practices have been sharing their values and commitment to high quality clinical care over the past year and now believe a full merger will help to provided improved access and choice for patients.
- Initial planning talks have been held with Chima Olugh, Primary Care Commissioning Manager in Lewisham.
- Preliminary engagement* with patients has been completed and the proposal has been put forward to both Patient Participation Group's.

* See page 16 for Engagement Plan

The Proposal (1/2)

- **This business case is intended to outline the case for the merger between Burnt Ash Surgery and Downham Family Medical Practice for your consideration.**
- This business case sets out a three-month lead-in time;

  - The registered patient list of Burnt Ash Surgery PMS contract is to be merged with the Downham Family Medical Practice PMS contract registered patient list on 1st October 2022.
  - Both practices will remain open and operational from both existing sites.
  - New telephony services have been implemented at both practices to ensure a positive patient experience.
  - We will plan the merger of both practice's EMIS systems over a weekend so as not to cause any disruption to patients.

The Proposal (2/2)

- The Merger will create a single registered patient list of c. 13,000, retaining the ODS code of G85057.
- Both practices will form Ashdown Medical Group.
- Dedicated leadership and managerial workforce model has been in place since June 2021.
- Burnt Ash Surgery has been accepted to join Sevenfields Primary Care Network (PCN). Lewisham Alliance PCN are aware of the impact the merger will have and are taking this into account for 2022/23 planning.
- Prior to the EMIS merge, patients will be allocated Burnt Ash or Downham Family as their Usual GP. This will ensure all staff are notified of where the patient received care prior to the merger. New patients registering at either site will be allocated the appropriate Usual GP. This system will highlight which neighbourhood the patient falls into eliminating any confusion when accessing community services and multi-disciplinary care.

Practice Overview

	Downham Family Medical Practice	Burnt Ash Surgery
Address of Practice	7-9 Moorside Road, Bromley, BR1 5EP	2 Handen Road, Lee, SE12 8NP
Contract Type	PMS	PMS
Registered List size Raw/weighted	6,828 / 6161	6144 / 6471
Opening Hours	Monday, Tuesday, Wednesday, Friday 8.00 – 18.30 Thursday 08.00 – 20.00 Saturdays 9.00 – 12.30	Monday, Tuesday, Wednesday 07.00 – 18.30 Thursday, Friday 08.00 – 18.30
Partners	Dr Ola Fagbohungbe, Dr Richard Omosule, Dr Anwuli Bosah	Dr Nadine Lawrence, Dr Alexandra Baker (15th July 2022)
Staff	2 PAs: 2 WTE, 2 Nurses: 1.2 FTE 1 Practice Manager: 0.5 FTE, 1 Operations Lead: 0.8FTE 1 Administrator: 0.4 FTE, 6 Receptionists: 4.8 FTE	1 GP: 0.75 WTE, 2 PAs: 1.6 WTE 1 Nurse: 1 WTE (starting July 22), 1 Practice Manager: 0.5 FTE, 1 Operations Lead: 1.0 FTE, 1 Prescribing Admin: 0.8 FTE, 1 Administrator: 0.66 FTE 6 Receptionists: 4.3 FTE
Languages spoken by staff	English, Nigerian, Georgian	English, Russian, Spanish, Polish, Romanian
Clinical system	EMIS Web	EMIS Web
QOF points 2020/21	554.51/567	550.26/567
CQC Rating	Good	Good
Locality working inc. PCN	Sevenfields PCN	Lewisham Alliance PCN – Accepted into Sevenfields PCN
Services offered	GP Extended Access Services, Core Services, Minor Surgery, Ear microsuction, Sexual Health and Family Planning, Travel vaccinations, Zoladex, Phlebotomy	GP Extended Access Services, Core Services, Sexual Health and Family Planning, Smoking Cessation, Travel vaccinations, Zoladex, Phlebotomy

Premises Overview

	Downham Family Medical Practice	Burnt Ash Surgery
Type of Property	Purpose built – within Health Centre Built in 1980's	Purpose built – within Health Centre Built in 1960's
Landlord	NHS Properties	Lewisham & Greenwich Trust
Leasehold/Freehold	Leasehold	Leasehold
Disabled Access	Yes – Practice on ground level. Disabled toilet on site	Yes – Practice on ground level. Disabled toilet on site
Disabled Parking	Yes	Yes
IPC Issues	None	Issue raised with L&GT regarding some outstanding repairs to clinical rooms and Legionella assessment over due. Working with ICS Estates to escalate and ensure works are carried out.
Clinical Rooms	7	7
Admin Rooms	3	3
Conference Room	Yes	Shared within Health Centre
Patient Waiting Room	Yes	Yes

Rationale for Merger (1/2)

GP Partner

In May 2021, Burnt Ash Surgery's Senior Partner gave notice of retirement and the part-time salaried GP also resigned with immediate effect due to personal commitments.

At the end of August 2021, Dr Antony retired from Burnt Ash Surgery and a new junior Partner joined but has since decided to leave the partnership with effect from July 2022.

Downham Family Medical Practice that has 3 GP Partners, including a Senior Partner with over 25yrs experience which will provide the support needed for Burnt Ash Surgery.

Management Services

In May 2021, Downham Family Medical Practice had a Practice Manager vacancy that could not be filled.

Louise Hassan, previous Practice Manager agreed to return and provide managerial support to both practices.

It was agreed that the practices would work collaboratively to share managerial and administration support. Both the Practice Manager and Operational Leads have been working across both sites since June 2021.

Staff Turnover

Lack of good managerial leadership at Downham Family Medical Practice prior to the collaborative working, had an effect on reception and administration staff turnover.

Burnt Ash Surgery went through changes with nursing staff due to various staff's personal reasons which left the practice having to rely on support from locums. The Lead Nurse and GP Academic Nurse from Downham Family have also covered shifts at Burnt Ash one day a week for the past 6 months.

Difficulty recruiting clinical and non-clinical staff, working together will provide joint resources.

Rationale for Merger (2/2)

The proposal is underpinned by key strategic and local drivers that will improve access, patient experience and safety, and build workforce resilience.

Strategic Drivers: Alignment with GPFV and NHS LTP

The combined practice list size of circa 13,000 patients will ensure an at scale working service model.

It aligns with the NHS Long Term Plan and the GP Forward View for larger practices working together to deal with the pressures in primary care and extend the range of convenient local services, creating genuinely integrated teams of GPs, community health and social care staff.

It also aligns with the ICBs strategy of working at scale with fewer contracts.

Improved long term viability of the practice with improved financial stability and more resilience.

Local Drivers: At scale resources and improved patient experience

With the practice working at scale it will;
Help improve patient access as patients will have a choice of two different practice sites to attend for their primary medical needs.

Ensure patients have access to a wider range of healthcare professionals who will work across all the sites and provide a variety of services.

Increase resilience due to a more integrated workforce.

Increase management resource and the longer term viability of the practice.

Benefits of the Merger – Staff (1/2)

Benefit	Rationale
Pooled resources and processes	Merging the two practices will increase current capacity as sharing clinical and allied professionals, services can be targeted to meet needs of our population. More leadership (clinical and non-clinical) and management capacity will be provided to support practice staff and support the practice with service transformation and oversee the day to day operations.
Improved workforce and wellbeing	The merged practice will create and maintain a happy, healthy, and attractive workplace for its staff. It will also allow for better networking opportunities for staff. Improved cover for all staff leave/absences by other team members which will reduced the need to use locum cover.
Enhanced business continuity	In any unforeseen circumstances, staff can continue to work from one or other site without any major disruption to the services provided.
Future recruitment and retention	The new infrastructure will offer more peer support, learning and development opportunities as well as career progression.

Benefits of the Merger – Staff (2/2)

Benefit	Rationale
Stability and efficiency	Increase stability and succession planning in partnership, allowing shared expertise and more flexibility and eliminating the requirement for one practice to become a single hander.
Governance and management processes	Larger clinical and non-clinical team to provide the support to strengthen clinical governance and performance with improved methods and best practice resulting in more effective and efficient processes across both sites.
Student support	Improve medical student and student nurse placement experience and to enhance development on both sites as training practices.
Training and retention of clinical staff	GP trainees and PA students are trained and supported within both practices. Two PAs trained within Downham Family have now taken permanent roles at Burnt Ash Surgery. Both surgeries are training practices.

Benefits of the Merger – Patients

Benefit	Rationale
Improved Patient Access	Improved access to services, more flexibility in appointments across the wider workforce and shorter waiting times made possible from improved efficiencies.
Improved patient experience	The practices will make use of the experience and strengths from each practice to improve patient care. Training will be put in place for all reception staff to ensure consistent and empathetic service is provided on both sites. There will be a more diverse clinical workforce in terms of skill mix and gender.
Convenient and multiple access methods	There will be more opportunities for service expansion, with the two sites, allowing greater choice of where patients can be seen for appointments. Access to more enhanced services such as minor surgery, micro suction and increased LARC appointments.
Continuity of Care	This will be achieved by ensuring every patient has a Named & Accountable GP. The staff will work as a broader team inclusive of allied healthcare professionals. Increased clinical cover for sickness absences.
Improved patient care	Both practices working within the same PCN will offer patients access to other healthcare providers to support holistic and social needs in the community. Opportunity to increase services through local working, innovation and service redesign. Both practices being part of Sevenfields PCN will provide better access to Social Prescribing, more Pharmacist appointments, Specialist Diabetic Nurse clinics, LARC PCN service, Health and Lifestyle Coaches and outdoor gym facilities. Well run PPG's within the PCN will inform patients of other lifestyle activities in the borough.

Proposed Time Line for Merger

Burnt Ash Surgery and Downham Family Medical Practice to merge EMIS instances on 1st October 2022.

Financial Implications

Costs associated with the merger are shown below:

Task	Estimated Cost	Comment
Costs associated with notifying patients of the merger.	N/A	There is no charge for PCSE to send 2nd Class Postage letter notifications to patients.
Clinical system merger costs including EMIS and Docman and London Shared Services.	£9,000.00	The practice would look to the ICB to support it financially with the integration costs
Support from London Shared Services (formerly the CSU).	N/A	SEL ICB will replace network hardware and will support the sites once the merger has been completed.

Stakeholder Engagement

Pre-merger Stakeholder Engagement

The practice have carried out considerable engagement as outlined below.

Stakeholder	Purpose	Method
Patients	To ensure all patients are aware of the changes, the rationale and the benefits of the merger (to minimise service disruption)	❑ Face to face meetings with PPGs – Downham Family 13th June 2022 Burnt Ash Surgery 23rd May 2022 ❑ Engagement with Healthwatch. ❑ Online survey. ❑ Posters and leaflets in the practices ❑ Fully trained reception staff to answer patient queries
Staff	To ensure all staff are aware of the changes, the rationale and the benefits. Provide reassurance.	❑ Face to face meetings – PLTs on 18th May, 29th June and 21st July 2022 ❑ Staff FAQs
PCN colleagues	To ensure PCN colleagues, shared PCN staff and community pharmacies are aware of the changes	❑ Face to face meetings ❑ Virtual meetings ❑ Leaflets to Pharmacies

Key Messages (1/2)

Messaging to patients

Key facts:

Burnt Ash Surgery and Downham Family Medical Practice are planning to merger to form a single patient list.

Changes and improvements:

Both practices will remain open on their current site and form Ashdown Medical Group sharing their values and commitment to high quality patient care.

There will be no staff redundancies and all staff will remain in practice. This new model will offer:

- Improvements to the overall range and quality of services to patients - *There will be no detrimental effect to the care that you receive*
- Improved access to services - *There will be no reduction in services at either practice*
- Improved access to more clinical staff for patients - *You can continue to see the same clinician that you see at the moment however the merger affords extended availability to healthcare professionals of different gender, medical knowledge and specialised clinics*
- Improved patient choice and increased GP and nurse availability - *You will have a wider choice of which clinician to see and working collaboratively will also provide support for across both sites during periods of staff absence, allowing for a more consistent level of care*

If you have any other questions, please visit your surgery website for a list of FAQs or email Louise Hassan at LEWCCG.g85057@nhs.net.

Key Messages (2/2)

Messaging to PCN's

In February 2022, an email was sent to Lewisham Alliance CDs to make them aware of the intention to merge and Burnt Ash Surgery would be joining Downham Family Medical Practice's ODS code. This would have an impact on the size of the PCN but would not be detrimental.

Other members of the PCN were informed of the merger at a virtual meeting in May 2022.

Messaging to other stakeholders:

"Burnt Ash Surgery and Downham Family Medical Practice are proposing a merger to form a single patient list. The practices will form Ashdown Medical Group pooling their management and clinical teams to offer greater resilience and a wider choice of services to our patients. Both Practices have been sharing their values and commitment to high quality clinical care over the past year and now believe a full merger will help to provided improved access and choice for patients."

Online Survey Results (1/3)

550 responses were received from the online Survey:

539 (99.26%) were patients at the practices

- 306 (56.15%) Burnt Ash
- 234 (42.94%) Downham Family Medical Practice
- 3 (0.92%) not a patient at either practice

The trend is that patients would rather stay at the surgery they are currently registered at. Further engagement will reassure patients that this will be possible and they will be given the option of which practice they would like an appointment with.

Patients comments suggest that they are unable to travel to the other practice due to being elderly, infirm or not having means of travel.

The triaging system in place will enable patients to talk to clinicians from either site without any impact on the patient. Patients will then be offered an appointment at their requested practice if needed.

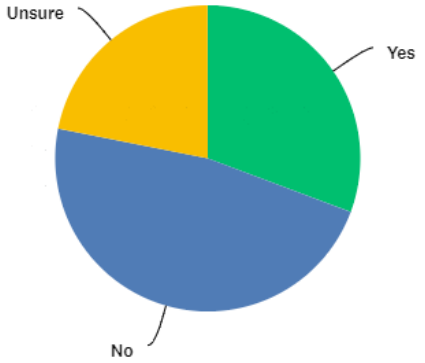
57.51% of patients commented they would not like to accept an appointment at a different site, patient engagement to date has reassured patients that they will be able to continue to attend their preferred practice and would only be asked to attend a different site in the circumstances of an emergency such as having to trigger our business continuity plan.

31.14% of patients are happy to travel and **14.29%** were unsure.

Patients are concerned that the level of care will be affected. Further engagement will give clarity how the merger will offer better cover for clinicians due to illness or leave, expand clinical skills and knowledge across both sites and improvement on staff retention which will provide improved access to appointments. Following the merger both sites will be able to offer expanded services, including dedicated LARC, minor surgery and micro suction services. This will improve the quality of services provided by Ashdown Medical Group.

Would you be prepared to go to another of our practices to receivespecialist care;

Answered: 544 Skipped: 6

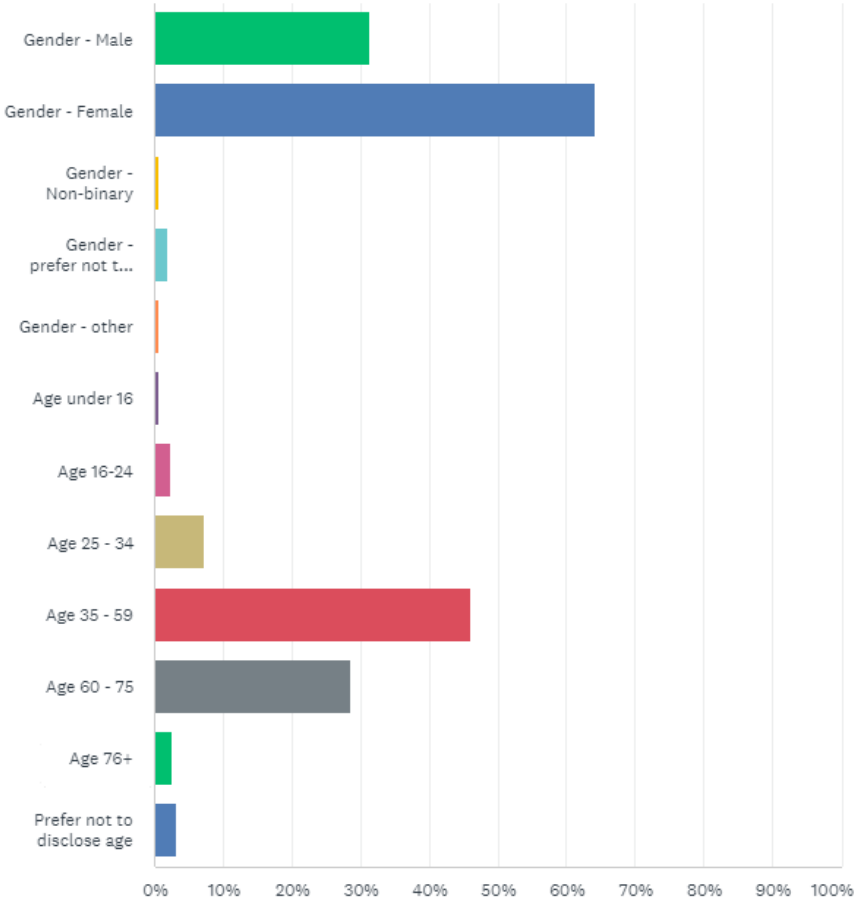


ANSWER CHOICES	RESPONSES	
Yes	30.70%	167
No	47.43%	258
Unsure	21.88%	119
TOTAL		544

Online Survey Results (2/3)

Equality Monitoring Questions

Answered: 544 Skipped: 6



ANSWER CHOICES	RESPONSES	
Gender - Male	31.43%	171
Gender - Female	64.15%	349
Gender - Non-binary	0.74%	4
Gender - prefer not to say	1.84%	10
Gender - other	0.55%	3
Age under 16	0.74%	4
Age 16-24	2.39%	13
Age 25 - 34	7.17%	39
Age 35 - 59	46.14%	251
Age 60 - 75	28.49%	155
Age 76+	2.57%	14
Prefer not to disclose age	3.13%	17
Total Respondents: 544		

Online Survey Results (3/3)

- Acknowledging and address the concerns of patients:
- A message will be displayed on the websites thanking patients for taking part in our survey and advising that:
- A further FAQs document will address the issues raised by the patients
  - This will be displayed on websites and in the practices.
- Letters with the FAQs will be sent to housebound and vulnerable patients to provide updates.
- PPG involvement will be encouraged to provide the practices with an understanding of the issues patient may be concerned about.
- A further survey will be sent out after the merger to gauge the level of service and ensure this is improving.
- Messages will be displayed in reception areas, websites and calling screens to inform patients that following the merger we will continue to operate and deliver services at the two surgeries and patients do not need to travel between the sites. New services will follow the patients rather than patients following the service. Minor surgery clinics, LARC services and Diabetic Nurse Specialist clinics will be delivered at both practices. This will be advantageous to the patients as they will continue to receive undisruptive services.

Engagement following approval (1/3)

We have laid out our planned approach to stakeholder engagement if merger is agreed

Stakeholder	Purpose	Method
Patients	To ensure all patients are aware of the approved merger, understand the benefits and are notified of any anticipated short term service disruption. The practice will use learning from previous practice mergers in the borough to ensure patients are fully prepared.	Consultation in the form of F2F patient engagement meeting with option to join virtually. One meeting will be planned on each site.
	Address patients concerns highlighted during the pre-merger engagement sessions and agree on how some of these can be resolved.	Ashdown Medical Group will publish a report to address concerns or queries and publish on websites, notice boards in reception areas and to the PPG groups

Engagement following approval (2/3)

Stakeholder	Purpose	Method
Staff	Key updates to be discussed at clinical and administration meetings to provide staff with key updates, minutes of meetings to be emailed to all staff.	Virtual or F2F meetings
PCN Colleagues	Inform key PCN colleagues (PCN CDs and managers) of updates on the merger planning	Virtual Monthly meetings

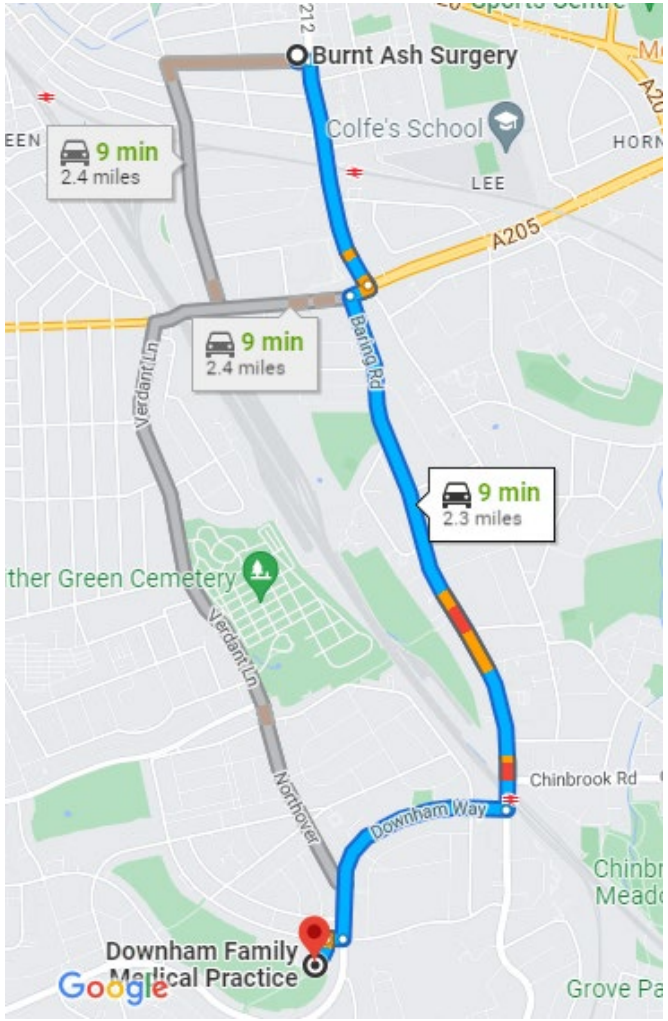
Engagement following approval (3/3)

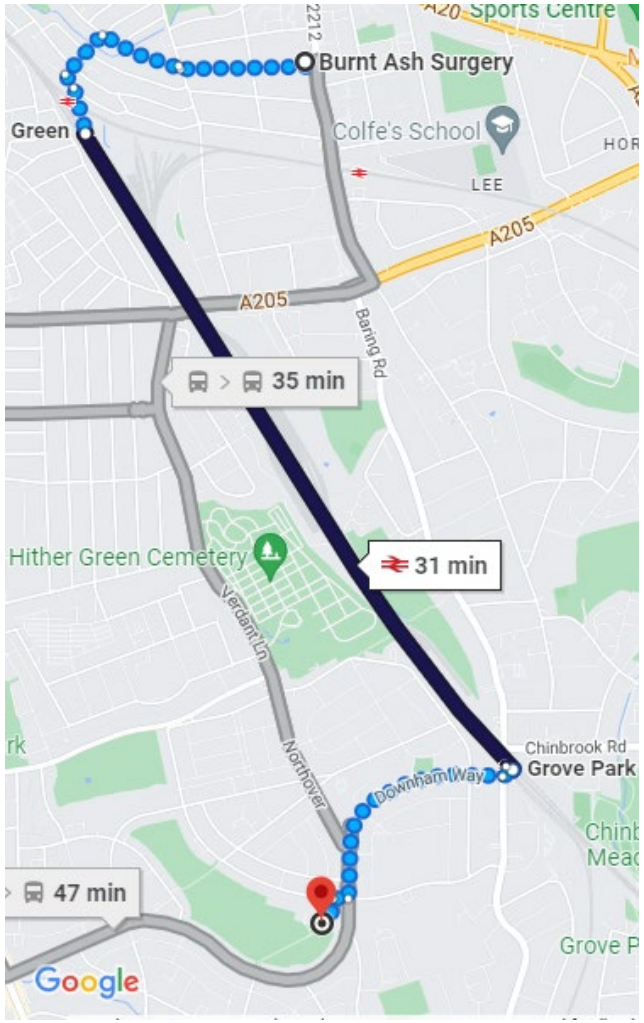
- The practices will work with the primary care team to ensure all stakeholders are informed of the proposal.
- Including SELDOC, local acute and community care providers (LGT), SLAM, 111, Lewisham Healthier Select Committee, Local MPs, Local Councillors and Lewisham Local Medical Committee.
- Following approval Ashdown Medical Group will promote patient feedback via AccuRx text messaging, online and in practice feedback forms to actively monitor the service provided by the practices.
- All vulnerable patients will be contacted nearer to the merger date to ensure they understand what the merger means for them and how they will be supported by Ashdown Medical Group.

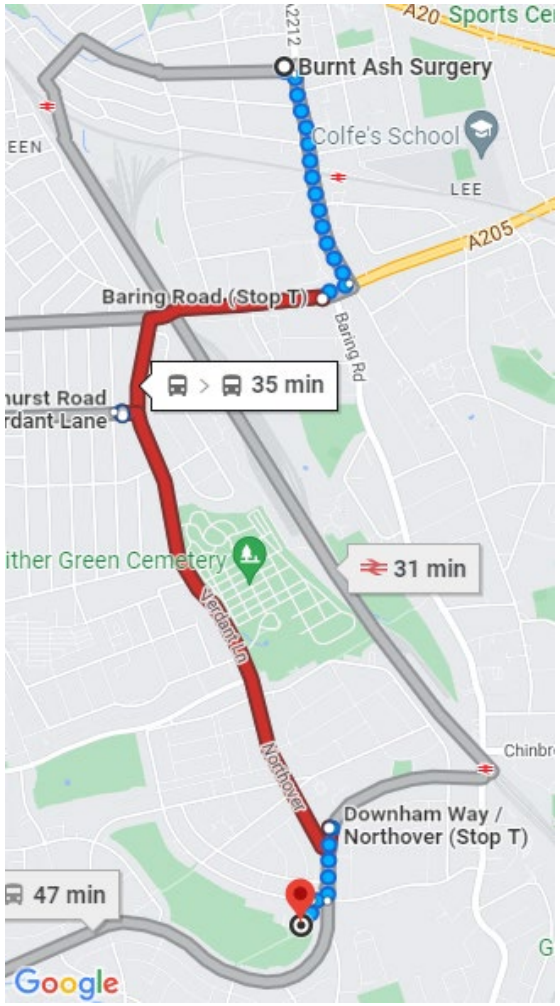
Key Facts of the Merger

Newly merged practice contract code	G85057
Practices to form:	Ashdown Medical Group
Intended contract merger date:	1/10/2022
Intended clinical system merger date :	To be confirmed (over a weekend in October 2022)
Changes to existing premises:	There are no planned premises closures
Changes to telephony:	Both practices use the same icloud telephony system which can be easily linked. Both practice telephone numbers will remain active
Planned changes to opening hours:	No change
Distance between practices:	1.73 miles between practices. Practice boundaries overlap
Travel options between practices:	It is an 8 – 10 minute drive between practices and both sites have free parking options with blue badge/disabled parking Bus routes – 202 and 284 / 273 and 284 / 273 and 124 /202 and 181

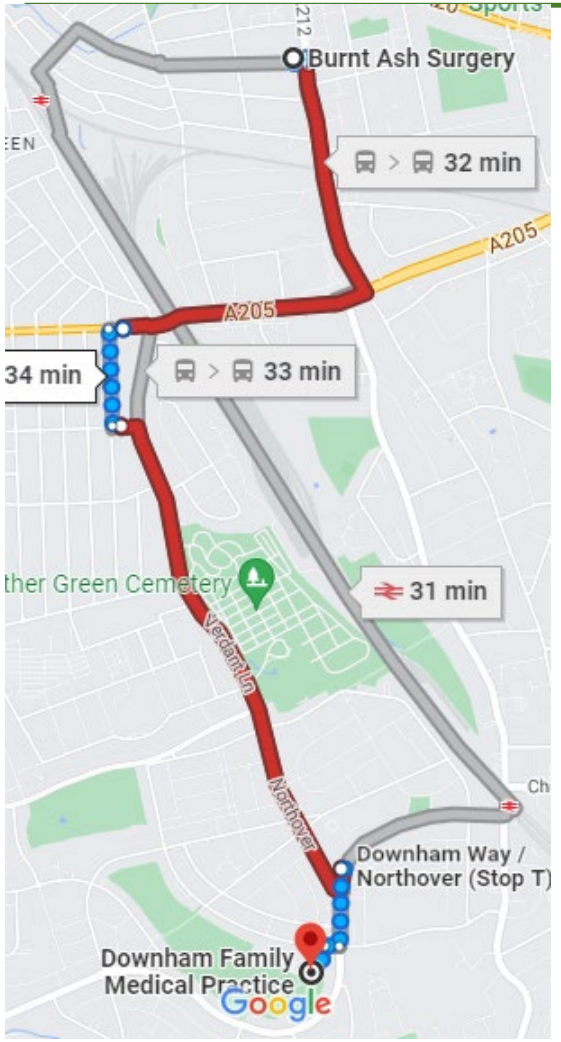
Travel Routes (1/2)

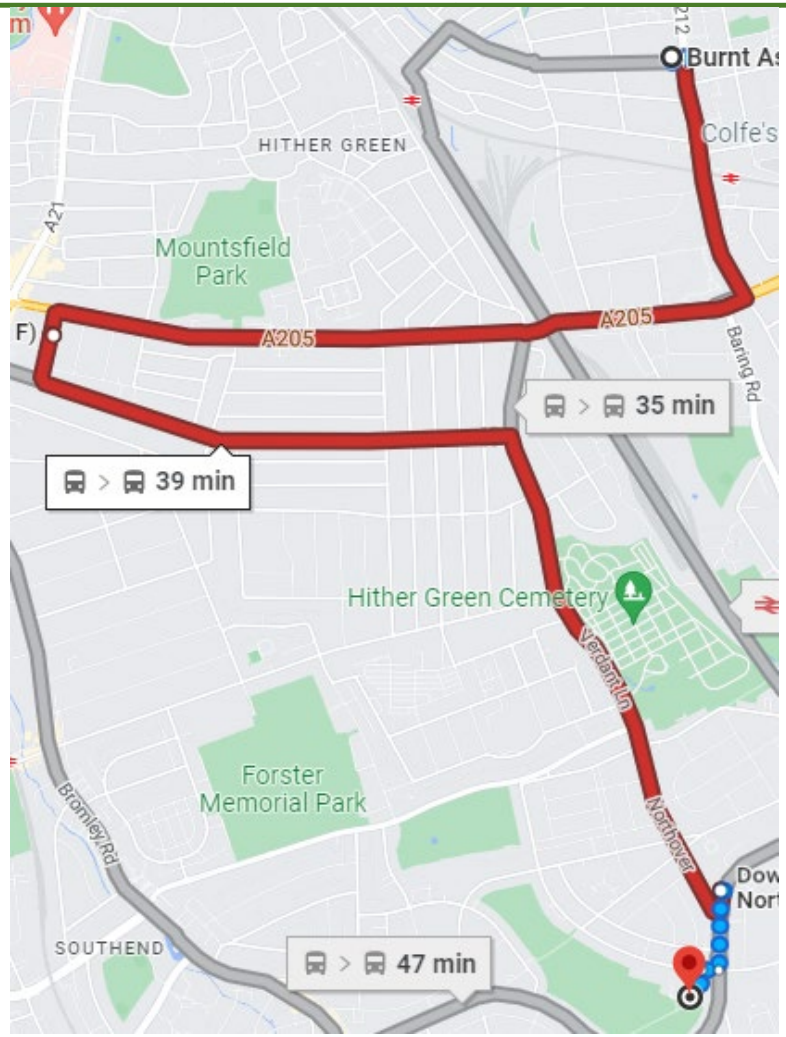


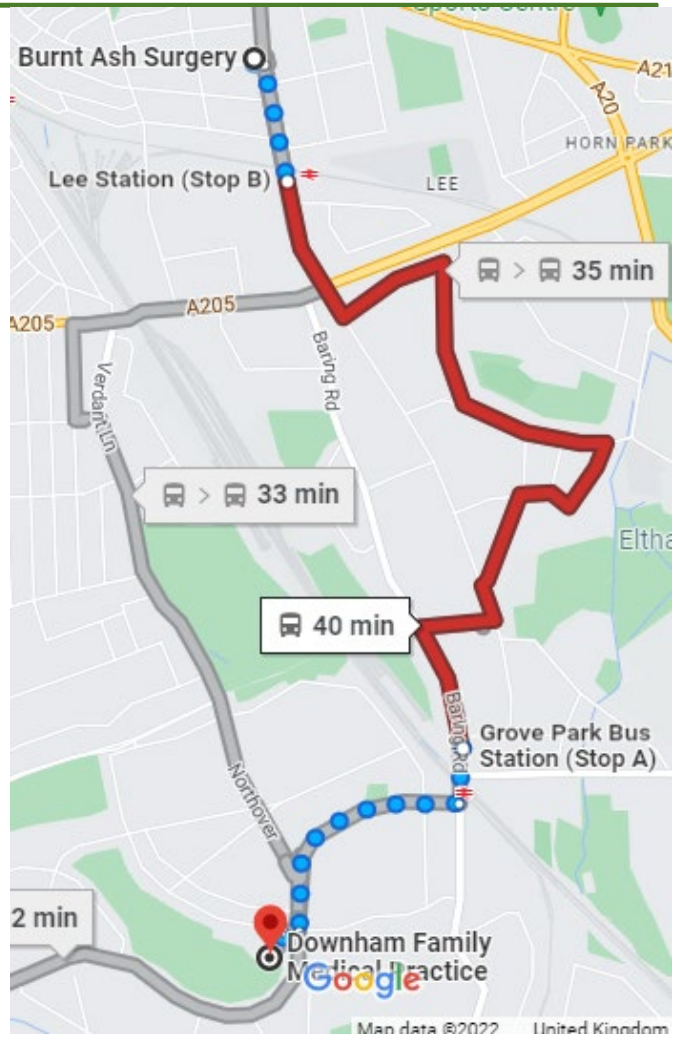




Travel Routes (2/2)

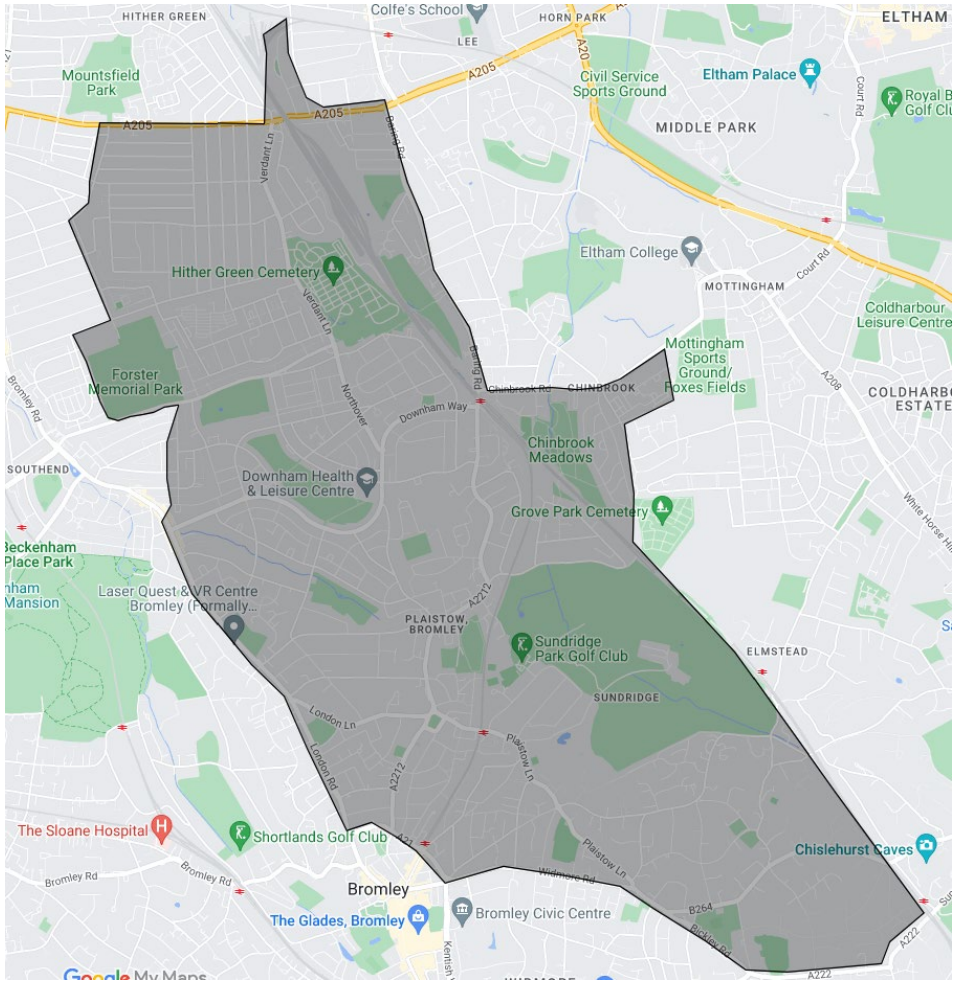




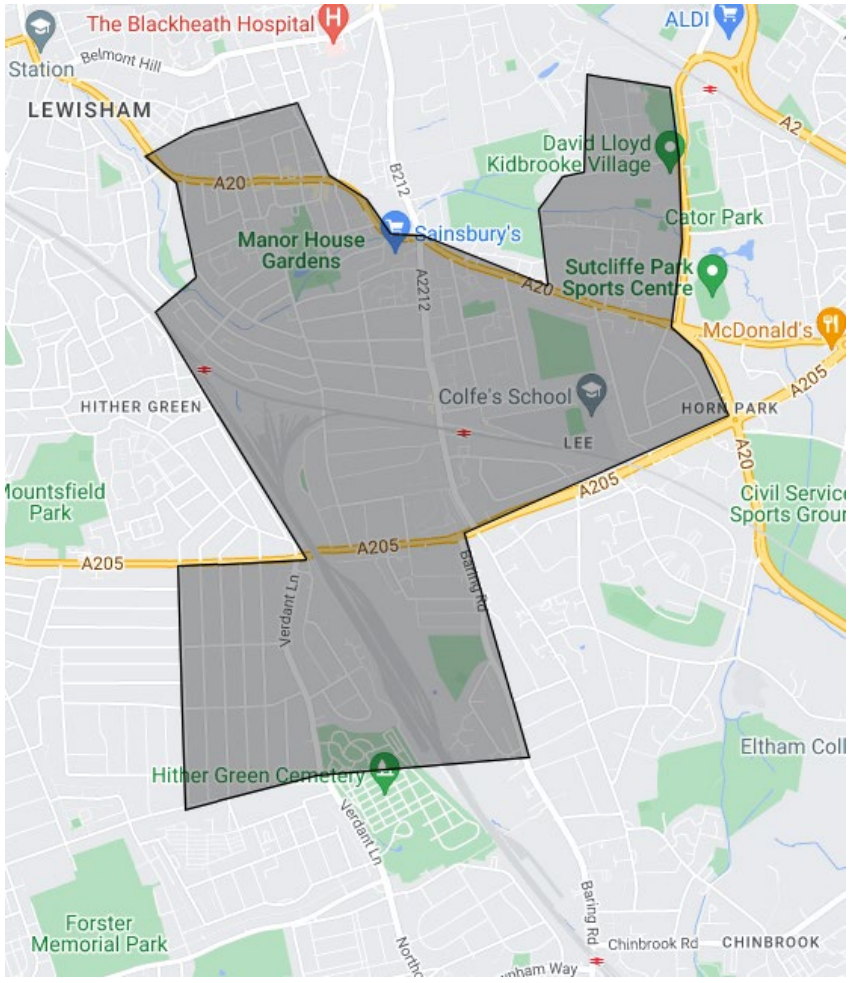


Practice Catchment Areas

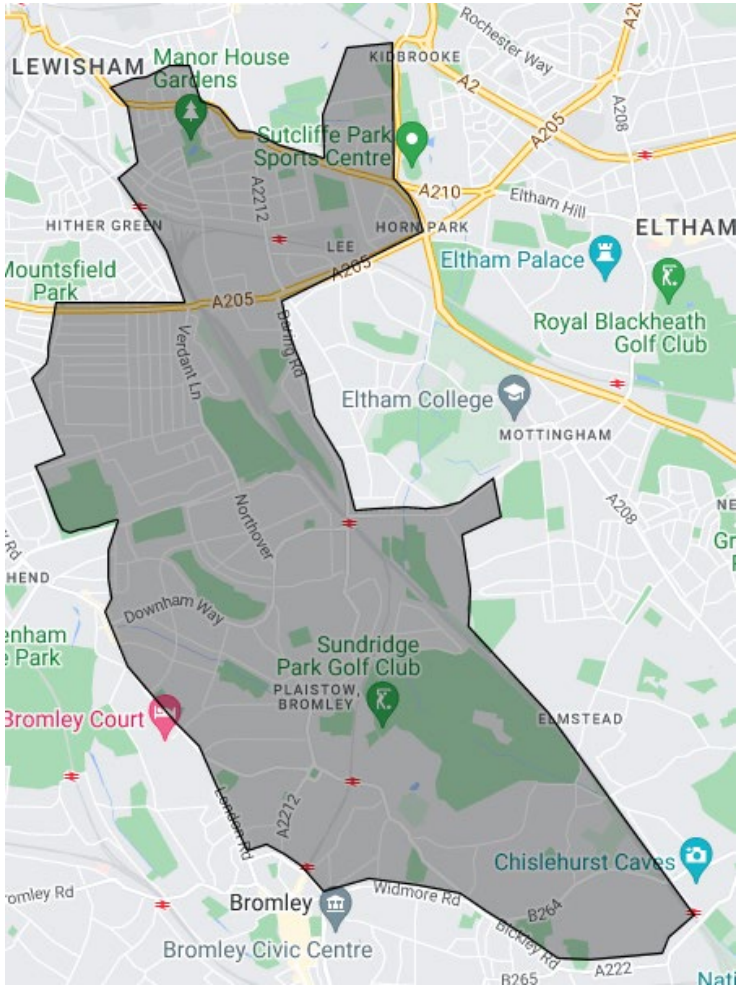
Downham Family Medical Practice



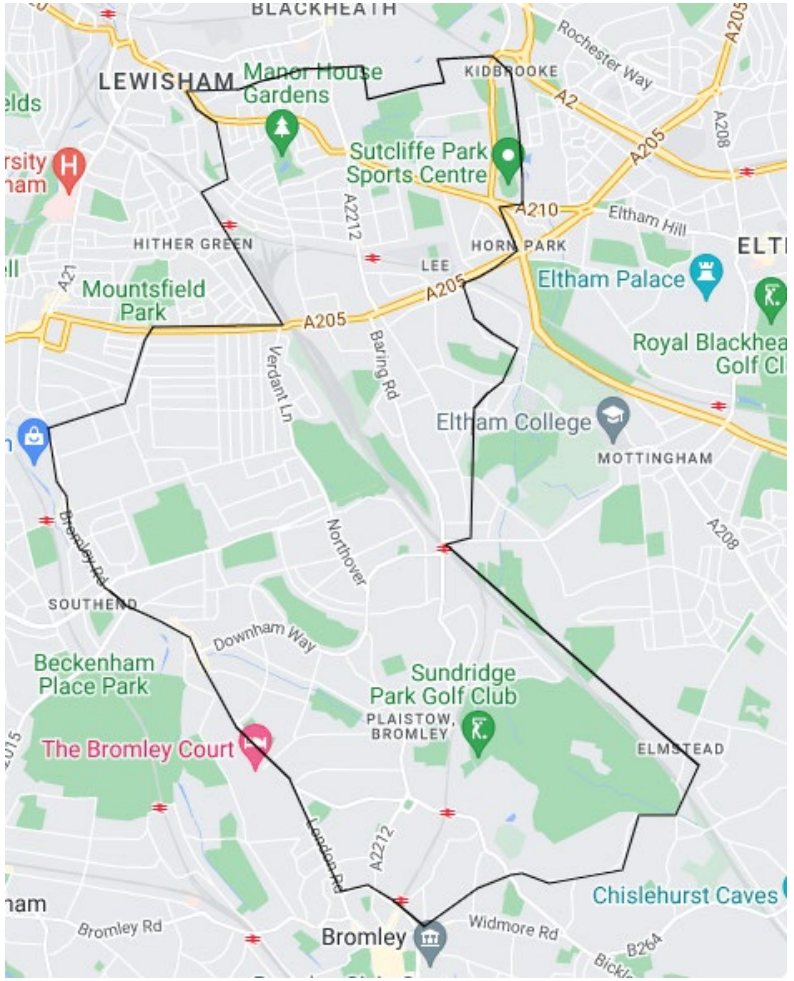
Burnt Ash Surgery



New Catchment Areas

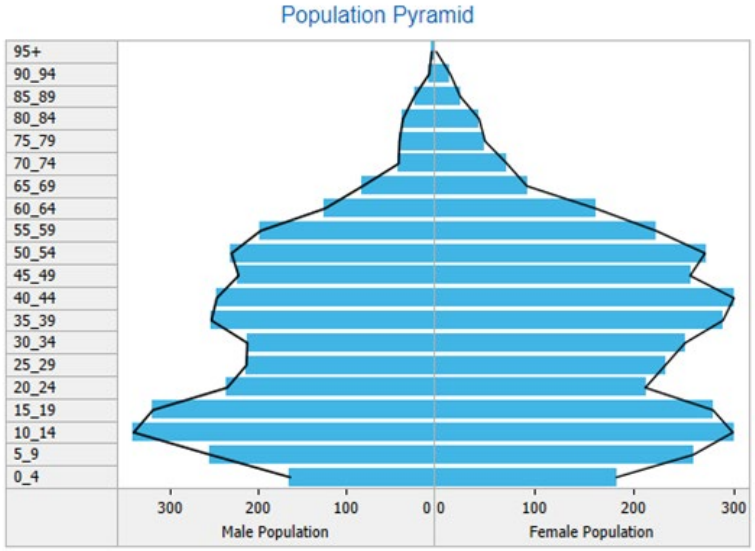


Includes outer area (No home visits)



Practice Demographics Comparison (1/2)

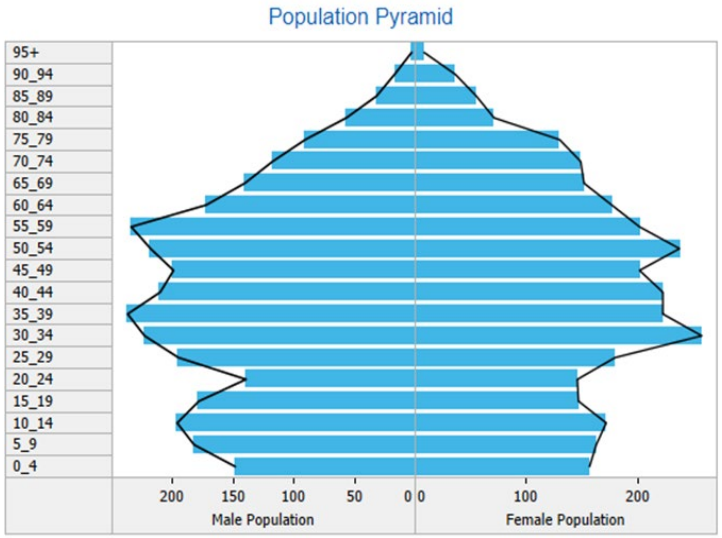
Downham Family Medical Practice



Practice Profile

Contract Type: PMS
Dispensing Practice: No
List Adjusted IMD: 32.75
List Adjusted IDACI: 0.27
List Adjusted ADAOPI: 0.26
%BME: 50.40
Practice List Size: 6,798
Weighted List Size: 6,058
Practice Rurality: Urban
Total GP FTE: 2.91
Other Direct Patient FTE: 3.12

Burnt Ash Surgery



Practice Profile

Contract Type: PMS
Dispensing Practice: No
List Adjusted IMD: 21.36
List Adjusted IDACI: 0.17
List Adjusted ADAOPI: 0.18
%BME: 38.70
Practice List Size: 6,092
Weighted List Size: 6,393
Practice Rurality: Urban
Total GP FTE: 2.56
Other Direct Patient FTE: 2.64

Practice Demographics Comparison (2/2)

- The overlapping catchment areas means the practice's demographics are not too dissimilar. Downham has a higher population of BAME and younger patients, while Burnt Ash has a higher population of older patients. As all clinicians understand the different demands of these demographics and the services provided in both practices will be mirrored, we do not envisage any impact on the services provided.
- The GPs in the practices have experience of working in different areas of Lewisham and have the knowledge and skill sets to adapt to varying demographics.
- Both practices have a highly dynamic population which keeps evolving and the merger between the practices will be advantageous to two practice populations. Patients who move property but stay within the Ashdown Medical Group catchment area will be able to remain with the practice they are currently registered with. This will be advantageous to patients who have comorbidity and value continuity of care.
- Nursing staff are currently working across both sites and are being introduced to the different ethnic make up and deprivation indicies. Physician Associates employed at Burnt Ash Surgery spent some of their training at Downham Family Medical Practice and are therefore aware of the needs of patients at both sites.
- Joint clinical meetings involving both practices will be used as a platform to share information and concerns regarding patients with specific needs, health issues and difficult to reach patients. Sevenfields Care Co-ordinators will support recalls for these patients.
- Following the merger, clinicians from both practices will attend the necessary MDM meetings to ensure they fully understand the needs of the vulnerable patients on both practice lists.

Risk Analysis – Risk Identification and Management (1/3)

A SWOT Analysis of the merger between the two practices was carried out to identify potential risks and provide solutions for such risks. The risks identified are linked to the weaknesses and threats in our SWOT analysis

Internal	**Strengths** • Improved sustainability in providing services • Improved access to services at multiple sites for patients • Economies of scale through ability to increase volume and type of services offered to patients • Ability to offer increased/extended patient access • Ability to bulk buy and reduce costs • Ability to share facilities and premises • Improved working at scale and sharing administrative work • Improved staff retention • Ability to offer greater clinical expertise and skills	**Weaknesses** • Each Practice will sacrifice an element of their independence as both practices have different processes and cultures • Staff of both practices will have to be integrated and have to learn to work in collaboration
External	**Opportunities** • Opportunity to offer greater training functions to develop more skilled workforce • Potential to reduce workload pressures • Greater chance of successfully bidding for contracts • Opportunity to become a pro-active practice	**Threats** • The liabilities which belong to each practice may pose an issue unless positive action is taken to mitigate the liabilities or ring fence them • Cost and time constraints may pose difficulties during initial stage of merger

Risk Analysis – Risk Identification and Management (2/3)

MITIGATING AGAINST POTENTIAL RISKS

Potential risk can arise either before or after the merger and it is important that such risks are identified and solutions proffered.

Risk Analysis and Management

1. **Lack of Due Diligence :** Due diligence is extremely important for both practices in order to learn as much as possible about the practice's financials, contracts, patients, demographics, and other pertinent information in order to avoid getting caught up in obligations they are not ready to assume such as litigation issues and complicated tax matters.

   Both Practices have engaged the services of foremost law firm – Hempsons Solicitors and Independent Medical Accountants for a thorough legal and financial due diligence. Both practices were happy to proceed with the merger following successful outcome of the due diligence reports.

2. **Miscalculating Synergies between the two Practices :** It is easy to be overly optimistic about the gains of a merger and underestimate how long synergies takes to come to fruition.

Risk Analysis – Risk Identification and Management (3/3)

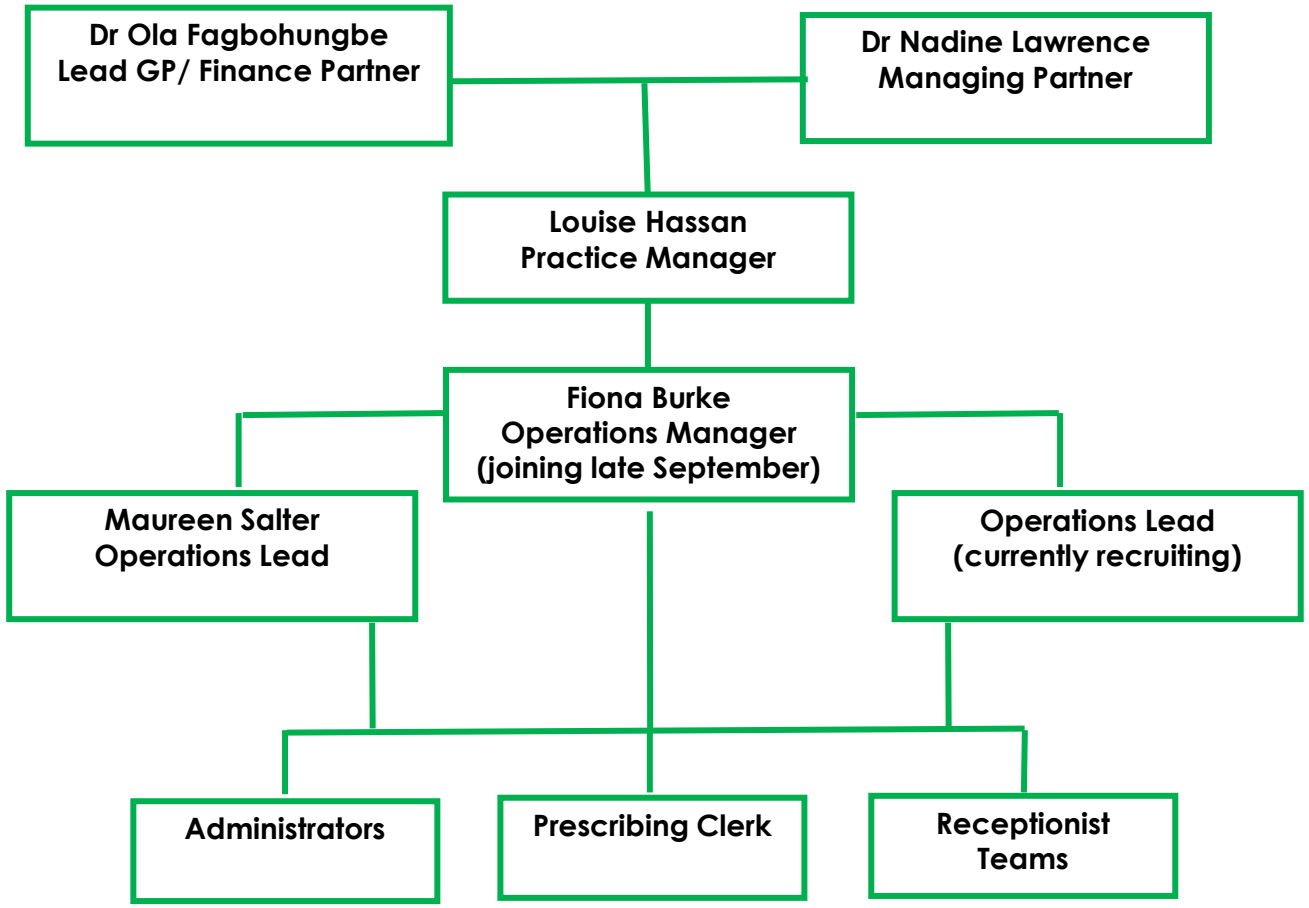
Following the due diligence process and regular partners meetings, we have been working collaboratively on consolidating workforces and operational processes in order to achieve the overall aim of ensuring that the combined practices are more valuable than they are individually.

3. **Integration Issues :** Significant integration issues can crop up after a merger. A merger is a major organisational change with a potential to alter many of the underlying processes behind how both practices operate. Different cultures may also pose a challenge.

   As the partners of the two practices have been meeting regularly and created a single management operational framework, managed by a single Practice Manager and supported by two Operational Leads, we have been learning and improving on the practices cultural and operational differences and streamlining our processes further by ensuring that staff on both sides, work across both practices.

   The two practices share the same values and ethos and are similar in so many respects. Both practices have been working collaboratively, working together under the same management and administration structure for the past 12 months. The Partners and staff are already bonding well both professionally and socially. There were shared events at Christmas and a summer social took place recently.

Ashdown Management Structure



Ashdown Medical Group Recruitment

Downham Family Medical Practice Current Staff	Burnt Ash Surgery Current Staff	Recruitment for Ashdown Medical Group
3 x GP Partners 3.0 FTE	2 x GP Partners - x 1 leaving Partnership (15th July) 2.0 FTE	
No salaried GPs	1 x Salaried GP 0.75 FTE	1 x Salaried GP offered position 0.75 FTE. Awaiting acceptance 1 x GP (Return to Practice Programme) starting in 01.09.2022 0.375 FTE with a view to employment within 6 months 0.75 FTE 1 x long term locum for 6 months starting 01.08.2022 0.75 FTE
1 x Physician Associate 1.0 FTE 1 x Physician Associate starting 01.08.2022 1.0 FTE	2 x Physician Associates 1.6 FTE	No further recruitment needed
1 x Nurse Prescriber currently 0.36 FTE. Up to 1.0 FTE from October/November 2022. 1 x Practice Nurse 0.7 FTE 1 x GP Academic Nurse 0.5 FTE. To be offered F/T employment in February 2023.	1 x Nurse Associate 1.0 FTE	1 x Sexual Health Nurse starting 01.08.2022 0.6 FTE (enrolled on Fundamentals course from September, will be fully qualified in February 2023)
	GP Registrar ST1 from 01.09.2022	
1 x Operations Lead 0.8 FTE	1 x Operations Manager starting 19.09.2022 1.0 FTE	1 x Operations Lead to be recruited 1.0 FTE
Administration and Reception staff 4.37 FTE	Administration and Reception staff 4.9 FTE	No further recruitment needed
		1 x Practice Pharmacist – recruitment in process 0.6 FTE 2 x PCN Pharmacists recruited – start date TBC

Appendix 1: Engagement Plan

Ashdown Medical Group: Engagement Plan (1/3)

Required Action	Outcome	Remaining Action	Status	Complete By
Liaise with PPG Groups	Ensure PPG members are made aware of plans to merge, given opportunity to feedback and kept updated of developments.	Keep PPG members informed of ongoing progress and key dates and the practices to receive feedback.	Ongoing	
Set up and carry out Patient Engagement Survey	Engage with patients via online survey (Survey Monkey) sent to all over 16's with a mobile number. Letters sent to all patients without a mobile number. Set up dedicated email for responses.	Feedback at the next patient engagement and produce further FAQs to address concerns raised.	Ongoing	1st September 2022
Patient engagement via paper questionnaires	Engage with patients who are not digitally enabled by distributing paper questionnaires at the practices.	Keep staff updated with plans and ensure they are comfortable to answer any patient queries.	Ongoing	11th July 2022
Put proposed merger details and FAQs on websites	Ensure patients are informed of proposed merger and what it will mean for patients	Keep website updated with progress and development, once merger date is closer advise of patient drop in sessions.	Ongoing	1st September 2022

Ashdown Medical Group: Engagement Plan (2/3)

Required Action	Outcome	Remaining Action	Status	Complete By
Proposed merger information in practice reception areas – posters, leaflets and FAQs	Ensure patients are informed of proposed merger and have an opportunity to speak with the clinicians or administration staff about concerns.		Complete	
Liaise with Health Watch Lewisham on patient engagement	Health Watch are currently visiting the practices on a regular basis and will be able to engage with patient groups to ensure they are aware of the proposed merger and feedback concerns.		Ongoing	31st July 2022
Active engagement with local practices, PCN, local pharmacies, support organisations and other key stakeholders.	Contact: SELDOC, local practices, One Health Lewisham, SLAM, PCSE, Local acute and community care providers, LMC to consider effects of the merger and ways to minimise disruption.	Discuss at MDM and safeguarding meetings to ensure social services, district nurses and health visitors are aware.	Ongoing	1st September 2022
Set up dedicated email address	Have a point of contact for all patients or service providers who have questions about the merger		Complete	

Ashdown Medical Group: Engagement Plan (3/3)

Required Action	Outcome	Remaining Action	Status	Complete By
Planned F2F and virtual engagement sessions following merger approval.	F2F meeting with virtual link to engage with patients.	Dates to be set for each site once merger date approved.	Not started	September 2022
Collate findings and concerns from engagement and agree actions to address.	Identify common themes and provide reassurance to patients. Continue to review patient engagement after merger to address concerns.	Common themes to be identified – addressed at the planned engagement meetings and published on websites.	Not started	31st August 2022
Identify and contact vulnerable patients from both practices to provide support with the merger where necessary.	Write letters or make telephone calls to identified patients informing them of the merger and reassure them of support they will continue to receive.	Letters and calls to be made once merger date approved.	Not started	September 2022

Appendix 2:
GP Survey Results

Burnt Ash Surgery

Lee Health Centre, 2 Handen Road, Lee, SE12 8NP

Practice Summary (PowerPoint)

Practice overview | Patient experience | Compare practice ▸

Where patient experience **is highest** compared with the ICS result

- **86%** of respondents find the receptionists at this GP practice helpful
  ICS result: 80% | National result: 82%
- **38%** of respondents usually get to see or speak to their preferred GP when they would like to
  ICS result: 36% | National result: 38%
- **93%** of respondents were given a time for their last general practice appointment
  ICS result: 91% | National result: 90%

Where patient experience **is lowest** compared with the ICS result

- **44%** of respondents describe their experience of making an appointment as good
  ICS result: 53% | National result: 56%
- **60%** of respondents were satisfied with the appointment they were offered
  ICS result: 67% | National result: 72%
- **54%** of respondents say they have had enough support from local services or organisations in the last 12 months to help manage their long-term condition(s)
  ICS result: 61% | National result: 65%

349 Surveys sent out

98 Surveys sent back

28% Completion rate

Downham Family Medical Practice

Downham Family Med Pract, 7-9 Moorside Road, Downham, BR1 5EP

Practice Summary (PowerPoint)

Practice overview | Patient experience | Compare practice ►

Where patient experience **is highest** compared with the ICS result

61% of respondents are satisfied with the general practice appointment times available
ICS result: 53% | National result: 55%

57% of respondents find it easy to get through to this GP practice by phone
ICS result: 51% | National result: 53%

84% of respondents find the receptionists at this GP practice helpful
ICS result: 80% | National result: 82%

Where patient experience **is lowest** compared with the ICS result

45% of respondents say they have had enough support from local services or organisations in the last 12 months to help manage their long-term condition(s)
ICS result: 61% | National result: 65%

65% of respondents felt the healthcare professional recognised or understood any mental health needs during their last general practice appointment
ICS result: 78% | National result: 81%

78% of respondents felt their needs were met during their last general practice appointment
ICS result: 89% | National result: 91%

657
Surveys sent out

111
Surveys sent back

17%
Completion rate

Your local GP services

	Burnt Ash Surgery	Downham Family Medical Practice
% of patients who find it easy to get through to this GP practice by phone Show breakdown	49% ICS result: 51% National result: 53%	57% ICS result: 51% National result: 53%
% of patients who find the receptionists at this GP practice helpful Show breakdown	86% ICS result: 80% National result: 82%	84% ICS result: 80% National result: 82%
% of patients who are satisfied with the general practice appointment times available Show breakdown	51% ICS result: 53% National result: 55%	61% ICS result: 53% National result: 55%
% of patients who usually get to see or speak to their preferred GP when they would like to Show breakdown	38% ICS result: 36% National result: 38%	35% ICS result: 36% National result: 38%

Your local GP services

	Burnt Ash Surgery	Downham Family Medical Practice
% of patients who were given a time for their last general practice appointment Show breakdown	93% ICS result: 91% National result: 90%	95% ICS result: 91% National result: 90%
% of patients who say the healthcare professional they saw or spoke to was good at giving them enough time during their last general practice appointment Show breakdown	79% ICS result: 81% National result: 83%	78% ICS result: 81% National result: 83%
% of patients who say the healthcare professional they saw or spoke to was good at listening to them during their last general practice appointment Show breakdown	84% ICS result: 83% National result: 85%	77% ICS result: 83% National result: 85%

Your local GP services

	Burnt Ash Surgery	Downham Family Medical Practice
% of patients who say the healthcare professional they saw or spoke to was good at treating them with care and concern during their last general practice appointment Show breakdown ⊕	76% ICS result: 81% National result: 83%	72% ICS result: 81% National result: 83%
% of patients who felt the healthcare professional recognised or understood any mental health needs during their last general practice appointment Show breakdown ⊕	73% ICS result: 78% National result: 81%	65% ICS result: 78% National result: 81%
% of patients who were involved as much as they wanted to be in decisions about their care and treatment during their last general practice appointment Show breakdown ⊕	87% ICS result: 89% National result: 90%	82% ICS result: 89% National result: 90%

Your local GP services

	Burnt Ash Surgery	Downham Family Medical Practice
% of patients who had confidence and trust in the healthcare professional they saw or spoke to during their last general practice appointment Show breakdown ⊕	93% ICS result: 92% National result: 93%	88% ICS result: 92% National result: 93%
% of patients who felt their needs were met during their last general practice appointment Show breakdown ⊕	88% ICS result: 89% National result: 91%	78% ICS result: 89% National result: 91%
% of patients who say they have had enough support from local services or organisations in the last 12 months to help manage their long-term condition(s) Show breakdown ⊕	54% ICS result: 61% National result: 65%	45% ICS result: 61% National result: 65%

GP Survey Comparison

- Both practice results show that patients are generally happy with the care they have received from the healthcare provider and patients felt involved in the decisions made about their care.
- Results show that patients find the receptionists helpful at both practices. Although the percentages in this area were higher than national results patients have scored both sites lower for their experience of making an appointment. Ashdown Medical Group will look to get feedback from patients to work on six months after the merger to monitor whether the patient experience has improved as well as highlight any issues.
- 49% of patients at Burnt Ash Surgery found it easy to get through to the practice compared to 57% of patients at Downham Family. During this survey year, both sites have struggled with staffing levels due to Covid sickness. Both sites now have a new telephony system in place which enable the incoming calls to be answered from either site. Ashdown Medical Group aim to make access via the telephones easier and promote online access for those patients with smart devices.
- Improvements required from access to local services to provide patients with more support. Sevenfields PCN is working on improving communication with local services and has employed social prescribers to support patients with information and access.
- The merger aims to improve access to appointments and patient satisfaction with the appointments offered. There will be greater choice of GP provision offering Burnt Ash patients the option to book with a male GP as well as the improved skill mix with different GP specialisms across the sites. Ashdown Medical Group will be employing a Practice Pharmacist to increase the number of appointments offered and free up GP appointments to allocate to more complex healthcare. A full time Nurse Associate at Burnt Ash, trained in Phlebotomy, will support Physician Associates with diabetic care as well as provide support to the Practice Nurses allowing more appointments to be booked for LTCs. Reception staff will be given Care Navigation training to ensure patients are signposted to other relevant services such as Pharmacy First and CPCS which will in turn provide more appointments in practice.

Appendix 3: Improvement Plan

Improvement Plan (1/4)

The merger of the two contracts provides an opportunity to review and improve some key areas through benefit of shared learning. As outlined in the Business Case there are some areas where the variation in performance can be improved.

No.	Improvement Area	Baseline Measurement	Action Due	Expected Outputs	Status	Person Responsible	Action By
1	Quality and Outcomes Framework achievement	2021/22 QOF achievements have not yet been published. Therefore the review will be based on 2020/21 data.	Due to the COVID-19 pandemic, QOF was suspended, and practices changed their working habits. ▪ Review processes on how QOF is managed practice ▪ Standardise according to best practice ▪ Update all staff and allocate areas of responsibility (clinical and non-clinical)	Both Administrators will have a joint process for call and recalls and provide support to both sites. Increase QOF achievement across both practices utilising the merged workforce.	Ongoing	Dr Anwuli Bosah	31.03.2022
2	Mental Health	<u>Burnt Ash Surgery</u> ○ Level 1 Trigger - Mental Health Comprehensive Care Plan – 35.10%. ○ Level 2 Trigger - SMI Alcohol Record – 26.30%. ○ Level 1 Trigger - SMI BP Record – 52.60%.	▪ Lead GP to monitor review progress ▪ Allocated clinics for reviews, utilise Enhanced Access hours to improve access ▪ Administrators to have robust recall system in place ▪ Increased workforce and Physician Associates will support reviews	Improve uptake at Downham Family Medical Practice and bring Burnt Ash Surgery up to match their targets	Ongoing	Dr Omosule/ Physician Associates	31.12.2022

Improvement Plan (2/4)

No.	Improvement Area	Baseline Measurement	Action Due	Expected Outputs	Status	Person Responsible	Action By
		<u>Downham Medical Family Practice</u> ○ Level 1 Trigger - Mental Health Comprehensive Care Plan – 65.90%. ○ Level 1 Trigger - SMI Alcohol Record – 83%. ○ Level 1 Trigger - SMI BP Record – 81.80%.					
3	Cervical Screening	<u>Burnt Ash Surgery</u> Level 1 Trigger – 69.90% <u>Downham Medical Family Practice</u> Level 1 Trigger – 73.50%.	▪ Appoint a nurse to lead ▪ Nurse Associate to complete cervical screening training to increase appointments ▪ Identify reasons for low achievement ▪ Review of call/recall / failsafe procedures ▪ Utitlise enhanced access hours to increase appointments and uptake	Meet QOF targets for both 25-49yrs and 50-65yrs	Ongoing	Lead Nurse & Nursing Team	31.03.2022

Improvement Plan (3/4)

No.	Improvement Area	Baseline Measurement	Action Due	Expected Outputs	Status	Person Responsible	Action By
4	Child Imms DTaP/IPV/Hib/ HepB (age 1 year)	Burnt Ash Surgery ○ Level 1 Trigger - 87.50%. Downham Medical Family Practice ○ Level 1 Trigger – 84.30%.	▪ Call and recall administrators to use robust system ▪ Nurses to call parents reluctant to give child the vaccine, educate the importance of immunisations ▪ Recent nursing recruitment should improve access ▪ Promote communication campaign ▪ PCN Care co-ordinators to support recalling hard to reach patients	Meet QOF immunisation targets	Ongoing	Lead Nurse & Care Coordinators	31.03.2022
5.	Child Imms Hib/MenC booster	Burnt Ash Surgery ○ Level 1 Trigger – 75.90% Downham Medical Family Practice ○ Level 1 Trigger – 81.10%.	As above	As above	Ongoing	Lead Nurse & Care Coordinators	31.03.2022
6.	Child Imms MMR (age 2 years)	Burnt Ash Surgery ○ Level 1 Trigger - 79.30%. Downham Family Medical Practice ○ Level 1 Trigger – 81.10%	As above	As above	Ongoing	Lead Nurse & Care Coordinators	31.03.2022

Improvement Plan (4/4)

No.	Improvement Area	Baseline Measurement	Action Due	Expected Outputs	Status	Person Responsible	Action By
7.	Child Imms PCV Booster	Burnt Ash Surgery ○ Level 1 Trigger - 70.70%. Downham Family Medical Practice ○ Level 1 Trigger – 78.40%.	As above	As above	Ongoing	Lead Nurse & Care Coordinators	31.03.2022
8.	2021/22 PMS Premium Contract Management Tool Quarter 4.	Burnt Ash Surgery ○ Childhood Immunisation: The 6-in-1 vaccine – 87%. ○ Serious Mental Illness – 45%. Downham Family Medical Practice ○ Childhood Immunisation: The 6-in-1 vaccine – 92%. ○ Serious Mental Illness – 45%.	▪ Administration and reception staff encouraged to make every contact count – gaining Alcohol and smoking status while taking calls from SMI patients. ▪ Regularly recall patients for blood tests and BP checks. ▪ Following all checks, patient will be booked in for a review by administrators ▪ Regular monitoring of the Child Imms reporting in Ardens to ensure vaccines are given within the time frame. ▪ Call and recalls weekly for all immunisation reporting. ▪ Increased nurse workforce at Burnt Ash Surgery will support better access.	Improved uptake of immunisations and reach national targets.	Ongoing	Dr Omosule/ Lead Nurse/ Care Co-ordinators	31.03.2022

Appendix 4: Equality and Health Inequalities Screening Tool

Equality and Health Inequalities Screening Tool (1/6)

A. General Information	
Date of Assessment	11 July 2022
Assessor Name(s) & Job Title(s)	Chima Olugh. Primary Care Commissioning Manager
Organisation	NHS South East London Integrated Care Board (Lewisham).
Name of the policy, function, service development	The separate PMS contracts of **Burnt Ash Surgery and Downham Family Medical Practice** will be merged to form one single PMS contract to form Ashdown Medical Group.
	The purpose of this Equality and Health Inequalities Screening Tool is to ensure that during and after the process of the contract merger patients registered at both practices continue to have unrestricted access to Primary Medical Services. The new merged practice will be known as Ashdown Medical Group. The two GP practices which will make up Ashdown Medical Group are; Burnt Ash Surgery - G85027 – 6,144 patients. Downham Family Medical Practice – G85057 – 6,828 patients. The planned timeline for the merger is 1st October 2022 The merged contracts will create a single registered patient list of circa 13,000, retaining the ODS code of G85057 which is the current Downham Family Medical Practice contract. Burnt Ash Surgery will operate as branch site. Burnt Ash Surgery has been accepted to join Sevenfields Primary Care Network (PCN). Lewisham Alliance PCN are aware of the impact the merger will have and are taking this into account for 2022/23 planning.

Equality and Health Inequalities Screening Tool (2/6)

The reason for the merger

In May 2021, Dr Leonardo Antony, Senior Partner, Burnt Ash Surgery gave notice of his plan to retire in September 2021 after over 20 years of service.

In June 2021, it was agreed that both Burnt Ash Surgery and Downham Family Medical Practice would share Practice Manager services provided by Louise Hassan after a vacancy became available at Downham.

Both Practices have been sharing their values and commitment to high quality clinical care over the past year and now believe a merger will help to provide improved access, choice, and quality for patients.

Benefits of the merger

<u>Improved patient experience</u>
The practices will make use of the experience and strengths from each practice to improve patient care. Training will be put in place for all reception staff to ensure consistent and empathetic service is provided on both sites. There will be a more diverse clinical workforce in terms of skill mix and gender.

<u>Improved Patient Access</u>
Improved access to services, more flexibility in appointments across the wider workforce and shorter waiting times made possible from improved efficiencies.

<u>Continuity of Care</u>
This will be achieved by ensuring every patient has a Named & Accountable GP.
The staff will work as a broader team inclusive of allied healthcare professionals.
Increased clinical cover for sickness absences.

Equality and Health Inequalities Screening Tool (3/6)

	Patient and stakeholder Engagement <u>How patients will be informed of the merger if approved</u> To ensure all patients are aware of the changes, the rationale and the benefits of the merger (to minimise service disruption) the practice has carried out the following: Face to face meetings with PPGs of both practices. Engagement with Healthwatch. An online patient survey. Text messages sent to all patients with a recent mobile telephone number known to the practice. Posters and leaflets have been put up in both practices. Reception staff have been trained to answer patient queries. <u>How the practices will respond to the issues raised through the patient engagement process</u> Ashdown Medical Group will produce and publicise a FAQs document to address the issues raised by its patients. Ashdown Medical Group acknowledge that some patients are concerned that the merger might affect access to services. Ashdown Medical Group will ensure that staffing and services will not be reduced if the merger goes ahead (and in fact there will be greater access to a wider range of staff and skills as a result). Ashdown Medical Group will keep patient engagement under review as part of its engagement plan.
Intended Outcomes	The merger will does not involve any site closures. <u>Intended outcomes of the merger include:</u> • Increased resilience and strength to secure the future of both practices and wider primary care across Sevenfields PCN and Lewisham.

Equality and Health Inequalities Screening Tool (4/6)

	• An increase in capacity by sharing clinical and allied professionals. • More leadership (clinical and non-clinical) and management capacity to support our practice staff and support the practice with the service transformation. • • Improved quality and continuity of care for patients with healthcare professionals. • • Improved access to services, more appointments and shorter waiting times. • • Patients will be able to book appointments at their preferred site. • • Ensure patients have access to a wider range of healthcare professionals who will work across all the sites and provide a variety of services.
Who will be affected by the merger	29 practice staff and of circa 13,000 patients.

Consideration for the nine protected characteristics and how the merger impacts any of them. The nine protected characteristics are as follows:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion and belief
- Sex
- Sexual orientation

Equality and Health Inequalities Screening Tool (5/6)

B. The Public Sector Equality Duty	
Could the merger help to reduce unlawful discrimination or prevent any other conduct prohibited by the Equality Act 2010? If yes, for which of the nine protected characteristics (see above)?	**No**
Could the merger undermine steps to reduce unlawful discrimination or prevent any other conduct prohibited by the Equality Act 2010? If yes, for which of the nine protected characteristics?	**No**
Could the merger help to advance equality of opportunity? If yes, for which of the nine protected characteristics?	**No**
Could the merger undermine the advancement of equality of opportunity? If yes, for which of the nine protected characteristics?	**No**
Could the merger help to foster good relations between groups who share protected characteristics? If yes, for which of the nine protected characteristics?	**No**
Could the merger undermine the fostering of good relations between groups who share protected characteristics. If yes, for which of the nine protected characteristics?	**No**

If you answered 'No' to any of the above, give your reasons why

It is anticipated that there will be no adverse equality impact upon the nine protected characteristic groups noted above, as any affected group will have the option to continue to register with Ashdown Medical Group.

Commissioners will ensure that information will be made available on transportation routes between the different sites, and neighbouring practices that are within a one-mile radius.

Equality and Health Inequalities Screening Tool (6/6)

C. The duty to have regard to reduce health inequalities	
Could the merger reduce inequalities in access to health care for any groups which face health inequalities? If yes for which groups?	**No**
Could the merger reduce inequalities in health outcomes for any groups which face health inequalities? If yes, for which groups?	**No**

If you answered 'yes' to any of the above, give your reasons why

Not Applicable

D. Please indicate if a Full Equality and Health Inequalities is recommended	NO
Project Lead: Chima Olugh, Primary Care Commissioning manager (Lewisham). NHS South East London Integrated Care Board.	Date completed: 27/07/2022

The signed and completed Equality and Health Inequalities Screening Tool should be attached as an appendix to the policy or function/service development documentation as evidence of completion and proof of review.

South East London Integrated Care System

NHS South East London

Proposed Merger between Burnt Ash Surgery (G85027) and Downham Family Medical Practice (G85057)

Borough	Lewisham		
Practice Details	Practice Names	Burnt Ash Surgery	Downham Family Medical Practice
	Contract Types	PMS – no end date	PMS – no end date
	Site Addresses	Lee Health Centre, 2 Handen Rd, SE12 8NP	7-9 Moorside Rd, Bromley BR1 5EP
	List Sizes Apr 22	Raw: 6144 Weighted: 6488.45	Raw: 6828 Weighted: 6177.19
	No of Partners	Two	Four
	Current CQC Rating	Good	Good
	PCN Details	Lewisham Alliance PCN. 6 practices. List size as at 01/04/2022 is 54,355.	Sevenfields PCN. 6 practices. List size as at 01/04/2022 is 62,492.

Recommended action for the Board

The Lewisham Care Partnership Strategic Board is asked to approve:

- The merger of the contracts and the patient lists of Burnt Ash Surgery and Downham Family Medical Practice.
- The change to Sevenfields and Lewisham Alliance PCN Core Network Practice membership as a result of the merger.

Summary of Key Issues

- The initial driving factor for the proposed merger was the notice to retire given by a senior partner from Burnt Ash Surgery in April 2021. This would leave the practice with only one partner on the contract making the practice less resilient and at risk of delivering safe patient services.
- A historic lack of good managerial leadership at Downham Family Medical Practice had an effect on reception and administration staff leading to a high staff turnover rate.
- The practice used this as an opportunity to explore ways to secure a sustainable and resilient service with the ability to extend service provision for patients and agreed a merger would be the best way forward.
- The merger will help create a resilient workforce, expansion of leadership (clinical and non-clinical staff) and more opportunity for peer clinical support, and upskilling of current staff.
- An arrangement was reached in June 2021 whereas Burnt Ash Surgery and Downham Family Medical Practice would share practice manager services, leadership and other managerial workforce.

- The signatories of the current practices contracts will be the signatories of the single, merged contract under the ODS code of G85057 which is the current code for Downham Family Medical Practice; Burnt Ash Surgery will in effect operate as a branch site. The new merged practice will be known as Ashdown Medical Group.
- There are no planned site closures as a result of the merger, and no patients will be deregistered.
- The practices belong to different Primary Care Networks (PCNs). Burnt Ash Surgery is part of Lewisham Alliance PCN while Downham Family Medical Practice is part of Sevenfields PCN.
- Following the merger Ashdown Medical Group will be part of Sevenfields PCN.
- The merger will result in a change to Sevenfields and Lewisham Alliance PCN Core Network Practice membership.
- Lewisham Alliance PCN is aware of the impact the merger will have on the Network Contract DES arrangements and has taken this into account for 2022/23 planning, including arrangements for the Additional Roles Reimbursement Sum and Enhanced Access.
- SEL ICB IT team will replace network hardware and will support the sites once the merger has been completed.
- Considerable patient and stakeholder engagement has been carried out and there is an engagement plan which outlines further engagement.
- There are a number of alternative practices within a 1 mile radius for patients to choose to register with should patients wish to not remain registered with the practice, subject to the approval of the proposed merger. Patients will be supported to reregister, should they not wish to remain registered with the practice.
- Local practices have confirmed that they have capacity to register up to 1,000 patients within their current resources.
- The practice merger will not make financial savings for SEL ICB in relation to the premises budget, but it will improve the long-term viability of the practice and financial stability.
- The proposal to merge the contracts aligns with the South East London strategy of working at scale with fewer contracts and larger patient lists.

Background of each of the Practices

Burnt Ash Surgery and Downham Family Medical Practice hold separate PMS contracts which they wish to merge. The merger date is indicative and subject to confirmation by EMIS following approval.

There will be no site closures as a result of the merger.

Burnt Ash Surgery

- Burnt Ash Surgery is a 1960's purpose built building located within Lee Health Centre which is owned by Lewisham & Greenwich Trust.
- It is co-located with another practice, Nightingale Surgery.
- The building is Disability Discrimination Act (DDA) and infection control compliant.

Downham Family Medical Practice

- Downham Family Medical Practice is located in a 1980's purpose built building located within Downham Health and Leisure Centre.
- Similar to Burnt Ash Surgery, it is co-located with another practice, ICO Health Group.
- The building is DDA and infection control compliant.

Merged Practice

- The merger will create a single registered patient list of circa 13,000 and retain the ODS code of G85057.
- Both practices use the same iCloud telephony system which can be easily linked following the merger. Both practice telephone numbers will remain active to ensure patients are able to contact the practices for patient care.
- Burnt Ash Surgery and Downham Family Medical Practice boundaries overlap, and the merged practice will retain the existing boundaries.
- An outer practice boundary has also been agreed with commissioners.
- The distance between the two practices is 1.73 miles, this is an 8 – 10 minute drive by car. Both sites have free parking options with blue badge/disabled parking.
- The practices are served by the 202, 284, 273, 124 and 181 buses.

Practice Performance

- Due to the COVID-19 pandemic, QOF was suspended, and practices changed their working habits.

The merged practice has agreed to;

- Review processes on how QOF is managed
- Update all staff and allocate areas of responsibility (both clinical and non-clinical).

These actions have been included in the practice improvement plan and will monitored by commissioners.

Table 1 illustrates the clinical indicators and practice achievement.

Table 1 - Clinical Indicators

PH Indicators	Time Period	BAS	DMFP
% Child Imms DTaP/IPV/Hib/HepB (age 1 year)	2020/21	87.5%	84.3%
% Child Imms Hib/MenC booster	2020/21	75.9%	81.1%
% Child Imms MMR (Age 2 yrs)	2020/21	79.3%	81.1%
% Child Imms PCV Booster	2020/21	70.7%	78.4%
Cervical Screening	2021/22 Q3	69.6%	73.5%

Practice Achievements from latest available data as of August 2022

Burnt Ash Surgery
15 Level 1 Triggers
5 Level 2 Trigger

Downham Family Medical Practice
13 Level 1 Triggers
0 Level 2 Trigger

Patient Experience Performance

Burnt Ash Surgery ratings in relation to patient experience (from the 2022 GP patient Survey) are above the Integrated Care System (ICS) average except in five areas:

a) Percentage of patients who find it easy to get through to the practice by phone.
b) Percentage of patients who are satisfied with general practice appointments available.
c) Percentage of patients who say the healthcare professional they saw or spoke to was good at giving them enough time during their last appointment.
d) Percentage of patients who felt the healthcare professional recognised or understood any mental health needs during their last appointment.
e) Percentage of patients who say they have had enough support from local services or organisations in the last 12 months to help manage their long term condition(s).

Downham Family Medical Practice ratings in relation to patient experience are also mainly above the ICS average except in the following areas:

a) Percentage of patients who usually get to see or speak to their preferred GP when they would like to.
b) Percentage of patients who say the healthcare professional they saw or spoke to was good at giving them enough time during their last appointment.
c) Percentage of patients who say the healthcare professional they saw or spoke to was good at listening to them during their last appointment.
d) Percentage of patients who say the healthcare professional they saw or spoke to was good at treating them with care and concern during their last appointment.
e) Percentage of patients who felt the healthcare professional recognised or understood any mental health needs during their last appointment.
f) Percentage of patients who were involved as much as they wanted to be in decisions about their care and treatment during their last appointment.
g) Percentage of patients who had confidence and trust in the healthcare professional they saw or spoke to during their last appointment.
h) Percentage of patients who felt their needs were met during their last appointment.

i) Percentage of patients who say they have had enough support from local services or organisations in the last 12 months to help manage their long term condition(s).

CQC Ratings

- Burnt Ash Surgery had a full CQC inspection in November 2016 and the report published in March 2017. The practice was rated 'Good' overall.

  Downham Family Medical Practice had its last full inspection in June 2022. The report is yet to be published.

- Its previous inspection was in September 2016 and the report was published in December 2016. The practice was rated 'Good' overall.

There are no contractual concerns for either practice.

Information about local demography

Burnt Ash Surgery

Population

- Burnt Ash Surgery is situated in the Lee Green ward.
- Lee Green has an estimated population of 16,080 residents.
- Among its residents, 48.8% identify as female, and 51.2% as male.
- Unfortunately, ONS population statistics do not include estimates for nonbinary gender identities.
- The average age in Lee Green is 37, compared to 36 in Lewisham as a whole, and 37 in London. This makes it one of the oldest wards in the borough.

Diversity: Ethnicity

- 54.1% of Lee Green residents have an ethnicity of White British (White English, Welsh, Scottish, or Northern Irish).
- Among those not White British, the three most common ethnicities are White Other (10.0%), Black Caribbean (7.5%), and Black African (6.1%).

Diversity: Country of birth

- 68.4% of Lee Green residents were born in England, compared to 64.0% in Lewisham as a whole.
- Among those not born in England, the three most common countries of birth are Jamaica (2.4%), Nigeria (2.2%), and Ireland (1.6%).

Diversity: Languages

- 85.2% of Lee Green residents speak English as their primary language, compared to 83.5% in Lewisham as a whole.
- Of the remaining residents, 12.3% can speak English well or very well.
- Among those not speaking English as their main language, the three most widely spoken languages are Polish (1.4%), Tamil (1.2%), and French (1.1%).

Deprivation

- Of the eight LSOAs in Lee Green, zero rank in the bottom 20% of the country (decile 1 or 2).

Fuel Poverty

- In the eight LSOAs in Lee Green, proportion of households fuel poor ranges from 12% to 18%.

Health and life expectancy

- The average life expectancy at birth for females in Lee Green is 85.2 years compared to England average of 83.2.
- The average life expectancy at birth for males in Lee Green is 78.9 years compared to England average of 79.6.

Downham Family Medical Practice

Population

- Downham has an estimated population of 18,224 residents, which makes it one of the larger constituencies in the borough (rank 5 of 19 wards).
- Among its residents, 52.3% identify as female, and 47.7% as male.
- The average age in Downham is 36, compared to 36 in Lewisham as a whole, and 37 in London.
- This makes it one of the oldest wards in the borough.

Diversity: Ethnicity

- 51.1% of Downham residents have an ethnicity of White British (White English, Welsh, Scottish, or Northern Irish), compared to 41.5% in Lewisham as a whole.
- Among those not White British, the three most common ethnicities are Black African (10.9%), Black Caribbean (9.5%), and White Other (6.0%).

Diversity: Country of birth

- 74.6% of Downham residents were born in England, compared to 64.0% in Lewisham as a whole, 61.1% in London, and 83.5% in England.
- Among those not born in England, the three most common countries of birth are Nigeria (3.1%), Jamaica (2.9%), and Sri Lanka (2.0%).

Diversity: Languages

- 88.5% of Downham residents speak English as their primary language, compared to 83.5% in Lewisham as a whole, 77.9% in London, and 92.0% in England.
- Of the remaining residents, 9.4% can speak English well or very well.
- Among those not speaking English as their main language, the three most widely spoken languages are Tamil (2.2%), Turkish (1.1%), and Polish (0.9%).

Deprivation

- Of the 12 LSOAs in Downham, seven rank in the bottom 20% of the country (decile 1 or 2).

Fuel Poverty

- In the 12 LSOAs in Downham, proportion of households fuel poor ranges from 14% to 30.2%.

Health and life expectancy

- The average life expectancy at birth for females in Downham is 83.8 years compared to England average of 83.2.
- The average life expectancy at birth for males in Downham is 77.4 years compared to England average of 79.6.

Capacity and Quality of Local Practices

Although there will be no site closures, officers undertook a quality and capacity review of local practices', within a 1 mile radius, to understand the impact on local practices should patients decide not to remain registered following the merger. See table 2 below.

Officers will monitor the numbers of patients that choose not to remain registered with the practice and ensure they are supported to register with a suitable practice of their choice.

Table 2

Practice Name	Woodlands Health Centre	Lee Road Surgery	The Lewisham Care Partnership	Everest Health Partnership	Manor Brook Medical Centre	Nightingale Surgery	Lewisham Medical Centre
Distance in Miles (NHS Choices)	0.5	0.6	0.9	0.4	0.4	0	0.4
Borough	**Lewisham**	**Lewisham**	**Lewisham**	**Greenwich**	**Greenwich**	**Lewisham**	**Lewisham**
List open	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Known capacity issues?	No	No	No	No	No	No	No
Workforce outlier?	No	No	No		No		No
Selected for resilience programme support in 2021/22?	No	Yes	No	N/A	N/A	Yes	No
CQC overall rating	Good	Good	Good	Good	Good	Good	Good
GPPS - "Would describe their overall experience of this GP practice as good". ICS Average 69%	51%	92%	78%	43%	89%	85%	75%
GPPS - "% of patients who find it easy to get through to this GP practice by phone". ICS Average 51%	28%	88%	62%	28%	58%	80%	60%
GPPS - "% of patients who were satisfied with the type of appointment they were offered". ICS Average 67%	45%	78%	54%	25%	76%	60%	50%
Number of additional patients which can be registered	3,000	1,500	3,000	500	500	300	3,000
Number of patients which can be registered with additional resources (max)	3,000	1,500	3,000	500	500	300	3,000

Potential Conflicts of Interest and mitigations	There is a direct conflict of interest for Dr Helen Tattersfield, Sevenfields Primary Care Network Clinical Director who is the PCN Clinical Representative on the Lewisham Care Partnership Board. The merged practice will result in a change to Sevenfields Core Network Practice membership. Any conflict of interest should be managed according to the ICBs Standards of Business Conduct and Conflict of Interest Management Policy.
Impacts of this proposal	
Key risks & mitigations (and/or BAF reference)	Should the merger not be approved Burnt Ash Surgery would face a significant threat to its workforce and its resilience and might ultimately have to hand back its contract to commissioners. A decision would then need to be made to ensure the 6,144 patients register with another practice (s), which would lead to issues in continuity of care for patients. The proposed merger ensures there is clear continuity of care for patients who choose to remain registered under the merged list.
Equalities legislation impact	▪ The Equality Impact Assessment undertaken, which is attached as part of the business case, confirms that it is anticipated that there will be no adverse equality impact on the protected characteristic groups. ▪ The affected group will have the option to continue to remain registered the merged practice. ▪ There will be no reduction of services following the merger. ▪ There will be no reduction in the merged practice's catchment area. ▪ Patients currently registered with both practices will remain patients of the newly merged practice unless they chose to reregister with another local practice of their choice. Patients will be supported in this regard. ▪ Both practices are DDA compliant. ▪ Both practices have engaged with patients to ensure they understand the pending changes in order to manage expectations.
Financial impact	▪ The estimated cost of the clinical system mergers is approximately £9,000.00, which will be funded by commissioners. ▪ The merger will not make financial savings for the ICB in relation to the premises budget as there are no site closures, it will however improve the long-term viability of Burnt Ash Surgery and ensure financial stability.
Impact on patients/service users	Refer to the key risks & mitigations and Equalities legislation impact sections, detailed above.
Impact on other practices and PCNs	▪ The two practices are from different PCNs and if the merger is approved the merged practice will be a member of Sevenfields PCN. This has already been agreed with the PCN.

	▪ Lewisham Alliance PCN is aware of the impact the merger might have and are taking this into account as part of its 2022/23 planning. ▪ Local practices have been informed of the impending merger and they have confirmed that they have enough capacity to register additional patients within their current resources, if necessary.
Estates impact	There will be no reduction in sites, as outlined in the business case. The Burnt Ash site requires some capital investment to make it more fit for purpose and ensure CQC compliance standards are met.
Workforce impact	Table 3 below shows the current workforce for each practice and areas where the merged practice plans to recruit. The patients will have access to a wide range of healthcare professionals who can provide quality patient care and enhance the patient experience journey.

Table 3

Downham Family Medical Practice Current Staff	Burnt Ash Surgery Current Staff	Recruitment for Ashdown Medical Group
3 x GP Partners 3.0 FTE	2 x GP Partners - x 1 leaving Partnership (15th July) 2.0 FTE	
No salaried GPs	1 x Salaried GP 0.75 FTE	1 x Salaried GP offered position 0.75 FTE. Awaiting acceptance 1 x GP (Return to Practice Programme) starting in 01.09.2022 0.375 FTE with a view to employment within 6 months 0.75 FTE 1 x long term locum for 6 months starting 01.08.2022 0.75 FTE
1 x Physician Associate 1.0 FTE 1 x Physician Associate starting 01.08.2022 1.0 FTE	2 x Physician Associates 1.6 FTE	No further recruitment needed
1 x Nurse Prescriber currently 0.36 FTE. Up to 1.0 FTE from October/November 2022. 1 x Practice Nurse 0.7 FTE 1 x GP Academic Nurse 0.5 FTE. To be offered F/T employment in February 2023.	1 x Nurse Associate 1.0 FTE	1 x Sexual Health Nurse starting 01.08.2022 0.6 FTE (enrolled on Fundamentals course from September, will be fully qualified in February 2023)
	GP Registrar ST1 from 01.09.2022	
1 x Operations Lead 0.8 FTE	1 x Operations Manager starting 19.09.2022 1.0 FTE	1 x Operations Lead to be recruited 1.0 FTE
Administration and Reception staff 4.37 FTE	Administration and Reception staff 4.9 FTE	No further recruitment needed
		1 x Practice Pharmacist – recruitment in process 0.6 FTE 2 x PCN Pharmacists recruited – start date TBC

Improve quality/ safety	▪ The merger of the two contracts provides an opportunity to review and improve some key areas through the benefit of shared learning. As outlined in the business case there are some areas where the variation in performance can be improved as identified by the practices and commissioners. ▪ The improvement plan aligns with the improvements identified as part of a review of performance data relating to the two practices. The improvement plan will be

	contractualised and monitored by commissioners to support its successful implementation.
Support integration	The merger will help bring together high quality general practice and ensure service continuity. It will also ensure the Burnt Ash site remains resilient and robust, with the ability to respond to new innovations and service delivery.
Does the recommendation align with the boroughs primary care strategy	▪ The proposed merger is in line with the ICBs strategic priorities, forward planning, and developments of the PCNs and working at scale. ▪ Furthermore, it aligns with the NHS Long Term Plan and the GP Forward View for larger practices working together to deal with the pressures in primary care and extend the range of convenient local services, creating genuinely integrated teams of GPs, community health and social care staff.
Wider support for this proposal	
Patient Engagement	Both practices met face to face with their PPGs, heavy users of practice services and vulnerable patient groups to gauge feedback as part of the pre-engagement process. As a result of the PPG meetings patients were provided with access to an online survey (either directly online or via a paper form) which was used to gather opinions and understand any concerns and put mitigations in place. A summary of the online results is included in the business case. ▪ 550 responses were received. ▪ 539 (99.26%) were patients at the two practices. Results indicate that; ▪ Patients would like to stay registered at their surgery site. Further engagement will be used to reassure patients that this will be possible, and they will be given the option of which site they would like to attend their appointment. ▪ Patient engagement to date has reassured patients that they will be able to continue to attend their preferred site. ▪ Patients would prefer not to travel to the other practice site due to being elderly, infirm or not having means of travel. The triage system in place will enable patients to talk to clinicians from either site without any impact on patient care. ▪ An estimated 31.14% of patients are happy to travel between sites. ▪ Further engagement will give clarity on how the merger will offer better cover for clinicians due to illness or leave, expand clinical skills and knowledge across both sites and improve staff retention. ▪ Across both sites there has been engagement with patients using platforms such as social media, practice websites, FAQs and emails. ▪ The practice plans to continue its engagement and highlight how concerns are being addressed, in the short, medium and long term.

	▪ If the merger is agreed, the practice will hold face-to-face and online drop-in sessions with patients at each site to further address any concerns.
Other Committee Discussion/ Borough Engagement	The Lewisham Primary Care Group formally discussed the merger proposals at its August 2022 meeting and feedback from the group was incorporated into the final business case. The updated merger proposals were formally endorsed at the September Primary Care Group meeting. Greenwich primary care commissioners have been informed to the proposed service change, should this merger be approved.
Stakeholder engagement, including PCN, LMC, Health Watch, Scrutiny committee, MP's, Councillors,	▪ Both practices have signed up to the Network Contract Directed Enhanced Service 2022/23. ▪ Lewisham PCNs and the GP Federation have been informed of the merger plans. ▪ The merger proposals were also supported by the Lewisham Local Medical Committee ▪ Healthwatch Lewisham (HWL) have also formally supported the proposal.
Public Engagement	Further engagement will take place as appropriate.

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 9
Enclosure 7

Title:	**ICB Month 4 Finance Report**
Meeting Date:	**29 September 2022**
Author:	Michael Cunningham, Associate Director of Finance
Executive Lead:	Mike Fox, Chief Financial Officer

Purpose of paper:	The purpose of the paper is to update the Lewisham Health & Care Partners Strategic Board as to the financial position of the ICB at Month 4.	Update / Information	X
		Discussion	X
		Decision	

Summary of main points:

This paper comprises two elements, firstly the key financial messages for the ICB – 'Lewisham place' to month 4, including the current financial position compared to budget and progress on savings.

The second element is the month 4 financial report for South-East London ICB as a whole. This is presented as Appendix A to the paper.

A more detailed 'Lewisham place' specific financial report is in the final stages of being developed which is intended to give a more integrated 'system' view of the financial position in Lewisham. This report will be discussed at a seminar of the LCP Strategic Board on 27th October, and thereafter will become a standing item at LCP Board meetings.

Key Financial Messages – Lewisham

- Whilst there are some over and underspends, the borough is reporting a break-even position to month 4 and break-even as a forecast outturn for the year.
- The main overspend £76k relates to prescribing and is driven by activity reflecting the number of items prescribed being significantly higher than in the same period last year. Several actions are being taken to more fully understand this position and ensure measures are taken to bring the position back as close to plan as possible.
- The savings requirement of £2,623k for 2022/23 has been fully identified. The YTD position at month 4 shows this is on track to being delivered. A similar savings requirement is expected for 2023/24 (to be confirmed once planning

guidance is received) which is anticipated to be more challenging to achieve and work has commenced in identifying these future year savings.

Key Financial Messages – South East London ICB

- Appendix A sets out the Month 4 financial position of the ICB. The ICB has a nine month reporting period in 2022/23 and reflects its establishment on 1 July 2022. The budget for the nine months is constructed from the CCG/ICB annual financial plan. As the CCG (as the predecessor organisation) delivered a £1,047k surplus during its final three months (of which £908k related to EFR under delivery), the ICB is able to overspend its allocation by this amount, so that across the whole financial year a financial position no worse than break-even is delivered.

- The ICB financial allocation for the Month 4 to 12 period is £2,493,049k. Due to the carry-forward of the Q1 CCG position, the ICB is able to spend up to £2,494,096k.

- The ICB is reporting an overall £190k overspend to Month 4. This reflects a **break-even position against its recurrent (BAU) allocation**, and a (£190k) overspend on the Covid vaccination programme. The vaccination costs are expected to be reimbursed in full by NHSE, thereby generating an overall break-even position. During the month, it was confirmed by NHSE that there would be no clawback of EFR under delivery, which is significant driver in the BAU break-even position being reported.

- The main risks within the ICB financial position relate to prescribing, continuing care and mental health. Whilst these budgets are all broadly in balance in month, the prescribing position in particular should be highlighted with May activity (prescribing data is received two months in arrears) above that seen in the last two years. Borough prescribing leads are currently reviewing the activity and identifying mitigations.

The ICB is forecasting a **break-even** position for the 2022/23 financial year.

Potential Conflicts of Interest				
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	**X**	**Southwark**	
	Equality Impact	Not applicable		
	Financial Impact	The paper sets out the ICB's financial position as at Month 4		
Other Engagement	Public Engagement	Not applicable		

	Other Committee Discussion/ Engagement	The ICB Finance Report Appendix A is a standing item at both the Planning and Finance Committee and the ICB Board
Recommendation:	The Lewisham Health & Care Partners Strategic Board is asked to **note** the financial position of the ICB as at Month 4.	

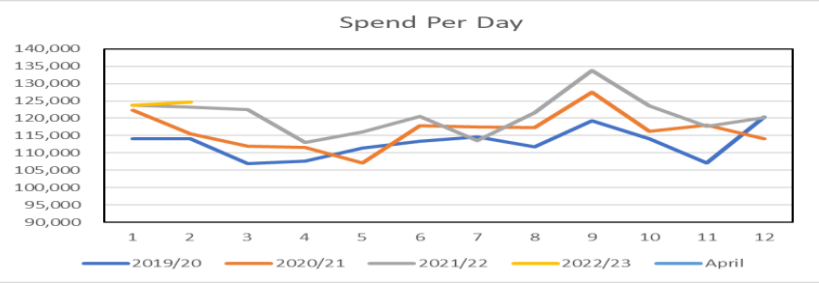
Key Financial Messages - Lewisham

NHS South East London

Overall Position

	YTD Budget £'000s	YTD Actual £'000s	YTD Variance £'000s
Acute Services	161	109	52
Community Health Services	1,906	1,906	-
Mental Health Services	512	536	(23)
Continuing Care Services	1,720	1,679	42
Prescribing	3,201	3,277	(76)
Other Primary Care Services	103	103	0
Other Programme Services	28	26	2
Delegated Primary Care Services	4,418	4,418	-
Corporate Budgets	360	355	5
Total Year to Date Budget	**12,409**	**12,408**	**1**

Key Indicator – Prescribing



Savings

	Target Savings £'000	Year to Date Plan £'000	Year to Date Delivery £'000	Year to Date Variance £'000	Forecast Delivery £'000	Forecast Variance £'000
Additional System Savings Requirement	469	156	156	0	469	0
Community Services	197	66	66	0	197	0
Continuing Care Services	501	167	167	0	501	0
Corporate/Running Cost	194	65	65	0	194	0
Mental Health Services	61	20	20	0	61	0
Other Acute Services	23	8	8	0	23	0
Other Primary Care Services	27	78	78	0	234	0
Other Programme	207	0	0	0	0	0
Prescribing	944	67	85	18	944	0
Total	**2,623**	**626**	**645**	**18**	**2,623**	**0**

- Whilst there are some over and underspends at month 4, the borough overall has achieved a break-even position for the month.
- The key overspends in the month relate to mental health and prescribing. The mental health overspend has been mainly caused by cost per case activity and this will be reviewed to identify what mitigations can be applied in future months.
- The prescribing overspend is driven mainly by activity reflecting the number of items prescribed, 6.4% higher than in the same period last year based on month 2 prescribing data. A series of GP practice visits is underway with the aim of influencing prescribing behaviour in those practices identified as outliers.
- Offsetting underspends relate to Acute Services and Continuing Care Services. The key driver for Acute Services is Urgent Care Centre activity which will need to be reviewed to confirm activity incurred has been fully charged for. Continuing Care Services underspend is driven by average cost per patient being less than budgeted, even though the number of patients in receipt of continuing care is on average higher than budgeted.
- The savings requirement of £2,623k for 2022/23 has been fully identified. The YTD position at month 4 shows this is on track to being delivered (£1,960k recurrently and £663k non recurrently) with a small over achievement on prescribing, despite the prescribing budget in total overspending as referenced above.

NHS
South East London

Appendix A

SEL ICB Finance Report

Month 4 2022/23

Contents

1. Executive Summary

NHS South East London

- This report sets out the Month 4 financial position of the ICB. The ICB has a nine month reporting period in 2022/23 and reflects its establishment on 1 July 2022. The budget for the nine months is constructed from the CCG/ICB annual financial plan. As the CCG (as the predecessor organisation) delivered a **£1,047k surplus** during its final three months (of which **£908k** related to **EFR under delivery**), the ICB is able to overspend its allocation by this amount, so that across the whole financial year a financial position no worse than break-even is delivered.

- The ICB financial allocation for the Month 4 to 12 period is **£2,493,049k.** Due to the carry-forward of the Q1 CCG position, **the ICB is able to spend up to £2,494,096k.** The ICB is reporting an overall **£190k overspend** to Month 4. This reflects a **break-even position** against its recurrent (BAU) allocation, and a **(£190k)** overspend on the Covid vaccination programme. The vaccination costs are expected to be reimbursed in full by NHSE, thereby generating an overall break-even position. During the month, it was confirmed by NHSE that there would be no clawback of EFR under delivery, which is significant driver in the BAU break-even position being reported.

- The main risks within the ICB financial position relate to prescribing, continuing care and mental health. Whilst these budgets are all broadly in balance in month, the prescribing position in particular should be highlighted with May activity (prescribing data is received two months in arrears) above that seen in the last two years. The activity profile is currently as expected, but if this increase continues into future months, the full year forecast impact (on a worst case basis) would be circa **£2,700k**. Borough prescribing leads are currently reviewing the activity and identifying mitigations.

- In reporting this Month 4 position, the ICB has delivered the following financial duties:
  - Delivering all targets under the **Better Practice Payments code**;
  - Subject to the usual annual review, delivered its commitments under the **Mental Health Investment Standard**; and
  - Delivered the **month-end cash position**, well within the target cash balance.

- The ICB is forecasting a **break-even** position for the 2022/23 financial year.

2. Revenue Resource Limit

NHS South East London

- The table below sets out the movements in the Revenue Resource Limit at Month 4. The allocation is consistent with the final 2022/23 Operating Plan and reflects confirmed additional national allocations for inflationary and localised cost pressures, together with further funding for ambulance services. In addition, the ICB also received Elective Recovery Funding (ERF) and additional System Development Funding (SDF). The final confirmed 2022/23 start allocation is **£3,903,078k.**

- The ICB's share of this allocation is £2,938,829k. In month, the ICB has received an additional £4,220k of allocations plus the £1,047k relating to the months 1-3 CCG underspend. This gives the **ICB a total allocation of £2,944,096k.**

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCGs
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Annual Budget	**125,212**	**215,006**	**162,769**	**187,409**	**146,255**	**144,257**	**2,922,170**	**3,903,078**
CCG Final Budget	**31,009**	**53,434**	**40,344**	**46,467**	**36,064**	**35,407**	**721,525**	**964,249**
ICB Start Budget	**94,203**	**161,573**	**122,426**	**140,942**	**110,191**	**108,850**	**2,200,645**	**2,938,829**
Internal Adjustments								
Enteral Feeds Virement (Full Year)	80						(80)	-
Clinical Staffing Structure (Months 4-12)	208	208	208	208	208	104	(1,144)	-
Mental Health SDF Allocation	745	1,661	1,218	393	213	505	(4,735)	-
Inflation/ Carry Forward Funding	541	1,245	683	758	923	450	(4,600)	-
Month 4 Allocations								
Cancer							1,519	**1,519**
Diabetes							544	**544**
ICB Double Running							440	**440**
Pulmonary Rehabilitation							482	**482**
Other Allocations							1,235	**1,235**
Month 4 Allocation	**95,777**	**164,687**	**124,535**	**142,301**	**111,535**	**109,909**	**2,194,306**	**2,943,049**
Months 1-3 Carry Forward (Allocated)							1,047	**1,047**
Month 4 Start Budget	**95,777**	**164,687**	**124,535**	**142,301**	**111,535**	**109,909**	**2,195,353**	**2,944,096**

Note: If read in conjunction with the final CCG finance report, NHSEI have ringfenced allocations (relating to pension costs) within the CCG only, and therefore there is a slight difference in the SEL CCG budget reported at Month 3.

3. Key Financial Indicators

South East London

- The below table sets out the ICB's performance against its main financial duties on both a year to date and forecast basis. As highlighted above, the ICB is reporting an overall overspend of **£190k** at Month 4 relating to Covid vaccination expenditure. We are expecting that this will be fully reimbursed by NHSE as per national funding arrangements. Once received a **break-even** (green rated) position will be reported.

- All other financial duties have been delivered for the year to Month 4 period. A balanced financial position is forecasted for the 2022/23 financial year.

Key Indicator Performance

	Year to Date		Forecast		
	Target	Actual	Target	Actual	
	£'000s	£'000s	£'000s	£'000s	
Agreed Surplus	-	(191)	-	(217)	
Expenditure not to exceed income	329,607	329,797	2,966,474	2,966,691	
Operating Under Resource Revenue Limit	327,121	327,311	2,944,096	2,944,313	
Not to exceed Running Cost Allowance	3,040	3,035	27,357	27,357	
Month End Cash Position (expected to be below target)	3,688	253	4,125	500	
Operating under Capital Resource Limit	n/a	n/a	n/a	n/a	
95% of NHS creditor payments within 30 days	95.0%	99.9%	95.0%	99.9%	
95% of non-NHS creditor payments within 30 days	95.0%	99.9%	95.0%	99.9%	
Mental Health Investment Standard (Annual)	134,560	134,560	403,680	403,680	

4. Budget Overview

NHS South East London

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCGs (Non Covid)	Covid-19	Total SEL CCGs
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Budget										
Acute Services	379	544	1,974	137	161	82	178,350	**181,627**	-	**181,627**
Community Health Services	1,189	5,973	1,910	1,765	1,906	2,257	19,051	**34,052**	-	**34,052**
Mental Health Services	837	1,026	690	1,623	512	489	36,480	**41,657**	-	**41,657**
Continuing Care Services	2,039	2,113	2,199	2,515	1,720	1,677	-	**12,264**	-	**12,264**
Prescribing	2,777	3,771	2,721	3,165	3,201	2,621	53	**18,309**	-	**18,309**
Other Primary Care Services	244	235	192	238	103	41	1,964	**3,017**	-	**3,017**
Other Programme Services	(29)	(44)	(38)	(44)	28	(21)	4,449	**4,300**	-	**4,300**
Delegated Primary Care Services	2,974	4,326	3,803	5,897	4,418	4,702	992	**27,111**	-	**27,111**
Corporate Budgets	289	393	400	518	360	376	2,451	**4,786**	-	**4,786**
Total Year to Date Budget	**10,698**	**18,337**	**13,850**	**15,813**	**12,409**	**12,225**	**243,789**	**327,122**	**-**	**327,121**

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCGs (Non Covid)	Covid-19	Total SEL CCGs
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Actual										
Acute Services	389	534	1,979	(3)	109	66	178,054	**181,128**	-	**181,128**
Community Health Services	1,189	5,955	1,919	1,765	1,906	2,257	18,818	**33,810**	-	**33,810**
Mental Health Services	825	1,043	613	1,636	536	604	36,470	**41,726**	-	**41,726**
Continuing Care Services	1,895	2,035	2,178	2,590	1,679	1,527	-	**11,904**	-	**11,904**
Prescribing	2,628	3,814	2,757	3,226	3,277	2,568	53	**18,323**	-	**18,323**
Other Primary Care Services	244	235	192	238	103	41	1,936	**2,989**	-	**2,989**
Other Programme Services	(29)	(44)	(48)	(44)	26	(33)	5,647	**5,475**	190	**5,665**
Delegated Primary Care Services	2,974	4,326	3,803	5,897	4,418	4,702	992	**27,111**	-	**27,111**
Corporate Budgets	272	392	411	482	355	355	2,389	**4,655**	-	**4,655**
Total Year to Date Actual	**10,386**	**18,291**	**13,804**	**15,787**	**12,408**	**12,087**	**244,358**	**327,121**	**190**	**327,311**

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCGs (Non Covid)	Covid-19	Total SEL CCGs
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Variance										
Acute Services	(10)	10	(5)	140	52	16	296	**499**	-	**499**
Community Health Services	-	18	(9)	-	-	-	233	**242**	-	**242**
Mental Health Services	12	(17)	76	(14)	(23)	(115)	10	**(70)**	-	**(70)**
Continuing Care Services	144	78	21	(75)	42	150	-	**360**	-	**360**
Prescribing	149	(43)	(36)	(61)	(76)	53	-	**(15)**	-	**(15)**
Other Primary Care Services	0	(0)	0	0	0	(0)	28	**28**	-	**28**
Other Programme Services	-	-	10	-	2	12	(1,198)	**(1,174)**	(190)	**(1,364)**
Delegated Primary Care Services	-	-	-	-	-	-	-	**-**	-	**-**
Corporate Budgets	17	0	(11)	36	5	21	62	**131**	-	**131**
Total Year to Date Variance	**312**	**46**	**46**	**26**	**1**	**138**	**(569)**	**0**	**(190)**	**(190)**

- At Month 4, the ICB is reporting an overall **£190k overspend**. This relates to expenditure on the **Covid vaccination programme** for which the ICB is expected to be reimbursed. The main financial risks for the delegated borough budgets relate to continuing care, prescribing and mental health services.

- The overall continuing care financial position is **£360k underspent,** but the underlying pressures are variable across the boroughs. While most boroughs are seeing a slight increase in activity in year, this is being offset by lower than anticipated price pressures. However it is still early in the financial year, with price negotiations on-going with providers and a risk that costs will increase as we move through the year. An area of concern remains the Lambeth Funded Nursing Care (FNC) budget where costs have increased higher than anticipated. Further work is on-going to understand, and then mitigate, the cost drivers.

- The ICB is reporting a **£15k overspend** against its prescribing position. This is built off the Month 2 2022/23 data and represents a slight improvement in-month. The prescribing data is showing initial signs of moving towards a more 'normal' activity profile following the impact of the pandemic on demand over the last couple of years. This budget will however require careful monitoring over the coming months.

- The mental health position is reporting a **£70k overspend**, with the main pressure relating to Southwark which is seeing an increase in its client cost base. Work is on-going to manage this position locally.

- The variances reported for central South East London Acute, Community and Mental Health budgets relate to non-block activity. To July, this position is generating a **£539k underspend**. A further assessment of the position will be made in coming months.

- More detail regarding the individual borough (Place) financial positions is provided later in this report.

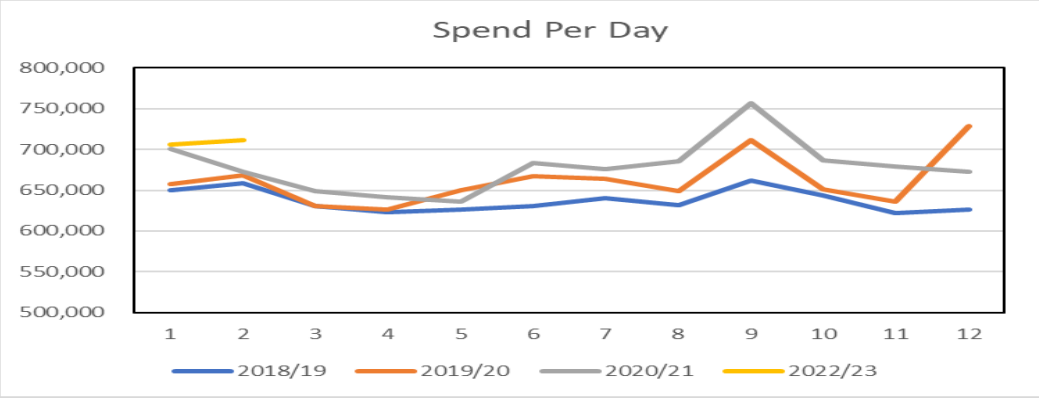
5. Prescribing

NHS South East London

Annual Comparison:

	Price Change From			Activity Change From		
	2019/20 vs. 2020/21	2020/21 vs. 2021/22	2021/22 vs. 2022/23	2019/20 vs. 2020/21	2020/21 vs. 2021/22	2021/22 vs. 2022/23
April	6.1%	3.5%	(3.7%)	0.4%	(0.4%)	1.6%
May	5.3%	3.2%	(3.1%)	(4.4%)	0.7%	4.9%
June	6.5%	2.5%		(3.5%)	6.4%	
July	6.1%	(0.2%)		(3.5%)	1.6%	
August	2.9%	(0.4%)		(4.9%)	4.0%	
September	4.6%	(0.6%)		(2.0%)	1.6%	
October	5.1%	(2.7%)		(3.2%)	1.0%	
November	5.0%	(1.2%)		0.5%	2.4%	
December	4.9%	(0.5%)		1.3%	1.1%	
January	7.0%	(3.5%)		(1.4%)	8.3%	
February	6.9%	(3.9%)		(0.2%)	1.9%	
March	(0.5%)	(2.6%)		(7.3%)	4.2%	
Total	**4.9%**	**(0.6%)**		**(2.4%)**	**2.7%**	
YTD Comparison	**5.7%**	**3.4%**	**(0.1%)**	**(2.0%)**	**0.1%**	**3.3%**

Spend Per Day:



- The Month 4 prescribing position is based upon May 2022 data as the PPA information is provided two months in arrears (the Month 4 data will be received at the end of September 2022, in time for Month 6 reporting). Based on the latest available data, the ICB is showing a **£15k overspend** year to date (YTD).

- The prescribing position represents a key ICB financial risk. Whilst the budget is broadly in balance, current May activity is above that seen in the last two years. The activity profile is currently as expected, but if this increase continues into future months, the full year forecast impact (on a worst case) would be circa £2,700k. The activity comparison on a borough basis is provided below:

Items Prescribed	South East London		Bexley		Bromley		Greenwich		Lambeth		Lewisham		Southwark	
	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23
April	81,269	82,558	12,829	13,428	13,875	14,257	12,522	12,885	16,987	16,748	11,396	11,716	13,655	13,523
May	78,660	82,488	12,211	13,077	13,588	14,197	12,202	12,773	16,064	16,987	11,326	11,966	13,266	13,486
June	78,757	-	12,456	-	13,546	-	12,458	-	15,902	-	11,326	-	13,067	-
July	74,153	-	11,883	-	12,742	-	11,569	-	15,147	-	10,569	-	12,242	-
August	75,862	-	12,167	-	12,943	-	11,989	-	15,586	-	10,774	-	12,402	-
September	78,128	-	12,736	-	13,377	-	11,862	-	16,097	-	11,151	-	12,903	-
October	77,572	-	12,703	-	13,883	-	11,880	-	15,659	-	10,799	-	12,647	-
November	79,855	-	12,873	-	14,021	-	12,078	-	16,371	-	11,556	-	12,954	-
December	86,720	-	14,383	-	15,281	-	13,320	-	17,350	-	12,483	-	13,901	-
January	84,291	-	13,212	-	14,616	-	13,411	-	17,282	-	11,912	-	13,857	-
February	77,645	-	12,554	-	13,099	-	12,187	-	15,778	-	11,196	-	12,829	-
March	78,664	-	12,442	-	13,660	-	12,163	-	16,019	-	11,399	-	12,981	-
Total	**79,211**		**12,691**	**2,135**	**13,706**	**2,293**	**12,288**	**2,068**	**16,168**	**2,719**	**11,312**	**1,909**	**13,043**	**2,177**
YTD Comparison	**79,965**	**82,523**	**12,520**	**13,249**	**13,732**	**14,227**	**12,362**	**12,828**	**16,526**	**16,870**	**11,361**	**11,844**	**13,460**	**13,504**

6. Continuing Care

NHS
South East London

Overview:

- The underlying financial position of the Continuing Care (CHC) budgets has been materially impacted by the pandemic, both in terms of patient numbers (due to the impact of initiatives such as the Hospital Discharge programme) together with the cost of packages as a result of the impact of the pandemic on wider price inflation.

- To mitigate these risks, 2022/23 budgets were built off an agreed patient activity baseline for each borough. Adjustments were then made to fund the impact of expected price inflation (3.05% at the time of the budget setting) and activity growth (1.80%).

- The overall CHC financial position at Month 4 is an **underspend of £360k**, although underlying financial and activity pressures are variable across the individual boroughs. Lambeth continues to present the largest risk to the position with Funded Nursing Care (FNC) activity significantly about the level anticipated. FNC is activity driven so work is on-going to review, understand and mitigate the position. The remaining boroughs are seeing a slight increase in activity in year, with this currently being offset by lower than anticipated price pressures. However it is still early in the financial year, with price negotiations on-going with providers and a risk that costs will increase as we move through the year.

- As part of the overall 2022/23 NHS funding settlement, the ICB received additional funding **of £1,800k** to offset anticipated price increases for CHC care packages. The ICB has established an uplift working group to review and manage these costs, and recommend how this extra funding is distributed amongst boroughs. The allocation of this funding will be worked through in Quarter 2.

7. Provider Position

NHS South East London

Overview:

- This is the most material area of ICB spend, and relates to contractual expenditure with NHS and Non NHS acute, community and mental health providers.

- In year, the ICB is forecasting to spend circa **£2,680,154k** of its total allocation on NHS block contracts, with payments to our local providers as follows:

    - Guys and St Thomas **£677,713k**
    - Kings College Hospital **£735,733k**
    - Lewisham and Greenwich **£580,480k**
    - South London and the Maudsley **£273,526k**
    - Oxleas **£210,278k**

- In month, the ICB position is showing a **£539k** underspend, with activity lower than anticipated with the ICB's acute independent sector providers and in the community position due to a slight underperformance against minor eye condition (MECs) activity. This position is anticipated to be driven by seasonal factors, with the year end position likely to be at **break-even**.

8. QIPP

South East London Clinical Commissioning Group

- The ICB has a QIPP savings ask of **£29.3m** for 2022/23. The 'by area' and borough positions are set out below. The savings identified include the impact of the NHS wide 1.1% tariff efficiency requirement.

- The position reported below includes both the Months 1-3 CCG position and the Month 4 ICB position. The budgets for the individual savings schemes have been phased equally, with the exception of Prescribing which has been phased based upon the expected impact of the specific savings schemes.

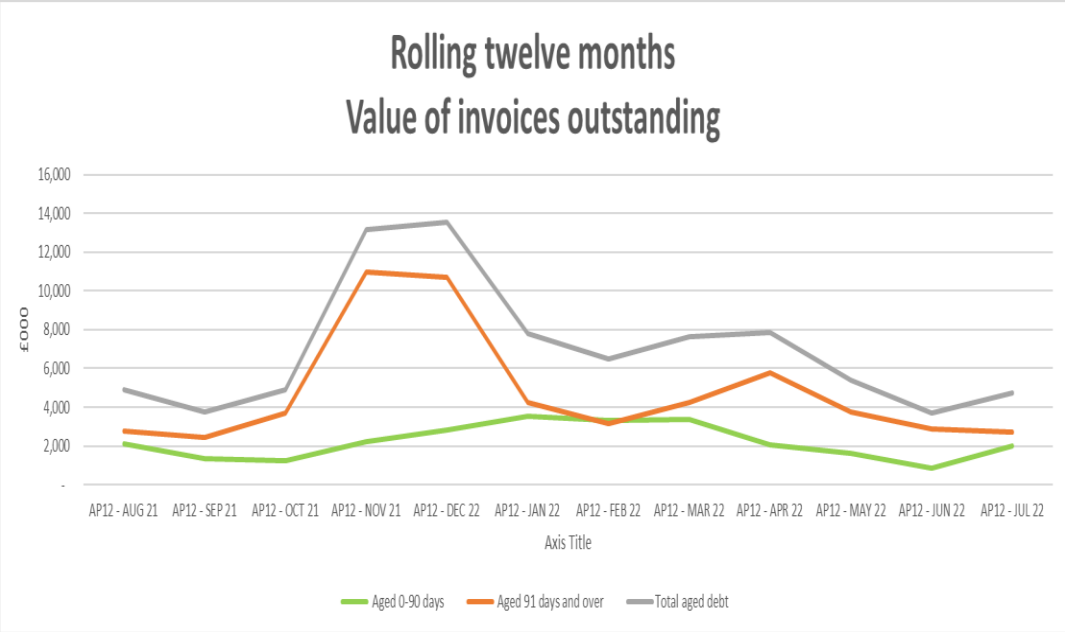
- Overall, the ICB savings plan is reporting an adverse variance of circa **£500k** at Month 4. This is almost entirely a result of the impact of the additional **£7,000k** savings ask (£3,000k borough and £4,000k central budgets) on the ICB to ensure that the ICS was able to submit a balanced 2022/23 operating plan. Whilst boroughs undertake a process to identify these savings on a recurrent basis, an element of the savings ask is being delivered through non-recurrent underspends in delegated budgets. Of the total savings plan of **£29.3m**, circa **£19.6m** is currently being delivered on a recurrent basis.

	Target Savings £'000	Year to Date Plan £'000	Year to Date Delivery £'000	Year to Date Variance £'000	Forecast Delivery £'000	Forecast Variance £'000
Additional System Savings Requirement	7,000	2,333	1,837	(497)	7,000	0
Central budgets	491	164	164	0	491	0
Community Services	2,541	880	881	0	2,641	0
Continuing Care Services	3,429	1,143	1,068	(75)	3,429	0
Corporate/Running Cost	2,727	902	1,039	137	2,705	0
Mental Health Services	601	200	200	0	601	0
Other Acute Services	812	271	271	0	814	0
Other Primary Care Services	194	200	200	0	601	0
Other Programme	8,349	2,620	2,620	0	7,861	0
Prescribing	3,161	400	310	(90)	3,161	0
Total	**29,305**	**9,115**	**8,590**	**(524)**	**29,305**	**0**

	Target Savings £'000	Year to Date Plan £'000	Year to Date Delivery £'000	Year to Date Variance £'000	Forecast Delivery £'000	Forecast Variance £'000
Bexley	2,013	594	516	(78)	2,013	0
Bromley	3,841	1,134	903	(231)	3,841	0
Greenwich	2,891	911	675	(235)	2,891	0
Lambeth	2,555	775	774	(1)	2,555	0
Lewisham	2,623	626	645	18	2,623	0
SEL Central	13,419	4,473	4,473	0	13,419	0
Southwark	1,963	602	605	3	1,963	0
Total	**29,305**	**9,115**	**8,590**	**(524)**	**29,305**	**0**

- The forecast outturn is reported as **break-even**, which reflects the confidence boroughs have in being able to deliver these savings by the end of the year. Prescribing and continuing care activity, in particular is very closely monitored on a on-going basis. It is expected that boroughs will have savings plans identified in full by Month 6.

9. Debtors Position



Overview:

- The ICB has an overall debt position of £4.7m at Month 4. Of, this circa £0.3m relates to debt over 3 months old. Following the work undertaken to resolve debt queries prior to the transition to the new ledger, the ICB is moving towards a more regular approach to debt management and will focus on ensuring recovery of its larger debts, and in minimising debts over 3 months old. Regular meetings with SBS are assisting in the collection of debt, with a focus on debt over 90 days which is continuing to reduce.
- The top 10 aged debtors are provided in the table below, with the main balances remaining with Circle Clinical Services, Bromley Healthcare, Bromley Training Hub, Bromley Council and other local NHS ICB organisations. These are being actively chased by borough finance colleagues.

Customer Group	Aged 0-30 days £000	Aged 1-30 days £000	Aged 31-60 days £000	Aged 61-90 days £000	Aged 91-120 days £000	Aged 121+ days £000	Total £000
NHS	359	1,527	103	4	9	25	2,027
Non-NHS	1,338	387	81	647	139	138	2,730
Unallocated	0	(9)	0	0	0	0	(9)
Total	**1,697**	**1,905**	**184**	**651**	**148**	**163**	**4,748**

Number	Supplier Name	Total Value £000	Total Volume	Aged 0-90 days Value £000	Aged 91 days and over Value £000	Aged 0-90 days Volume	Aged 91 days and over Volume
1	CIRCLE CLINICAL SERVICES LTD	1048	1	1048	0	1	0
2	BROMLEY HEALTHCARE CIC	454	4	104	350	3	1
3	NHS NORTH EAST LONDON ICB	448	2	448	0	2	0
4	NHS NORTH WEST LONDON ICB	423	3	423	0	3	0
5	NHS ENGLAND	342	10	326	16	7	3
6	NHS NORTH CENTRAL LONDON ICB	284	3	284	0	3	0
7	NHS SOUTH WEST LONDON ICB	267	5	266	1	4	1
8	FREE RADICAL NETWORK	219	1	0	219	0	1
9	BROMLEY EDUCATION AND TRAINING HUB	175	3	145	30	2	1
10	BROMLEY LONDON BOROUGH COUNCIL	173	2	0	173	0	2

10. Cash Position

- The ICB is operating within the same cash regime as its predecessor CCG, therefore cash is being managed across the two organisations for this year.
- The Maximum Cash Drawdown (MCD) as at Month 4 after accounting for payments made on behalf of the ICB by the NHS Business Authority (largely relating to prescribing expenditure) is **£3,836m.** The actual cash balance at the end of Month 4 was **£253k**, well within the target set by NHSE.
- There was a need to draw down supplementary cash in July to cover block payments and clearance of invoices which had been cutover from the CCG ledger plus invoices such as BCF for quarter 2 which had not been received into the old ledger before closure. The uncertainties around the timings of actions with regards to the transition to the new ledger made cash forecasting very difficult in July. In August, there has not been the need to enact a supplementary drawdown which is positive news.
- At month 4, the ICB has drawn down 30.85% of the available cash compared to the budget cash figure of 33.30%. The ICB expects to utilise its cash limit in full by the year end.

Annual Cash Drawdown Requirement for 2022/23	2022/23 AP4 - JUL 22	2022/23 AP3 - JUN 22	2022/23 Month on month movement
	£000s	£000s	£000s
ICB ACDR (M4-12)	2,945,143		2,945,143
CCG ACDR (M1-3)	963,944	963,944	0
Capital allocation			
Less:			
Prescription Pricing Authority	(72,691)	(55,262)	(17,430)
Other Central / BSA payments- HOT	(797)	(611)	(187)
Pension uplift 6.3%		(454)	454
Add back PCSE System Error			0
Remaining Cash limit	**3,835,598**	**907,618**	**2,927,980**

Cash Drawdown	Monthly Main Draw down £000s	Supplementary Draw down £000s	Cumulative Draw down £000s	Proportion of CCG cash requirement %	KPI - 1.25% or less of main drawdown £000s	Month end bank balance £000s	Percentage of cash balance to main draw
Apr-22	290,000	27,000	317,000	34.93%	3,625	2,830	0.98%
May-22	292,000	0	609,000	67.10%	3,650	1,254	0.43%
Jun-22	287,000	0	896,000	98.72%	3,588	856	0.30%
Jul-22	295,000	15,000	1,206,000	31.44%	3,688	253	0.09%
Aug-22	310,000	0	1,516,000	39.52%			
Sep-22							
Oct-22							
Nov-22							
Dec-22							
Jan-23							
Feb-23							
Mar-23							
	1,474,000	**42,000**					

- The cash key performance indicator (KPI) has been achieved in all months so far this year, showing continued successful management of the cash position by the ICB's finance team to achieve the target cash balance.

11. Better Practice Payments Code (BPPC)

NHS South East London

- Under the BPPC, ICBs are expected to pay 95% of all creditors within 30 days of the receipt of invoices. This is measured in terms of the total value of invoices and the number of invoices by count. To date the ICB has met the target cumulatively on both value and count by NHS and non NHS and therefore the target is green on all cumulative aspects. It is similarly expected that this target will be met in full at the end of the year. All in month targets were also met.

- NHSE has requested that all NHS organisations should strive to pay creditors within 7 days to provide assurance on cash flows for organisations. This has obviously assisted in achieving good BPPC performance.

	2022/23 AP4 - JUL 22		2022/23 AP3 - JUN 22		2022/23 Year to date	
	Number	£000	Number	£000	Number	£000
Non-NHS Payables:						
Total Non-NHS trade invoices paid in the month	1,258	34,584	4,653	60,866	14105	248,732
Total Non-NHS trade invoices paid within target	1,258	34,584	4,469	58,837	13735	244,940
Percentage of non-NHS trade invoices paid within target	100.0%	100.0%	96.0%	96.7%	97.4%	98.5%
NHS Payables:						
Total NHS trade invoices paid in the month	39	247,933	133	228,897	416	933,421
Total NHS trade invoices paid within target	39	247,933	127	228,297	410	932,821
Percentage of NHS trade invoices paid within target	100.0%	100.0%	95.5%	99.7%	98.6%	99.9%
Combined non NHS and NHS:						
Total Non-NHS trade invoices paid in the month	1,297	282,517	4,786	289,763	14,521	1,182,153
Total Non-NHS trade invoices paid within target	1,297	282,517	4,596	287,134	14,145	1,177,762
Percentage of all trade invoices paid within target	100.0%	100.0%	96.0%	99.1%	97.4%	99.6%

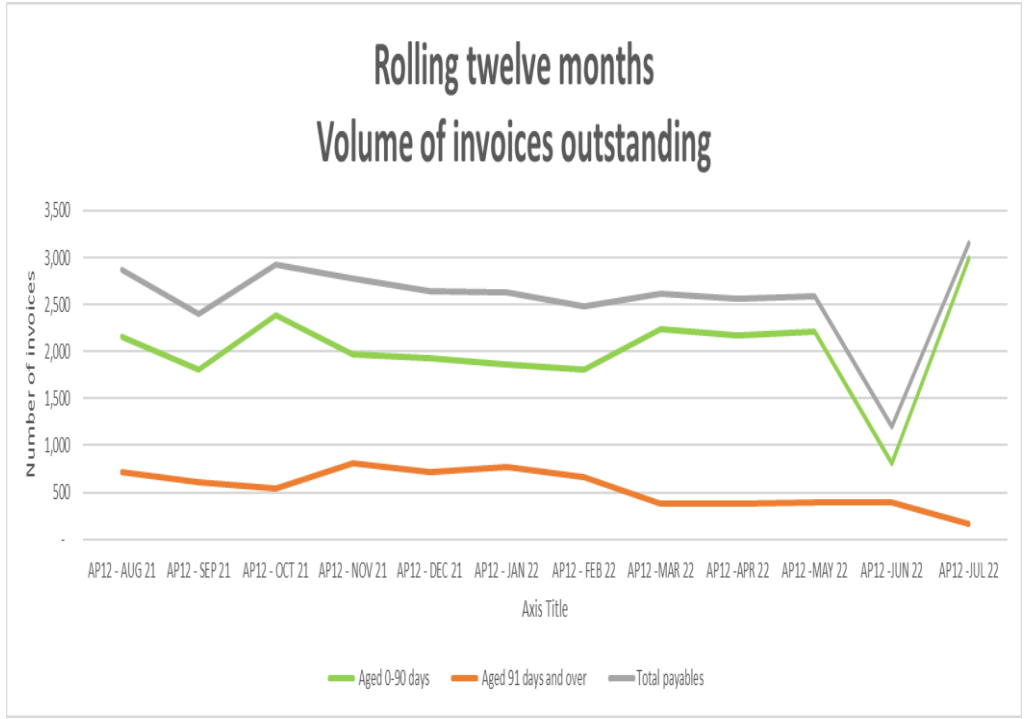
12. Aged Creditors

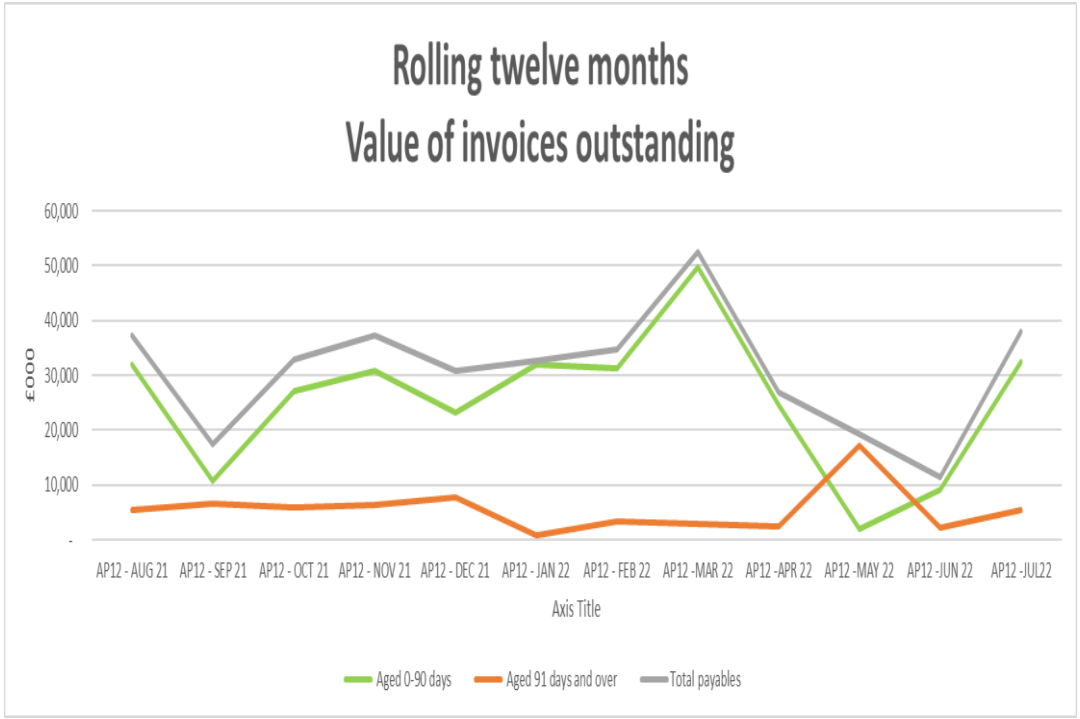
Following the implementation of the new financial ledger for the ICB, there has been an increase in the volume of invoices outstanding. This is due to the work undertake to reduce volumes for the end of June, followed by a period of no invoices being scanned and then the opening of the new ledger for suppliers to submit invoices. The volume of invoices over 91 days continues to decrease which is positive.

The value of invoices outstanding has also increased in July for the same reasons as outlined above. The value of items over 91 days however has increased and this will be investigated further.

Work is ongoing to clear all the items over 91 days over the next few weeks and try to maintain a reduced level of outstanding invoices following the good work undertaken in the lead up to the transition to the new ICB ledger. Our ongoing monthly target is to have no more than 1,500 invoices outstanding at month-end.

As part of routine monthly reporting for 2022/23, high value invoices are being reviewed to establish if they can be settled and budget holders are being reminded on a regular basis to review their workflows.





SEL ICB Finance Report

Updates from Boroughs

Month 4

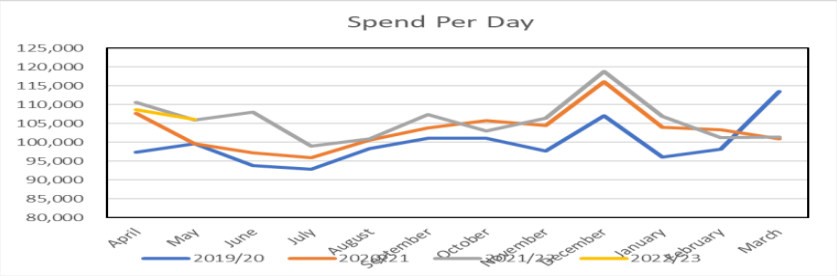
Appendix 1 - Bexley

NHS South East London

Overall Position

	YTD Budget £'000s	YTD Actual £'000s	YTD Variance £'000s
Acute Services	379	389	(10)
Community Health Services	1,189	1,189	-
Mental Health Services	837	825	12
Continuing Care Services	2,039	1,895	144
Prescribing	2,777	2,628	149
Other Primary Care Services	244	244	0
Other Programme Services	(29)	(29)	-
Delegated Primary Care Services	2,974	2,974	-
Corporate Budgets	289	272	17
Total Year to Date Budget	**10,698**	**10,386**	**312**

Key Indicator – Prescribing



Savings

	Target Savings £'000	Year to Date Plan £'000	Year to Date Delivery £'000	Year to Date Variance £'000	Forecast Delivery £'000	Forecast Variance £'000
Additional System Savings Requirement	399	133	0	-133	399	0
Community Services	189	63	63	0	189	0
Continuing Care Services	560	187	187	0	560	0
Corporate/Running Cost	121	40	95	55	121	0
Mental Health Services	91	30	30	0	91	0
Other Acute Services	3	1	1	0	3	0
Other Primary Care Services	29	10	10	0	29	0
Other Programme	189	63	63	0	189	0
Prescribing	432	67	67	0	432	0
Total	**2,013**	**594**	**516**	**-78**	**2,013**	**0**

- At month 4, Bexley is reporting a £312k underspend year to date, this is made up of a small overspend on Urgent Treatment Centre (UTC) costs within acute services which is offset against underspends in Mental Health Services and Corporate budgets. The majority of this underspend is non-recurrent, with an updated budget profile in place from month 5.
- The corporate underspend is due to the level of vacancies currently being carried with no backfill support.
- The two main areas of underspend are prescribing and CHC, Bexley place has benefited from favourable non recurrent movements in both its CHC and prescribing position, as more complete reporting information has been made available since that reported at month 3. It is expected that Bexley will achieve at least an overall break-even position at the year end.
- Whilst it is early in the year and only 2 months of prescribing data has been received, there was a reduction on the spend per day for April (driven by activity) which has recovered to last year's position in May. This trend will be monitored during the year.
- In terms of savings, plans are in place for the initial savings targets given to Bexley and these are largely on track. However, for the £399k additional savings target, Bexley are still identifying plans for this to be delivered on a recurrent basis if possible and a paper is going to SMT on 24 August for approval.
- There is an emerging cost pressure of circa £200k arising which needs further investigation in relation to our community dietetics service. This is due to increased demand over the past 12 months and a paper is being written for our SMT next week. This will also be reflected in our local risk register.

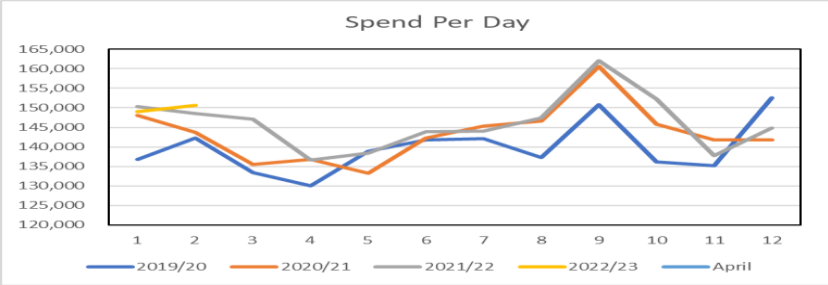
Appendix 2 - Bromley

NHS South East London

Overall Position

	YTD Budget £'000s	YTD Actual £'000s	YTD Variance £'000s
Acute Services	544	534	10
Community Health Services	5,973	5,955	18
Mental Health Services	1,026	1,043	(17)
Continuing Care Services	2,113	2,035	78
Prescribing	3,771	3,814	(43)
Other Primary Care Services	235	235	(0)
Other Programme Services	(44)	(44)	-
Delegated Primary Care Services	4,326	4,326	-
Corporate Budgets	393	392	0
Total Year to Date Budget	**18,337**	**18,291**	**46**

Key Indicator – Prescribing



Savings

	Target Savings £'000	Year to Date Plan £'000	Year to Date Delivery £'000	Year to Date Variance £'000	Forecast Delivery £'000	Forecast Variance £'000
Additional System Savings Requirement	566	189	0	-189	566	0
Community Services	1,387	462	462	0	1,387	0
Continuing Care Services	568	189	189	0	568	0
Corporate/Running Cost	241	80	80	0	241	0
Mental Health Services	103	34	34	0	103	0
Other Acute Services	26	9	9	0	26	0
Other Primary Care Services	45	15	15	0	45	0
Other Programme	267	89	89	0	267	0
Prescribing	638	67	24	-43	638	0
Total	**3,841**	**1,134**	**903**	**-231**	**3,841**	**0**

The Month 4 position is £46k underspent and the borough are forecasting a break-even position at year end.

Community budgets are currently £18k underspent. As we move out of the pandemic and back to business as usual arrangements there is a risk that activity will increase. This will be closely tracked and action plans to mitigate spend will be implemented if required.

The borough team are developing the Bromley@Home pathway across One Bromley LCP partners, accessing investment earmarked from the National Virtual Ward Programme, which will provide system wide benefits to patients and organisations.

The mental health budget is overspent by £17k due to higher than budgeted cost per case activity. Expenditure is volatile due to its low volume/high-cost nature and will be closely monitored.

The CHC position is £78k underspent due to average package prices being slightly lower than budgeted levels.

The Prescribing position is £43k overspent, based on the Month 2 PPA data. The overspend is due in part to slippage in the savings plan. The Medicines Optimisation team are developing additional schemes and are confident that the annual savings target will be achieved. The position will be closely monitored over the next few months.

Savings – the additional system savings schemes are being developed (target date is Month 6) and are likely to be delivered in-year from non-recurrent solutions. Recurrent savings will impact from 2023/24, including any additional savings resulting from the new financial year planning and budgeting process.

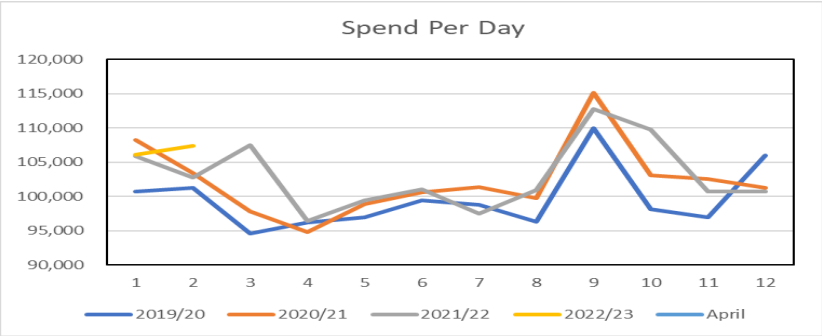
Appendix 3 - Greenwich

NHS South East London

Overall Position

	YTD Budget £'000s	YTD Actual £'000s	YTD Variance £'000s
Acute Services	1,974	1,979	(5)
Community Health Services	1,910	1,919	(9)
Mental Health Services	690	613	76
Continuing Care Services	2,199	2,178	21
Prescribing	2,721	2,757	(36)
Other Primary Care Services	192	192	0
Other Programme Services	(38)	(48)	10
Delegated Primary Care Services	3,803	3,803	-
Corporate Budgets	400	411	(11)
Total Year to Date Budget	**13,850**	**13,804**	**46**

Key Indicator – Prescribing



Savings

	Target Savings £'000	Year to Date Plan £'000	Year to Date Delivery £'000	Year to Date Variance £'000	Forecast Delivery £'000	Forecast Variance £'000
Additional System Savings Requirement	530	177	0	-177	530	0
Community Services	403	134	134	0	403	0
Continuing Care Services	599	200	200	0	599	0
Corporate/Running Cost	277	92	92	0	277	0
Mental Health Services	66	22	22	0	66	0
Other Acute Services	436	145	145	0	436	0
Other Primary Care Services	34	11	11	0	34	0
Other Programme	187	62	62	0	187	0
Prescribing	359	67	8	-59	359	0
Total	**2,891**	**911**	**675**	**-235**	**2,891**	**0**

- The overall borough position is £46k favourable, with an underspend in Mental Health (Female PICU) mitigating slight pressures in other areas. These pressures will be the focus of upcoming detailed budget meetings to ensure the appropriate mitigations are in place.
- The pressure in Prescribing is attributable to higher activity in April/May, assumed in part to seasonal factors (e.g. bank holidays) and that this will compensate over month 3 and month 4 and revert to planned levels thereafter.
- CHC is aligned with plan. The composition of price & activity variance drivers will be monitored closely hereon along with ongoing ledger/database reconciliation reviews.
- Additional (£530k) savings have not been recurrently identified, albeit non recurrent mitigations have been identified for the current year to enable a balanced position to be delivered at month 4.
- Budgets include the initial tranche of non recurrent allocations (Mental Health), and will be updated on receipt of future borough specific allocations as made available by NHSE.
- Key actions for month 5 are to progress identification of recurrent solutions for the Vacancy Factor (£300k), and Additional Savings (£500k) and formulating a fully scoped 'Winter' plan to identify potential pressures & the appropriate mitigations to ensure delivery of the overall financial plan.

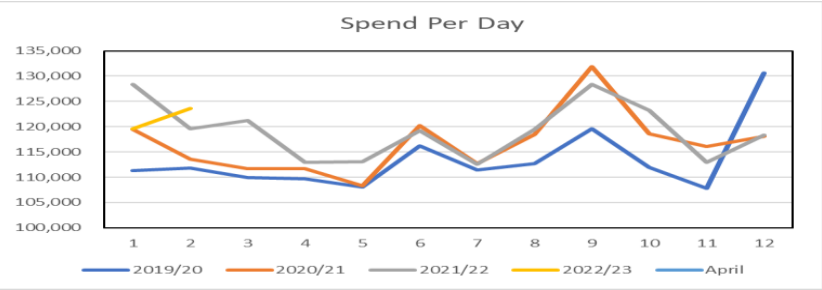
Appendix 4 - Lambeth

NHS South East London

Overall Position

	YTD Budget £'000s	YTD Actual £'000s	YTD Variance £'000s
Acute Services	137	(3)	140
Community Health Services	1,765	1,765	-
Mental Health Services	1,623	1,636	(14)
Continuing Care Services	2,515	2,590	(75)
Prescribing	3,165	3,226	(61)
Other Primary Care Services	238	238	0
Other Programme Services	(44)	(44)	-
Delegated Primary Care Services	5,897	5,897	-
Corporate Budgets	518	482	36
Total Year to Date Budget	**15,813**	**15,787**	**26**

Key Indicator – Prescribing



Savings

	Target Savings £'000	Year to Date Plan £'000	Year to Date Delivery £'000	Year to Date Variance £'000	Forecast Delivery £'000	Forecast Variance £'000
Additional System Savings Requirement	571	190	325	135	571	0
Community Services	157	52	52	0	157	0
Continuing Care Services	702	234	159	-75	702	0
Corporate/Running Cost	218	73	73	0	218	0
Mental Health Services	196	65	65	0	196	0
Other Acute Services	18	6	6	0	18	0
Other Primary Care Services	44	15	15	0	44	0
Other Programme	218	73	73	0	218	0
Prescribing	431	67	6	-61	431	0
Total	**2,555**	**775**	**774**	**-1**	**2,555**	**0**

- The borough is reporting an overall £26k underspend at Month 4. The reported position includes £75k overspend on Continuing Healthcare (CHC) (including Funded Nursing Care), £61k overspend on Prescribing, £14k overspend on Mental Health offset by underspends in Acute, Community and Corporate budgets.
- The Acute Services reported position reflects the level of borough's Urgent Care Centre spend and activity. The corporate budget underspend reflects the current level of vacancies.
- The CHC position is driven by increase in the number of clients within Funded Nursing Care (FNC). Work on-going to understand the drivers behind the reported position and this will be discussed as part of Month 4 budget holder meetings.
- The Prescribing month 4 position is based upon May 2022 year to date (YTD) data as the PPA information is provided two months in arrears. The £61k YTD overspend is mainly driven by 4.21% increase in number of items prescribed for April and May 2022 combined when compared to the same period last year. The Medicines Optimisation team are undertaking Practice visits with the aim of influencing prescribing behaviour among outliers.
- The 2022/23 borough savings requirement is £2,555k and is on track to deliver (circa £1,766k recurrently and £789k non recurrently) both YTD and forecast outturn.
- Health and Care Service leads within ICB and Council are working together to address financial pressures within the local health and care economy.

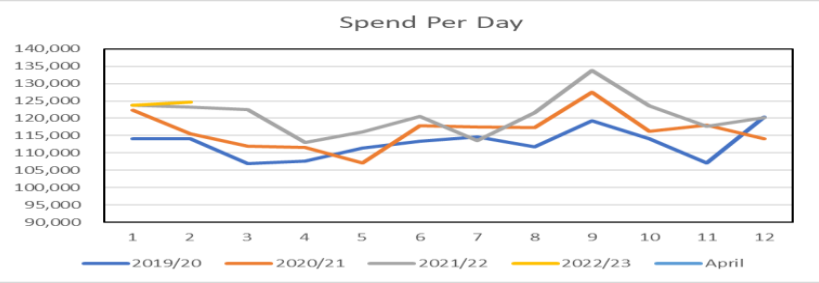
Appendix 5 - Lewisham

NHS South East London

Overall Position

	YTD Budget £'000s	YTD Actual £'000s	YTD Variance £'000s
Acute Services	161	109	52
Community Health Services	1,906	1,906	-
Mental Health Services	512	536	(23)
Continuing Care Services	1,720	1,679	42
Prescribing	3,201	3,277	(76)
Other Primary Care Services	103	103	0
Other Programme Services	28	26	2
Delegated Primary Care Services	4,418	4,418	-
Corporate Budgets	360	355	5
Total Year to Date Budget	**12,409**	**12,408**	**1**

Key Indicator – Prescribing



Savings

	Target Savings £'000	Year to Date Plan £'000	Year to Date Delivery £'000	Year to Date Variance £'000	Forecast Delivery £'000	Forecast Variance £'000
Additional System Savings Requirement	469	156	156	0	469	0
Community Services	197	66	66	0	197	0
Continuing Care Services	501	167	167	0	501	0
Corporate/Running Cost	194	65	65	0	194	0
Mental Health Services	61	20	20	0	61	0
Other Acute Services	23	8	8	0	23	0
Other Primary Care Services	27	78	78	0	234	0
Other Programme	207	0	0	0	0	0
Prescribing	944	67	85	18	944	0
Total	**2,623**	**626**	**645**	**18**	**2,623**	**0**

- Whilst there are some over and underspends at month 4, the borough overall has achieved a break-even position for the month.
- The key overspends in the month relate to mental health and prescribing. The mental health overspend has been mainly caused by cost per case activity and this will be reviewed to identify what mitigations can be applied in future months.
- The prescribing overspend is driven mainly by activity reflecting the number of items prescribed, 6.4% higher than in the same period last year based on month 2 prescribing data. A series of GP practice visits is underway with the aim of influencing prescribing behaviour in those practices identified as outliers.
- Offsetting underspends relate to Acute Services and Continuing Care Services. The key driver for Acute Services is Urgent Care Centre activity which will need to be reviewed to confirm activity incurred has been fully charged for. Continuing Care Services underspend is driven by average cost per patient being less than budgeted, even though the number of patients in receipt of continuing care is on average higher than budgeted.
- The savings requirement of £2,623k for 2022/23 has been fully identified. The YTD position at month 4 shows this is on track to being delivered (£1,960k recurrently and £663k non recurrently) with a small over achievement on prescribing, despite the prescribing budget in total overspending as referenced above.

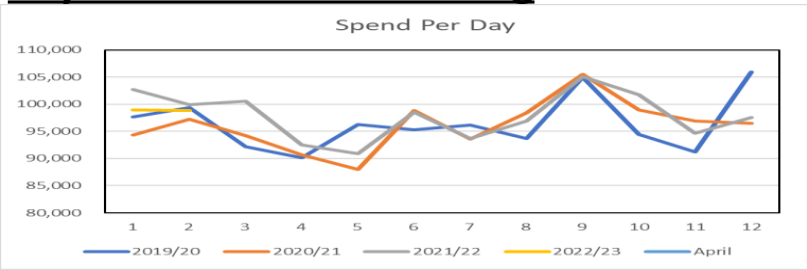
Appendix 6 - Southwark

NHS South East London

Overall Position

	YTD Budget £'000s	YTD Actual £'000s	YTD Variance £'000s
Acute Services	82	66	16
Community Health Services	2,257	2,257	-
Mental Health Services	489	604	(115)
Continuing Care Services	1,677	1,527	150
Prescribing	2,621	2,568	53
Other Primary Care Services	41	41	(0)
Other Programme Services	(21)	(33)	12
Delegated Primary Care Services	4,702	4,702	-
Corporate Budgets	376	355	21
Total Year to Date Budget	**12,225**	**12,087**	**138**

Key Indicator – Prescribing



Savings

	Target Savings £'000	Year to Date Plan £'000	Year to Date Delivery £'000	Year to Date Variance £'000	Forecast Delivery £'000	Forecast Variance £'000
Additional System Savings Requirement	465	155	22	-133	465	0
Community Services	154	85	85	0	254	0
Continuing Care Services	477	159	159	0	477	0
Corporate/Running Cost	138	39	121	82	116	0
Mental Health Services	58	19	19	0	58	0
Other Acute Services	18	7	7	0	20	0
Other Primary Care Services	15	72	72	0	215	0
Other Programme	281	0	0	0	0	0
Prescribing	357	67	120	53	357	0
Total	**1,963**	**602**	**605**	**3**	**1,963**	**0**

- The borough is reporting an underspend of £138k as at the end of month 4.
- The key variances relate to Mental Health and Continuing Care Services.
- The Mental Health position is an overspend of £115k and represents the biggest area of risk to the borough position. Whilst agreement has been reached between the council and the ICB on cost sharing for section 117 Mental Health and Learning Disabilities placements, costs continue to increase for all placements. The borough is monitoring this cost pressure closely and is working to mitigate these risks.
- The Continuing Health Care position is an underspend of £150k and this is mainly due to average price of clients being lower than planned, despite an increase in the number of patients.
- Although 'other primary care' is showing break-even, an increase in activity in the out of hours contract is forecasted to generate significant pressures against this budget. The borough plans to use growth and investment funding to mitigate this cost pressure.
- The corporate underspend is due to the level of vacancies and secondments within the borough and slippage on recruitment and backfill.
- Borough is required to deliver savings of £1,963k and plans have currently been identified for circa £1,490k. We expected full delivery against these plans on a recurrent basis. The borough is currently identifying its additional savings ask (circa £465k) and this to be completed by Month 6.

Lewisham Local Care Partners Strategic Board

Cover Sheet

Item N/A
Enclosure N/A

Title:	**Safeguarding Children and Young People**
Meeting Date:	**29 September 2022**
Author:	Margaret Mansfield, Designated Nurse Safeguarding and Interim Designated Nurse Children Looked After Dr Bola Adeyemi, Consultant Community Paediatrician and Designated Doctor for Safeguarding Children
Executive Lead:	Ceri Jacob, Lewisham Place Executive Lead

Purpose of paper:	The report is provided to the Board to update on the progress and activities of Safeguarding Children and Young People.	Update / Information	**X**
		Discussion	
		Decision	

Summary of main points:

- Designated Professionals are continuing to maintain collaborative working to deliver the LSCP agenda together with Named professionals across the health economy.
- There have been no new Child Safeguarding Practice Reviews commissioned.
- Protocols and guidance have been developed to support practitioners in their assessments and to obtain better outcomes.
- The partnership is preparing for a Joint Targeted Area Inspection.
- The Safeguarding GP Lead Forum for children and adults continues with good attendance.

Potential Conflicts of Interest	**None.**			
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	**X**	**Southwark**	
	Equality Impact	N/A		
	Financial Impact	None		

Other Engagement	Public Engagement	None
	Other Committee Discussion/ Engagement	
Recommendation:	For noting.	

South East London Integrated Care System

NHS South East London

Safeguarding Children and Young People: September 2022

The Designated Professionals are continuing to maintain collaborative working with partnerships to deliver the LSCP function and agenda, and support health providers.

Child Safeguarding Practice Reviews: In this reporting period, there were no new Child Safeguarding Practice Reviews commissioned by the LSCP. The Designated Professionals have been supporting the Learning from Practice Panel towards progression of a Child Safeguarding Practice Review for Child FB (17-year-old who died from a fatal stabbing). The final report for Child FA (an 8-year-old child who died unexpectedly following a short period of illness) has been published. The learning from reviews is being implemented.

Child Sexual Abuse (CSA) Pathway: The Designated and Named Professionals have worked with partners to develop a Multi-agency CSA Pathway, which has now been signed off. The pathway has been developed to provide professionals with clear processes to follow and enable them to work effectively when there are disclosures of CSA, including assessment and emotional support. CSA training and awareness is ongoing underway.

Multi-agency Discharge Protocol: During this reporting period, the Designated Professionals have worked with the partners to complete a Discharge Protocol. The protocol has been devised to support practitioners with a clear process for discharge and safety planning for children and young people who present and require a multi-agency response to address their safeguarding and mental health needs.

Multi-agency Guidance for Management of Perplexing Presentation or Fabricated or Induced Illness: The Designated and Named professionals have worked with partners to produce this guidance. Its purpose is to support multi-agency practitioners to make appropriate decisions on how to safeguard children who present with perplexing presentations and/or fabricated or induced illness and advise practitioners on how to recognise these issues, how to assess risk and how to manage these types of presentations to obtain better outcomes for children.

Audit: The Designated Professionals have supported the partnership in the completion of a live Multi-agency Child Sexual Abuse (CSA) Familial audit. The audit intended to improve understanding of the multiagency response to CSA. This was initiated following the CSA Pathway audit, where a number of actions were agreed, including the aforementioned. The recommendations from the audit are being implemented.

Audit: The Named professional has completed a Neonatal Discharge Summary audit in response to learning from Child Safeguarding Review (Child FC). The audit highlighted a positive outcome in that 75% of the dip sampled babies have a 'discharge summary' on their records. The audit highlighted the need for improved processes in ensuring discharge summaries are completed in full and sent to the mother's registered GP practice. This finding is being implemented.

Safeguarding Children and Adult Policy: Following transition of the CCG to ICS/ICB, the Designated Nurse has led the production of the Safeguarding Children and Adults Policy to align with changes and ensure staff have an updated policy.

Joint Targeted Area Inspection (JTAI): The Local Safeguarding Children Partnership is preparing for the JTAI. Lewisham has not had a JTAI in the past, so we are of the view that we might be inspected this time round. This is an inspection of multi-agency response to the identification of initial need and risk in a local authority area. It is carried out under section 20 of the Children's Act 2004. The inspection is carried out for three weeks by Ofsted, CQC, Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services. During the period of inspection, they will focus on either MASH or Child Criminal Exploitation. The Designated Professionals have been engaged and are preparing health organisations. An additional Task and Finish group has been set up to support with preparation.

Sudden Unexpected Death in Infant (SUDI): In response to sudden unexpected deaths in infants, the Designated and Named professionals are continuing to work in partnership to develop and sustain a programme for prevention of SUDI. A Task and Finish group is in progress developing awareness raising tools which also incorporate other associated issues that impact on parents and new-born i.e. supporting new parents with crying babies.

Partnership Working: Designated professionals and Named professionals continued to work in partnership with other agencies and have supported in the development of protocols and guidance. Within SEL ICB, Lewisham recruitment to Designated Nurse for Children Looked After post is ongoing. There is interim cover in place to ensure business continuity. Primary care and SLaM do not have vacant safeguarding children posts. Lewisham and Greenwich Trust have recruited to some of the vacant safeguarding children posts and recruitment is ongoing.

Safeguarding GP Leads Forum: The joint adults and children Safeguarding GP lead forum continues to progress with good attendance. In the last quarter, the forum received training on mental health and update on health visiting service. Case discussion on vulnerable families and changes to the Standard Operating Procedures for multi-disciplinary vulnerable families meetings were covered in the session.

Child Death Reviews: The Designated Nurse has continued to support Child Death Review processes with a view to identifying where there are safeguarding concerns.

In this reporting period, there were no child deaths referred for consideration of Child Safeguarding practice review. However, learning and themes identified are being addressed.

Authors:

Dr Abimbola Adeyemi – Designated Doctor for Safeguarding Children

Margaret Mansfield – Designated Nurse for Safeguarding Children and Young People and Interim Designated Nurse Children Looked After

15 September 2022

Place Executive Group (PEG) Meeting

Minutes of the meeting held on 15 September 2022 at 16.00 hrs via Teams

Present:

Ceri Jacob – Place Executive Lead (Chair)	(CJ)
Lizzie Howe – Corporate Governance Lead Lewisham (Minutes)	(LH)
Lauren Woolhead – PA/Business Support Lewisham	(LW)
Sarah Wainer – Director of System Transformation	(SW)
Charles Malcolm-Smith – People & Provider Development Lead	(CMS)
Kenny Gregory - Director of Adult Integrated Commissioning (Acting)	(KG)
Ashley O'Shaughnessy – Associate Director of Primary Care	(AOS)
Sara Rahman – Joint Commissioning CYP	(SR)
Dr Catherine Mbema – Director of Public Health	(CMb)
Lisa Hancock – SEL ICB	(LHa)
Sandra Iskander - Acting Chief Strategy, Partnerships & Transformation Officer, LGT	(SI)
Anne Hooper – Lay Member for Lewisham	(AH)
Tom Hastings – LGT	(TH)
Amanda Lloyd – System Transformation & Change Lead	(AL)
Sam Gray – Lewisham Service Director, SLaM	(SG)
Joan Hutton – Director of Adult Social Care	(JH)
Belinda McCall – LGT	(BM)
Simon Morioka – PPL	(SM)
Reda Misghina – PPL	(RM)
Matthew Hopkins – LGT	(MH)
Prad Velayuthan – OHL	(PV)

Apologies: None received

		Actioned by
1.	**Welcome, apologies for absence, Minutes of the previous meeting held on 3 August 2022** CJ welcomed everyone to the PEG meeting. Apologies for absence were noted.	

	Minutes of the previous meeting held on 3 August 2022 were agreed as a correct record. Actions – noted would be picked up outside of meeting or covered under agenda item.	
2.	**Funding for GP Hub & ED Streaming and treating proposal at UHL** Amanda Lloyd presented the agenda item. Slides shared on screen. The service had been initiated as a test to support ED performance during the winter. Pressures have continued through spring and summer. Evaluation of the service is positive. It is anticipated that there will be an additional 23,000 slots that patients from ED can be streamed into where clinically appropriate. The cost to the end of March 2023 is £650k with the service re-starting from October 2022. Non-recurrent funding has been identified to support this initiative. CJ noted work to reshape the front door offer with the Trust will need to be completed before the end of March 2023 so that a decision can be made on the service post March 2023. AOS said also talk to OHL about 111capacity as part of UC service, ring fence capacity. **The PEG Approved the proposal.**	
3.	**Community Health Plan – Home First** Amanda Lloyd introduced Lisa Hancock and Joan Hutton who were key to this work. Slides shared on screen. Work was underway to improve discharge pathways to support patients home or to another place of care as soon as they are clinically ready. JH advised it was a change journey and culture change was a key focus. Practitioners and clinicians have been taken through a	

	structured methodology, success and co-design to support discharge from hospital. Also had service users and carers feedback. The work links in with the LBL Empowering Lewisham programme. LHa said they had ran 3 workshops with 25 people across health and social care. Patients identified that discharge could feel very stressful and there is a need for collaborative and simpler processes. It was also identified that staff need to feel valued for the work that they do. LHa had started process in May 2022 so it is still early days however, feedback from staff is already more positive about the process of discharge and reflect greater collaboration. CJ noted that the work will support and underpin winter pressures work. Also, that there is a need to look at discharge from acute mental health beds as part of managing winter pressures. CJ queried if this would lead to any structural changes or just working differently? LHa not sure at this time; it could just be that people need to work differently to achieve the desired improvements.	
4.	**Engagement Assurance Committee & People's Partnership Committee** Charles Malcolm-Smith presented the agenda item along with Anne Hooper, Lay Member and Simon Morioka from PPL. SM shared slides which had previously been shared with the PEG. Project started nearly a year ago. It had been the intention of Lewisham Health and Care partners to support development of a new model of citizen and community engagement. Initial recommendations had been approved by the Board in February 2022. There are two further proposals for PEG to consider today: • People's Partnership committee (equal partner to the Partnership) • Engagement Assurance Committee (subcommittee of LCP Board)	

	Aims and objectives noted, feedback from stakeholder groups, meeting next week. Questions for PEG noted. AH acknowledged that the groups will develop and evolve overtime and there is no expectation they will be perfect from the first day. CMS said it was about establishing what is practical for further work. Noted LCP meeting on 29/09 and workshop in October. Important to work with what we have and then fine tune. CMS too take questions around funding time into next discussion.	
5.	**Enhanced Access** Ashley O'Shaughnessy presented the agenda item. Noted formal paper to LCP on 29/09 as well. AOS updated that PCN plans were submitted by end of August and shared with the national team (it is a national specification). Focus is now on mobilisation and supporting all 6 PCN's to commence the service on 01/10. There are weekly meetings with PCNs. The main issues are workforce, estates and IT. PCNs are being asked to test their readiness against certain scenarios as part of the weekly assurance meetings. There is the loss of same day appointments as a result of the new service and this is being mitigated through the Stream and Treat service at UHL ED. SI asked if there was a summary of changes? More in hours and out of hours? CJ advised can share slides. AOS said a more comprehensive paper will be going to LCP on 29/09.	
6.	**Risk Register** CJ advised primary care risks were to be discussed. AOS updated they were probably generated 6-12 months ago and are due for further review. There are 4 risks. First two are risks not fully mitigated and work is ongoing with practices. Risks R8 and R9 noted.	

	SW commented on issues with digital access for some patients noted by Lewisham Healthwatch. Plans for addressing digital exclusion will need to come to a future PEG. CJ noted that changes to the enhanced access service also impacted on the GP Federation and that this should be reflected in the risks. **Action**: AOS to update Primary Care risks.	**AOS**
7.	**Health Inequalities update** Agenda item was led by Dr Catherine Mbema CMb shared slides to the group, which will be circulated round to the group after this meeting. This piece of work follows on from the work via the Health Well Being Board since 2018, the plan has since been refreshed and we now have a two-year programme. The aim for the programme is to work in partnerships to think about how we can have more equitable access, experience and outcomes for Lewisham residents across our health and care services Will continue to have a focus on those who are from black and other minority communities which was the main focus previously back in 2018. SR: Keen to get Dr Catherine Mberna involved/linked in with some of the work her team are doing already. CJ: Looking at our population this is an essential piece of work. Is this currently been engaged and supported in the right way and is there the right level of representation from the trust? CJ: to forward an email from Charles Malcolm-Smith to link in/support into this CMb in relation to the trust our main link is with Sandra and Matt. Knight Hills is overseeing this piece of work which is linked into the trust via the Inequality Board.	

	With regards SLaM there is a gap. CMB to touch base with Sam Gray outside of the meeting to go through best ways of closing the gaps.	
8.	**Strategic Communications** Agenda point was led by Sarah Wainer. • Changes have been made across the system and within this group and as a system we need to find a better way to communicate the changes well in advance to be able to prepare. • Preference is for acceptance from PEG this is something that will have to be looked at going forward at a wider system. • CJ: to touch base with Sam Gray/Tom Hastings/Belinda McCall with the nominated person as point of contact for short notice changes.	**CJ**
	Sandra Iskander item SI presented the agenda item. Noted Matt Hopkins also here. Slides shared on screen. Integrated acute and community provider, an important part of our services, act as a bridge for people's care. Developing this plan, sets out ambitions for the service, part of a much wider system. Vision for community services slide noted. Success criteria, and aspirations, spoke to staff, partners, patients and community groups, policy drivers, specific ambitions, arrived at five. • Quality of services • Innovate in new ways of care • High performing • Make the most of data • Understand services and work in partnership with the system Do not have data richness at the moment and need to ensure quality whilst managing changing needs, increasing complexity and health inequalities. The Trust is working with partners and joining up across the system. Workforce slide noted with risks from high vacancy rates, nursing retirement age, recruitment retention and other issues. Noted	

	lack of connectivity between different IT systems to make the most of tech advances to support services. Community health services are a wide and vast range of services and there is a need to better communicate and simplify where possible. Feedback is welcome and the Trust can update on progress and impact couple of times a year if requested. KG welcomed prevention work, how we can utilise other services in the system, prevention expertise. CJ queried how can people engage? SI responded that the Trust had just appointed a lead for community services. There is also the care at home alliance to take forward LCP work. CJ commented reshape the alliance rather than a separate Board, can pick up outside.	
9.	**Any other business** • CJ asked all to send slides shared at today's PEG meeting to send to LH/LW for them to share round. • CJ suggested the following items for the next PEG meeting • Feedback from the priority workshop, along with the data pack that will be used. • Have a clearer understanding what the big programmes going to be – Dr Emma Nixon (Frailty and Older People clinical care professional) will be reaching out into the trust to start making connections • CJ expressed interest to the group to raise any agenda items they wish to bring to the meeting.	
10.	**Date of next meeting** Thursday 13 October at 16.00 hrs via Teams.	