SEL ICB Board Meeting

Tuesday 24 November 2026, 11:00 - 14:00

Walworth Town Hall, 151 Walworth Road, SE17 1RS

Agenda

11:00 - 11:10
10 min

1. Welcome and Introductions

Information *Sir Richard Douglas*

1.1. Apologies for absence

Information *Sir Richard Douglas*

To note apologies for absence received.

1.2. Declarations of Interest

Information *Sir Richard Douglas*

To note Board members declarations of interest and confirm no additional interests are to be declared.

1.2. Register of SEL Board member interests.pdf (3 pages)

1.3. Approval of minutes of the last Board meeting held in public

Information *Sir Richard Douglas*

To approve the minutes of the Board meeting held on 22 July 2026.

1.3 Draft Minutes of the ICB board 22 July 2026.pdf (12 pages)

11:10 - 11:55
45 min

2. Borough Spotlight - Southwark VCSE

Presentation

To showcase one approach to how the ICB in Southwark is working with the Voluntary and Community Sector to reduce health inequalities and deliver neighbourhood health.

For decision

11:55 - 12:10
15 min

3. Governance Report

Decision *Ben Luscombe*

To provide Board members with an update on Governance matters, including any decisions required by the Board.

3. Governance report SEL.pdf (3 pages)
3i. SORD revised Nov 2026.pdf (39 pages)
3ii. Neighbourhood ToR revised Nov 2026.pdf (10 pages)
3iii. SCC ToR revised Nov 2026.pdf (12 pages)

For discussion

12:10 - 12:20
10 min

4. Acute Services Review

Discussion *Ed Waller; Sandra Iskander*

To provide an update on the outcomes of the Acute Services Review

- 4. ASR report.pdf (3 pages)
- 4i. 261008 SEL ASR - Final Summary Report.pdf (15 pages)

12:20 - 13:10
50 min

5. Committee Updates

Discussion

5.1. Strategic Commissioning Committee Update

Discussion *Georgina Fekete; Ed Waller*

To provide an update to the Board on the activities and decisions of the Strategic Commissioning Committee, together with reports on Commissioning Intentions and SIF, Month 6 financial position, and performance.

- 5.1 Committee update - SEL SCC.pdf (3 pages)

5.1.1. M6 Finance Report

Discussion *Dinah McLannahan*

- 5.1.1 SEL M6 finance report.pdf (4 pages)
- 5.1.1ii_SEL ICB MonthlyFinanceReport Month 6_2627.pdf (23 pages)

5.1.2. Performance Report

Discussion *Ed Waller*

- 5.1.2i Performance report SEL.pdf (3 pages)
- 5.1.2ii SEL performance summary_Nov 2026.pdf (19 pages)

5.1.3. SIF and Commissioning Intentions Approach

Discussion *Ed Waller*

- 5.1.3_5.1.4 CIs_MTFS_SIF_SEL.pdf (4 pages)
- 5.1.3_5.1.4ii_Appx 1. CI_SIF_MTFS SEL.pdf (44 pages)

5.1.4. Medium Term Financial Strategy

Discussion *Dinah McLannahan*

5.2. Audit, Risk and Assurance Committee Update

Discussion *Mike Parkinson*

To provide an update to the Board on the activities and decisions of the Audit, Risk and Assurance Committee

- 5.2 Committee update - SEL ARAC.pdf (3 pages)

5.3. Patient Safety Committee Update

Discussion *Anu Singh*

To provide an update to the Board on the activities and decisions of the Patient Safety Committee, including discussion on the Thirlwall Inquiry outcomes

- 5.3 Committee update - SEL PSC.pdf (2 pages)

5.4. Neighbourhood Strategic Delivery Committee Update

Discussion *Paul Najsarek*

To provide an update to the Board on the activities and decisions of the Neighbourhood Strategic Delivery Committee

- 5.4 Committee update - SEL NSDC.pdf (2 pages)

5.5. Joint Transition Committee Update

Discussion *Georgina Fekete*

To provide an update to the Board on the activities and decisions of the Joint Transition Committee

- 5.5 Committee update - Joint Transition Comm.pdf (5 pages)
- 5.5i_Appx 1. LEWISHAM Delegation Function transfer checklist.pdf (17 pages)

5.6. Remuneration Committee Update

Discussion *Anu Singh*

To provide an update to the Board on the activities and decisions of the Remuneration Committee

- 5.6 Committee update - SEL RC.pdf (2 pages)

13:10 - 13:25
15 min

6. Board Assurance Framework

Discussion *Ben Luscombe*

To present to the Board the current risk position, seek agreement to proposed closures, and set out the planned BAF refresh.

- 6. SEL BAF report.pdf (2 pages)
- 6i_Appx 1. SEL ICB BAF for Board - November 2026 - APPROVED.pdf (13 pages)
- 6ii_Appx 2. SEL BAF - November 2026.pdf (1 pages)

13:25 - 13:40
15 min

7. Organisation Report

Information *Andrew Bland*

To provide an overview and update on any SEL specific issues, achievements and highlights, not raised elsewhere in the committee-led reports.

- 7. Organisation Report FULL.pdf (12 pages)

13:40 - 13:50
10 min

8. Any Other Business

Discussion *Sir Richard Douglas*

13:50 - 14:00
10 min

9. Public Questions

Discussion *Sir Richard Douglas*

Members of the public are invited to ask questions. Priority will be given to those questions received in writing in advance of the meeting.

Date of next meeting: 23 February 2027

NHS
South East London

NHS South East London Integrated Care Board
Register of Interests declared by Board members
Date: 13/11/2026

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
Committee members					
Sir Richard Douglas, CB	Chair	1. Senior Counsel for Evoke Incisive, a healthcare policy and communications consultancy	Financial interest	March 2016	Current
		2. Trustee, Place2Be, an organisation providing mental health support in schools	Non-financial professional interest	June 2022	Current
		3. Trustee, Demelza Hospice Care for Children, non-remunerated role.	Non-financial professional interest	August 2022	Current
		4. Non-executive member, Department of Health & Social Care	Financial Interest	January 2024	Current
		1. Chair, NHS South West London ICB	Financial Interest	1 February 2026	Current
Georgina Fekete	Non executive director	None to declare	n/a	n/a	n/a
Paul Najsarek	Non executive director	1. Advisor to Care Quality Commission on their approach to local authority assurance	Non-financial professional interest	1 April 2022	Current
		2. Non-executive director - The Health Foundation	Non-financial professional interest	1 March 2023	Current
		3. Trustee of Waythrough	Non-Financial professional interest	1 April 2022	Current
		4. Director, Paul Policy Practice Ltd	Financial interest	24 December 2021	Current
		5. Advisor to DA Languages Ltd	Non-Financial professional interest	1 July 2024	Current
		6. Improvement advisor to Blackpool Council	Non-Financial professional interest	22 September 2025	Current
		7. Chair of London Neighbourhood Delivery Board (NHSE London appointment)	Non-Financial professional interest	1 September 2025	Current
		8. Governor, Christ The King Primary School	Non-Financial professional interest	3 August 2025	Current
Mike Parkinson	Non executive director	None to declare	n/a	n/a	n/a
Anu Singh	Non executive director	1. Independent Chair of Lambeth Adult Safeguarding Board.	Non-financial professional interest	April 2021	Current
				2020	Current

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
		2. Member of the advisory committee on Fuel Poverty.	Non-financial professional interest	April 2020	Current
		3. Non-executive director on the Parliamentary and Health Ombudsman.	Non-financial professional interest	September 2024	September 2025
		4. Chair, Black Country ICB	Financial interest	1 October 2025	Current
		5. Chair, Leicester, Leicestershire & Rutland ICB and Northamptonshire ICB	Financial interest		
Andrew Bland	Chief Executive Officer	1. Chief Executive Officer, NHS South West London ICB	Financial interest	9 February 2026	Current
		2. Partner is a programme director employed by Guys and St Thomas's NHS FT	Indirect interest	1 April 2022	Current
Elaine Clancy	Chief Quality and Nursing Officer	1. School Governor, Langley Park School for Girls	Non-financial personal interest	1 April 2023	Current
		2. Trustee for the 1930 Fund for District Nurses	Non-financial personal interest	1 April 2023	Current
		3. Secondment to GESH NHS Trust	Non-financial professional interest	15 September 2025	7 September 2026
Dr Toby Garrood	Medical Director	1. Shareholding in Serac Healthcare	Financial Interest	1 April 2020	Current
		2. Consultant rheumatologist at Guy's and St Thomas' NHS Foundation Trust (GSTT)	Financial Interest	7 October 2009	Current
		3. In my role at GSTT I have received research and service development grant funding from Versus Arthritis, Guy's and St Thomas' Charity, Pfizer, Gilead and NHSx	Financial Interest	1 January 2015	Current
		4. I undertake private practice at London Bridge Hospital	Financial Interest	1 January 2012	30 October 2026
		5. Honorary Treasurer for British Society for Rheumatology	Non-financial professional interest	1 April 2020	30 October 2026
Dinah McLannahan	Chief Finance and Compliance Officer	1. Independent trustee of Your Trust charity in West Midlands	Non-financial personal interest	1 April 2025	Current
		2. Treasurer, Mini and Juniors Section, Old Halesonians Rugby Football Club	Non-financial personal interest	1 April 2025	Current
Ed Waller	Chief Commissioning Officer	1. Life member of Diabetes UK	Non-financial personal interest	7 September 2026	Current
		2. Wife is employed by Kings College Hospital NHS FT as a consultant	Indirect interest	7 September 2026	Current

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
Paul Calaminus	Partner member, mental health services	1. Chief Executive, South London and Maudsley NHS Foundation Trust	Financial Interest	1 August 2026	Current
Jennifer Daothong	Partner member, Local Authority	1. Chief Executive, London Borough of Lewisham	Financial interest	24 September 2025	Current
Dr Ify Okocha	Partner member, community services	1. Chief Executive (employee) of Oxleas NHS Foundation Trust 2. Director, Dr C I Okocha Ltd, providing specialist psychiatric consultation and care 3. Director, Sard JV Software Development 4. Director, Oxleas Prison Services Ltd, providing pharmacy services to prisons and Kent and South East London 5. Holds admitting and practicing privileges for psychiatric cases to Nightingale Hospital 6. Fellow of the Royal College of Psychiatrists 7. Fellow of the Royal Society of Medicine 8. International Fellow of the American Psychiatric Association 9. Member of the British Association of Psychopharmacology 10. Member of the Faculty of Medical Leadership and Management 11. Advisor to several organisations including Care Quality Commission, Kings Fund, NHS Providers and NHS Confederation.	Financial interest Financial interest Financial interest Financial interest Financial interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest	1 November 2021 1 January 1996 2011 27 September 2016 1 January 1992 1 January 1992 1 January 1992 1 January 1985 1 January 1985 1 January 1985 1 January 1985	Current Current Current Current Current Current Current Current Current Current Current
Matthew Trainer	Partner member, acute services	1. Chief Executive, Kings College Hospital NHS Foundation Trust	Financial interest	6 July 2026	Current
Dr George Verghese	Partner member, primary care services	1. GP partner, Waterloo Health Centre 2. Lambeth Together training and development hub director 3. Lambeth Healthcare GP Federation shareholder practice	Financial interest Non-financial professional interest Non-financial professional interest	1 August 2013 1 January 2022 1 August 2019	Current Current Current

DRAFT

Integrated Care Board meeting in Public

Minutes of the meeting on 22 July 2026

Coin Street Neighbourhood Centre

Present:

Name	Title and organisation
Richard Douglas [Chair]	ICB Chair
Andrew Bland	ICB Chief Executive Officer
Dr Angela Bhan	Bromley Place Executive Lead
David Borland	Greenwich Place Executive Lead
Diana Braithwaite	Bexley Place Executive Lead
Andrew Eyres	Lambeth Place Executive Lead
Tosca Fairchild	Chief of Staff
Georgina Fekete	Non Executive Member
Dr Toby Garrood	ICB Joint Medical Director
Elaine Clancy	Chief Nurse
Peter Matthews	Non-Executive Member
Dinah McLannahan	Chief Finance Officer
Paul Najsarek	Non-Executive Member
Darren Summers	Southwark Place Executive Lead
Anu Singh	Non Executive Member
Matthew Trainer	Chief Executive Kings College Hospital NHS FT
Dr George Verghese	Partner Member Primary Care

In attendance:

Harriet Agyepong	Associate Director of Performance
Holly Eden	Director of Delivery for Neighbourhood and Population Health
Mike Parkinson	Non-Executive Member
Denis Lafitte	CDIO
Ranjeet Kaile	ICB Director of Communications and Engagement
Kallie Heyburn	Neighbourhood Delivery Director
Deborah Travers (item 2)	Acting Deputy Director of Adult Social Care Bexley
Rebecca Bingham	Live Well Age Well coordinator
Flora Faith-Kelly	Creative Health Program Manager
Heather Gilmour	Managing Director SEL Acute Provider Collaborative
Jen Cassettari	Director of Operations and Partnerships Guys & St Thomas NHSFT

1.	**Welcome and Apologies**
1.01	Apologies were noted from, Crystal Akass, Gabi Darby, Ade Odunlade, Amanda Pritchard, Ben Travis Ceri Jacob and Dr Ify Okocha. The Chair reduced the requirement for partner members to two members.
1.02	There were no conflicts of interest advised with respect to items on the agenda.
1.03	The notes of the previous meeting were approved as an accurate record

1.04	The action log was updated.
2.	**Bexley Borough Showcase**
2.01	Diana Braithwaite introduced as showcase the Bexley Live Well, Age Well Hub. Kallie Heyburn explained that supporting people with frailty was a strategic priority for Bexley, noting that a 2024 review had found that frailty affected 27% of the population and cost primary and secondary care approximately £43m, with falls one of the biggest drivers of emergency admissions. The team had met with local residents to hear their priorities and held a further workshop to test a proposed model.
2.02	Deborah Travers described the chosen model as a way of providing preventative support for people with mild or developing frail responding to residents who in engagement had asked for places to go to help them stay healthy and well, find advice and stay connected to the community. Attendees of the hub were also supported to find other relevant services an Aging Well navigator from the voluntary sector in Bexley, backed by an integrated neighbourhood team from across Bexley Care including mental health, physical health and social care, who also helped find people who could benefit from the service.
2.03	Rebecca Bingham noted that the library in Sidcup had been chosen as a new building with a prominent location easily accessible by transport. The building was shared with a cinema and open seven days a week. By bringing the hub into the library residents were able to access the library for two additional weekdays and the local café had benefited from the trade. A bright and fun brand and promotional posters had been developed with the engagement group. Starting in January the hub had offered a broad range activities in 184 sessions attended by 1400 people.
2.04	Flora Faith-Kelly shared some of the survey responses received from people who had attended the creative or movement-based sessions. Participants reported more optimism around the future, feeling confident and good about themselves. There had been success in supporting participants in one activity to find other activities that they could move onto next, both in the Live Well Age Well hub but also with other trusted community partners.
2.05	Sir Richard Douglas welcomed the presentation, noting that initiatives to manage frailty of this helped not only the frail population but resources to all other parts of the NHS.
2.06	Dr Angela Bhan asked what outcomes it was hoped to measure given the difficulties for example of find the impact on stroke and heart disease, and asked if there had been any attempt to gear activities particular cultures.
2.07	Georgina Fekete asked if the cost savings were being measured and how much the total projected cost of frailty could be reduced by scaling approaches of this kind.
2.08	Dr George Verghese asked how people presenting with an abnormality or higher acuity were managed and signposted to statutory services. The cohort of people accessing the services appeared very wide and raised the question about sustainability if the model became very popular.

2.09	Mike Parkinson remarked on high cost of avoidable admissions set out in the pack and asked how feasible it would be to track improvement in this figure recognising it maybe too early
2.10	Kallie Hayburn noted that outcomes for prevention were difficult to manage but a data sharing agreement was being explored to collect some of the data, as well as admission avoidance. There was also work to try to ensure a consistent approach to the recording of frailty in primary care, as well feedback from the patients as part of assessments. The model included a skill set from preventative activities to experienced frailty specialist nurses with a team able to identify which patients could be supported in the community and voluntary sector and those with more severe frailty requiring clinical intervention. Work to examine conveyances for care homes which did not result in admission showed that there was an opportunity for some to avoid crisis with the right support.
2.11	Diana Braithwaite noted that although north of the borough there were significant West African South Asian and Nepalese communities where the team would look to provide culturally sensitive support, the population of Frogmore was predominately White British.
2.12	Anu Singh observed that with creative health interventions there could be a great deal of time and energy trying to measure and convince others on ROI and efficacy in a way that was not required with other clinical or health interventions. This effort may be better spent on targeting the individuals who would truly benefit from the longer-term and shorter-term interventions.
2.13	Dr Toby Garrood added that soon the programme would require more investment which would mean disinvestment in other things. It would therefore be important to have the evidence base to back this up and sometimes initiatives were not quite big enough to get this evidence.
2.14	Holly Eden welcomed the way the Bexley team was connecting their leading preventative work to the work on the moderate to severe frailty which was the priority for the year. By demonstrating impact across south east London on the higher-risk groups the strategy could also maintain investment in prevention elements.
2.15	Andrew Bland noted that there was a number of requests for hubs of various kinds and concern at a regional level that there may be too many to be affordable. The evidence base was important to be able to explain what approach was being taken in each area. There also seemed to be an opportunity to assist the voluntary and community sector by providing low cost estate.
2.16	Diana Braithwaite noted that in Bexley there had been work with the local authority and community providers to bring this together, with the Lakeside Health Centre a good example with GP practices, services from Lewisham and Greenwich trust and soon a family hub.
3.	**ICB Governance Framework**
3.01	Sir Richard Douglas set the ICB governance framework changes in the context of national changes to the role of ICBs, the Boards own reflections on the effectiveness of governance arrangements, and working of the ICB with SWL ICB as a cluster. Andrew Bland explained that putting governance in place was one of three actions along with establishing an operating model for the new ICB, and

	culture and ways of working, adding that although some responsibilities had been removed, there was agreement on the need for a convening role in the system.
3.02	Tosca Fairchild outlined the process of development of the proposals which aimed to create a governance which was simpler and more proportionate, reflective of the ICBs strategic commissioning role. Working across both clustered ICBs, a clearer delegation framework had been created which consolidated previous documents, as well as a simpler committee structure and updates to terms of reference reflecting a strategic board focused on long term priorities and outcomes for the population, with clearly defined responsibilities for the Board, senior management team and officers.
3.03	Paul Najsarek asked if the Health Bill currently being considered by parliament would necessitate changes. He advocated working through the changes in practice with committees likely to wish to make refinements themselves. The way that this governance would engage with the development of neighbourhood plans was of particular interest and mapping out how items might proceed through the governance would be useful.
3.04	Georgina Fekete emphasised the responsibility of the Board to make the governance work, the importance of ways of working and a review after 6 months to check that the arrangements worked, particularly given a smaller executive.
3.05	Dr Toby Garrood noted a possible typo in 4.3 of the strategic commissioning committee Terms of Reference. Referring to the Neighbourhood delivery committee, he queried the absence of nursing and evaluation which would be important elements of neighbourhoods.
3.06	Dr George Verghese noted that there had been conversations in the current neighbourhood group about how to include a broad input such as nursing and community pharmacy. There a more general point about representation and clinical input that could be considered by the board as part of its ways of working.
3.07	The Board **approved** the proposed ICB Governance Framework and supporting governance documents.
3.08	The Board **approved** the constitutional and governance amendments set out within the accompanying papers.
3.09	The Board **noted** that the constitutional amendments require subsequent approval by NHS England and agree that the necessary approval process should be initiated following Board approval.
3.10	The Board **agreed** that the ICB Governance Framework will take effect 1st October 2026 following Board approval and become the governance framework through which the ICB operates, subject to the constitutional approval requirements described above.
4	**Update on Bromley Community Services**
4.01	Dr Angela Bhan referred to the paper which updated the Board on mobilisation following the Boards approval of the award of the Bromley community services contract to Bromley Healthcare CIC. The organisation was an active participant in discussions on neighbourhood implementation, a new chief executive was now in place, and there was good progress towards the December deadline for

	mobilisation.
4.02	The Board **noted** that the June 2026 milestones for the Bromley Community Services Contract mobilisation plan had been met and that there was good confidence future milestones would be met.
5	**Annual Report and accounts**
5.01	Tosca Fairchild noted that the ICB annual report and accounts had been confirmed through the audit and risk committee and were presented to the board publicly.
5.02	Peter Matthew asked if a summary would be produced. Tosca Fairchild confirmed that a six-page summary had been published.
5.03	The Board noted the ICB 2025/26 annual report and accounts.
6	**Chief Executive Officers Report**
6.01	Sir Richard Douglas welcomed the inclusion in the report of a summary of the Mann report on Antisemitism and noted that the recommendations would be given further consideration by the Board but not put to a decision at today's meeting.
6.02	Andrew Bland noted that Ockenden and Amos reports into maternity services had been released and would be discussed later in the agenda. The Board had welcomed Dinah McLannahan as CFCO and Elaine Clancy as Chief Nurse and quality officer. A process for the medical director was being finalised, and the Chief Commissioning Officer Ed Waller would start in September.
6.03	Following the release of final structure in the ICB change process, staff had been informed of the consequences for them as individuals, and results of appeals of these outcomes were being communicated this week. Although many colleagues now had more information and certainty about the future, there would continue to be anxiety as colleagues left on voluntary redundancy and interviews to fill the structure commenced. There was considerable work to ensure the transition to the new structure would be as safe and orderly as possible.
6.04	Dr George Verghese welcomed the update on the strategic investment fund which was an important step in increasingly allocating resources towards services based in the community.
6.05	Ranjeet Kaile paid tribute to the work of the Ceri Jacob as SRO and others who had worked under difficult circumstances to carry out the change programme.
6.06	The Board noted the chief executive officers report.
7	**Board Assurance Framework**
7.01	Tosca Fairchild introduced the Board Assurance Framework for approval. Changes to individual risks had been highlighted and an annual review had been carried out. 41 risks had been closed and 13 new risks had been added resulting in a total of 83 risks across the ICB's risk registers. Fourteen of these exceeded the tolerance thresholds and were included on the Board Assurance Framework. A new risk related to delivery of the ICB strategic commitments had been introduced and consolidated three previous performance risks.

7.02	Sir Richard Douglas noted that over the course of its meetings the Board had now conducted discussions about most of the areas of concern in the risk register. There were however risks at Place and system level related to autism and ADHD diagnostics which had previously been flagged for further dicsussion. A discussion on the issues, measures taken in response and their effectiveness should come back to the board. New and emerging infectious diseases and pandemics and variation on funded nursing care might be other areas where the board may wish to explore in more detail. **Action**
7.03	Paul Najsarek asked whether the consolidation of elective and UEC performance into a single risk could mean losing some of the granularity needed to implement mitigations, asking if this was now common practice amongst ICBs, but supported the intention to take a more strategic approach.
7.04	Georgina Fekete reflected on whether the risk register adequately enabled the Board to ascertain whether the ICBs strategic plan was being delivered and asked if there were too many risks for the reduced bandwidth of the combined executive team.
7.05	Andrew Bland acknowledged the tension between strategic risks and operational risks, suggesting the Board was currently obliged to operate from both perspective but there was an opportunity to further consider the approach ahead of transition to the new governance arrangements.
7.06	The Board approved the Board Assurance Framework.
8	**Overall Report of ICB committees and provider collaboratives**
8.01	Tosca Fairchild referred to the ICB committees report, noting items requiring a decision from the Board listed in the paper.
8.02	The Board **noted** the report.
8.03	The Board **approved** the revised Section 75 agreement with London Borough of Lewisham.
8.04	The Board **approved** the revised Terms of Reference for the Lambeth Together Local Care Partnership Board.
8.05	The Board **approved** the revised Terms of Reference for the Greenwich Charitable Funds Committee.
9	**Performance Report**
9.01	Harriet Agyepong presented the report noting mixed performance across the standards and targets of the ICB. Some performance areas had improved, including cancer faster diagnosis standard, primary care appointments, uptake of community pharmacy and health checks for people with learning disability. Other areas were challenged including urgent and emergency care, 62 day waits for Cancer, the six-week diagnostic target and mental health crisis flows and community waits. Monthly reports were being provided to the team on how many patients were being placed outside of area and there was a plan to have no patients out of area by March 2028 except those requiring female psychiatric intensive care. Future reports would focus on areas that ICBs would be asked to

	manage going forward.
9.02	Holly Eden highlighted that the recent GP patient survey results, whilst not a constitutional standard, had shown a 3% improvement in overall experience for SEL bringing it back towards average levels, and some areas had achieved above-average increases of 6% to 8% for example ease of contact for different routes. These improvements were thanks to the efforts of GPs and pharmacy and dental colleagues and the primary care access recovery programme.
9.03	Georgina Fekete asked what could be learned from areas where the system had performed well, and whether it was possible to differentiate which of the mitigating actions listed had most driven the improvement.
9.04	Andrew Bland noted that it was likely that drivers of the change were multifaceted, and in the past attempts to associate very precise outputs of each action had not proved successful. Matthew Trainer referred added that it was important to focus clinical teams effort on the right part of the waiting list noting that particular specialties were more challenged than others.
9.05	Dr George Verghese suggested that as a consequence of welcome improvement in access shown by the GP survey the board needed to consider the strategically the consequences for waiting lists of increased referrals, and the role of consultant connect and advice and guidance.
9.06	The Board noted the performance report
10	**Finance Report**
10.01	Dinah McLannahan referred to the report noting performance on track against the break-even plan for 2026/27. The ICB was forecasting to remain within its running cost allowance, was paying almost all invoices within 30 days and was forecasting to achieve the Mental Health Investment Standard. The biggest financial risk was the growth in ASD and ADHD assessments which was being managed within delegated budgets to Places.
10.02	Paul Najsarek commented that the ICBs role and accountabilities were undergoing transition and asked about the implications for future reporting, for example whether finance would be presented from a system as well as ICB perspective.
10.03	Andrew Bland noted that over the long term, system finances were a major driver of ICB finances, and therefore of interest to the Board. Financial sustainability was a strategic risk to the ICB, and so it would be important for the ICB to work through the system sustainability group and strategic commissioning committee to understand and support improvement.
10.04	The Board noted the Finance report.
11	**Quality and Safeguarding report**
11.01	Elaine Clancy presented the report, highlighting 20 ‘never events’ reported for South East London and noting the continued learning work which was taking place in response. Safeguarding partnerships continued their activity of sharing intelligence and strengthening safeguarding training and monitoring. All-age continuing care continued to experience demand pressure and performance challenges. The Local Maternity and Neonatal System were managing a broad

	programme of improvements and focus on safety capacity and co-ordination in light of national reports. There was continued challenge in relation to infection prevention control with all trusts making efforts in response to above trajectory levels of several types of microorganisms The quality directorate was contributing to work with local authorities in response to the SEND reform white paper.
11.02	Georgina Fekete noted that the quality strategy had been released with three domains of safety, patient experience and effectiveness. Noting the focus of the current report on safety, she asked how the ICB would move to consider the other domains. Elaine Clancy agreed that as the team changed and worked across the cluster future reports would change as the quality strategy was considered.
11.03	Sir Richard Douglas noted that in future meetings it would be useful for the board and committees to explore continuing healthcare and patient complaints.
11.04	The Board noted the Quality and Safeguarding report.
12	**Maternity Update**
12.01	Elaine Clancy presented the overview of reports into maternity services including the Ockenden and Amos reports and offered condolences to the families who had been impacted by the events in the reports on made difficult and upsetting reading. It was disappointing to see so many similar themes to previous Ockenden reports and the Kirkup report. In south east London maternity units continued to make improvements and implement learning and early learning and insights from the reports had been shared with midwifery and obstetric colleagues to work on ahead of publication. She shared that at a meeting with a group of newly qualified midwives she had been greatly impressed with their compassion and enthusiasm for the role and what needed to be done. The ICB had a role to ensure services it commissioned were safe and well staffed, and it was important to work with Region to ensure roles were clear as the ICB transitioned. Maternity services had changed over the years and the ICB as strategic commissioners working with providers and the maternity voices partnership needed to consider changing demographics, with often older mothers with more complex health needs, long-term conditions as well as a reducing birth rate and more complex births. The paper had provided an overview of maternity services and some assurance of the work continuing in south east London
12.02	Paul Najsarek noted that the Board had heard previous reports on the work which was happening to improve maternity services but it would be helpful to be clearer on the assessment of services in south east London, whether they reflected weaknesses that had been identified nationally or whether some areas were in a better position.
12.03	Georgina Fekete agreed with the need to identify gaps and also what areas were within the control of the ICB and part of its role. As strategic commissioners, the ICB may have a role in enabling less fragmented care pathways as had been highlighted. There was often an impulse in crisis situations to put stronger governance (more layers), but oversight already seemed heavy and it was important to put in place governance that would empower people on the front line.
12.04	Darren Summers welcomed the presentation of the reports to the board and commented that although the reports seemed to focus on governance and process it would be important to complement this by reporting outcomes and experience so

	that the board was monitoring actual changed outcomes and experience for women and families.
12.05	Dr Toby Garrood reflected on the importance of paying attention to patient experience, which was a critical point of triangulation and often an early warning before other signals emerged.
12.06	Matthew Trainer noted that there had been a large increase in elective c-sections and a falling birth rate, meaning the pathway was different to 5 years ago. Some of the staffing ratios assumed natural birth, however there was insufficient theatre space for the growth in planned c-sections leading to delays of planned procedures and an increase in emergency c sections. The effect on morale of needing to respond quite frequently to negative national reports was worrying with some evidence that newer midwives were not staying as long as the trust would like.
12.07	Dr George Verghese agreed that the reviews did not always take into account changes in the pathway. Important role for a strategic commissioning organise to synthesise. Noting that as the NHS Chair Penny Dash had acknowledged there were two many reports. Increasing listening capacity.
12.08	Sir Richard Douglas suggested the quality committee could further explore some of the demand and capacity.
13	**Diagnostic Services**
13.01	Heather Gilmour described diagnostics as a critical enabler of the systems work from cancer pathways, elective recovery, elective care and increasingly neighbourhoods, but covering a very broad range of modalities. Providers led delivery, improvements and recovery plans, supported in collaborative work by the Acute Provider Collaborative (APC) and the ICBs role was to align priorities and investment.
13.02	Harriet Agyepong presented performance showing that slides set out performance against DM01 (waiting time for a collection of key diagnostic tests), with systems asked to make sure no more than 1% of patients waited more than 6 weeks. There had been some positive movement in the trust and ICB performance towards alignment with London and national performance, but there remained challenges in non-obstetric ultrasound, audiology and MRI.
13.03	Heather Gilmour noted that the APC supported three existing networks for Imaging, Endoscopy and Cardiology as well as collaboration with primary care. Diagnostic demand often outstripped general demand due to increasingly complex procedures and so gains were often incremental. The APC provided support with bids for national funding such as for the existing CDCs, and newer more efficient equipment which could benefit care, as well as digital support such as the decision support tool implemented as part of ICE Order comms which had helped support tests being cancelled in 5% of cases and changed in 45%, providing assurance that tests ordered met criteria for Royal College of Radiologists. There was also work to consider optimising internal referrals and to assess demand over the next 5 years.
13.04	Jen Cassettari added that Guys and St Thomas's NHSFT in collaboration with Kings College NHSFT were developing a proposal for a new CDC in Elephant and Castle providing easier access to a range of modalities for people Lambeth and Southwark, if the bid was successful the focus would be ensuring the centre was

	accessible and integrated with digital tools.
13.05	Harriet Agyepong summarised by pointing out that there was no single issue and therefore no single solution, but that work was already underway in many areas. The success of all work however required a coordinated approach across the providers, APC and the ICB with its new strategic role.
13.06	Andrew Eyres welcomed the additional capacity a CDC might provide, but asked which patients would be asked to travel to each site, noting that the major hospitals were reasonably accessible.
13.07	Dr Toby Garrood noted that DM01 did not measure the time taken to produce and receive the reports after the test had been conducted therefore it would be useful consider diagnostics in context of pathways. It would be useful to understand variation in demand with quite significant variation shown by recent oncology work. To prevent the increased capacity would bring increased demand it would be useful to consider how pathways would be re-configured to take full advantage of capacity. Patient experience seemed to suggest that patients were more tolerant of having to travel if they were able to get all their tests done at the same time, suggesting that one-stop-shops where possible were to be preferred.
13.08	Dr George Verghese asked how much of the demand was attributable community and general practice and how much to secondary and tertiary care. Noting the commitment to standardise and improve GP direct access he suggested this should be expanded to integrated neighbourhood teams as a whole.
13.09	Diana Braithwaite supported the need for reporting that distinguished different parts of the process and sources of demand, and asked if the lessons had been learned from the Queen Marys Hospital CDC, and how the proposed new CDC would integrate with the system to avoid drawing away workforce from existing provision in outer borough areas.
13.10	Jen Cassettari emphasised that patient choice would always be respected. Currently the acute trusts were putting on extra capacity to try to improve their diagnostic performance and some of those patients could be seen in a CDC in the community. There would still be a cohort of patients who needed to or chose to come to the acute site.
13.11	Demand management Guys and St Thomas point of view really keen to try to do the next 18 months as much work on demand management to understand this including patients who came to the trust for other care and had tests in the hospital but could have their tests locally.
13.12	Close working to ensure the service integrated with local neighbourhood teams working, as well as supporting the women and children's hub located at the proposed CDC site (Wooden Spoon house). There had been liaison with Lewisham and Greenwich trust to learn the lessons of the roll out and there would be sufficient patients going to both CDCs.
13.13	Angela Bhan suggested more point of care testing in emergency care, and as general practices and neighbourhoods were looking after more complex patients there would be benefit to cardiology in practices and neighbourhoods. She pointed out that it would not be the same solution that would be appropriate for all diagnostics. For example blood tests would be better carried out in GP surgeries and high streets rather than at CDCs.

13.14	Paul Najsarek echoed the point on the diversity of modalities and suggested a map of each type of test with the channel of access would help understand the landscape. There was also a considerable private market for diagnostics and as a strategic commissioner the impact on this market and effects of this could not be ignored.
13.15	Georgina Fekete suggested the board might consider the trade offs in relation to spend in this area and whether there were more cost effective and impactful solutions which could be invested in. Innovation around market shaping to get more from limited resources if demand would continue to increase.
13.16	Harriet Agyepong noted that there had been a bid for point of care testing funding from national fund. The proposed CDC was not the only solution and further modelling of demand and capacity would help inform any market shaping.
13.17	Andrew Bland pointed out that the role of the ICB may not always be to shape markets which may be something providers would take on. As a previous example much of the 'outsourcing' of endoscopy was actually in-sourcing as providers took on areas where they had identified gaps.
13.18	The Board **noted** the current position and improvement activity, recognised diagnostics as a system-wide strategic commissioning issue and supported the proposed framing of the ICB role and welcomed future discussion on proposals such as the CDC.
14	**Any Other Business**
14.01	Sir Richard Douglas thanked Peter Matthew on behalf of the Board for his service as Non-Executive member. Peter Matthew thanked colleagues for their support on the complex work of the ICB and recalling the ambition set at the ICBs first meeting for the new organisation to work differently to what had gone before, reflected that the renewed focus on neighbourhood delivery was one way in which it had started to achieve this.
15	**Public Questions** *Members of the public on behalf of Keep Our NHS Public submitted the following question. Regarding the Synnovis-run private pathology service for the SEL ICB population, Keep Our NHS Public was concerned to read in the recent GSTT Board minutes that:* *1. There are concerns about the timeliness and quality of microbiology, tissue and cancer diagnostic test results (and the Health Services Journal has highlighted other quality issues also).* *2. There is a £2m deficit on the budget which we understand make cause significant and damaging staff cuts and hence affect service quality* *3. Despite writing several times to the ICB asking about the total amount lost to the tax payer from the cyber attack on Synnovis 2 years ago, we still have not had a final response.*
15.01	As question was also submitted at the board in writing and the Chair agreed to publish a response from the ICB. *A member of the public who was a reflected that GP in training observed that there was an opportunity to use neighbourhood centres to explain Do Not Attempt*

	Resuscitation and lasting power of attorney as well as physical activities. He asked if the ICB was interested to work with private investors along with social care to develop neighbourhood health and neighbourhood health centres.
15.02	Holly Eden confirmed that providing information on DNAR was part of core requirements for neighbourhood health but may not necessarily be delivered in centres but could be via GP practices and other settings.
15.03	Dr George Verghese noted that the estates team were actively working on how estates could support neighbourhood health. Andrew Bland noted that as a general principle the NHS was open to exploring partnerships with the private sector and had a track record of making the most of public estate. Individual decisions however would depend on the detail of each case.
	Close

NHS
South East London

Governance Report

Agenda item: 3

Executive Lead: Dinah McLannahan, Chief Finance and Compliance Officer

Report by: Ben Luscombe, Director of Corporate Services

Paper type: Decision

Conflicts of Interest: None identified

1. Purpose and recommendation

The purpose of this report is to update the Board on progress with the ICB's governance arrangements over the last quarter and seek approval for any proposed changes.

The Board is asked to:

- **Note** the approval of the revised Constitution by NHS England.
- **Note** the ongoing work on the risk management framework.
- **Note** the decisions made in other meetings.
- **Approve** the revisions to the Scheme of Reservation and Delegation detailed below.
- **Approve** the amendments to the Terms of Reference for the Neighbourhood Strategic Delivery Committee detailed below.
- **Approve** the amendments to the Terms of Reference for the Strategic Commissioning Committee detailed below.

2. Background and context

Following approval of the ICB's new governance arrangements by the Board at its last meeting of 22 July 2026, the governance and risk and assurance teams have been working with the ICB executives to implement the arrangements. This has focused on the implementation of committee meetings, and the development of a risk management framework proposal.

As a consequence, some further changes have been proposed to some terms of reference, and the Scheme of Reservation and Delegation (SoRD), which are detailed below for the Boards consideration.

In addition, the revised Constitution which was discussed at the last meeting of the Board and reflected changes to its composition, was approved by NHS England on 14 October 2026.

3. Activity undertaken

All Committees of the Board have held their first meeting, where terms of reference were discussed and acknowledged. Where changes were proposed the terms of reference have been brought to the Board within this paper for re-approval. Committees will operate on an individual ICB basis but agendas will be aligned across the same committees within the Cluster for consistency.

A risk management framework proposal was presented to the Audit, Risk and Assurance Committee and was endorsed by the Committee for further work to take place with the Board on risk appetite definitions and process development.

Following publication of the suite of governance documents agreed at the last Board, some feedback has been received to clarify the status of some committees and groups, and to reflect legislative updates around procurement rules, which will require an update to be made to the Scheme of Reservation and Delegation (SoRD). These changes are detailed below.

4. Decisions and Outcomes

The below revisions to documents have already been considered and endorsed by the respective Committees, and are presented to the Board today for approval:

1) Scheme of Reservation and Delegation
   Amendments are proposed as follows:
   - Section 11 Medicines Optimisation
     - Clarify total value for SWL based on population size
     - Expand commentary for delegated authority where estimated total yearly cost per drug is up to £25k per 100k population to explain the role of the Integrated Medicines Optimisation Committee (IMOC) as the recommending authority to the Chief Pharmacist
     - Amend delegation of authority where estimated total yearly cost per drug is above £25k per 100k population to Senior Management Team on recommendation of IMOC.
     - Add a note on the ICBs obligations to fund and resource medicines and treatments recommended by NICEs Technology Appraisals.
   - Section 27 Quotation, Tendering and Contract Procedures
     - Add explicit guidance on PSR non-compliant awards process
     - Cross reference standard revenue limits for goods and services tendering, and amend values to reflect PSR requirements
     - Update procurement legislation references

2) Terms of reference for Neighbourhood Strategic Delivery Committee
   - Include the Chief Commissioning Officer as a member of the committee.
   - Specify the number of Place representatives in membership and minimum for quoracy.

3) Terms of reference for Strategic Commissioning Committee
   - ToR to be explicit that second non-executive member is Deputy Chair of Committee.
   - Remove specific attendees and state individuals will be invited on an “as and when” basis to provide subject matter expertise as required by the agenda.

5. Decisions made in other meetings

Part 2 meetings are used to allow the Board to meet in private to discuss items that may be business or commercially sensitive and matters that are confidential in nature.

The following items were discussed during Part 2 Board meetings on the following dates. They are recorded here to ensure that all Board members are aware of decisions that have been made, by the Board, in other meetings.

19 August 2026

- Received a paper on cyber security, which included approval of the appointment of a Board-level executive Cyber Lead (ICB CFCO) and the proposed approach for ongoing responsibility and management of cyber for the ICB, and endorsed a proposed cyber improvement roadmap and continued investment approach.
- Received a briefing on the Amos and Ockendon reports.

30 September 2026

- Signed off the SEL Winter Plan, including approval of the SEL Board Assurance statement
- Approved the transfer of the estates function to Guys and St Thomas's NHS Foundation Trust and Oxleas NHS Foundation Trust, following confirmation of assurance received by the Joint Transition Committee

Appendices and supporting information

Appendix A – revised Scheme of Reservation and Delegation
Appendix B – Revised Terms of Reference for Neighbourhood Strategic Delivery Committee
Appendix C – Revised Terms of Reference for Strategic Commissioning Committee

NHS South East London ICB & NHS South West London ICB Integrated Scheme of Reservation & Delegation

The arrangements made by NHS South East London Integrated Care Board (SEL) and NHS South West London Integrated Care Board (SWL) for the reservation and delegation of decisions are set out in this integrated Scheme of Reservation and Delegation (SoRD).

Each ICB remains accountable for all its functions, including those that it has delegated, however acknowledging that the current clustering arrangements in place between SEL and SWL, as the consequent Board roles held by individuals across both ICB Boards, the delegations are combined within a single document for ease of reference.

Given the individual statutory status of each ICB, delegations may differ between ICBs. These are clearly noted in the document and must be adhered to.

This SoRD may be amended from time to time to reflect changes in legislation, ICB policy or operational requirements.

The ICB will coordinate regular reviews of financial, procurement and contracts signing financial delegations for positions and limits.

This document should be read in conjunction with Board committee terms of reference, which detail the responsibilities within the remit of each committee. Specific delegations from the Board to committee are shown in the tables below.

A revised version is submitted to the Senior Management Team and Audit, Risk and Assurance Committees for endorsement before submission to the respective ICB Boards for approval.

Accountability

ICB employees are reminded of their accountability under this Scheme of Reservation and Delegation, and the associated obligations.

As an officer of the ICB with delegated authorities, as detailed in this document, you have personal accountability for:

- Complying with all the authority limits set out in this document, noting that variations exist between SEL ICB and SWL ICB delegated limits, and applying these appropriately.
- Delivering your service within the budgetary limits set, unless express agreement to a variance to budget is reached with the respective delegated officers in advance
- Regularly monitoring income and expenditure against agreed budgets, including meeting your management accountant on a monthly basis.
- Highlighting any significant actual or forecast variances to your executive director (or the CFCO if you are an executive director yourself) and finance business partner as early as possible in order that mitigating actions can be developed and implemented.
- Ensuring awareness and compliance to the ICBs counter fraud, bribery and corruption policies within your teams at all times.
- Ensuring adherence to the respective ICBs Standard of Business Conduct Policy.
- Complying with all organisational policies and procedures.
- Ensuring appropriate local systems are in place to ensure these delegations are operated effectively.
- Providing the necessary reports to respective ICB committees, to enable those committees to conduct their assurance duties as required.

Failure to adhere to organisational policies and procedures, including adherence with the delegated authority limits within the Scheme of Reservation and Delegation and Operational Scheme of Delegation may result in disciplinary action in line with the organisations Policy.

Section A:

NHS South East London ICB & NHS South West London ICB Integrated Scheme of Reservation & Delegation

V1

Decision	Reserved or delegated to Board	Chief Executive	Chief Finance and Compliance Officer	Committees and Sub-committees
STRATEGY				
Agree the vision and values and overall strategic direction of the ICB	✓			
Agree the overall South East London and South West London Neighbourhood strategy	✓			
Agree joint working on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability	✓			
GOVERNANCE ARRANGEMENTS				
Prepare the ICB's overarching Scheme of Reservation and Delegation			✓	
Approval of the group's overarching Scheme of Reservation and Delegation.	✓			
Prepare the ICB's operational scheme of delegation.			✓	
Approval of the ICB's operational scheme of delegation.	✓ (as part of SoRD)			
Consideration and approval of applications to NHS England on any matter concerning changes to the ICB's constitution or standing orders.	✓			

Decision	Reserved or delegated to Board	Chief Executive	Chief Finance and Compliance Officer	Committees and Sub-committees
Prepare detailed financial policies that underpin the ICB's standing financial instructions			✓	
Approve policies required to ensure ICB meets statutory or legislative guidance	✓			
Approve operational policies required to provide internal direction (which do not relate to specific statutory or legislative guidance)				Senior Management Team
Approve any changes to the ICB's committee structure	✓			
Approval of the arrangements for discharging the ICB's statutory financial duties.	✓			In consultation with Audit, Risk and Assurance Committee
Exercise or delegation of those functions of the ICB which have not been reserved to the board or other committee or sub-committee or [specified] employee		✓		
Authority to make decisions relating to operational matters, within the financial limits specified in the Operational Scheme of Delegation, where not explicitly delegated elsewhere or defined elsewhere in the Scheme of Delegation				Senior Management Team
APPROVAL OF PLANS				
Approval of the NHS Joint Forward plan	✓			
APPROVAL OF BUDGETS AND FINANCE MATTERS				
Approval of the ICB's annual corporate budgets	✓			

Decision	Reserved or delegated to Board	Chief Executive	Chief Finance and Compliance Officer	Committees and Sub-committees
Approval of a comprehensive system of internal control, including budgetary control, that underpins the effective, efficient and economic operation of the ICB				Audit, Risk and Assurance Committee
Approval of the ICB's annual report and annual accounts				Audit, Risk and Assurance Committee
OPERATING STRUCTURES AND HR MATTERS				
Approval of the ICB's operating structure (in relation to organisational structures within the ICB)	✓			
Approval of terms and conditions, pensions, remuneration, fees and allowances payable to board members, employees and to other persons providing services to the ICB outside of agenda for change				Remuneration Committee
Approval of the use of any Redundancy Scheme (RS)				Remuneration Committee
Approval of TUPE or other staff transfer schemes				Remuneration Committee
Approval of the arrangements for discharging the ICB's statutory duties as an employer	✓			
Leading system implementation of people priorities including delivery of the People Plan and People Promise by aligning partners across the ICS to develop and support 'one workforce', including through closer collaboration across the health and care sector, with local government, the voluntary and community sector and volunteers	✓			

Decision	Reserved or delegated to Board	Chief Executive	Chief Finance and Compliance Officer	Committees and Sub-committees
CLINICAL QUALITY AND PATIENT SAFETY				
Approve arrangements to minimise clinical risk and maximise patient safety				Patient Safety Committee
Approve arrangements to secure continuous improvement in quality and patient outcomes				Strategic Commissioning Committee
Approve arrangements for supporting NHS England in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services.				Patient Safety Committee
RISK & ASSURANCE MATTERS				
Approval of the ICB's counter fraud and security management arrangements				Audit, Risk and Assurance Committee
Approval of the ICB's risk management arrangements.				Audit, Risk and Assurance Committee
Approval of changes to the provision or delivery of assurance services to the ICB including internal audit and counter fraud				Audit, Risk and Assurance Committee
Approve the appointment (and where necessary dismissal) of external auditors (and where necessary change/removal) of external audit				Audit, Risk and Assurance Committee acting as Auditor Panel

Decision	Reserved or delegated to Board	Chief Executive	Chief Finance and Compliance Officer	Committees and Sub-committees
CORPORATE MATTERS				
Approve ICBs publication scheme		✓		
Approval of the ICB's contracts for corporate support (for example finance provision)		✓		
COMMISSIONING, CONTRACTING AND RISK POOLING				
Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other Integrated Care Boards or pooled budget arrangements under section 75 of the NHS Act 2006).	✓			
Approval of the ICB's contracts for any contracting / commissioning support including in respect of any commissioning functions delegated by NHSE		✓		
Approval of a new pooled budget, with a South East or South West London local authority	✓			
Approve decisions delegated to joint committees established under section 75 of the 2006 Act.	✓			
Approve primary care commissioning arrangements in South East and South West London (Bexley, Bromley, Greenwich, Lambeth, Southwark, Lewisham and Kingston, Richmond, Croydon, Wandsworth, Merton, Sutton)				SEL: Strategic Commissioning Committee
Approval of the arrangements for promoting integration and co-ordinating the commissioning of services with other integrated care boards, provider collaboratives, place and/or with the local authority/ies, where appropriate	✓			

Decision	Reserved or delegated to Board	Chief Executive	Chief Finance and Compliance Officer	Committees and Sub-committees
Approval of the arrangements for discharging the ICB's statutory duties associated with its commissioning functions for promoting improvement in the quality of services and promoting the involvement of each patient, patient choice, public engagement and consultation				Strategic Commissioning Committee
Approval of the arrangements for discharging the ICB's statutory duties associated with its commissioning functions to promote reductions in inequalities	✓			

Section B:

NHS South East London ICB & NHS South West London ICB
Integrated Operational Scheme of Delegation (schedule of matters delegated to officers and committees)

1. Introduction

1.1 This Operational Scheme of Delegation has been developed in conjunction with the organisation's Standing Financial Instructions and will provide guidance for the ICB.

1.2 The delegation shown below is the lowest level to which authority is delegated. Authority can be delegated upwards with no further action being required. However, delegation to lower levels is only permitted with written approval of the Chief Executive Officer. Decision making with a financial impact must be carried out in accordance with the ICB's Standing Orders, Prime Financial Policies and detailed financial procedures. All financial limits in this schedule of matters delegated to Officers are subject to sufficient budget being available.

1.3 The Standing Financial Instructions set out the financial responsibilities of the various Committees, Groups and individuals within the ICB.

2. Levels of Delegation

2.1 The Operational Scheme of Delegation covers only matters delegated by NHSE to the ICB and those matters reserved for the ICB Board its committees, Executive Officers and/or Partners.

2.2 Further delegation may be approved:

a. by the ICB Board in approving specific management policies

b. by the ICB Chief Executive

c. as part of Financial Procedures approved by the Chief Finance and Compliance Officer (CFCO)

2.3 Each Executive Director will need to consider the arrangements for authorisation of expenditure against delegated budgets and further delegation of management/professional responsibilities.

2.4 In accordance with the Scheme of Delegation the ICB Board exercises financial supervision and control by:

a. Authorising the operational plan;
b. Requiring the submission and approval of budgets within approved allocations / overall income;
c. Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and
d. Defining specific responsibilities placed on members of the ICB Board, its Committees, Partners and employees as indicated in the Scheme of Delegation.

2.5 Once the ICB Board, has reviewed and approved the Operating Plan and any supporting financial plan / budget, the Board, will delegate approval to the Chief Executive; the Chief Finance and Compliance Officer and other Executive Directors and employees to commit these resources for the purpose set out in the plan subject to the financial thresholds set out in this document.

2.6 Levels of Sub-Delegation
The Delegation of financial limits are also linked to the position/role of the staff member and the Levels outlined in Schedule 1 will be those set on the financial system.

2.7 Types of Delegation Authority

The types of financial delegation outlined in this document include:

a. Expenditure approval delegations
b. Invoices and credit note requests
c. Business case approval delegations

d. Procurement delegations
e. Contracts signing delegations
f. Other non-financial delegations.

3. Principles

3.1 General Delegation Principles

3.2 Delegates Must:

a. Act within your authority by ensuring you hold the relevant delegation
b. Understand your authority by referring to relevant guidance, limitations and directions
c. Act with the ICB's values in mind
d. Avoid conflicts of interest
e. Consider the ICB's business needs
f. Seek expert advice when making a decision
g. Make decisions objectively, reasonably and fairly.

3.3 Delegates Must Not:

a. Exercise delegations in respect of someone outside of your immediate line of control
b. Exercise powers in respect of a position higher than your own
c. Exercise a delegation in respect of yourself (i.e. confer a personal benefit)
d. Exercise a delegation on behalf of an absent employee unless it is within the scope of your delegated authority, or you are officially acting in the position.

3.4 Compliance

a. All delegates are required to comply with manuals and directives issued by the ICB

b. Delegated authority is subject to internal controls and to any overriding National laws

3.5 Responsibility

a. Delegations are made to positions, not to persons, and are specific to the position's work unit and/or role. Ultimate responsibility for performance of the functions or exercise of the authority or power rests with the authority holder.

b. Where an authority holder delegates an authority to an individual position, the person occupying that position becomes personally accountable for the delivery of that authority.

c. The delegation to a position is unique and is not transferable by the delegate.

d. Delegations extend to the Officer substantively appointed to that position and any person acting in that position for a specified period unless otherwise excluded in the terms of the temporary appointment. Delegations do not extend to volunteers.

e. Where the Scheme of Delegation specifies a delegate, the position to which the delegate reports is also deemed to have the delegated authority except where otherwise determined by legislation, policy or a Chief Executive instruction.

f. Where the permanent Officer takes leave, it is their responsibility to instruct the relieving Officer (and the finance department) of the level of delegation that is attached to the position and the responsibilities associated with the delegation for the agreed period. In case of the Chief Executive Officer their responsibility would be delegated to the Deputy Chief Executive Officer in the first instance for any leave.

3.6 Application

a. Delegates are expected to exercise their powers, authorities, duties or functions delegated to them in a responsible, efficient, consistent and cost-effective manner.

b. Discretion is to be utilised by the delegate in determining whether to exercise a delegation or refer the matter to a higher authority.

c. When an Officer is exercising their financial delegation, they are required to clearly provide their name, position and date when signing.

3.7 Financial Delegation Principles

3.8 Delegates Must:

a. Only approve expenditure in cost centres under the delegate's authority
b. Only approve expenditure where there is sufficient budget to cover the cost
c. Only approve expenditure on goods and services related to official work and business use
d. Only approve expenditure where all relevant ICB's procedures and policies have been followed
e. Only approve expenditure to the financial limit of the delegation
f. Only approve expenditure where evidence exists that goods have been received and/or services have been performed in accordance with and at the rate/s of an agreed contract or arrangement
g. Employees are to note that an expenditure approval is to be given prior to any commitment being made, contract signed, or purchase order raised.

3.9 Delegates Must Not:

a. approve a gift or settlement of any legal claim unless specifically delegated this authority
b. transfer the financial delegation granted by the ICB Chief Executive to another employee
c. break one purchase down into several smaller items to avoid breaching the financial limit of the delegation
d. approve expenditure on capital works, contracts or special payments unless specifically delegated this authority
e. exceed their delegation limits even if automated systems permit this to occur
f. Approve any expenditure incurred by the delegate on travel, meals, conferences and other similar expenditure
g. Assume the financial delegation of an absent delegate if you are not authorised to do so.
h.

3.10 Suspension, Revocations and Reductions in Financial Delegations

a. The terms of any financial delegation cannot be exceeded under any circumstances.

b. Financial delegations cannot be sub-delegated once granted by the ICB Chief Executive.

c. Improper performance of responsibilities may result in disciplinary action being taken against the employee concerned.

d. The power to revoke, suspend or reduce financial delegations granted to positions within the ICB rests with the Chief Executive in respect of delegations made.

e. If circumstances arise which warrant the suspension, revocation or reduction of a financial delegation, full details must be forwarded to the ICB's Chief Finance and Compliance Officer. The ICB's Chief Finance and Compliance Officer will submit an appropriate recommendation to the Chief Executive for consideration.

f. If the recommendation is approved, the delegation will be amended to reflect that reduction, suspension or revocation.

3.11 Reviewing and Maintaining the Scheme of Delegations

a. This Scheme of Delegation may be amended from time to time to reflect changes in legislation, ICB policy or operational requirements.

b. The ICB will coordinate regular reviews of financial, procurement and contracts signing financial delegations for positions and limits. A revised version is submitted to the Senior Management Team (SMT) and Audit, Risk and Assurance Committee for endorsement before submitting it to the ICB Board for approval.

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
1	**Bank Accounts** Maintenance and operation in accordance with banking mandates.	All banking must be managed in accordance with organisational Standing Financial Instructions (SFIs) and Standing Orders (SOs).
2	**ICB Budgets** All ICB staff have the responsibility of keeping expenditure to within agreed budgets. The following delegated authority to spend is only extended to where the approved budget is available: a) At individual budget level (Pay and non-Pay) b) At a service level c) For the totality of service covered by directorate d) For the totality of the budget delegated to Place e) The totality of the ICB budget **In the event of an urgent unpredicted need for expenditure which does not have allocated budget, no expenditure must be committed to without prior discussion with the Chief Finance and Compliance Officer or Chief Executive.** **Management of budgets – variations to agreed budgets:** a) Approving expenditure where there is a variation to budget, or in the tender price up to 10% or £100,000 whichever is the higher. b) Approving expenditure where there is a variation to budget or in the tender price greater than 10% or £100,000 and less than 20% or £250,000, whichever is the higher. c) Approving expenditure where there is a variation to budget or in the tender price greater than 20% or £250,000, whichever is the higher. **Budget Virements:** a) At individual budget level within a service up to £10,000 b) At individual budget level within a service over £10,000 and < £100,000	a) Budget Holders b) Head of Service/Departmental Manager c) Executive Director d) Place Executive Director e) Chief Executive a) Chief Finance and Compliance Officer or Chief Executive Officer b) Chief Finance and Compliance Officer and Chief Executive Officer c) ICB Board a) Budget Holders b) Executive Directors

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	c) Between services up to £500,000 d) Services greater than £500,000 Virements should not be used to create new budgets. Virements are not permitted between pay and non-pay budgets. The virement must be signed by both the budget holder from whom the budget is transferring and the budget holder to whom the budget is transferring.	c) Chief Finance and Compliance Officer or Chief Executive Officer d) ICB Board
3	**Business Case and Investment Approvals** Business cases for investments must be prepared for changes to services and/or expenditure including capital or revenue, procurement of services and pathway redesigns. Business cases seeking external funding must be approved by the relevant body prior to making the external request for funds. The following delegated authority is only extended to where the approved budget is available: Capital: a) Estimated cost up to £2.50m b) Estimated cost up to £5.00m c) Estimated cost up to £10.00m d) Estimated cost up to £24.99m e) Above £25.00m The ICB is required to have oversight of significant investment (no matter whether they are revenue or capital or a combination) made by partners in the system to ensure they align with the ICS and ICP strategy and provide value for money. These business cases typically relate to additional funds made available by NHSE for specific projects and the strategic investments as part of the system-wide capital plan. On agreeing they align to the system priorities, are affordable and value for money the ICB will be expected to write a letter of support for the scheme. Where the NHS makes allocations to individual organisations within the ICS/allocation values are updated in year e.g. pay awards. These would be excluded from requiring a business case.	a) Chief Finance and Compliance Officer b) Chief Executive Officer c) CFO and CEO/SMT d) SMT e) ICB Board

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	Prior to the ICB reviewing and agreeing its support to any cases it is expected these will have been through individual partner organisations governance (in line with their SFIs and Scheme of Delegation). The appropriate approval process for a business case is determined by the value of the business case. Business cases should follow national guidance in their construct: **Letters of Support** *a) Estimated cost up to £5m* *b) Estimated cost up to £10m* *c) Estimated cost up to £20m* *d) Estimated cost up to £50m* *e) Above £50m* Revenue: Annual values L1 - <£50k L2 - £50k-£250k L3 - £250k-£2.5m L4 - £2.5m - £10m L5 - £10m - £25m L6 - >£25m Where expenditure is not fully budgeted for, the capital limits will apply – for example the CFCO will have delegated authority up to £2.50m.	a) CFCO b) CFCO and CEO c) CFCO, CEO and SMT d) SMT and SCC e) SMT, SCC and ICB Board Decision Owner / Committee Involvement Budget Holder – None Director – Exec visibility Exec Director – SMT reporting SMT – Notify SCC SCC – SMT (prior to SCC) Board – Final Approval

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
4	**Capital Schemes** The financial limits for quotations, tendering and contract procedures are set out below in section 30 and apply to capital expenditure. In addition, the following delegations apply to capital schemes: a) Selection of architects, quantity surveyors, consultant engineer and other professional advisers within EU regulations b) Financial monitoring and reporting on all capital scheme expenditure c) Granting and termination of leases with annual rent <£100,000 d) Granting and termination of leases with annual rent >£100,000 The ICB capital plan is developed and then reviewed by Senior Management Team before being approved by the ICB Board prior to publication. ICB capital includes: a) Primary care improvement grants b) Primary care ICT grants c) Buildings and equipment d) Leases (under IFRS16) – including the authority to extend or exit tenancy agreements for ICB offices It excludes tenancy agreements and void costs that should be managed in line with non-pay revenue investments/spends unless specifically listed below: a) preparation and signature of all tenancy agreements/ licences b) Extensions to existing leases c) Letting of premises to/from outside organisations d) Approval of rent based on professional assessment ICB capital projects are subject to the DHSC and Cabinet office rules for approval as in the Procurement Section. Authority to approve capital expenditure in excess of the total capital budget	a) Chief Executive or Chief Finance and Compliance Officer on recommendation of estates director b) Chief Finance and Compliance Officer c) Chief Finance and Compliance Officer d) SMT a) Chief Finance and Compliance Officer b) Chief Finance and Compliance Officer c) Chief Finance and Compliance Officer and Chief Executive d) Chief Finance and Compliance Officer Approval of an increase in the total capital budget above the value signed off by ICB Board would breach CDEL and is not permitted.

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	Charitable and Endowment Funds	
	NHS Greenwich Charitable Fund	NHS South East London ICB (SEL ICB) is the Corporate Trustee for NHS Greenwich Charitable Funds.
	Approval of Charity purpose, vision and strategic objectives	SEL ICB Board
	Approval of annual charitable funds budget	Chief Finance and Compliance Officer
	Approval of annual report and assuring compliance	Chief Finance and Compliance Officer
	Day to day control and management of charitable fund	Place Executive Lead (Greenwich)
	Approval of grants: a) Up to £10k b) £10k to £200k c) £200k+	a) Associate Director of Finance (Greenwich & Lewisham) b) Place Executive Lead (Greenwich) c) Chief Finance and Compliance Officer (on recommendation from Charitable Funds Committee)
5	**Clinical Trials**	
	Authorisation of Clinical Trials	Chief Executive Officer and Medical Director.
6	**Discretionary Grants to Local Authorities and Voluntary Bodies**	
	Discretionary grants to local authorities and voluntary bodies should only be awarded in exceptional circumstances. The expectation of the ICB is that all contractual commitments are made through the normal procurement process for contracts and in line with the approval limits set out in section 30 below.	For all agreements to provide grants/ MOUs to third parties including local authorities and voluntary bodies: Chief Finance and Compliance officer or Chief Executive or Chief Commissioning Officer

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
7	**Commissioning Expenditure - purchase of Healthcare from all bodies** i) Service Level Agreements (SLAs) SLAs within the annual budget: a) Signing of annual local contracts/voluntary sector contracts and SLAs up to £5m b) Signing of annual local contracts/voluntary sector contracts and minor SLAs over £5m Authorisation of monthly invoices in excess of agreed SLA value. ii) Contract Exclusions (NHS and Non-NHS) Individual Funding Requests (IFRs) a) Approval of Requisitions in line with approved IFR b) Approval of Purchase Order iii) All other contract exclusions iv) For any other funded commissioning arrangements under this category not included above: Agreement of Named Placements (not Continuing Healthcare Placements) a) Up to £50,000 and within approved budget b) Above £50,000 or in excess of available resources **Continuing Healthcare Packages** To recognise the current differences between the processes in SEL ICB and SWL ICB, different authority limits shown below for each ICB:	a) Executive Director b) Chief Executive and Chief Finance and Compliance Officer Deputy Chief Executive/ Chief Finance and Compliance Officer and reported to SMT for information. a) IFR Lead after IFR panel approval of expenditure b) Procurement Operations Manager Executive Director Chief Finance and Compliance Officer, or Chief Executive Officer, or Chief Commissioning Officer a) Head of service b) Executive Director

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	SWL ICB Delegation for all placements, value relates to the period of award up to the next review point. a) Up to £1,500 per week or £75,000 per annum b) Up to £4,000 per week or £200,000 per annum c) Up to £10,000 per week or £500,000 per annum d) Above £10,000 or over £500,000 per annum SEL ICB a) Agreement of named placements up to £1,650 per week b) between £1,651 and £3,450 per week c) for values exceeding those above d) Signing of Contract for placements e) Approval of invoices within package contract value as per ISFE limits f) Authorisation of monthly invoices in excess of contract value **Joint commissioning with Local Authorities** Where services are being commissioned jointly with local authorities, delegated responsibility for the arrangements will by held by the Place Executive Leads, with assurance and co-ordination delivered by the Neighbourhood Delivery Committee.	a) Deputy director of CHC *b)* Operational Place lead *On recommendation of the Deputy Director of CHC* *c)* Chief Nursing and Quality Officer *On recommendation of the Operational Place lead* *d)* Senior Management Team *On recommendation of the Chief Nursing and Quality Officer* a) CHC teams within boroughs b) Head of service c) Executive Director d) Head of service up to value of £100,000 and Executive Director for over £100,000 e) As per ISFE limits set per user f) Executive Director Place Executive lead holds delegated responsibility, with assurance and oversight through Neighbourhood Delivery Committees.
8	**Complaints (Patients and Relatives)** a) Overall responsibility for ensuring that all complaints are dealt with effectively b) Responsibility for ensuring that complaints are investigated thoroughly c) Medico – Legal Complaints - Co-ordination of their management	a) Chief Executive b) Relevant Executive Director c) Director of Corporate Services

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
9	**Condemning & Disposal of capitalised equipment** Items obsolete, redundant, stolen, and irreparable or cannot be repaired cost effectively. *Note: these write-offs, once agreed, will impact on individual budgets – there is no central provision. A bad debt write-off for these purposes is the writing off of any income due to the ICB whether or not invoiced – it does not include adjustments relating to invoices raised in error.*	Approval for disposal to be made by two officers - the Chief Finance and Compliance Officer plus either the Chief Executive or Director of Corporate Services. All disposals to be reported to the next meeting of the Audit Risk and Assurance Committee.
10(a)	**Payments to Independent Contractors - GP contract payments including pensions SEL ICB ONLY** Notifying GP practices of approved annual allocation Approval of regular monthly instalments schedules of approved reimbursements: a) <£20,000,000 as per SE London schedule b) >£20,000,001 as per SE London schedule Further reimbursement of expenditure within approved allocation, including Out of Hours (OOH) Community Schemes and Local Incentive Schemes expenditure: a) Up to £10,000 b) £10,001 to £50,000 c) Over £50,000	Executive Director a) Head of service and Associate Director of Corporate Finance b) As above plus Director of Operational Finance a) Borough Head of Primary Care (or equivalent) b) Borough Director of Primary Care (or equivalent) c) Executive Director
10(b)	**Payments to Independent Contractors – Primary Care Dental, Ophthalmology and Community Pharmacy** Approval of regular monthly instalments schedules of approved reimbursements: a) less than £20,000,000 as per SE London schedule b) greater than £20,000,001 as per SE London schedule	a) Director or Chief Commissioning Officer and Associate Director of Corporate Finance b) Director or Executive Director and Director of Corporate Finance

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	Approval of contract changes on dental system	Director or Executive Director
11	**Medicines Optimisation** Authorisation of New Drugs: a) Estimated total yearly cost per drug of up to £25,000 per 100,000 population (£500,000 for South East London based on 2 million population, £375,000 for South West London based on 1.5 million population) b) Estimated total yearly cost per drug above £25,000 per 100,000 population (£500,000 for South East London based on 2 million population, £375,000 for South West London based on 1.5 million population)	a) ~~Chief Pharmacist~~The ICB Chief Pharmacist exercises delegated authority for decisions relating to the introduction of new and repurposed medicines, following consideration and recommendation through the Integrated Medicines Optimisation Committee (IMOC), and is responsible for ensuring that IMOC operates in accordance with approved terms of reference and delegated limits. b) Senior Management Team (SMT)~~CC~~ on the recommendation of Integrated Medicines Optimisation Committee (IMOC)~~medicines optimisation tea~~ Note: The NHS is legally obliged to fund and resource medicines and treatments recommended by NICE's Technology Appraisals. For drugs recommended within NICE Technology Appraisals and being used within NICE criteria and where the total yearly cost is above £25,000 per 100,000 population – these will be highlighted to the SMT for information only. Where NICE guidance is not followed, this should be reported to the Board at the next opportunity.
12	**Legal matters** Engagement of legal advice **Where costs are estimated to exceed £100k, SMT to be alerted.** Legal settlements	Approval by an Executive Director and Director of Corporate Services. Chief Executive and Chief Finance and Compliance Officer approval
13	**Engagement of Agency Staff** All agency Costs of £600 or more per day (excluding VAT) or over 6 months in duration (regardless of cost) will require approval by NHSE via submission of a business case.	For SEL ICB Prior to engaging any agency/interim staff, staff must follow the Hiring of Interim Resources Policy and comply with the NHS England and ICB guidance.

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
		All requests for agency staff (regardless of the daily rate and length of contract) require the approval of the VR panel before any appointment can be made. Prior endorsement is required from finance and HR. **For booking of agency/interim staff and approval of invoices, within budget:** a) Up to £10,000 – budget holder b) £10,001 to £50,000 – head of service c) Over £50,000 – Executive director The sums above exclude VAT, agency fees and expenses. **For booking of Bank or Agency Staff – in excess of budget:** Employment of fixed term contractors is approved by Executive Director – following approval by the VR panel Fixed Term contractors should be considered where the requirement is time limited. In all cases HR advice should be taken prior to recruitment to understand any ICB liability that may be incurred at the end of the assignment. Approval is via the VR panel.
14	**Extended Role Activities** Approval of Nurses to undertake duties/procedures which can properly be described as beyond the normal scope of Nursing Practice.	Chief Nursing and Quality Officer
15	**Facilities for staff not employed by the ICB to gain practical experience** a) Professional Recognition, Honorary Contracts and other Memorandums of Understanding b) Non-Medical Work experience students	a) Chief Nurse or Medical Director (as appropriate) - HR to be advised b) An ICB Director - HR to be advised
16	**Review of fire precautions at ICB sites**	Director of Corporate Services in conjunction with local authority/landlord as appropriate

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
17	**Hospitality and Gifts** Responsibility for implementing arrangements to ensure Conflicts of Interest and Gifts and Hospitality policy is adhered to. Limits as determined in the ICBs Conflicts of Interest/ Standards of Business Conduct Policy.	Director of Corporate Services
18	**Arrangements for Internal and External Audit – including the implementation of Audit Recommendations**	All audit plans will be approved by the ICB's Audit, Risk and Assurance Committee on the recommendation of the Chief Finance and Compliance Officer or Director of Operational Finance.
19	**Approval of any proposed non-audit based professional services to be delivered by the ICB's external auditor**	Chief Finance and Compliance Officer AND the Chair of the Audit, Risk and Assurance Committee *Prior endorsement required by:* Senior Management Team Approval noted by the Audit, Risk and Assurance Committee
20	**Insurance Policies including NHSLA** Negotiation and agreement of premiums Ensuring the ICB has arrangements in place for the provision of adequate insurance cover for the ICB that are not indemnified through the NHS Resolution	Director of Corporate Services Chief Executive and Chief Finance and Compliance Officer, via Director of Corporate Services
21	**Certification of invoices where no Purchase Order or contractual arrangement is in place** a) Up to £10,000 b) £10,001 to £50,000 c) £50,001 to £250,000 d) £250,001 to £1,000,000 e) £1,000,001 to £5,000,000 f) £5,000,001 to £10,000,000 g) Up to £500.0m h) Up to £1.0bn	a) Budget managers at Bands 6 and 7 b) Budget managers at Band 8a and 8b c) Assistant/Associate Directors at Band 8c and 8d d) Directors at Band 9 e) ICB Operational Director of Finance f) Borough, Place Directors or equivalent (VSM) g) Deputy Chief Executive Officer h) Chief Executive Officer and Chief Finance and Compliance Officer
22	**Losses, Write-off & Compensation** a) Losses and Cash due to theft, fraud, overpayment etc. b) Fruitless Payments (including abandoned Capital Schemes)	a) Chief Finance and Compliance Officer b) Chief Finance and Compliance Officer

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	c) Claims Abandoned d) Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g. fraud, theft, arson) or other e) Compensation payments made under legal obligation f) Extra Contractual payments to contractors g) Ex-gratia Payments to Patients and staff for loss of personal effects h) Ex-gratia payments for Clinical negligence (negotiated settlements following legal advice) – up to £250,000 including claimant's legal costs i) Ex-gratia payments for personal injury claims involving negligence where legal advice obtained and followed j) Other ex-gratia payments except cases of maladministration where there is no financial loss by claimant - up to £50,000 k) Write back of Non-NHS Debtors < £250,000 l) Write back of Non-NHS Debtors > £250,000	c) Chief Finance and Compliance Officer d) Chief Finance and Compliance Officer e) Chief Finance and Compliance Officer and Chief Executive f) Chief Finance and Compliance Officer g) Chief Finance and Compliance Officer h) Chief Finance and Compliance Officer i) Chief Finance and Compliance Officer j) Chief Finance and Compliance Officer k) Chief Finance and Compliance Officer l) Audit, Risk and Assurance Committee
23	**Maintenance & Update of ICB Financial Procedures**	Chief Finance and Compliance Officer
24	**Management Consultants** All contracts for management consultants will require agreement in line with any ICB process and reporting to NHS England in addition to the process below. All contracts for management consultants over £50,000 require a business case to be submitted to NHS England for approval prior to any appointment being made. All requests for management consultancy must be assessed as being consistent with IR35 compliance before any appointment can be made. a) Obtaining at least 3 quotations / carrying out competitive interviews, **within budget**, where aggregate commitment in any one year or total commitment is to £24,999. b) Obtaining at least 3 competitive tenders / quotes or undertaking competitive interviews **within budget**, where aggregate commitment in any one year is £25,000 or more c) Authorising contracts of engagement following the above.	a) Executive Director b) Executive Director c) Executive Director

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	d) Authorisation of consultants **in excess of budget.**	d) Chief Finance and Compliance Officer or Chief Executive
25	**Personnel & Pay** This is subject to compliance with all ICB recruitment processes, e.g. submission to VR/recruitment panel.	
	a) Authority to fill funded post on the establishment with permanent staff	a) Pre-approval by Director, Finance lead and HR. Once confirmation/approval received from VR panel/RSC, JD and advert to be sent to the Resources team by recruiting manager. HR to be informed.
	b) Authority to appoint staff to post not on the agreed establishment	b) As above for a). Chief Executive approval will be required should there be no recruitment panel in place.
	c) All requests for upgrading/re-grading to be dealt with in accordance with ICB procedures and recruitment panel approval.	c) Once approval received, finance department and workforce department to be informed of outcome for budgetary and ESR purposes.
	d) Approval of the extension of staff on fixed term contracts within budget.	d) Fixed term contracts should only be extended in specific circumstances. In all cases this should be discussed with HR and the relevant financial officer prior to submission of a request to the VR/recruitment panel.
	e) Pay i) Staff appointments – Executive directors and other directors referenced on the ICB Board ii) Approval of remuneration arrangements (including additional allowances above basic salary) – all staff levels excluding Executive Directors and Directors referenced in the Board iii) Approval of remuneration arrangements for Executive Directors and other Directors referenced on the ICB Board iv) Authority to complete standing data forms affecting pay, new starters, variations and leavers v) Authority to authorise overtime/flexible working vi) Authority to authorise travel & Subsistence expenses on Workforce vii) Approval of staff timesheets – both substantive and temporary staff	e) i) Chief Executive and Chair ii) Human Resources and finance leads and relevant executive director iii) Remuneration Committee iv) Budget holder and Associate Director of Corporate Finance. HR to be informed. All staff change forms must be approved by a Director and either the Chief Financial Officer or Director of Corporate Finance. v) Line Manager (with guidance from a Director) vi) Line Manager vii) Line Manager
	f) Leave i) Approval of Annual Leave	f) i) Line Manager

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	ii) Approval to carry forward annual leave	ii) Annual leave carry over will be approved in line with the annual leave policy for each respective ICB.
	iii) Payment of Annual Leave in exceptional circumstances	iii) Chief Executive
	iv) Special leave for bereavement up to 5 days	iv) Head of Service
	v) Extended Special Leave for bereavement	v) Executive Director
	vi) Special leave arrangements • carers leave - up to 3 days in any six-month period • carers leave - up to 5 days in any six-month period	vi) • Head of Service. HR to be informed • Executive Director. HR to be informed
	vii) Leave without pay	vii) Executive Director
	viii) Time off in lieu	viii) Line manager
	ix) Maternity and Paternity Leave – paid and unpaid	ix) Automatic approval as per guidance and ICB Policy; HR to be informed.
	g) Sick Leave (in exceptional circumstances) i) Extension of sick leave – in line with contract of employment ii) Extension of sick leave – any non-contractual payments iii) Return to work part-time on full pay to assist recovery	g) i) To seek advice from the Director of HR before any extension is agreed ii) Remuneration Committee iii) Executive Director with advice with advice from occupational health and HR.
	h) Study Leave i) Study leave outside the UK ii) All other study leave (UK)	h) i) Chief Executive in line with ICB training policy ii) Executive Director in line with ICB training policy
	i) Removal Expenses, Excess Rent and House Purchase (to be agreed prior to advertising posts). Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview): i) Up to £2,000 ii) Over £2,000	i) Executive Director, and notification to HR ii) Chief Executive and notification to HR
	j) Grievance Procedure All grievance cases must be dealt with strictly in accordance with the applicable ICB Grievance Procedure and the advice of HR	As per applicable (i.e. SEL or SWL) ICB procedure
	k) Authorised Car & Mobile Phone Users i) Requests for new posts to be authorised as car users ii) Requests for new posts to be authorised as mobile telephone users	k) i) As per applicable ICB policy ii) As per applicable ICB policy
	l) Redundancy	l) Remuneration Committee with support from HR and appropriate permission/approvals from NHS England. Chief Finance and Compliance Officer to be consulted at all times.

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	Authorisation to agree voluntary redundancy and determine compulsory redundancies in accordance with policy m) Ill Health Retirement Decision to pursue retirement on the grounds of ill-health. n) Employment of voluntary workers / work experience. o) Approval of expense claim within assigned delegation limit (refer schedule 1) and claim is allowable per the NHS Terms and Conditions of Service handbook p) Approval of expense claim above assigned delegation limit (refer schedule 1) and claim is allowable per the NHS Terms and Conditions of Service handbook	m) Chief Executive or Executive Director following advice from HR **and** occupational health. n) An ICB Director with advice from HR o) Employees line manager p) Executive Director
26	**Petty Cash Disbursements**	The ICB has no petty cash function.
27	**Quotation, Tendering & Contract Procedures** For Health Care services of any Contract Value, The Health Care Services (Provider Selection Regime) Regulations 2023 (PSR) and supporting Statutory Guidance, must be followed. PSR Provider Representations: Decisions following escalation of Representations made against a Provider Selection Regime decision, to the NHSE Independent Patient Choice and Procurement Panel PSR Non- Compliant Awards - Formal PSR procedures may be waived or a non-compliant award approved by the Chief Executive and Chief Financial Officer in the circumstances set out in the non-healthcare section below.	SMT Approved by the Chief Finance and Compliance Officer (up to £100,000) and Chief Finance and Compliance Officer and Chief Executive (£100,000 and over); reported to the Audit, Risk and Assurance Committee. ~~Where the Chief Executive is requesting an Urgent Award or Urgent Contract Modification, approval is by the Chair and the Chief Finance and Compliance Officer.~~

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	PSR Urgent Awards or Urgent Contract Modifications: Where: a) a new service needs to be arranged rapidly in an unforeseen emergency or local, regional or national crisis, e.g., to deal with a pandemic. b) urgent quality/safety concerns pose risks to patients or the public and necessitate rapid changes. c) an existing provider is suddenly unable to provide services under an existing contract (for example, a provider becomes insolvent or experiences a sudden lack of critical workforce) and a new provider needs to be found. An urgent award or modification must only be made when all the below apply: a) the award or modification must be made urgently the reason for the urgency was not foreseeable by and is not attributable to the relevant authority. b) delaying the award of the contract to conduct a full application of the regime would be likely to pose a risk to patient or public safety. Urgent Awards or Urgent Contract Modifications must not be used if the urgency is attributable to the ICB not leaving sufficient time to make procurement decisions and run a provider selection process– poor planning is not an acceptable reason to use these provisions. With the exception of Section (i) below, relating to Contract Variations, the remainder of this section (30) only applies to non-healthcare services.	Approval in line with the revenue and contract approval limits
	For non-health care services the following applies: This section does not apply to Management Consultants (see section 26) (or other services included elsewhere within this schedule) ~~a) Goods/services up to £24,999 - (Minimum of 1 written quote required)~~	Approval in line with the revenue and contract approval limits ~~a) Head of Service~~

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	~~b) Goods/services from £25,000 - £75,000 (Minimum of 3 written quotations required)~~ ~~c) Goods/services from £75,000 - £100,000 (Minimum of 3 competitive tenders required)~~ ~~d) Goods/services from £100,000 - £200,000 (Minimum of 3 competitive tenders required)~~ ~~e) Goods/services over £200,000 - (Minimum of 4 competitive tenders required)~~ ~~f) Waiving of quotations and tenders subject to Standing Financial Instructions~~	~~b) Associate Director or Director~~ ~~c) Executive Director~~ ~~d) Chief Finance and Compliance Officer~~ ~~e) Chief Executive~~ ~~f) Approved by the Chief Finance and Compliance Officer (up to £100,000) and Chief Finance and Compliance Officer and Chief Executive (£100,000 and over); reported to the Audit, Risk and Assurance Committee. Where the Chief Executive is requesting the tender waiver, approval is by the Chair and the Chief Finance and Compliance Officer.~~ ~~g) Two senior officers/managers designated by the CEO/CFCO and not from the originating department.~~ ~~h) Chief Finance and Compliance Officer~~ ~~i) Executive Director~~ ~~ii) Chief Finance and Compliance Officer~~
	a) Goods/ services up to £24,999 – minimum of 1 written quotation b) Goods/services from £25,000 - £74,999. Request a minimum of 3 written quotations, contract can be awarded if less than 3 quotes received. c) Goods/ services from £75,000 - £207,719. Request a minimum of 5 tenders, contract can be awarded if less than 5 tenders received. d) Goods/services listed under light-touch – from £75,000 – £663,539. Request a minimum of 5 tenders, contract can be awarded if less than 5 tenders received. e) Goods/services equal to or greater than £207,720 (current goods and services threshold). Full competitive tenders as per PA2023. f) Light Touch contracts equal to or greater than £663,540 (current light touch contracts threshold). Full competitive tenders as per PA2023. g) Waiving of quotations and tenders subject to Standing Financial Instructions.	a) Approval in line with the revenue and contract approval limits. b) Approval in line with the revenue and contract approval limits. c) Approval in line with the revenue and contract approval limits. d) Approval in line with the revenue and contract approval limits. e) Approval in line with the revenue and contract approval limits. f) Approval in line with the revenue and contract approval limits. g) Approved by the Chief Finance and Compliance Officer (up to £100,000) and Chief Finance and Compliance Officer and Chief Executive (£100,000 and over); reported to the Audit, Risk and

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	g)h) Opening Tenders and Quotations h)i) Authorisation of payments to public partnership schemes under existing contracts i)j) Contract variations i) Variation of +/- 20% of contract value and less than £100,000 ii) Variation of over 20% of contract value and/or more than £100,000 Exceptions and instances where formal tendering/quotes need not be applied: Where: a) the estimated expenditure or income does not, or is not reasonably expected to, exceed £24,999 or b) where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with. Formal tendering procedures may be waived or a non-compliant award approved by the Chief Executive and Chief Finance and Compliance~~ial~~ Officer in the following circumstances: ~~c) in very exceptional circumstances where formal tendering/quoting procedures would not be practicable or the estimated expenditure would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate record;~~ ~~d) where the requirement is covered by an existing contract;~~ ~~e) where PASA agreements or Public Sector Framework Agreements are in place;~~ ~~f) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;~~ ~~g) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;~~	Assurance Committee. Where the Chief Executive is requesting the tender waiver, approval is by the Chair and the Chief Finance and Compliance Officer. h) Sealed tenders and quotations will be opened by the procurement lead via the tendering portal. i) Chief Finance and Compliance Officer. j) i) Executive Director ii) Chief Finance and Compliance Officer

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	~~h) where specialist expertise is required and is available from only one source;~~ ~~i) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;~~ ~~j) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;~~ ~~k) for the provision of legal advice and services providing that any legal firm or partnership commissioned is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned. The Chief Executive, Chief Financial Officer, Chief of Staff will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.~~ ~~l) where allowed and provided for in the Capital Investment Manual.~~ a) In very exceptional circumstances where the Chief Executive Officer decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate ICB record; b) Where the requirement is covered by an existing contract; c) Where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender; d) Where specialist expertise is required and is available from only one source; e) There is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; f) Where no bids or no suitable bids were received in a compliant procurement process;	

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	g) Immediate risk to patient safety; h) Existing contract/ provider unexpectedly unable to provide services so new provider required; i) Other exceptional circumstances. The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure, except in exceptional circumstances. The Chief Executive & Chief Financial Officer will abide by the anti-bribery policy for the ICB at all times when approving tender waivers. Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and reported to the Audit, Risk and Assurance -Committee. ~~**Selection of preferred tenderer(s)/compliant direct contract award under either the *Public Procurement Regulations 2015* or the *Provider lection Regime Regulations 2023***~~ ~~This delegation has application when a formal competitive tender process is conducted. At the conclusion of the tender evaluation stage, the evaluation team will make a decision on the award of contracts and will prepare a recommendation report that recommends the preferred tenderer(s). The report will detail the factors (including price, quality, and timing) that define the tender that provides the best overall value for money, and provide a comparison with the details of the nearest competing bids, where appropriate, with reasons for their rejection.~~ ~~The Delegated Officers have authority to approve the recommendation report. Following approval award, post-tender negotiations can be initiated with the successful tenderer to improve the successful offer, where appropriate, and the formal contract should be prepared.~~ ~~Where a purchase exceeds the limit set in the Public Contracts Regulations 2015, but only a single provider is identified having advertised our requirements,~~	

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	~~approval must be sought from the Chief Finance and Compliance Officer together with one other executive prior to award of the contract.~~ PA23 permits direct awards under some circumstances – this would not be subject to a waiver. However the necessary procurement advice should be sought and governance approval obtained. Capital Revenue Up to £2,500,000 (if within delegated budget) Over £2,500,000 to £10~~5~~,000,000 (if within delegated budget) Over £10~~5~~,000,000 up to £25,000,000 Over £25,000,000	Chief Finance and Compliance Officer Contract and Procurement group *Prior endorsement required by* Place, Primary Care Executive or Department as appropriate Senior Management Team Prior endorsement required by: Contract and Procurement group Place, Primary Care Executive or Department as appropriate Strategic Commissioning Committee *Prior endorsement required by:* Senior Management Team, Contract and Procurement group Place, Primary Care Executive or Department as appropriate ICB Board *Prior endorsement required by:* Contract and Procurement group, Senior Management Team AND Strategic Commissioning Committee Place, Primary Care Executive or Department as appropriate

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	Authority to approve acceptance of late tenders Tender received within two hours after the specified tender closing time Tender received more than two hours after the specified tender closing time **Commercial contracts** *A commercial contract could take the form of a deed, contract, agreement, release, discharge, indemnity, guarantee, consent, instrument, and any other documents which binds the ICB legally to another party by imposing an obligation on each party* a) Less than £2,500,000 b) Over £2,500,000 up to £7,500,000 *c)* Over £7,500,000 and Better Care Fund investment/ Section 75 agreement	Executive director or manager Chief Finance and Compliance Officer a) Chief Executive OR Chief Finance and Compliance Officer OR Chief Commissioning Officer *Prior approval required by:* Contracting and Procurement Group b) Chief Executive OR Chief Finance and Compliance Officer OR Chief Commissioning Officer *Prior approval required by:* Contracting and Procurement Group c) ICB Chair or Chief Executive or Chief Finance and Compliance Officer or Chief Commissioning Officer *Prior approval required by:* Strategic Commissioning Committee
28	**Research Projects** Authorisation of Research Projects	SMT in conjunction with the Chief Nursing and Quality Officer
29	**Register of Interests** The keeping of a Declaration of Interests Register	Director of Corporate Services.

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
30	**Commercial Sponsorship** Sponsorship of events, including courses, conferences and meetings by external bodies should only be approved if it can be demonstrated that the event will result in clear benefits for SEL ICB and the wider NHS.	Approval by the Chief Executive or Chair only and entry in declarations of interest register required.
31	**Extension of Contract** Where an extension to an existing contract (both NHS and non-NHS) is required and is **allowable in the contract and is within budget**, details should be provided of the term of extension and the monetary value of the extension. Before any contract extension is agreed, a review will be required that demonstrates positive assurance in respect of value for money, performance and quality. Set up of new suppliers	Approval of the contract extension (including the review of the contract) is as per the delegated limits as set out in section 8 above. There is no automatic delegated approval for contracts to be extended. Instead, a contract tender waiver (for non-healthcare services) or Urgent Award/Urgent Contract Modification (for healthcare services) would need to be produced and approved in accordance with the limits set out in section 30 above. Requests need to be submitted to the Financial Controller, with supporting evidence. Once approved the request will be forwarded to the national SBS team for actioning.
32	**Raising of sales orders** Authorisation of sales orders for goods or services provided by the ICB: a) Up to £10,000 (credit memo up to £10,000) b) £10,001 to £100,000 (credit memo £10,001 up to £50,000) c) £100,001 to £250,000 (credit memo £50,001 to £250,000) d) £250,001 to £500,000 (credit memo £250,001 to £1,000,000) e) £500,001 to £1,000,000 f) £1,000,001 to £2,500,000 (credit memo up to £5,000,000) g) £500,001 to £2,500,000 (credit memo up to £10,000,000) h) Up to £5,000,000 (credit memo up to £500.0m) i) Up to £1.0bn (credit memo up to £1.0bn) j) No delegated financial responsibility	a) Budget managers at Bands 6 and 7 b) Budget managers at Band 8a and 8b c) Assistant/Associate Directors at Band 8c and 8d d) Directors at Band 9 e) ICB Finance Directors f) ICB Finance Directors g) Borough Directors or equivalent (VSM) h) Deputy Chief Executive i) Chief Executive and Chief Finance and Compliance Officer j) System Administration

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
33	**Sealing of Documents**	Two of the following are required to seal documents: Chief Executive Officer Chief Finance and Compliance Officer Chief Medical Officer Chief Nursing Officer
34	**Disposal of Records** Physical records, either on site or held in archive by a third party, should be disposed of in accordance with the ICBs approval Records Retention Schedule.	Director of Corporate Services
35	**Authority to sign non legally binding administrative arrangements** *This delegation has application when the ICB is entering into non-legally binding administrative arrangement with one or more other parties. The non-legally binding administrative arrangements could relate to one of the following:* • *Memoranda of Understanding (either intra-ICB, with other NHS organisations, or with a commercial third party)* • *Service level agreements (intra/Inter ICB, other NHS Organisations)* • *Operating level agreements (intra/Inter ICB, other NHS Organisations)*	Chief Executive or Chief Finance and Compliance Officer or Chief Commissioning Officer

Section C:

Delegation levels

Revenue

Level	Value	Decision Owner	Committee Involvement
L1	<£50k	Budget Holder	None
L2	£50k-£250k	Director	Exec visibility
L3	£250k-£2.5m	Exec Director	SMT reporting
L4	£2.5m-£10m	SMT	Notify SCC
L5	£10m-£25m	SCC	SMT prior review and recommendation
L6	>£25m	Board	Final Approval

Capital

Value	
<£2.5m	Chief Finance and Compliance Officer
£2.5m - £5m	CEO
£5m - £10m	CFCO and CEO / SMT
£10m - £25m	SMT
>£25m	Board

NHS South East London
Integrated Care Board

Neighbourhood Strategic Delivery Committee

Terms of Reference

Document Management

Revision history

Version	Date	Summary of changes
0.1	April 2026	Initial core parts of ToRs developed by directors of Neighbourhood Delivery in SEL and SWL
0.2	15 May 2026	Initial draft in ToRs template by SEL governance team for engagement
0.3	3 June 2026	Updated to incorporate amendments proposed by SWL Director of Corporate and SEL NEM member for governance
0.4	12 June 2026	Updated to incorporate suggestions from ICB NEMs
0.5	28 June 2026	CEO review and comments.
1.0	22 July 2026	Version approved by Board.
1.1	17 November 2026	Amendments proposed to Board following review at first Committee meeting.

Approved by

Version	Date	Committee / Group name
1.0	22 July 2026	Board approved

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1. Constitution

1.1 The Neighbourhood Strategic Delivery Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a committee of the Board. in accordance with its Constitution, Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation (SoRD).

1.2 These Terms of Reference (ToR) set out the membership, remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board.

2. Authority

2.1 The Neighbourhood Strategic Delivery Committee is authorised by the ICB Board:

- Undertake any activity within its ToR;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Neighbourhood Strategic Delivery Committee) within its remit as outlined in these ToR;
- Commission any reports it deems necessary to help fulfil its obligations;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so, the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Neighbourhood Strategic Delivery Committee members. The Neighbourhood Strategic Delivery Committee shall determine the membership and ToR of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and SoRD but may not delegate any decisions to such groups.

2.2 For the avoidance of doubt, the Neighbourhood Strategic Delivery Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD, except as outlined in these ToR.

2.3 The Neighbourhood Strategic Delivery Committee has no executive powers, other than those delegated in the SoRD and specified in these ToR.

3. Purpose

3.1 The purpose of the Neighbourhood Strategic Delivery Committee will be to act as the principal forum for agreeing the overall SEL ICB approach to development of the

Neighbourhood Health Service and assuring progress in delivering the Neighbourhood Health Service on behalf of the Board.

3.2 The committee will develop proposals for care models, strategic plans, outcomes and key enablers for integrated neighbourhood health and care.

3.3 The Committee has a role in ensuring alignment of other system plans with the Neighbourhood Delivery Plan and the effective delivery of agreed ICB priorities and outcomes where relevant. Whilst those other plans (e.g. digital, estates and people) may be led by other parts of the system, the Neighbourhood Delivery Committee will work with the relevant accountable bodies across the system with the aim of ensuring that relevant transformation and delivery plans support the delivery of integrated neighbourhood health and care.

3.4 The Committee will be responsible for ensuring the delivery of commissioning priorities and actions relating to the development and delivery of neighbourhood care as set by the Strategic Commissioning Committee. The Neighbourhood Strategic Delivery Committee will not make decisions on any commissioning activities (i.e. the award of new contracts).

3.5 The committee will also operate as a key component of the wider system partnership arrangements, working in close alignment with system groups responsible for system sustainability, workforce, digital and estates. Executive members of the committee will provide the primary link between these forums, ensuring strategic alignment and coordinated delivery across the system.

4. Responsibilities of the Neighbourhood Strategic Delivery Committee

4.1 The committee will undertake the following responsibilities:

4.2 Advise and provide recommendations to the Board on the strategic direction of the integrated neighbourhood health and care, the overall delivery roadmap and milestones and setting of population health outcomes.

4.3 Provide oversight of the development of key neighbourhood strategies and resources including the model of care.

4.4 Approve plans with integrator partnerships for the development of integrated neighbourhood health and care.

4.5 Monitor delivery progress, ensuring plans are adjusted as required to secure delivery of agreed outcome and milestones. This will include driving improvement further and faster where it is feasible to do so.

4.6 Provide assurance to the Board on the delivery of commissioning priorities and actions relating to the development and delivery of neighbourhood care as set by the Strategic Commissioning Committee, managing unwarranted variation in approach.

4.7 Provides assurance to the Board on the ICB's response to NHS England and The Department of Health and Social Care's neighbourhood health requirements.

4.8 Assures the work of ICB executives as part of other groups across London and within South East London to facilitate the development to the tools and infrastructure required to enable integrated neighbourhood health and care.

4.9 Through the committee's executive membership links to system partnership groups in SEL on system sustainability, workforce, digital and estates, and also the London Neighbourhood Board.

5. Membership and attendance

Membership

5.1 The Neighbourhood Strategic Delivery Committee membership is as follows:

- Non-Executive Director – Co-Chair
- Local Authority representative (executive member representing the local authority sector) – Co-Chair
- ICB Partner Member (Primary Care)
- Chief Commissioning Officer
- Seven Place representatives (comprisincluding three representatives from ICB place leadership and four provider integrators).
- Director of Delivery for Neighbourhoods and Population Health
- Director of Strategic Commissioning
- Director of Public Health (representing the local authority sector)
- Representative of mental health sector
- VCSE Alliance Representative
- ICB Medical Director

5.2 The role of Chair will be undertaken by the ICB Non-Executive Director and the Local Authority Member, who will act as co-Chair.

5.3 Members are required to attend a minimum of 75% of meetings, other than absence due to sickness.

5.4 Members may nominate deputies to represent them in their absence and make decisions on their behalf, subject to the approval of the Chair.

5.5 Members will possess between them knowledge, skills and experience in the issues pertinent to the Neighbourhood Strategic Delivery Committee's business. When determining the membership of the Neighbourhood Strategic Delivery Committee, active consideration will be made to diversity and equality.

Chair and vice chair

5.6 The Neighbourhood Strategic Delivery Committee will be chaired by a member appointed on account of their specific knowledge skills and experience making them suitable to chair the Neighbourhood Strategic Delivery Committee.

5.7 Neighbourhood Strategic Delivery Committee members may appoint a Vice Chair who will be nominated by the Chair of the Neighbourhood Strategic Delivery Committee. If the Committee Chair is absent or is disqualified from participating by a conflict of interest, the Vice Chair, if present, shall preside. If the Chair or Vice Chair are absent from any meeting, a Chair shall be nominated by other members attending that meeting.

5.8 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Attendees

5.9 The Neighbourhood Strategic Delivery Committee shall have the following non-voting attendees (as and when required):

- Other Directors and/or Managers as appropriate;

5.10 Attendees may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

5.11 Attendees may nominate deputies to represent them in their absence, with agreement of the Chair.

5.12 The Neighbourhood Strategic Delivery Committee may call additional experts to attend meetings on a case by case basis to inform discussion.

5.13 The Neighbourhood Strategic Delivery Committee may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

5.14 The Chair of the ICB will be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

5.15 The Neighbourhood Strategic Delivery Committee Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate discussion of particular matters.

6. Meeting Frequency, Quoracy and Decisions

6.1 The Neighbourhood Strategic Delivery Committee will usually meet once f each quarter. Arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

6.2 The Board, Chair or Chief Executive may ask the Neighbourhood Strategic Delivery Committee to convene further meetings to discuss particular issues on which they want the committee's advice.

6.3 Meetings will be held in-person, unless previously agreed by the Chair. The Neighbourhood Strategic Delivery Committee may choose to meet online, via MS Teams or suitable alternative platform.

Quorum

6.4 For a meeting to be quorate the following members will be required:

- One of Non-Executive Director – Co-Chair or local authority representative – Co-Chair (proposed)
- Four Place representatives (including at least one PEL~~representatives from ICB place leadership and provider integrators~~)
- SEL Director of Delivery for Neighbourhoods and Population Health.

6.5 If any member of the Neighbourhood Strategic Delivery Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

6.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

6.7 Decisions will be taken in accordance with the Standing Orders. The Neighbourhood Strategic Delivery Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

6.8 Only members of the Neighbourhood Strategic Delivery Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

6.9 Where there is a split vote, with no clear majority, the Chair of the Neighbourhood Strategic Delivery Committee will hold the casting vote.

6.10 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through email or other electronic communication.

6.11 Any decisions taken virtually must be recorded at the next scheduled meeting.

7. Accountability and reporting

7.1 The Neighbourhood Strategic Delivery Committee is accountable to the ICB Board and shall provide reports to the ICB Board on how it discharges its responsibilities and shall draw to the attention to any issues that require disclosure or require action.

7.2 The Neighbourhood Strategic Delivery Committee shall make any such recommendations to the Board as it deems appropriate on any area within its remit where action or improvement is needed.

7.3 The minutes of the meetings shall be formally recorded by the secretary and approved at the next scheduled meeting.

7.4 The Neighbourhood Strategic Delivery Committee will report to the ICB Board at least annually to describe how it has fulfilled its ToR, give details of any significant issues that it has considered, and how they were addressed.

7.5 The committee will, as required and through its executive members, act to ensure there is alignment between its work and that of system partnership Boards for sustainability, workforce, estates and digital.

8. Conflicts of Interest

8.1 Conflicts of Interest shall be dealt with in accordance with the ICB Conflicts of Interest Policy.

8.2 The Neighbourhood Strategic Delivery Committee will have a Conflicts of Interest Register that will be presented as a standing item on the agenda.

8.3 All members and attendees of the Neighbourhood Strategic Delivery Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The Chair will determine if there is a conflict of interest such that the member and/or attendee will be required not to participate in a discussion.

9. Behaviours and Conduct

ICB values

9.1 Members will be expected to conduct business in line with the ICB values and objectives.

9.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

9.3 Members must demonstrably consider the equality and diversity implications of decisions they make.

10. Secretariat and Administration

10.1 The Neighbourhood Strategic Delivery Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken, agreed with the Chair, and a record of matters arising. Action points and issues, with progress updates, will be carried forward between meetings;
- The Chair is supported to prepare and deliver reports to the ICB Board and;
- The Neighbourhood Strategic Delivery Committee is updated on pertinent issues / areas of interest / policy developments.

11. Review

11.1 The Neighbourhood Strategic Delivery Committee will review its effectiveness at least annually and recommend any changes it considers necessary to the ICB Board.

11.2 These ToR will be reviewed at least annually and more frequently if required. Any proposed amendments to the ToR will be submitted to the ICB Board for approval.

Date of approval: 22 July 2026

Date of next review: June 2027

NHS South East London Integrated Care Board
Strategic Commissioning Committee
Terms of Reference

Document Management

Revision history

Version	Date	Summary of changes
0.1	April 2026	Initial core parts of ToRs developed by Directors of Commissioning in SEL ICB
0.2	15 May 2026	Initial draft in ToRs template by SEL governance team for engagement
0.3	28 May 2026	To reflect SWL F&P Committee inputs on future committee functions
0.4	3 June 2026	Updated to incorporate amendments proposed by SWL Director of Corporate and SEL NEM member for governance
0.5	10 June 2026	Updated to incorporate amendments proposed by SWL and SEL NEMs
0.6	28 June 2026	CEO review and comments
0.7	7 July 2026	Added 2 x PELs as committee members
1.1	30 October 2026	Amendments following initial meeting of Committee

Approved by

Version	Date	Committee / Group name
1.0	22 July 2026	ICB Board

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1. Constitution

1.1 The Strategic Commissioning Committee is established by the Integrated Care Board (the Board or ICB) as a committee of the Board. in accordance with its Constitution, Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation (SoRD).

1.2 These Terms of Reference (ToR) set out the membership, remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board. They will be published as part of the Governance Handbook on the ICB's website.

2. Authority

2.1 The Strategic Commissioning Committee is authorised by the Board to:

- Undertake any activity within its ToR;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Strategic Commissioning Committee) within its remit as outlined in these ToR;
- Commission any reports it deems necessary to help fulfil its obligations;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so, the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Strategic Commissioning Committee members. The Strategic Commissioning Committee shall determine the membership and ToR of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and SoRD but may not delegate any decisions to such groups.

2.2 For the avoidance of doubt, the Strategic Commissioning Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD, except as outlined in these ToR.

2.3 The Strategic Commissioning Committee has no executive powers, other than those delegated in the SoRD and specified in these ToR.

3. Purpose

3.1 The Strategic Commissioning Committee is established to act as the principal forum for strategic commissioning development and oversight on behalf of the Board.

3.2 The ICB's core purpose is strategic commissioning, inclusive of the development of enhanced strategic commissioning capabilities and approaches, with an increasing focus on improving population health outcomes, reducing inequalities, delivering its strategic ambitions (including the 'left shift' towards prevention, community-based care and digital), commissioning high quality, effective and efficient services and exercising its system convening role working with partners.

3.3 The Strategic Commissioning Committee is a formal committee of the ICB Board and will be authorised by the Board to put forward proposals which meet the objectives of the ICB's strategic plan, including proposals for service change, procurement, outcomes and key enablers for strategic commissioning.

3.4 The Committee has a role in ensuring alignment of borough based joint commissioning with the ICB strategy and the effective delivery of agreed ICB priorities and outcomes where relevant. Joint commissioning will be led at place (with defined budgets and commissioning responsibility) to enable close alignment with local authority commissioning and delivery responsibilities, including public health and social care and with a focus on ensuring that joint commissioning arrangements support integration of services and care for local populations.

3.5 The Committee will have a close working relationship with the Neighbourhood Based Care Committee. The Neighbourhood Based Care Committee will be responsible for overseeing the delivery of the ICB's neighbourhood based care agenda which includes ensuring the delivery of commissioning priorities and actions relating to the development and delivery of neighbourhood care. The Strategic Commissioning Committee will have a role in ensuring that the ICB's strategic commissioning, operational plans and use of payor/contracting functions support the effective delivery of the agreed neighbourhood care objectives and outcomes.

3.6 An annual programme of business will be agreed before the start of the financial year and will include strategic commissioning, integrated planning, affordability, delivery oversight and performance and assurance matters. The programme will remain flexible to new and emerging priorities, risks and system pressures.

4. Responsibilities of the Strategic Commissioning Committee

4.1 The committee will operate across the commissioning cycle in an advisory and scrutinising capacity, providing targeted assurance to support the Board rather than replicating an oversight role.

4.2 The committee will take decisions on matters delegated to it as determined by the ICB's SoRD.

4.3 A key role of the committee's is to advise and provide recommendations to the Board to ensure commissioning strategy is data and insights driven and reflects population need, inequalities, and the Board's agreed strategic intent, ensuring consideration of the evidence supporting health outcomes, clinical outcomes and cost-effectiveness.

4.4 Specific responsibilities of the Committee are as follows. In discharging these responsibilities the Committee will:

Delivery of the ICB strategy

4.5 Provide assurance to the Board on the delivery of the ICB's strategic ambitions, including the 'three shifts' and impact on outcomes and value.

4.6 Assure that there is alignment between commissioning priorities, operational planning, activity assumptions, workforce implications and financial frameworks to support delivery of agreed outcomes and system sustainability.

4.7 Advise the Board on major service change, reconfiguration, investment prioritisation, affordability considerations and strategic trade-offs to support Board decision making.

4.8 Provide oversight and scrutiny of strategic commissioning and procurement approaches relating to major service transformation, contracting arrangements and commercial decisions within the scope of the SoRD.

4.9 Provide strategic oversight of how the ICB uses its commissioning, contracting and 'payor function' responsibilities to shape the future health and care market to help contribute to delivery of its longer-term strategic objectives.

4.10 Provide advice, support and oversight of the development of key strategic commissioning capabilities and outputs e.g. frameworks and decision-making tools to support decision making and prioritisation, outcomes and evaluation.

4.11 Approve arrangements to secure continuous improvement in quality and patient outcomes

4.12 Ensure the ICB's underpinning care pathway and borough based joint commissioning integrated arrangements are aligned to the ICB's commissioning strategy and financial frameworks.

In-year contract delivery and performance

4.13 Review integrated system performance across commissioned services including financial, activity. quality[1], and delivery performance, together with associated risk, prioritising material variance, affordability and strategic concern.

4.14 Review delivery of savings, efficiency and productivity programmes linked to the ICB's commissioning, revenue and capital plans, including associated risks, mitigations and delivery confidence.

[1] The SCC will assume primary responsibility for the oversight of the quality of ICB-commissioned services as is required by current NHSE / NQB guidance. The ICB Patient Safety Committee will focus on assurance related to the safety and quality of care for the ICB's statutory functions, such as CHC, LeDeR. See Patient Safety Committee ToRs.

4.15 Review forecast financial and operational performance, including material risks, delivery assumptions and mitigating actions relating to commissioned services and system plans.

4.16 Escalate material financial, operational and commissioning or delivery concerns to the Board where risks, performance or affordability issues exceed agreed tolerances or require strategic decision-making.

4.17 Assure the evaluation of the impact and outcomes of services commissioned by the ICB including consideration of patients' views / voice, to ensure that lessons learned are identified and used to inform future commissioning decisions.

Other responsibilities

4.18 Approval of contracts at a level specified in the SoRD.

4.19 During the transition to new legislation, new Board membership and future ICB governance arrangements, the Committee may provide an important forum for review and discussion of key commissioning matters, supporting the ICB to conduct its commissioning business.

5. Membership and attendance

Membership

5.1 The Strategic Commissioning Committee membership is as follows:

- 5.1.1 Non Executive Lead – Chair
- 5.1.2 Non Executive Director – Deputy Chair
- 5.1.3 ICB Chief Executive Officer
- 5.1.4 Chief Commissioning Officer
- 5.1.5 Directors of Strategic Commissioning
- 5.1.6 Chief Financial & Compliance Officer
- 5.1.7 Place Executive Leads x 2 (representing all place PELs)
- 5.1.8 Chief Nurse
- 5.1.9 Medical Director.

5.2 The role of Chair will be undertaken by Non-Executive Lead.

5.3 Members are required to attend a minimum of 75% of meetings, other than absence due to sickness.

5.4 Members may nominate deputies to represent them in their absence and make decisions on their behalf, subject to the approval of the Chair.

5.5 Members will possess between them knowledge, skills and experience in the issues pertinent to the Strategic Commissioning Committee 's business. When determining the membership of the Strategic Commissioning Committee, active consideration will be made to diversity and equality.

Chair and Deputy~~vice~~ chair

5.6 The Strategic Commissioning Committee will be chaired by a member appointed on account of their specific knowledge skills and experience making them suitable to chair the Strategic Commissioning Committee.

5.7 Strategic Commissioning Committee members may appoint a Deputy~~Vice~~ Chair who will be nominated by the Chair of the Strategic Commissioning Committee. If the Committee Chair is absent or is disqualified from participating by a conflict of interest, the Deputy~~Vice~~ Chair, if present, shall preside. If the Chair or Deputy~~Vice~~ Chair are absent from any meeting, a Chair shall be nominated by other members attending that meeting.

5.8 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Attendees

~~5.9 The Strategic Commissioning Committee shall have the following non-voting attendees (as and when required), noting this list is not intended to be exhaustive and may also change over time as agreed with the committee Chair:~~

- ~~Chief Pharmacist for the ICB,~~
- ~~Director of Delivery for Neighbourhoods and Population Health~~
- ~~Director of Insights~~
- ~~Additional Place Executive Leads~~
- ~~Director of Public Health.~~

5.9 The Committee Chair will invite additional individuals to attend a meeting to provide subject matter expertise and advice as required by the agenda.

5.10 Attendees may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

~~5.11 Attendees may nominate deputies to represent them in their absence, with agreement of the Chair.~~

~~5.12 The Strategic Commissioning Committee may call additional experts to attend meetings on a case-by-case basis to inform discussion.~~

~~5.13~~5.11 The Strategic Commissioning Committee may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

~~5.14~~5.12 The Chair of the ICB will be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

~~5.15~~5.13 The Strategic Commissioning Committee Chair may ask any or all of those in attendance ~~who normally attend, but~~ who are not members, to withdraw to facilitate open and frank discussion of particular matters.

6. Meeting Frequency, Quoracy and Decisions

6.1 The Strategic Commissioning Committee will usually meet every six weeks~~two months~~. Arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

6.2 The Board, Chair or Chief Executive may ask the Strategic Commissioning Committee to convene further meetings to discuss particular issues on which they want the committee's advice.

6.3 Meetings will be held in-person, unless previously agreed by the Chair. The Strategic Commissioning Committee may choose to meet online, via MS Teams or suitable alternative platform.

Quorum

6.4 For a meeting to be quorate the following members will be required:

6.4.1 Chair or Deputy Chair;

6.4.2 One Director of Strategic Commissioning;

6.4.3 Finance Representative;

6.4.4 Place Executive Lead

6.4.5 Medical Director or Chief Nurse

6.5 If any member of the Strategic Commissioning Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

6.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

6.7 Decisions will be taken in accordance with the Standing Orders. The Strategic Commissioning Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

6.8 Only members of the Strategic Commissioning Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

6.9 Where there is a split vote, with no clear majority, the Chair of the Strategic Commissioning Committee will hold the casting vote.

6.10 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through email or other electronic communication.

6.11 Any decisions taken virtually must be recorded at the next scheduled meeting.

7. Accountability and reporting

7.1 The Strategic Commissioning Committee is accountable to the ICB Board and shall provide reports to the Board on how it discharges its responsibilities and shall draw to the attention to any issues that require disclosure or require action.

7.2 The Strategic Commissioning Committee shall make any such recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

7.3 The minutes of the meetings shall be formally recorded by the secretary and approved at the next scheduled meeting.

7.4 The Strategic Commissioning Committee will report to the Board at least annually to describe how it has fulfilled its ToR, give details of any significant issues that it has considered, and how they were addressed.

8. Conflicts of Interest

8.1 Conflicts of Interest shall be dealt with in accordance with the ICB Conflicts of Interest Policy.

8.2 The Strategic Commissioning Committee will have a Conflicts of Interest Register that will be presented as a standing item on the agenda.

8.3 All members and attendees of the Strategic Commissioning Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The Chair will determine if there is a conflict of interest such that the member and/or attendee will be required not to participate in a discussion.

9. Behaviours and Conduct

ICB values

9.1 Members will be expected to conduct business in line with the ICB values and objectives.

9.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

9.3 Members must demonstrably consider the equality and diversity implications of decisions they make.

10. Secretariat and Administration

10.1 The Strategic Commissioning Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken, agreed with the Chair, and a record of matters arising. Action points and issues, with progress updates, will be carried forward between meetings;
- The Chair is supported to prepare and deliver reports to the Board; and
- The Strategic Commissioning Committee is updated on pertinent issues / areas of interest / policy developments.

11. Review

11.1 The Strategic Commissioning Committee will review its effectiveness at least annually and recommend any changes it considers necessary to the Board.

11.2 These ToR will be reviewed at least annually and more frequently if required. Any proposed amendments to the ToR will be submitted to the Board for approval.

Date of approval: 22 July 2026

Date of next review: June 2027

NHS
South East London

Acute Services Review

Agenda item: 4

Executive Lead: Ed Waller, Chief Commissioning Officer

Report by: Sandra Iskander, Programme Director

Paper type: Information

Conflicts of Interest: None identified

1. Purpose and recommendation

The purpose of this report is to provide to the Board an update on the progress and outcomes of the Acute Services Review, together with next steps.

The Board is asked to:

- **Note** the updates and next steps proposed.

2. Background

The South East London acute system is under significant financial pressure. The ICB and acute providers jointly commissioned external support to undertake an Acute Services Review (ASR) to identify the system-wide transformation needed to move from structural deficit to financial balance.

Over a number of months, they undertook extensive data analysis, interviewed dozens of senior staff and held three system-wide workshops to identify care pathway, service transformation and reconfiguration options which would reduce overall spend on hospital-based services. The final report is now available and is presented to each organisation's Board for formal consideration.

3. Overview of findings

The case for change outlines the impacts of an ageing population and deteriorating health. The over 65 population is expected to increase by 24% in the next 10 years, making up 15% of the population by 2036. Without any major transformation, patients with moderate and high will increase due to poor health from 43% to 54% of the population. In a do-nothing scenario, emergency attendances rise by 15% between 2025/26 and 2035/36, outpatient appointments by 21% to 5.4 million a year, and non-elective and elective bed days by around 25%.

This in turn increases the financial pressure on the ICB and providers. According to the projected counterfactual financial position, the acute system deficit will rise to rise to £1 billion by 2030/31 before efficiency delivery. The report sets out the interconnected role of commissioner-led transformation, productivity improvements, and cross-provider service change to achieve sustainability.

A number of actions are proposed:

- **Invest in prevention** – Expand targeted programmes on obesity, cardiovascular disease, diabetes, respiratory disease, and anxiety and depression
- **Shift to proactive models of care** – Implement proactive and community-based models of care, delivered through the integrator agenda
- **Close the efficiency gap** – Extend CIPs across the full five years and identify where productivity will come from, individually or through additional system collaboration
- **Deliver three cross-provider programmes** – Outpatient transformation, elective surgical hubs, and breast surgery consolidation
- **Scope wider services** – Aim for a smaller acute footprint for oral and dental, review maternity, general paediatrics and non-tertiary cancer surgery in South East London and specialised services on a London footprint.

Taken together, the commissioner-led transformation and full efficiency delivery move all three acute providers closer to financial sustainability by 2030/31. The cross-provider transformation programmes are intended to close that residual gap and to reduce the delivery risk attached to efficiency requirements that remain unidentified in the outer years.

4. Rationale for cross provider programmes

1. Outpatient transformation

The three acute providers in South East London delivered 4.2m outpatient appointments in 2025/26 and demand is growing at around 4.5% a year. Modelling of reducible activity identifies approximately 500,000 appointments that could be avoided or shifted through redesigning models of care.

A collaborative programme, underpinned by the shared Epic platform, should deliver standardised pathways, single points of access and streamlined diagnostics, better organising care around patient need.

2. Elective surgical hubs

Several surgical specialties delivered in SEL are below the national average and recommended targets for theatre utilisation, cases per list, utilisation of treatment rooms, and day case rates. Establishing high volume and complex surgical hubs is a critical enabler to improve productivity, utilisation of resources and potentially lower unit costs. A detailed change management process is required to explore and agree options to reconfigure surgical services.

3. Consolidate breast surgery

Four separate sites deliver inpatient and day case breast surgical services, some with low volumes. Consolidation of breast surgery may contribute to overall improvements in quality and outcomes and could be delivered in conjunction with the development of surgical hubs. Consideration would need to be given to other parts of the pathway (screening, diagnostics, plastics) which could be explored through a full change programme.

5. Implementation and next steps

SEL ICB and providers have agreed to give further consideration to the recommended areas of opportunity. We already have programmes of work underway to improve population health through prevention and to support people with long term conditions in the community through developing neighbourhood health, as set out in our strategic plans. Providers have plans in place to improve productivity and efficiency. To establish the scope for further opportunities, formal work programmes will be set up, with a named SRO and an agreed mandate outlining objectives, success metrics and an implementation plan. This will inform resourcing, with the expectation that existing resource will be redeployed to these priorities where possible. The System Sustainability Group will provide strategic direction, and the executive members are responsible for ensuring alignment across and within organisations. Legacy collaborative arrangements will be reviewed and streamlined where possible. Any formal decisions will be taken through existing governance structures and any changes to service configuration would follow a formal change process as set out in NHSE guidance and legislation.

6. Key points for the Board to note:

- The ASR has provided the system with a shared understanding of current and future challenges, and how they might realistically be addressed. As a result, providers are able to consider further opportunities for collaboration.
- Recommendations around investing in prevention and shifting to proactive models of care align with the priorities set out in the Five Year Strategic Commissioning Plan and reinforce the commitment to deliver this at pace and scale.
- Delivering cross provider programmes can help mitigate the risk associated with very challenging efficiency targets.
- Focus will now turn to designing a delivery approach which sets us up for success.

South East London Integrated Care System

South East London Acute Services Review

Summary Report

8 October 2026

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1. Introduction

Context

The South East London acute system is under significant pressure with an underlying financial deficit of £256m in 2025/26.[1] Approximately 52% of ICB spend is on acute services and current efficiency programmes are carrying delivery risk, with CIPs largely unidentified for the next five years and unlikely to bridge the financial gap.[2] Within this context, the Acute Services Review was jointly commissioned by the ICB and acute providers to identify the system-wide transformation needed to move from structural deficit to financial balance.

The Acute Services Review builds on existing system-wide work, including by the System Sustainability Programme, Acute Provider Collaborative, and South London Office of Specialised Services. Aligned with the NHS 10 Year Plan, the Acute Services Review sets out the case to fundamentally shift and transform the way that care is delivered to improve outcomes and ensure future sustainability. The findings span commissioner-led population health planning, provider productivity, and collaborative transformation that extends beyond individual trust boundaries.

Scope and purpose

This report outlines the findings and recommendations of the Acute Services Review. Its purpose is to define the system-wide action required to deliver the long-term financial sustainability of acute services in South East London.

There were five core components to the Acute Services Review:

1. Establishing the case for change through population health and financial modelling of the medium- to long-term do-nothing position for South East London;
2. Scoping the opportunity for commissioner-led transformation and the potential impact of prevention initiatives and new models of care;
3. Identifying the productivity opportunity within each acute provider;
4. Aligning on key cross-provider transformation programmes that unlock value beyond individual trust efficiency programmes; and
5. Exploring wider opportunities for transformation and the appropriate geographical planning levels for future review.

Approach and limitations

The Acute Services Review draws on quantitative analysis from the CF Health Strata© patient-level segmentation model, provider and ICB financial plans, NHS England productivity assessments, and demand and capacity modelling. Quantitative analysis has been supplemented by extensive engagement across the system.

The following areas have not been considered in the Acute Services Review and should form part of future phases of work:

- Detailed design of transformation programmes and potential service configurations;
- Assessment of the workforce, estate, technology, resources, and capital required to deliver service change; and
- Options appraisal and impact assessments that form part of formal service change processes.

[1] SEL ICB and acute provider financial modelling 2025/26 – 2030/31, (July 2026).
[2] Ibid; Acute provider CIPs (May 2026).

2. Making the case for change

The case for change underscores the impact of deteriorating health, growing activity, and financial pressures across South East London. It establishes the need to transform the way services are planned, commissioned, and delivered to improve health outcomes and achieve future financial sustainability.

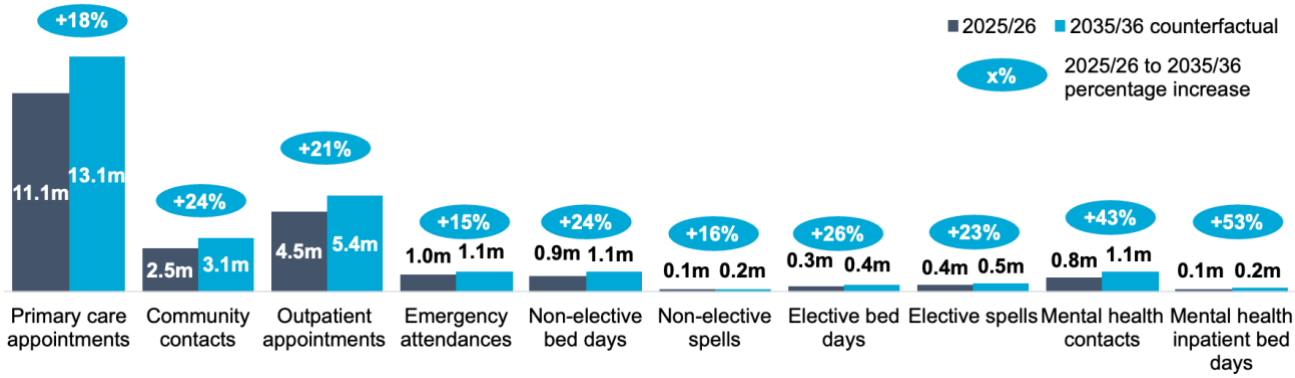
Impact of ageing and deteriorating health

While the population in South East London is projected to grow by 4% over the next decade,[3] the over-65 population will increase by 24%, with the fastest growth in the inner boroughs, which currently have the youngest populations.[4] With the over-65 population currently accounting for almost four times the per-person cost of working-age residents, this shift in the age profile will increase financial pressures for South East London.[5]

In combination with an ageing population, demand for healthcare services will further increase in response to the projected deterioration of health. In 2025/26, the 43% of the total population in moderate and high need cohorts accounted for 82% of total commissioner spend of £4.9 billion.[6] This included people with long term conditions, cancer, severe mental illness, frailty or dementia, and end of life care needs. By 2035/36, these cohorts are projected to reach 54% of the population and 87% of spend, with total healthcare spend rising to £6.2 billion.[7]

In the do-nothing scenario, demand grows across every point of delivery (**Figure 1**). Emergency attendances rise by 15% between 2025/26 and 2035/36, outpatient appointments by 21% to 5.4 million a year, and non-elective and elective bed days by around 25%.[8] This outpaces population growth of 4%, indicating that rising health needs rather than demographic change is the principal driver. The modelled bed requirement for the GP registered population reaches 4,572 by 2035/36 against 3,914 general and acute beds currently open, a shortfall of around 650 beds that cannot be met within current capacity without major transformation to deliver service change.[9]

Figure 1: Projected do-nothing activity volumes by point of delivery, 2025/26 – 2035/36



Source: © Carnall Farrar Limited, Health Strata segmentation model of SEL GP-registered population based on proprietary methods, SEL database, (July 2026).

[3] ONS, Population projections 2025 – 2035, (2022-based edition).
[4] Ibid.
[5] © Carnall Farrar Limited, Health Strata segmentation model of SEL GP-registered population based on proprietary methods, SEL database, (July 2026).
[6] Ibid.
[7] Ibid.
[8] Ibid.
[9] Ibid; NHS England, Bed availability and occupancy – KH03, Quarter 4 2025-26.

Do-nothing financial position

In the do-nothing scenario, the South East London ICB financial position deteriorates to a £293 million deficit by 2030/31 even after the impact of deconstruction of the block and system efficiency requirement.[10] This is driven by a combination of factors, including demographic growth, non-demographic growth, and cost inflation. South East London is also 3.62% above target for core services and 18.32% above target for specialised services, and annual convergence will reduce the allocation growth while demand rises.[11]

The combined deficit for the acute providers is projected to rise from £256 million in 2025/26 to £1 billion by 2030/31 before CIP delivery.[12] Further, deficit support funding is to be phased out from 2026/27 and the acute providers will be required to navigate the income impacts of deconstruction of the block.

These pressures are encountered nationally, but three factors amplify them locally: the case-mix complexity of a largely tertiary and specialised provider base, significant productivity gaps against peers estimated by NHS England across the three trusts,[13] and higher pay and estate inflation as London providers.

Returning acute services to sustainability will require system-wide change that extends beyond existing programmes. The following pages of this report set out the interconnected role of commissioner-led transformation, productivity improvements, and cross-provider service change to achieve sustainability. It builds on national policy, and the body of improvement work already underway in South East London with the aim of increasing the scale and pace of change.

[10] SEL ICB and acute provider financial modelling 2025/26 – 2030/31, (July 2026).
[11] NHS England, ICB allocations 2026/27 – 2028/29, (December 2025).
[12] SEL ICB and acute provider financial modelling 2025/26 – 2030/31, (July 2026).
[13] NHS England, Productivity Improvement Packs, (2025).

3. Maximising the value of the NHS allocation

In the new operating model for the NHS, the ICB is accountable for securing the best value from its allocation. The South East London ICB Strategic Commissioning Plan sets the direction for delivering allocative efficiency in line with the three shifts outlined in the NHS 10 Year Health Plan: sickness to prevention, hospital to community, and analogue to digital. There is the opportunity for commissioner-led transformation to improve health outcomes and system sustainability.

Opportunity to reduce the growth in prevalence and progression of ill health

Targeted focus and investment in prevention is key to long-term health gain, slowing the growth in avoidable ill health, and reducing the demand it places on the system. Five conditions were prioritised for modelling in the Acute Services Review, based on the forecasted increase in burden and the available evidence on modifiable risk factors: cardiovascular disease, diabetes, respiratory disease, anxiety and depression, and obesity.

The South East London Prevention Framework is built on three interconnected tiers of universal prevention, targeted early detection and intervention for high-risk communities, and at-scale secondary and tertiary prevention for the population.[14] The modelling covers the NHS-deliverable elements, including case finding, pharmacological management, structured behavioural and digital programmes, and smoking cessation pathways.

The prevention modelling targets a 15% decrease in transition rates to higher-needs segments to reduce future incidence of disease. On that basis, 13,800 fewer residents develop anxiety and depression by 2035/36, 9,300 fewer respiratory disease, 6,600 diabetes, 6,100 cardiovascular disease, and 4,200 obesity, resulting in a gross saving of £160 million.[15]

Opportunity to improve care for the population

The NHS 10 Year Health Plan establishes the case for shifting towards more community-based and digitally enabled care to achieve sustainability. The Acute Services Review builds on that ambition by examining variation in the cost of meeting similar needs across South East London. Commissioner-spend per person varies materially across the six boroughs after controlling for age, health need, deprivation, and inner or outer London. Where that variation is unwarranted and addressable, scaling proactive and integrated community-based care offers a means of meeting the same level of need at lower cost.

Core20 and non-Core20 populations were benchmarked separately, in each case against the inner or outer London borough with the lowest spend per person that also scores at or above average on an index of quality and outcome measures. Fifteen non-Core20 cohorts agreed with the ICB represent a potential gross variation opportunity of £375 million, and fourteen Core20 cohorts has an opportunity of £110 million.[16]

The scale of the variation indicates substantial potential to improve value from existing commissioner spend. Realising it depends on the shift from hospital to community, delivered largely through the integrated neighbourhood team model set out in the ICB's Strategic Commissioning Plan. Care that is proactive, integrated and digitally enabled will meet need earlier and in lower-cost settings, reducing demand and cost pressure on acute providers.

Impact of commissioner-led transformation

Delivering targeted prevention initiatives and transforming models of care to address variation generate a gross potential opportunity of £645 million in terms of commissioner spend

[14] SEL ICB Strategic Commissioning Plan, (February 2026).
[15] © Carnall Farrar Limited, Health Strata segmentation model of SEL GP-registered population based on proprietary methods, SEL database, (July 2026).
[16] Ibid.

(**Figure 2**).[17] Realising it requires an estimated investment of £230 million, giving an annual net opportunity of £415 million when implemented and realised at full scale.

Delivery of commissioner-led transformation depends on population health management analytics to target intervention, digital tools and shared care records, workforce development for cross-organisational and enhanced roles, and contracting and financial mechanisms that support multi-year change. Acute providers are central to this, contributing specialist expertise to integrated neighbourhood teams and, in all cases in South East London, hosting the integrator function that allows partners to operate them at scale.

Figure 2: Opportunity size of commissioner-led transformations

	Potential gross opportunity	Investment required*	Investment rate	Potential net opportunity
Reducing the growth in prevalence and progression of ill health	£160m	£62m	39%	**£99m**
Transforming models of care: non-Core20 population	£375m	£122m	33%	**£252m**
Transforming models of care: Core20 population	£110m	£45m	41%	**£65m**
Total	**£645m**	**£230m**	**36%**	**£415m**

Note: *Investment calculations are estimated based on prior work conducted by CF in other systems where similar cohorts and conditions have been selected for allocative commissioning opportunities.

[17] Ibid.

4. Targeting provider productivity improvements

The 2025 Spending Review settlement requires the NHS to deliver annual productivity improvement of at least 2% over the next three years.[18] This section of the report outlines the productivity targets for the purposes of the Acute Services Review, developed with provider finance teams, and the potential delivery risk attached to them.

Productivity targets and current CIPs

Each provider's Medium Term Financial Plan sets a productivity requirement over three years, in line with the national shift from annual to multi-year planning. Working with each finance team, these plans have been extended across the full five-year period and expressed as a percentage of operating expenditure:

- GSTT with 3.7% in 2026/27 declining to 2.0% by 2030/31;
- KCHT with 4.3% in 2026/27 declining to 3.3% by 2030/31; and
- LGT with 5.0% in 2026/27 declining to 3.4% by 2030/31.

These trajectories meet the national requirement for at least 2% annual productivity improvement and reflect both confirmed plans for year one and assumptions agreed with finance teams for subsequent years.

Current trust CIP plans do not extend across the full five-year period, and the outer years are largely unidentified. Confirmed 2026/27 CIPs across the three providers total £185 million as at March 2026: GSTT £143 million, KCHT £26 million and LGT £16 million.[19]

Closing this gap will require further productivity opportunities to be identified in each year. This may be partly achievable through individual provider efforts to reduce length of stay, headcount or band/agency spend, and non pay costs. However, system-level transformation will be required to address structural challenges and unlock additional productivity opportunities beyond what is achievable by individual trusts.

[18] NHS England, Productivity plan – update, (February 2026).
[19] Provider CIPs, (March 2026). Note these figures have likely increased or changed since the development of this report.

5. Delivering cross-provider transformation

The purpose of cross-provider transformation is to address structural challenges across the system, including sub-scale services, workforce fragility, fragmented pathways, and inefficient use of resources. By collaborating as a system, the ambition is to drive productivity and quality beyond the level achievable locally.

Engagement and workshops identified four cross-provider opportunities that are explored further in this section of the report:

- Transforming outpatient care into a new model of planned specialist care, which has the potential to deliver material savings for the acute system through avoiding or shifting first and follow-up appointments;
- Establishing elective surgical hubs for high volume specialties, which has the potential to mitigate projected capacity shortfalls through productivity improvements and could deliver savings by releasing bed and theatre session capacity if commissioner-led transformation is also achieved;
- Consolidating breast surgery to strengthen service quality and resilience, which should be explored alongside other surgical consolidation to ensure the appropriate distribution of system capacity; and
- Pursuing alternative ways forward for oral and dental care that have less significant capital implications (e.g., consolidation of specialist activity where possible and shifting of residual and non-specialist activity into the available community estate).

Outpatient transformation

Outpatient services are the largest single point of acute contact in South East London, with 3.0 million appointments delivered in 2025/26 to the GP-registered population.[20] While there has been some improvement in recent years, the providers in South East London still perform inconsistently against the national median for key performance metrics:[21]

- Pre-referral specialist advice is used at 5.1 to 6.4% against a median of 7.8%;
- Missed appointment rates of 8.0 to 9.7% compare with a national median of 6.3%;
- Patient-initiated follow-up rates are above the national median at GSTT, but below it at KCHT and LGT; and
- Remote consultation rates are above the national median at GSTT and KCHT, but below it at LGT.

There is scope to build upon the work of individual trusts and embark on a significant transformation programme to define the future model of planned specialist care for South East London. The move to a shared Epic platform across South East London makes this a timely opportunity to design once and deliver new models for the three providers that is tailored to patient need and consists of:

- Standardised pathways and guidelines;
- Single points of access (SPOA) into planned specialist care, standardised, and in some cases shared, across providers; and
- Straight to test model for harmonised clinical pathways.

The potential impact of redesigning planned specialist care was analysed using the population health segmentation model, grouping appointments by patient need and applying reducibility assumptions to each group. The modelling identifies 506,000 appointments that

[20] © Carnall Farrar Limited, Health Strata segmentation model of SEL GP-registered population based on proprietary methods, SEL database, (July 2026).
[21] NHS England, Model Hospital – Outpatients, (February 2026).

could be avoided or shifted in 2025/26, comprising 217,000 first appointments and 289,000 follow-ups, and a gross annual saving of £80.0 million on National Cost Collection basis.

Undertaking a cross-provider outpatient transformation programme presents additional opportunity to address sub-scale or fragmented medical specialties that would benefit from consolidation to strengthen service resilience and quality. Further financial benefit may also be realised through rationalising the estate in which outpatient services are delivered.

Elective surgical hubs

Currently, surgical activity is delivered across multiple sites for six elective specialties: orthopaedics, gynaecology, urology, ENT, ophthalmology, and general surgery. The configuration of this activity across South East London is associated with several sites performing below the national average or recommended productivity targets for:

- Theatre utilisation where the majority of sites fall below the 85% target (e.g., urology ranges from 53% to 78% between South East London sites);[22]
- Cases per four-hour session which are below the national median for 17 of 34 site-specialty combinations;[23] and
- Daycase rates which are below the national mean for high volume, low complexity (HVLC) ENT, urology, and general surgery.[24]

In the do-nothing scenario, growth in demand is projected to become increasingly unsustainable. By 2030/31, South East London is estimated to be short of 52 weekly theatre sessions for elective orthopaedics, gynaecology, urology, ENT, ophthalmology, and general surgery.[25] The projected bed and theatre session deficits establish a clear case for change as the acute system in its current configuration will be unable to financially sustain the capacity shortfalls in the six specialties.

Significant transformation will therefore be required to change the way services are delivered across the system to ensure future sustainability. Surgical hubs are a national priority supported by GIRFT that concentrate elective activity and ring-fence capacity to deliver significant productivity improvements. GIRFT sets out the conditions for realising the benefits, including separating high volume from complex work, day case surgery as the default, standard case durations, and theatre utilisation of 85%.

Illustrative scenarios were modelled to test the plausibility and impact of establishing high volume and complex surgical hubs in South East London by 2030/31. Reconfiguring and delivering the productivity improvements associated with surgical hubs move the system from a shortfall of 52 theatre sessions to a surplus in the strongest scenario.[26] The modelling demonstrates that establishing surgical hubs can mitigate the projected capacity shortfalls, with further system-wide transformation required in parallel to close the remaining gaps.

Within this context, additional surgical hub scenario modelling was undertaken that incorporates the impact of commissioner-led transformation and broader productivity improvements. System-wide transformation delivered in tandem with surgical hubs moves every scenario into surplus on beds and theatre sessions, with an indicative annual opportunity between £16 and £28 million from released bed and theatre session capacity.[27] However, achieving these benefits are conditional on prevention initiatives and community-based care models reducing acute demand growth in the next five years, and the system working together to drive productivity beyond the level achievable locally.

[22] NHS England, Model Hospital – Theatre utilisation by speciality and site, (February 2026).
[23] NHS England, Model Hospital – Average number of cases per equivalent 4-hour valid elective session by speciality and site, (February 2026).
[24] HES APC, Daycase rates by speciality and site, 2025.
[25] SEL demand and capacity modelling, (September 2026).
[26] Ibid.
[27] Ibid.

As next steps, further work is required across South East London to assess the suitability of the theatre estate against GIRFT standards. Any change to the configuration of services would then need to follow a service change process in compliance with NHSE guidance, HM Treasury Green Book, and legal duties. More detailed demand and capacity modelling is also required that accounts for patient complexity and extends to wider surgical specialties including cancer, as these have not been included in the above demand and capacity outputs.

Breast surgery consolidation

The breast service pathway has challenges spanning screening, referral, one-stop diagnosis, surgery and plastics, and follow-up. In particular, screening coverage in inner South East London sits around 10 percentage points below the England average,[28] and breast cancer mortality has risen in Bexley and Greenwich over the last decade.[29] Sixty-two day combined performance has remained below the 85% standard at GSTT and KCHT since April 2023.[30]

Noting the performance and quality challenges, work is currently being led across the system to redesign of the wider breast pathway, covering mastalgia, one-stop triple assessment and a single plastics pathway. The Acute Services Review examined the specific opportunity to consolidate breast surgery only. Its findings sit alongside existing redesign programmes and do not substitute broader work.

Breast surgery is delivered from four sites, with around 1,700 admitted spells in 2025: 762 at Guy's, 367 at the PRUH, 297 at Denmark Hill and 294 at QEH.[31] Delivered as a single service, that volume would rank fifth nationally and sit above the top decile of 1,300 spells, against a national median of 634 per provider.[32] Three of the four sites operate at less than half the national median provider volume. Stakeholders further reported workforce fragility challenges at the sites, with reliance on insourcing.

Scale is the foundation for establishing service excellence and delivering high quality care, training, and research.[33] Three of the four current breast surgery sites are sub-scale in South East London, which limits the patient population, workforce resilience, and infrastructure. Consolidation of breast surgery to achieve scale may therefore support improvements in quality, and together with the surgical hubs, simplify the organisation of surgical activity across South East London.

Illustrative scenarios were modelled to test the plausibility and potential financial benefits of consolidating breast surgery, with complex activity consolidated onto one or two centres, routine day case activity retained locally, and screening and diagnostics maintained locally in every scenario. Modelling of potential reconfiguration scenarios and assumed productivity benefits suggest a possible saving of up to £1 million a year when delivered in conjunction with commissioner-led transformation.[34] Although this is a small figure, there are also potential benefits in terms of improving service resilience and quality. It should also be considered alongside other surgical consolidation to ensure the appropriate distribution of system capacity.

In line with the next steps for elective surgical hubs, an assessment of estate suitability and detailed demand and capacity modelling should be undertaken for breast surgery alongside plastics. Any change to the configuration of services would then need to follow a service change process in compliance with NHSE guidance, HM Treasury Green Book, and legal duties.

[28] Fingertips (OHID), Indicator: breast cancer screening coverage, 2015 – 2025.
[29] Fingertips (OHID), Mortality rate from breast cancer, 2012-14 – 2022-24.
[30] NHS England, Cancer Waiting Times Statistics, April 2023 – May 2026.
[31] HES APC, Breast surgery spells by site, 2025.
[32] Ibid.
[33] CF, World Leading Services Framework, (July 2026).
[34] SEL demand and capacity modelling, (September 2026).

Oral and dental health

Specialist dental, oral surgery and maxillofacial services are delivered from two acute sites two miles apart, in partnership with King's College London. Combined admitted activity is more than nine times the national median, and GSTT is the largest provider of oral and dental outpatient care in England.[35] Estate condition is the primary driver for change: the Denmark Hill Dental Institute retains limited serviceable life and Guy's Tower is constrained in space and suitability for high-footfall ambulatory care.[36]

A 2023 Strategic Outline Case preferred a purpose-built centre with community satellites at an outturn capital cost of £226.1 million, identifying the capital requirement but deferring value for money testing.[37] Modelling for the Acute Services Review applies an indicative cost per dental chair to the reduction in chairs under each option, giving a cost reduction of £10.5 million a year for the preferred option. Consolidation onto a single existing site was costed at £86.6 million[38] and modelled to deliver £9.7 million, within 8% of that saving for just over a third of the capital. Both figures depend on chair reductions that assume an extended working pattern already piloted and judged unsustainable, so should be treated as indicative.

The scale of capital requirement has halted progress on this programme, and a lower capital route is needed. Changing models of care would allow the service to be delivered from a materially smaller acute footprint, with specialist activity consolidated where clinically appropriate and residual activity moved into community estate. This releases acute estate and avoids further capital spend on facilities that are not fit for purpose.

Planning should begin now that involves assessing estate suitability, developing a full set of options, and undertaking detailed demand and capacity modelling. Any change to the configuration of services would then need to follow a service change process in compliance with NHSE guidance, HM Treasury Green Book, and legal duties.

[35] HES APC and OPS, 2024/25.
[36] SEL, Dentistry 2030 Strategic Outline Case, (2023).
[37] Ibid.
[38] Ibid.

6. Analysing the impact of transformation

Without transformation and service change, the acute system deficit is projected to rise from £256 million in 2025/26 to £1 billion by 2030/31 before efficiency delivery.[39] As outlined in this report, returning acute services to sustainability will therefore require system-wide change that extends beyond existing programmes.

Commissioner-led transformations generate substantial financial benefit for the system. These transformations impact the activity profiles by suppressing demand for acute services and result in income and cost effects across the system. For the ICB, the transformation opportunities close the do-nothing position almost entirely. Applying the prevention, inequalities and models of care opportunities, net of the investment each requires, returns the commissioner from a £293 million deficit to a £3 million surplus in 2030/31.[40]

For the providers, the significance of the transformation opportunities is not only the financial impact, but their mechanism in reducing activity. Prevention and new models of care reduce the growth in demand rather than reducing below the current baseline levels of activity, so the majority of the income and cost reduction offsets forecast growth. The providers are committed to delivering £1.1 billion of efficiency over the period, most of which remains largely unidentified, and a significant proportion of which is currently absorbed to meet the costs associated with rising demand. By flattening the growth line, commissioner-led transformation reduces the volume of activity that the demand related provider efficiency programmes must absorb, allowing those programmes to deliver genuine reductions in the costs associated with care rather than holding the position against demand. The two are complementary rather than additive: commissioner-led transformation creates the headroom in which provider productivity plans become credible and deliverable.

Taken together, the commissioner-led transformation and full efficiency delivery move all three acute providers closer to financial sustainability by 2030/31. They move from do-nothing deficit positions of £440 million at GSTT, £369 million at KCHT, and £201 million at LGT to a residual position of a £29 million deficit, breakeven (with a remaining £149 million residual disaggregation), and a £18 million deficit respectively.[41]

The cross-provider transformation programmes are intended to reduce that residual gap and to mitigate the delivery risk attached to efficiency requirements that remain unidentified in the outer years. Outpatient transformation presents gross opportunity of £80 million on National Cost Collection basis, with the financial benefits distributed between the commissioner and the providers. Elective surgical hubs deliver £16 and £28 million from released bed and theatre session capacity when delivered in conjunction with commissioner-led transformation and productivity improvements. Similarly, consolidation of breast surgery to improve overall quality has an opportunity of £0.8 million to £0.9 million. The reconfiguration of oral and dental services delivers a gross annual opportunity of £9.7 million to £10.5 million through chair based cost-reduction, depending on the option pursued.

Unlike the commissioner led opportunities, which are phased over the planning period, these figures are stated as in-year values when delivered at full scale, as no delivery timescale has been assumed. Realisation will depend on investment and the pace at which each programme is implemented, and earlier delivery would generate a greater recurrent benefit over the period to 2030/31.

[39] SEL ICB and acute provider financial modelling 2025/26 – 2030/31, (July 2026).
[40] Ibid. Note: Includes net impact of outpatient transformation.
[41] Ibid. Note: Includes net impact of outpatient transformation.

7. Considering wider opportunities for future review

The Acute Services Review explored five further areas where scale or changing demand indicates a case for change. These areas provide direction for future sustainability review programmes and their appropriate geographical level for planning.

Maternity

Maternity is spread across ten sites in South London. Deliveries have decreased by 14% since 2019 and fertility rates continue to decline. As volumes decline, more sites will fall below viable scale, and over half are projected to drop under the 2,500-delivery sustainability threshold by 2035.[42] This will further exacerbate the current financial challenge as every maternity site in South London is loss-making, with a combined deficit of over £140m.[43]

While there is need to review maternity in both the South East and South West London systems, any changes in South East London should derive from planning on a South East London footprint. This mitigates the risk of delay in both systems that joint planning could create, and recognises that South West London already has work underway.

General paediatrics

Acute general paediatric activity is predominantly addressing local needs, with limited flow between South East and South West London. Around 89 beds are needed across 7 sites in South East London, with the PRUH, UHL and QEH each requiring less than 15 beds almost entirely for non-elective activity.[44] At these volumes, the cost of 24/7 consultant cover may not be proportionate to activity. Overall, there is opportunity to plan general paediatrics and maternity together across South East London to address the sustainability challenges given the clinical interdependencies between the services.

Non-tertiary surgery for cancer

Surgical treatment for cancer shows a long tail of low-volume provision, with sub-scale services scattered across South London. However, admitted cancer activity is predominantly local, with South East London patients making up 78% of activity across the three trusts and most South West London providers serving their local populations.[45] As such, it should be planned on a South East London basis, with consideration of inward flows from Kent, Medway and Sussex.

Specialised paediatrics, cancer and cardiothoracic

Specialised paediatrics, cancer and cardiothoracic services have significant activity flows across London and wider catchments (e.g., in specialised paediatrics, GSTT draws 65% of activity from outside of South East London).[46] Activity is also concentrated in a few large providers with long tails of sub-scale services (e.g., in specialised cancer, 60% of providers in London make up 7% of activity).[47] The London Specialised Services Review was commissioned in 2026 to review the case for planning services to improve quality of care and sustainability of services. Within this context, planning of these specialised services should occur collaboratively across London's ICSs, rather than at a South London footprint.

Major trauma

Specialised major trauma services are delivered by four London providers: Barts (727 spells), KCHT (654), St George's (493) and Imperial/St Mary's (1.5k).[48] The co-dependency requirements for major trauma are resulting in potentially unsustainable services at the four major trauma sites, including vascular surgery. These sustainability challenges should be considered through a London-wide review of the co-dependency framework.

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[42] HES APC, (2025); National Advisory Team, Guidance on reconfiguration of maternity and children's services, (2015).
[43] HES APC and OPS, (2025).
[44] HES APC, (2025).
[45] Ibid.
[46] SUS, (2025/26).
[47] Ibid.
[48] Ibid.

8. Conclusions and recommendations

South East London has a significant financial and demand challenge that is growing and beyond what existing improvement programmes can close. System-wide action is required to deliver the long-term financial sustainability of acute services in South East London. This spans commissioner-led transformation, neighbourhood health, provider productivity, and collaborative change programmes that extend beyond individual trust boundaries.

Recommendations

1. The ICB should expand investment in targeted prevention programmes and work in collaboration with local authorities to deliver initiatives focussed on obesity; CVD; diabetes; respiratory disease; anxiety and depression.
2. The ICB and each integrator should collaborate to transform models of care to deliver proactive, integrated, and community-based care in alignment with the neighbourhood health agenda.
3. Each provider should extend CIPs across the full five-year period and identify where there is opportunity to deliver productivity improvements either individually or through system-wide collaboration.
4. The three providers and the ICB should mobilise system-wide transformation and service change in the following areas:
    - Outpatient transformation programme to design planned specialist care once and deliver it across all three organisations, leveraging the shared Epic platform and embedding standardised pathways and single points of access.
    - Elective surgical hubs to determine feasibility to concentrate activity, ring-fence capacity, and deliver productivity improvements and financial benefits for the system. This must start from development of a detailed demand and capacity modelling exercise covering all specialties and be associated with a theatres and estates review to confirm the ability for GIRFT standards to be met.
    - Breast surgery to consolidate surgical activity to strengthen service resilience and improve quality.
5. The ICB and acute providers should work to address other services identified through this review to ensure high quality care and system sustainability:
    - Oral and dental health should be explored for a smaller acute estate footprint, consolidating specialist activity where clinically appropriate and moving residual and non-specialist activity into community estate.
    - Maternity and general paediatrics should be jointly explored for transformation in South East London.
    - Non-tertiary surgery for cancer should be considered as part of the above mentioned elective surgical hubs and breast surgery consolidation.
    - Specialised services transformation, including specialised paediatrics, cancer, and cardiothoracic, should be considered as part of the London Specialised Services Review.

NHS
South East London

Committee Update – Strategic Commissioning Committee

Agenda item: 5.1

Executive Lead: Ed Waller, Chief Commissioning Officer

Report by: Georgina Fekete, Committee Chair

Paper type: Information

Conflicts of Interest: None identified

1. Purpose and recommendation

The purpose of this report is to provide to the Board an update on the activity of the Strategic Commissioning Committee, including decisions made, since the last Board meeting.

The Board is asked to:

- **Note** the items of discussion
- **Note** the outcomes of the committee discussions
- **Note** the amendments to the Committee Terms of Reference, which are included for Board approval in the Governance Update under a separate part of the agenda.

2. Background and context

Since the last meeting of the Board on 22 July 2026, the Strategic Commissioning Committee (SCC) has met once. This was the first meeting of the committee.

Membership comprises two non-executive directors as committee chair and deputy chair, together with the Chief Executive, Chief Commissioning Officer, Chief Finance and Compliance Officer, ICB Medical Director, ICB Chief Nursing and Quality Officer, two Place Executive Leads and the Directors of Strategic Commissioning.

The Chairs of the respective SCCs in South East London and South West London ICB's are working closely together to ensure agendas between the two committees are aligned, whilst remaining flexible to respond to any emerging issues affecting one or other ICB uniquely.

3. Activity undertaken

The October 2026 meeting covered the following items:

Governance and ways of working
The committee reviewed the terms of reference approved at the last Board with some amendments proposed to clarify membership roles, and an acknowledgement of the committee's purpose.

Ways of working for the committee were discussed, including meeting formats, expectations of members, and the aspirations of members in terms of what the committee would look like a year from now. There was an overriding desire to ensure the Committee was able to be assured the ICB's strategic commissioning activity was securing best outcomes for residents and patients, in a resource efficient and effective way, challenging activity where needed and ensuring the right prioritisation. The Committee recognised the links with the Neighbourhood Strategic Delivery Committee and Patient Safety Committee around quality to ensure nothing was missed.

Commissioning
Draft Commissioning Intentions were discussed, including planning timeframes and the Medium Term Financial Strategy (MTFS). The members recognised the desire to commission what was promised against the 5 year plan, with transformation constrained by capacity. Members sought clarification on the rationale, risks and potential outcomes of the choices in the Strategic Investment Fund (SIF) and how the Commissioning intentions consider performance issues and the results of the Acute Services Review (see below). Members noted the development of a future prioritisation framework to aid commissioning choices. Members were asked to confirm agreement to the direction of travel within the MTFS and noted it presented a challenging picture as demand continued to grow.

Performance Oversight
October performance across the system was discussed by the Committee, noting the ambition to develop more integrated reporting across performance, finance and quality objectives in the near future. The Committee discussed what information they felt was needed to deliver on their objectives and how this could be achieved, noting a move towards a self-service data environment was planned and agreed that the Committee in its role would undertake deep dives on areas that are facing challenges.

The Board Assurance Framework and corporate risks were discussed with the Committee recognising the need to land the correct level of oversight whilst note repeating the role of the Board in maintaining an overall strategic view.

Financial performance at month 5 was also presented and discussed, noting the ICB remained on target to break even, with running cost reductions in line with plan.

Acute Services Review
The Committee received a report on the Acute Services Review commissioned by the ICB, noting concerns about the need to focus on the right issues to achieve improvement, and considering next steps. Timescales and governance structure had been agreed but some additional work was needed before recommendations were made to the Board.

4. Decisions and Outcomes

The following outcomes were agreed by the Committee within their own scope of responsibility:

- Committee responsibilities as laid out in the Terms of Reference were **noted.**
- A change was requested to the Terms of Reference to enable greater flexibility around the attendance of non-members of the Committee.

Decisions made by the Committee were within the scope of its delegated authority stated in the Scheme of Reservation and Delegation.

NHS
South East London

Finance report: Month 6, 2026/27

Agenda item: 5.1.1

Reporting period: April to September 2026

Executive Lead: Dinah McLannahan - Chief Finance and Compliance Officer

Report by: ICB Finance Team

Paper type: Information and assurance

Conflicts of Interest: No specific conflicts are identified in the report. Members should declare any relevant interests in accordance with ICB policy.

1. Purpose and recommendation

To provide public assurance on the ICB's financial performance for April to September 2026, its forecast for the year ending 31 March 2027, and delivery of savings and financial duties. Board consideration enables scrutiny of the pressures and assumptions underpinning the balanced forecast. This is a monitoring report; no new expenditure or service change is submitted for approval.

The Board is asked to:

- Note the reported balanced Month 6 position and balanced year-end forecast; note reported savings of £41.227 million against an annual target of £82.458 million and forecast delivery of financial duties; and discuss the principal risks and the assurance required to sustain financial balance.

2. Background and context

The ICB's 2026/27 financial plan provides for breakeven. The attached report covers the first six months of the year and includes updates for all six boroughs. It reports a balanced overall position, with mental health pressures offset by underspends elsewhere. The September funding allocation reduced by £26.317 million, including a £27.948 million provider efficiency adjustment, partly offset by additional allocations. Further funding changes are expected during the year. The ICB is also managing a £21.4 million annual funding reduction associated with organisational change.

3. Analysis and evidence

Overall performance: The ICB reports breakeven at Month 6 and forecasts breakeven at year-end. Boroughs collectively report a £13,000 year-to-date underspend; each forecasts balance or an underspend.

Savings: Reported delivery of £41.227 million is in line with the six-month plan. The full £82.458 million annual target is forecast to be delivered. Approximately £29 million is assessed as medium or high delivery risk; the report expects all planned savings to be recurrent.

Spending pressures: Mental health expenditure is £5.327 million above budget year to date, including pressures from Right to Choose ADHD and autism assessments and individual care packages. Continuing healthcare is £1.057 million below budget, with a forecast £1.782 million underspend; the forecast has deteriorated by £1.332 million since Month 5. Prescribing is broadly balanced overall, but includes two months of estimates and remains exposed to price and demand changes.

Other duties: Running costs are reported as balanced, with a forecast outturn of £31.797 million. The report records 99.6% of invoices paid within 30 days and cash within the permitted limit. Core mental health spending is forecast at £568.090 million against a £566.806 million minimum; compliance remains subject to independent annual review.

4. Options and trade-offs

No options appraisal or new investment decision is presented. The report describes management of pressures through savings delivery, care-pathway work, review of care packages and offsets from underspends and released provisions. These measures support in-year balance, but one-off releases do not resolve recurrent cost pressures. The Board should distinguish assurance on the current forecast

from assurance on longer-term sustainability. Any subsequent service or investment proposals would require separate consideration through the appropriate governance routes.

5. Implications, impacts and risks

Finance and statutory duties: The balanced forecast remains dependent on managing demand-led pressures, delivering savings and sustaining offsetting underspends. Key risks include Right to Choose assessments, mental health placements, continuing healthcare needs and prices, prescribing costs and an approximately £5 million reduction in GP funding following the national patient-list review. Some offsets are explicitly one-off. Mitigations reported include pathway commissioning, care-package reviews, monitoring of savings and further borough-level actions.

Residents, quality, safety and safeguarding: This monitoring paper proposes no specific service change. The report notes that limiting other investment partly offsets mental health pressures. It does not provide a quantified assessment of the impact on access, quality or safeguarding; financial balance alone should not be taken as assurance on these matters.

Equalities and health inequalities: No specific impact assessment is included. Any subsequent proposals affecting services or access should be assessed for their impact on residents and inequalities through the relevant decision-making process.

Workforce and delivery: Vacancies have contributed approximately £5.8 million of organisational cost underspends used to offset the funding reduction. The report also identifies risks to commissioning, contract and budget management capacity during organisational change. Revised budgets for October to March are due in the next report.

Assurance gaps: The recurrence of savings should be considered alongside reliance on one-off benefits; estimated activity and delayed data create forecast uncertainty. Core Mental Health Investment Standard headroom is £1.284 million, with compliance subject to annual review. The forecast dental underspend of £2.500 million is against a protected budget and is subject to further action.

6. Engagement and approvals

The report brings together ICB-wide and borough financial positions and draws on the September financial return to NHS England. It describes joint work across boroughs on Right to Choose pressures, reviews involving service and finance leads, and continuing provider price negotiations. It does not record specific public engagement, prior committee consideration or formal approvals for this paper. Any prior scrutiny and outstanding actions should be confirmed before submission. No new service decision requiring approval is sought through this report.

7. Next steps and oversight

The Board is asked to note the reported Month 6 position, balanced year-end forecast and savings delivery, and discuss the principal risks and assurance required.

The proposed follow-up is for the Chief Finance Officer and Finance Team, working with borough and service leads, to continue monthly monitoring of demand-led pressures, savings delivery and the sustainability of offsets, escalating material deterioration through the established governance arrangements. The next monthly report is expected to include revised October-to-March organisational budgets reflecting the new structure and the £19 per person running cost limit.

Chair: Richard Douglas CB CEO: Andrew Bland

Before publication, confirm the meeting details, named executive lead and author, prior scrutiny and approvals; reconcile the allocation discrepancy; and check the presentation of forecast financial duties. Board feedback should inform subsequent reporting and any additional assurance requested.

Appendices and supporting information

Appendix 1: South East London ICB finance report, April to September 2026

NHS
South East London

South East London ICB finance report

April to September 2026
Month 6 of 2026/27

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NHS South East London

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How to read this report

The reporting period is April to September 2026.
Year-end means 31 March 2027. Forecasts are estimates.
ICB means Integrated Care Board.
A balanced budget means spending matches available funding.
In tables, £000 or £k means thousands of pounds. £m means millions.
YTD means April to September. FOT means the expected year-end result.

1. Financial targets and progress

NHS South East London

- At September 2026, the ICB reports a balanced position against its funding limit and expects to balance its budget for 2026/27.
- Savings of £41.227 million match the plan for April to September. All boroughs expect to balance their budgets or underspend by year-end.
- The ICB reports a balanced position against its running cost allowance and reports meeting its financial duties for April to September.

Target	Measure	Forecast Month 12 Position	Reported status
Balanced budget	Spending matches available funding	Final outturn breakeven position	Achieved
Savings	Deliver £82.458m of savings in 2026/27.	Final outturn £82.458m of savings.	Achieved
Mental Health Investment Standard	Increase Mental Health expenditure by 3.24%, in line with allocation growth	Final outturn increase 4.41%.	Achieved
Running costs	ICB running costs not to exceed £31.797m	Final spend £31.797m	Achieved
Invoice payments	Paying 95% of invoices within 30 days	99.6% of invoices paid within 30 days	Achieved
Cash balance	Cash balance at month end within the 1.25% draw down limit	Cash 0.37% of drawdown limit	Achieved

2. Summary

NHS South East London

- At September 2026, South East London Integrated Care Board (ICB) reports a balanced financial position and expects to balance its budget for 2026/27. Mental health spending pressures are currently offset by underspends elsewhere. Funding totals need confirmation: the narrative gives £5,598.616 million, while detailed tables show £5,984.616 million.
- Funding: the allocation fell by £26.317 million in September. The next page explains the changes. The original financial plan also aimed for a balanced budget.
- Prescribing: four months of 2026/27 data are available. Including estimates for two further months, spending across the main and other prescribing budgets is £39,000 below budget. Drug shortages and national price changes could increase costs later in the year.
- NHS continuing healthcare: spending is £1.057 million below budget for April to September. The expected full-year underspend is £1.782 million. Both have reduced since last month. Estimates for claims relating to earlier care have changed. Bexley and Bromley expect small overspends. Boroughs have set aside money for price increases still to be agreed or implemented.
- Mental health: spending is £5.327 million above budget for April to September, an increase from last month. Pressures include care charged per person and Right to Choose services. Attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) assessments remain significant pressures across the boroughs. The ICB is commissioning work to improve care pathways.
- Boroughs: their combined position is broadly balanced. Bromley is £24,000 over budget, mainly because of mental health costs, but has improved since last month. Greenwich is £343,000 over budget because of prescribing and mental health costs. Every borough expects to balance its budget or underspend and must identify further actions to manage risks.
- Running costs: the ICB reports a balanced position. Savings of £5.8 million so far are helping offset a £21.4 million annual funding reduction linked to organisational changes. The 2025/26 accounts included redundancy costs as amounts owed or estimates of future payments, so these do not create a new cost in the 2026/27 position.
- Other financial duties: the ICB reports meeting invoice payment targets and keeping month-end cash within its limit. It expects to meet the Mental Health Investment Standard, subject to the annual review.
- Outlook: the expected year-end position remains balanced. This depends on managing the spending pressures and risks described in this report.

3. Changes to NHS funding

NHS South East London

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL ICB
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
ICB Start Budget (as per submitted plan)	**109,388**	**208,005**	**130,682**	**145,879**	**119,148**	**113,778**	**5,074,926**	**5,901,806**
M2 Internal Adjustments	538	527	837	788	1,912		-4,604	**0**
M2 Allocations	205	956	292	50	71	102	46,911	**48,587**
M2 Budget	**110,132**	**209,488**	**131,811**	**146,717**	**121,131**	**113,880**	**5,117,233**	**5,950,393**
M3 Internal Adjustments	8	-10	-10	-984	10	-1,047	2,033	**0**
M3 Allocations		527				550	43,752	**44,829**
M3 Budget	**110,140**	**210,005**	**131,801**	**145,733**	**121,141**	**113,383**	**5,163,018**	**5,995,222**
M4 Internal Adjustments	-174	-599	-94	15	-8	0	860	**0**
M4 Allocations							6,491	**6,491**
M4 Budget	**109,966**	**209,406**	**131,707**	**145,748**	**121,133**	**113,383**	**5,170,369**	**6,001,713**
M5 Internal Adjustments	231	296	205	191	121	121	-1,165	**0**
M5 Allocations							9,221	**9,221**
M5 Budget	**110,197**	**209,701**	**131,912**	**145,940**	**121,254**	**113,503**	**5,178,426**	**6,010,934**
M6 Internal Adjustments								
Various PCD internal adjustments	695	352	731		308		-2086	**0**
Other internal virements	55	105	42	3	170	55	-431	**0**
M6 Allocations								
26/27 Efficiency Adjustment							(27,948)	**(27,948)**
Hybrid Closed Loop 26/27 Q1 payment							599	**599**
Obesity Pathway Improvement Programme (OPIP)							521	**521**
Various GIRFT allocations							261	**261**
2026/27 Seasonal Vaccination/Big Week/November Intiative							150	**150**
Other minor allocations under £50k							100	**100**
M6 Budget	**110,948**	**210,158**	**132,685**	**145,943**	**121,732**	**113,559**	**5,149,591**	**5,984,616**

- The table shows the ICB's annual funding limit, called the Revenue Resource Limit (RRL). Table values are in thousands of pounds.
- The starting allocation was £5,901.806 million, in line with the operating plan.

- In September, the allocation fell by £26.317 million to £5,598.616 million.
- Planned funding of £2.227 million, labelled SDF, was still pending at month 6.
- A provider efficiency adjustment reduced 2026/27 funding by £27.948 million.
- September additions included £599,000 for hybrid closed loop technology, £521,000 for the Obesity Pathway Improvement Programme, £261,000 for Getting It Right First Time initiatives and £150,000 for seasonal vaccination. Other adjustments totalled £100,000.
- Further funding changes, both ongoing and one-off, are expected during the year.

4. Spending against budget at September 2026

NHS South East London

Allocation Expenditure	Annual Budget £000s	Forecast Outturn £000s	Forecast Variance £000s	Previous Month Forecast Variance £000s	Movement from last month £000s
Total Allocation (Income)	**(£5,984,616)**				
Expenditure:					
Acute Services (NHS & non-NHS)	£3,362,100	£3,361,467	£634	£655	(£22)
Specialist Commissioning	£250,083	£247,413	£2,670	£2,670	£0
Community Health Services	£583,979	£577,680	£6,299	£3,827	£2,472
All Age Continuing Healthcare	£171,009	£169,226	£1,782	£3,114	(£1,332)
Corporate & Other	£89,024	£90,822	(£1,798)	(£2,170)	£372
Mental Health	£779,940	£789,393	(£9,453)	(£8,096)	(£1,357)
Primary Care (Incl Prescribing & Delegated)	£748,481	£748,614	(£133)	£0	(£133)
Total Expenditure:	**£5,984,616**	**£5,984,616**	**£0**	**£0**	**(£0)**
Surplus/(Deficit)	**£0**				

- The overall position is balanced. Mental health is the main area of overspending, including ADHD services. April to September spending on ADHD was about £6.4 million against a £3.1 million budget. Underspending in community services offsets this pressure. Table values are in thousands of pounds.

5. Prescribing costs

NHS South East London

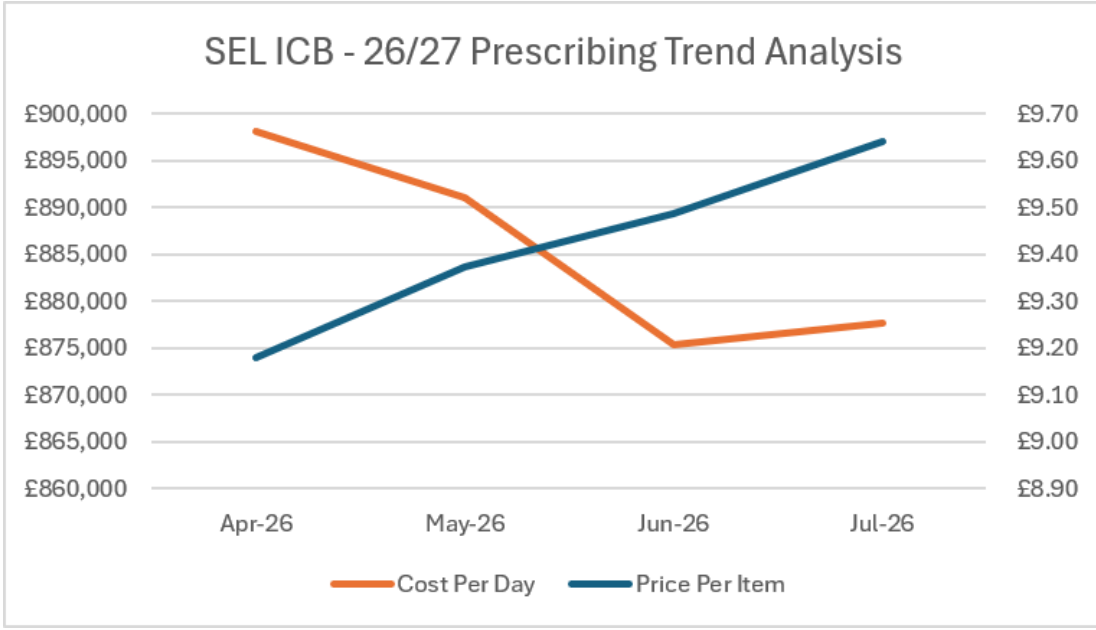
- The main prescribing budget (labelled PPA) is balanced overall for April to September. Borough results vary, including a £372,000 overspend in Lambeth. Other prescribing budgets are £39,000 below budget so far and expect a £46,000 full-year underspend. Table values are in thousands of pounds.

M06 Prescribing	Total 26/27 PPA Spend £'000s	M06 YTD Budget £'000s	YTD Variance - (over)/under £'000s	Annual Budget £'000s
BEXLEY	19,731	19,883	153	39,505
BROMLEY	25,671	25,888	217	51,435
GREENWICH	20,161	20,009	(152)	39,754
LAMBETH	22,906	22,534	(372)	44,771
LEWISHAM	23,170	23,430	260	46,551
SOUTHWARK	19,178	19,072	(106)	37,893
SOUTH EAST LONDON	4,098	4,098	(0)	8,146
Prescribing PPA	**134,914**	**134,914**	**(0)**	**268,055**

- April to July prescribing costs rose by 6.0% in South East London, compared with 7.7% nationally and 7.3% across London. The cost per item rose by 2.0%, compared with 3.5% across London ICBs. These comparisons use the same period in 2025/26 and 2026/27.

Prescribing
Comparison of April to July 2025 v April to July 2026

	2025/26 April to July	2026/27 April to July	Change £	Change %
South East London ICB:				
Expenditure (£'000)	84,337	89,402	5,065	**6.0%**
Number of Items ('000)	9,126	9,487	360	**3.9%**
£/Item	9.24	9.42	0.18	**2.0%**
South West London ICB:				
Expenditure (£'000)	69,905	75,295	5,390	**7.7%**
Number of Items ('000)	8,658	8,921	263	**3.0%**
£/Item	8.07	8.44	0.37	**4.5%**
London ICBs:				
Expenditure (£'000)	431,520	463,223	31,703	**7.3%**
Number of Items ('000)	52,503	54,471	1,968	**3.7%**
£/Item	8.22	8.50	0.29	**3.5%**
All England ICBs:				
Expenditure (£'000)	3,458,843	3,723,728	264,885	**7.7%**
Number of Items ('000)	421,674	431,224	9,549	**2.3%**
£/Item	8.20	8.64	0.43	**5.3%**



6. Dental, eye care and community pharmacy

NHS South East London

Financial Summary by Service Line - Six Months to 30th September 2026			
Service Line Description	**YTD Budget £000s**	**YTD Actuals £000s**	**YTD Variance £000s- (over)/under**
ACUTE DENTAL and NCAs	29,603	29,603	(0)
COMMUNITY DENTAL	4,330	4,330	0
PRIMARY CARE **Dental**	57,447	56,197	1,250
DENTAL SERVICES (Ring Fenced)	**91,381**	**90,131**	**1,250**
PRIMARY CARE **Ophthalmic**	8,815	8,730	85
PRIMARY CARE **Pharmacy**	24,309	24,309	0
Delegated **Property**	371	371	0
Grand Total	**124,876**	**123,541**	**1,335**

Dental services

- Spending is £1.250 million below budget for April to September. The ICB expects a £2.500 million underspend against its £183.398 million protected annual dental budget (1.3%) and is working on actions to address it. Monthly estimates use the national e-Den dental report. Property costs include rent for dentists using NHS Property Services or Community Health Partnerships premises.

Eye care services

- Spending is £85,000 below budget so far, with a £170,000 full-year underspend expected. Most spending covers NHS sight tests and optical vouchers claimed by opticians in South East London, wherever the patient lives. The ICB must pay eligible claims under the national framework.

Community pharmacy

- The ICB reports a balanced position so far and expects to balance the full-year budget. Information arrives about two months late. Only four months of data are available, so the remaining spending estimates use average monthly costs adjusted for prescribing days.

7. GP service budgets

NHS South East London

Financial Summary by Service Line - Six Months to 30th September 2026			
Service Line Description	**YTD Budget £000s**	**YTD Actuals £000s**	**YTD Variance £000s- (over)/under**
Core Payments to Practices (Including Premium)	143,078	143,106	(28)
Enhanced Services	976	976	0
Quality and Outcome Framework (QOF)	9,396	9,396	(0)
Premises Payment	18,362	18,392	(30)
Other Administered Funds (Maternity etc)	2,566	2,542	23
Personally Administered Drugs	430	430	0
Other Medical Services	432	446	(14)
Primary Care Networks	47,388	47,387	1
Business Rates Review	0	0	0
Prior Year Accruals	0	0	(0)
Other	0	1	(1)
Grand Total	**222,628**	**222,677**	**(49)**

- The GP service budget, called delegated primary care, is £49,000 over its £222.677 million budget for April to September. The ICB expects a balanced year-end position. Key risks are:
- Funding: a national review of GP patient lists has reduced the allocation by about £5 million. If patient numbers do not fall by the same proportion, costs could exceed funding. The ICB expects a clearer picture when July to September list data become available at the end of October.
- Premises: rent reviews can lead to backdated costs. The accounts include estimates for these costs within the property revaluation budget.
- Temporary GP cover: reimbursement claims are difficult to predict because their timing and duration vary. The ICB will monitor spending against previous years and update its forecasts.

8. NHS continuing healthcare

NHS South East London

Borough	Budgeted Client No	Actual Client No	YTD Budget £k	YTD Actual £k	YTD Var (Adv)/Fav	Annual Budget £k
PB - Bexley	1,311	960	13,436	14,037	600	26,872
PB - Bromley	1,683	1,304	14,929	15,063	134	29,857
PB - Greenwich	780	614	16,145	15,359	786	32,289
PB - Lambeth	985	700	17,879	17,686	193	35,759
PB - Lewisham	659	514	12,748	12,743	4	25,495
PB - Southwark	651	480	10,368	9,560	808	20,736
Total	**6,069**	**4,572**	**85,504**	**84,448**	**1,057**	**171,009**

- At September, NHS continuing healthcare (CHC) is £1.057 million below budget. The expected full-year underspend is £1.782 million. After allowing for the annual NHS-funded nursing care price increase, the forecast has worsened by £1.332 million since last month. Changes in care needs, particularly children's continuing care, and revised estimates for claims relating to earlier care explain the change.
- Bexley and Bromley are over budget so far, while Greenwich and Southwark are under budget. Greenwich's underspend mainly relates to fully NHS-funded adult care and personal health budgets. Southwark's relates to fully NHS-funded adult care, palliative care and children's care packages.
- Borough budgets include money set aside for inflation-related price increases. Negotiations with some providers continue. CHC means NHS continuing healthcare. Table values are in thousands of pounds.

9. Payments to service providers

Contracts for care account for the largest share of the ICB's spending. They cover NHS and non-NHS hospital, community and mental health services. Many use block contracts, which agree a set payment for services.

- The ICB expects to spend about £4,446.904 million on NHS block contracts in 2026/27. This includes the following payments to local providers:
- Guy's and St Thomas' £1,182.557 million
  - King's College Hospital £1,125.554 million
  - Lewisham and Greenwich £777.877 million
  - South London and Maudsley £399.273 million
  - Oxleas £354.348 million
  - The reported position for these NHS services is balanced, with a balanced year-end position also expected.

10. Organisational running costs

NHS South East London

	Annual Budget	Year to Date		
		Budget	Actual	Variance
Boroughs	£	£	£	£
Bexley	3,181,440	1,590,719	1,316,777	273,942
Bromley	4,396,854	2,198,427	1,913,735	284,693
Greenwich	3,736,254	1,868,127	1,534,072	334,055
Lambeth	4,878,223	2,439,111	2,175,364	263,747
Lewisham	3,465,718	1,732,859	1,452,664	280,196
Southwark	4,499,772	2,249,885	1,922,275	327,611
Subtotal	24,158,261	12,079,129	10,314,886	1,764,243
Central				
CESEL	1,060,671	530,335	360,828	169,507
Chief of Staff	3,482,603	1,741,301	1,356,351	384,950
Comms & Engagement	1,884,256	942,128	637,881	304,247
Digital	1,826,220	913,110	332,245	580,865
Digital - IM&T	3,511,978	1,755,989	1,666,665	89,324
Estates	729,057	364,529	468,289	(103,761)
Executive Team/GB	2,617,893	1,333,186	1,274,192	58,993
Finance	3,061,668	1,530,835	1,229,147	301,688
London ICS Network	0	0	0	0
Medical Director - CCPL	1,509,059	754,529	660,029	94,501
Medical Director - ICS	300,124	150,062	145,778	4,283
Medicines Optimisation	4,820,290	2,410,145	1,425,554	984,592
Planning & Commissioning	9,168,702	4,560,112	3,668,891	891,221
Quality & Nursing	2,142,423	1,071,212	1,062,953	8,259
SEL Other	813,524	406,762	37,231	369,531
Other Corporate Budgets inc Non Pay	4,048,870	2,024,435	2,126,760	(102,325)
Subtotal	40,977,338	20,488,669	16,452,794	4,035,875
Grand Total	65,135,600	32,567,799	26,767,680	5,800,119

- The table shows organisational programme and running costs for April to September. Values are in pounds (£).
- These costs are about £5.8 million below budget, mainly because of vacant posts. This includes staff who have left, or are starting to leave, through the two voluntary redundancy phases.
- The accounts report a balanced position so far and for year-end. The ICB is using the underspend to offset a £21.4 million annual funding reduction linked to organisational changes. National funding assumed all required reductions would take effect from 1 April 2026.
- Next month's report will include revised budgets for October to March, reflecting the new structure. These budgets should meet the £19 per person running cost limit.
- The table excludes redundancy costs. The ICB recorded amounts owed and estimated future payments in the 2025/26 accounts, and charges payments against those amounts.

11. Ongoing financial position

NHS South East London

Underlying Position	Expected Sign	2_16ALLOCATION Allocation Forecast 31/03/2027 Year Ending £'000	2_16FOT Expenditure Forecast 31/03/2027 Year Ending £'000	2_16VAR Surplus / (Deficit) Forecast 31/03/2027 Year Ending £'000	2_16COMM Commentary Forecast 31/03/2027 Year Ending TEXT	Maincode Subcode
FY2026-27 Forecast	+/-	(5,984,616)	5,984,616	0		BRIDGE0010
Forecast non-recurring efficiencies	+/-		0	0		BRIDGE0020
Forecast deficit support funding	+/-	0		0		BRIDGE0030
Non recurring business rules revenue bonus	+/-	0		0		BRIDGE0040
Deficit repayment	+/-	0		0		BRIDGE0050
FYE of recurring efficiencies - cash out	-		0	0		BRIDGE0060
FYE of recurring efficiencies - other	-		0	0		BRIDGE0070
FYE of ICB cost savings	-		0	0		BRIDGE0080
FYE of planned investments	+		0	0		BRIDGE0090
Non-Recurring Redundancy costs	-		0	0		BRIDGE0100
Non-Recurring Cost of Change (Excluding redundancy)	-		0	0		BRIDGE0110
Other impacts 1	+/-			0		BRIDGE0120
Other impacts 2	+/-			0		BRIDGE0130
Other impacts 3	+/-			0		BRIDGE0140
Other impacts 4	+/-			0		BRIDGE0150
Other impacts 5	+/-			0		BRIDGE0160
FY2026-27 Underlying Position	+/-	(5,984,616)	5,984,616	0		BRIDGETOTAL

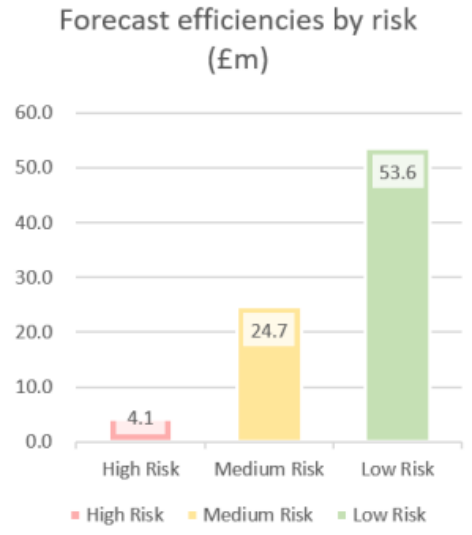
- The table comes from the September financial return to NHS England. It shows that ongoing funding and costs are balanced, in line with the 2026/27 plan. Savings delivery also matches the plan so far. The 2025/26 accounts included estimates and amounts owed for redundancies linked to organisational changes. The ICB expects these amounts to cover all related liabilities.

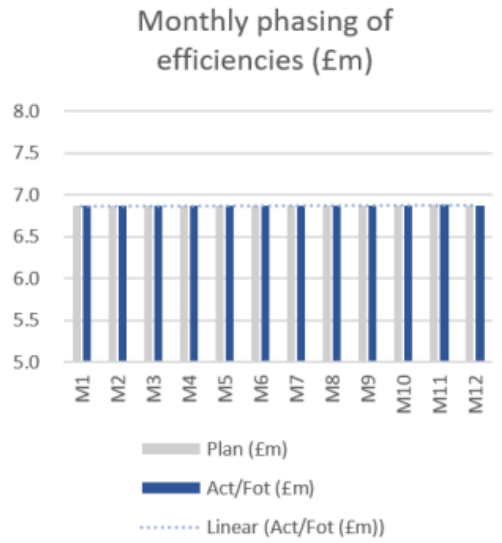
12. 12. Savings plans at September 2026

South East London

- The ICB plans to save £82.458 million in 2026/27, mainly in primary care, hospital and community healthcare.
- About £15.4 million relates to individual schemes that boroughs can monitor through their financial results, such as continuing healthcare reviews and prescribing changes. The ICB largely built the remaining savings into budgets at the start of the year.
- About £29 million of borough savings carry a medium or high delivery risk. Pressures include ADHD service prices and demand, prescribing costs and continuing healthcare.
- The table compares savings achieved so far and expected full-year savings with the plan.
- At September, reported savings match the plan. The ICB expects to deliver the full annual target.
- All planned savings are expected to continue in future years, rather than provide only a one-off benefit.

	Year-to-Date			Forecast		
	Plan	Actual	Variance	Plan	Forecast	Variance
Providers	£m	£m	£m	£m	£m	£m
Bexley	1.1	1.4	0.3	2.2	2.5	0.4
Bromley	1.0	1.3	0.3	1.9	2.3	0.4
Greenwich	1.1	1.3	0.2	2.2	2.7	0.5
Lambeth	1.1	1.1	(0.0)	2.2	2.2	0.0
Lewisham	2.7	2.8	0.1	5.4	5.6	0.1
Southwark	0.7	0.7	(0.1)	1.5	1.5	0.0
Borough Total	**7.7**	**8.5**	**0.8**	**15.4**	**16.7**	**1.3**
Other Programmes	33.5	32.7	(0.8)	67.1	65.8	(1.3)
Total	**41.2**	**41.2**	**(0.0)**	**82.5**	**82.5**	**(0.0)**





13. Mental health spending requirements for 2026/27

NHS South East London

Mental Health Investment Standard (excluding LD and Dementia) and Delegated Specialised Commissioning Mental Health Investment Standard:	Expected Sign	2_1Achieve01 MHIS Achieved per plans submitted 31/03/2026 Desc 31/03/2027 Year Ending TEXT	2_1PLAN%01 2026/27 allocation growth Plan 31/03/2027 Year Ending %	2_1AuditedPY 2025/26 Outturn Actual 31/03/2026 Year Ending £'000	2_1TARGET01 Target MHIS spend 2026/27 Target 31/03/2027 Year Ending £'000	2_1ACT02 FOT 2026/27 Forecast 31/03/2027 Year Ending £'000	2_1VAR%01 Excess / Shortfall in 2026/27 MHIS Delivery % Actual 31/03/2027 Year Ending %	2_1VAR02 Excess / Shortfall in 2026/27 MHIS Delivery Actual 31/03/2027 Year Ending £'000	2_1Achieve02 MHIS Achieved in 2026/27? Desc 31/03/2027 Year Ending TEXT	2_1POP01 Projected Population 2026/27 YTD 31/03/2027 Year Ending Number	2_1Achieve03 SCMHIS Achieved per plans submitted 31/03/2026 Desc 31/03/2027 Year Ending TEXT	2_1SCMHISAuditedPY 2025/26 SCMHIS Outturn Actual 31/03/2026 Year Ending £'000	2_1TARGET02 Target SCMHIS spend 2026/27 Target 31/03/2027 Year Ending £'000	2_1ACT03 SCMHIS FOT 2026/27 Forecast 31/03/2027 Year Ending £'000	2_1SCMHISVAR%01 Excess / Shortfall in 2026/27 SCMHIS Delivery % Actual 31/03/2027 Year Ending %	2_1SCMHISVAR02 Excess / Shortfall in 2026/27 SCMHIS Delivery Actual 31/03/2027 Year Ending £'000	2_1SCMHISAchieve02 SCMHIS Achieved in 2026/27? Desc 31/03/2027 Year Ending TEXT	2_1COMM01 Commentary for Variances Desc 31/03/2027 Year Ending TEXT
MHIS Achievement	+/-	Yes	3.24%	550,303	566,806	568,090	0.23%	1,284	Yes	2,757,608	Yes	91,032	92,573	96,657	4.41%	4,083	Yes	

The Mental Health Investment Standard (MHIS) sets a minimum level of spending on eligible mental health services.

- The original core target was £560.171 million, a 2.03% increase on 2025/26. Following pay award funding, the required increase rose to 3.24% and the target to £566.806 million. A further pay allocation caused a small change since month 4. Spending remains subject to independent annual review.
- There are two separate requirements:
  - Core mental health services: a minimum of £566.806 million.
  - Specialised services transferred from NHS England: a separate minimum of £92.573 million. The South London Partnership manages the relevant contracts.
- The standard excludes spending on learning disabilities, autism and dementia, as well as ADHD and the physical healthcare element of continuing healthcare and Section 117 mental health aftercare. It also excludes SDF and other one-off allocations, although most SDF funding has moved into the ongoing funding allocation.
- At September, the ICB expects core spending of £568.090 million, £1.284 million (0.23%) above target. It expects specialised spending of £96.657 million, with a reported margin of £4.083 million above target. The table and September return to NHS England provide more detail.

South East London ICB finance report

Borough updates
April to September 2026

1. Borough summary at September 2026

NHS South East London

Area of spend	YTD Budget £000s	YTD Actual £000s	YTD Variance £000s	Perivious Month Forecast Variance £000s	Movement from Last month £000s
Acute Services (NHS & non-NHS)	£7,290	£7,288	£2	(£2)	£4
Specialist Commissioning	£0	£0	£0	£0	£0
Community Health Services	£128,888	£124,995	£3,893	£1,037	£2,856
All Age Continuing Healthcare	£85,504	£84,448	£1,056	£88	£968
Corpoarate & Other	£12,703	£12,453	£250	£125	£125
Mental Health	£44,815	£50,143	(£5,328)	(£1,336)	(£3,992)
Primary Care (Incl Prescrining and Delegated)	£360,196	£360,056	£140	£0	£140
SEL PLACE Total	**£639,396**	**£639,383**	**£13**	**(£88)**	**£101**

- Together, the boroughs report a £13,000 underspend for April to September, a £101,000 improvement since last month. Individual results range from £228,000 below budget in Lewisham to £343,000 above budget in Greenwich.
- Mental health has the largest expected overspend, at £5.328 million. The main pressures are Right to Choose ADHD and autism assessments and care charged per person. The pressure rose by about £4 million this month, mainly after a review improved spending estimates. The review compared provider invoices with activity recorded through triage and used the midpoint. Updated costs per person also increased the reported spending in boroughs.
- Community services are £3.893 million below budget, mainly in Bexley, Bromley and Lambeth. Bexley and Lambeth released money previously held for cost pressures. Bromley underspent on intermediate care. Continuing healthcare underspends reflect children's services, agreed releases of money held for price increases and revised amounts set aside for claims relating to earlier care.

2. Bexley: April to September 2026

NHS South East London

Overall position

	Year to date Budget	Year to date Actual	Year to date Variance	Annual Budget	Forecast Outturn	Forecast Variance
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Acute Services	345	348	(3)	690	697	(7)
Community Health Services	13,151	12,078	1,073	26,303	24,156	2,146
Mental Health Services	5,778	6,504	(726)	11,556	12,994	(1,439)
Continuing Care Services	13,436	14,037	(600)	26,872	28,073	(1,201)
Prescribing	20,049	19,896	153	39,837	39,837	0
Other Primary Care Services	1,004	1,004	0	2,009	2,009	0
Other Programme Services	250	0	250	500	0	500
Corporate Budgets	1,591	1,591	0	3,181	3,181	0
Total	**55,605**	**55,458**	**147**	**110,948**	**110,948**	**0**

- Bexley is £147,000 below budget for April to September and expects a balanced year-end position.
- Mental health services are £726,000 over budget so far, with a £1.439 million full-year overspend expected. More placements and higher average costs are affecting learning disability and mental health aftercare under Section 117. Right to Choose ADHD and autism assessments by independent providers also add costs. Bexley is working with other South East London boroughs on a shared approach to this pressure.
- Continuing healthcare: £600,000 over budget so far, with a £1.201 million full-year overspend expected. More people need placements, including some high-cost care. The position has stabilised in recent months. The team continues to monitor savings.
- Community health services: £1.073 million below budget so far, with a £2.146 million full-year underspend expected. This includes one-off savings and the release of uncommitted budgets.
- Prescribing: £153,000 below budget so far, with a balanced year-end position expected. Two months of spending are estimates because data arrive late.
- Other programme services: £250,000 below budget so far, with a £500,000 full-year underspend expected. The borough released uncommitted funding for growth to help offset other pressures.
- Organisational costs: balanced so far and at year-end. Until the new ICB structure starts, the ICB will manage differences from staff budgets centrally.
- Hospital and other primary care services: broadly on budget so far and for the full year.

3. Bromley: April to September 2026

NHS South East London

Overall position

	Year to date Budget	Year to date Actual	Year to date Variance	Annual Budget	Forecast Outturn	Forecast Variance
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Acute Services	3,360	3,360	0	6,721	6,721	0
Community Health Services	49,161	47,893	1,267	98,321	95,787	2,535
Mental Health Services	8,311	9,785	(1,473)	16,623	19,087	(2,464)
Continuing Care Services	14,929	15,063	(134)	29,857	30,126	(268)
Prescribing	26,091	25,873	217	51,840	51,840	0
Other Primary Care Services	1,199	1,100	99	2,398	2,200	198
Corporate Budgets	2,198	2,198	0	4,397	4,397	0
Total	**105,249**	**105,273**	**(24)**	**210,158**	**210,158**	**0**

- Bromley is £24,000 over budget for April to September and expects a balanced year-end position.
- Prescribing: £217,000 below budget so far, with a balanced year-end position expected. Two months of spending are estimates because data arrive late.
- Hospital services: balanced so far and for the full year.
- Mental health services: £1.473 million over budget so far, with a £2.464 million full-year overspend expected. The main pressure is Right to Choose ADHD and autism assessments by independent providers. Releasing £383,000 set aside for last year's assessment bills provides a one-off benefit because it is no longer needed. Bromley is working with other South East London boroughs on a shared approach. More learning disability and Section 117 mental health aftercare placements, at higher average costs, also add pressure.
- Community health services: £1.267 million below budget so far, with a £2.535 million full-year underspend expected, mainly from releasing uncommitted funding for growth and other budgets.
- Continuing healthcare: £134,000 over budget so far, with a £268,000 full-year overspend expected. Significant ongoing cost pressures remain. Releasing £583,000 set aside for last year's bills partly offsets them this year.
- Organisational costs: balanced so far and at year-end. Until the new ICB structure starts, the ICB will manage differences from staff budgets centrally.
- Other primary care services: £99,000 below budget so far, with a £198,000 full-year underspend expected.

4. Greenwich: April to September 2026

NHS South East London

Overall position

Description	Annual Budget £'000s	Year to date Budget £'000s	Year to date Actual £'000s	Year to date Variance £'000s	Forecast Outturn £'000s	Forecast Variance £'000s
Acute Services	5,957	2,979	2,979	(0)	5,957	0
Community Health Services	36,635	18,318	18,363	(45)	36,725	(90)
Mental Health Services	11,297	5,649	6,580	(932)	12,779	(1,482)
Continuing Care Services	32,289	16,145	15,359	786	30,717	1,572
Prescribing	40,124	20,193	20,345	(152)	40,124	0
Other Primary Care Services	2,646	1,323	1,323	(0)	2,646	0
Corporate Budgets	3,736	1,868	1,868	0	3,736	0
Sub-Total	**132,685**	**66,474**	**66,817**	**(343)**	**132,685**	**0**

- Greenwich is £343,000 over budget for April to September and expects a balanced year-end position.
- Prescribing: £152,000 above budget, using the main prescribing dataset (labelled PPA).
- Mental health: £932,000 above budget, mainly because of jointly funded placements (£550,000) and Right to Choose ADHD and autism activity (£270,000). The forecast includes a £450,000 one-off benefit from releasing money set aside for last year's assessment bills. This supports the expected balanced position. Mental health remains a key financial risk and the borough will monitor it closely.
- NHS continuing healthcare: £786,000 below budget because the borough commissioned fewer placements.
- Hospital and community services: broadly on budget. Community services show a small increase in costs under contracts linked to activity, including audiology.
- The expected balanced year-end position depends in part on the £450,000 one-off benefit described above.

5. Lambeth: April to September 2026

NHS South East London

Overall position

Service Area	Year to date Budget £'000s	Year to date Actual £'000s	Year to date Variance £'000s	Annual Budget £'000s	Forecast Outturn £'000s	Forecast Variance £'000s
Acute Services	236	236	0	472	472	0
Community Health Services	15,237	13,727	1,509	30,923	28,764	2,160
Mental Health Services	12,600	13,970	-1,370	25,200	27,791	-2,592
Continuing Care Services	17,879	17,686	193	35,759	35,372	386
Prescribing	22,573	22,906	-333	44,849	44,849	0
Other Primary Care Services	1,931	1,931	0	3,862	3,816	46
Corporate Budgets	2,439	2,439	0	4,878	4,878	0
Total	**72,895**	**72,895**	**-0**	**145,942**	**145,942**	**0**

- Lambeth reports a balanced position for April to September and expects to balance its year-end budget. The forecast includes a £2.592 million mental health overspend, offset by community health (£2.160 million below budget) and continuing healthcare (£386,000 below budget), alongside other budget movements.
- The main risks are rapidly rising referrals to independent providers for ADHD and autism assessments, and the cost of individual mental health placements.
- Mental health: these assessment and placement budgets together face a £5.229 million expected overspend. Limiting other investment partly offsets this pressure within the overall mental health budget.
- NHS continuing healthcare: a £386,000 full-year underspend is expected. Reviews cover high-cost care packages and placements outside the borough, alongside work to improve value. In September, 529 people received continuing healthcare or NHS-funded nursing care.
- Prescribing: £333,000 over budget so far, with a balanced year-end position expected. The result uses four months of actual data and estimates for two months because data arrive late.
- Other risks include demand for jointly funded support for children and young people, and audiology services.

6. Lewisham: April to September 2026

NHS South East London

Overall position

Description	Annual Budget £'000s	Year to date Budget £'000s	Year to date Actual £'000s	Year to date Variance £'000s	Forecast Outturn £'000s	Forecast Variance £'000s
Acute Services	668	334	334	0	668	0
Community Health Services	30,800	15,400	15,315	85	30,629	170
Mental Health Services	11,486	5,743	5,864	(121)	11,661	(175)
Continuing Care Services	25,495	12,748	12,743	4	25,486	9
Prescribing	47,267	23,788	23,528	260	47,267	0
Other Primary Care Services	2,526	1,263	1,263	(0)	2,526	(0)
Programme Wide Projects	26	13	13	0	26	0
Corporate Budgets	3,466	1,733	1,733	0	3,466	0
Sub-Total	**121,733**	**61,020**	**60,793**	**228**	**121,729**	**4**

- Lewisham is £228,000 below budget for April to September and expects a balanced year-end position.
- Prescribing: £260,000 below budget, using the main prescribing dataset (labelled PPA).
- Mental health: £121,000 above budget because of jointly funded placements.
- NHS continuing healthcare: £4,000 below budget.
- Community services: £85,000 below budget, reflecting planned savings that support the overall position.
- The year-end forecast remains in line with the financial plan.

7. Southwark: April to September 2026

NHS South East London

Overall position

Service Area	Year to date Budget £'000s	Year to date Actual £'000s	Year to date Variance £'000s	Annual Budget £'000s	Forecast Outturn £'000s	Forecast Variance £'000s
Acute Services	36	31	6	73	61	11
Community Health Services	17,622	17,618	3	35,243	35,237	6
Mental Health Services	6,735	7,440	-706	13,469	14,771	-1,302
Continuing Care Services	10,368	9,560	808	20,736	19,452	1,284
Prescribing	19,122	19,228	-106	37,993	37,993	0
Other Primary Care Services	411	411	0	822	822	0
Other Programme Services	362	362	0	723	723	0
Corporate Budgets	2,250	2,250	0	4,500	4,500	0
Total	**56,905**	**56,900**	**6**	**113,559**	**113,559**	**-0**

- Southwark is £6,000 below budget for April to September and expects a balanced year-end position. The forecast includes a £1.302 million mental health overspend, partly offset by a £1.284 million continuing healthcare underspend.
- The main risks are rapidly rising referrals to independent providers for ADHD and autism assessments, and the cost of individual mental health placements.
- Mental health: Right to Choose assessments face a £1.607 million expected overspend. Limiting other investment partly offsets this pressure. Service and finance leads are reviewing individual placement spending across client groups.
- NHS continuing healthcare: a £1.284 million full-year underspend is expected. Reviews cover high-cost care packages and placements outside the borough. Results also reflect the release of money set aside for historic reimbursement claims that have expired. Work to improve value continues. In September, 325 people received continuing healthcare or NHS-funded nursing care.
- Prescribing: £106,000 over budget so far, with a balanced year-end position expected. The result uses four months of actual data and estimates for two months because data arrive late.
- Other risks include audiology and prescribing demand. Vacancies and high staff turnover during the ICB's organisational changes could limit its ability to plan and commission services, including managing contracts and budgets.

NHS
South East London

Performance Report

Agenda item: 5.1.2

Executive Lead: Ed Waller

Report by: Ed Waller

Paper type: Discussion

Conflicts of Interest: None identified

1. Purpose and recommendation

The report provides the Board with a summary of performance across a range of national performance metrics. It is intended to ensure Board members are appraised of progress against key operational planning commitments and understand the areas of challenge, risk and improvement focus.

The Board is asked to:

- Note the update and consider any implications for system assurance and delivery oversight.

2. Background and context

The report supports the Board's oversight of delivery by setting out the performance position together with a summary analysis across a range of key performance areas, including urgent and emergency care, cancer, referral to treatment, diagnostics, primary care, mental health, community services and continuing healthcare.

Where performance is below trajectory, the paper outlines the agreed recovery actions and improvement trajectories.

3. Analysis and evidence

Performance across key priority areas remains mixed. There is notable progress across several areas of primary and community care. However, there remains ongoing pressures in the system particularly in the acute sector with operational challenges impacting performance in urgent and emergency care, elective recovery, diagnostics and mental health flow.

General practice access, Pharmacy First and community waiting times are ahead of or meeting plan. However, Urgent Community Response referral rates and virtual ward utilisation remain below target, with improvement plans under development.

Learning disability and autism inpatient numbers remain above target, driven by increased admissions among children and young people, while long waits for CYP community mental health services remain a concern. Positively, annual health checks, out-of-area placements and several key mental health access measures are performing well.
Acute pressures remain a principal challenge. UEC performance remains below plan, while cancer 62-day performance, diagnostic waits and elective 52-week waits continue to require focused improvement.

4. Options and trade-offs

Recovery actions and opportunities for each service delivery area are detailed in the appendix report.

5. Implications, impacts and risks

There remains ongoing pressures in the system particularly in the acute sector with operational challenges impacting performance in urgent and emergency care, elective recovery, diagnostics and mental health flow.

6. Engagement and approvals

The five-year Strategic Commissioning Plan underpinning these proposals was developed in partnership with system partners and incorporated previous engagement with residents and patients on their experience of and access to care. The paper also describes a number of areas being developed collaboratively with provider, primary care, VCSE and integrator partners.

For the SIF specifically, the proposed timetable includes discussion and review of proposed strategic investment areas by the Strategic Commissioning Committee in December, followed by ICB Board consideration in January, with mobilisation during Q4.

7. Next steps and oversight

The Strategic Commissioning Committee will continue to maintain oversight and provide challenge on areas of performance where variances are noted. Where improvement plans are proposed or anticipated for specific service areas, these are detailed in the attached Appendix report.

Appendices and supporting information

Appendix 1: SEL System Performance Summary November 2026

NHS South East London
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Working together for a healthier south London

SEL System Performance Summary November 2026

SEL ICB Board – 24 November 2026

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Summary of YTD position – November 2026 (1 of 3):

Area	YTD summary and key issues
Urgent & Emergency Care (UEC)	• Published 4-hour performance for the SEL footprint (including standalone Urgent Treatment Centre (UTC) activity) has been below the combined Trust plan during 2026/27. The percentage of 12 hours waits (from arrival) has also not met the combined planning trajectory for the majority of the current year.This is reflective of the continued pressures in emergency departments. • Additionally, the summer heatwaves have driven high summer attendance numbers compared to previous years at all SEL Emergency Department (ED) sites which impacted patient flow • Discharge performance has remained relatively stable during 2026/27 with approximately 89% of patients being discharge on their discharge ready date (DRD) each month. The planned improvement in discharge performance, however, is not being achieved. • Demand, capacity and flow challenges continue across physical and mental health, with ongoing improvement work across the care pathway.This includes front door management and use of alternatives to emergency departments, implementation of 'Criteria to Admit' (CTA) across sites and in-hospital management, including same day emergency care and improving lengths of stay for patients.
Cancer	• System level performance against the 28 day Faster Diagnosis Standard (FDS) has been broadly in line with the agreed trajectory for 2026/27 since May 2026. • 62-day performance has remained a challenge in 2026/27. There has, however, been improvement over the last 12 months. Backlog position has now reduced and is in line with national expectations. • 31-day performance during the current year has been broadly in line with the planned trajectory, although some months are challenged. The key driver is surgical capacity. • The system focus continues to be improving pathway efficiency, inter-trust transfers and treatment capacity.Focused support is being provided to address service and provider level specialty challenges.
Referral to Treatment Times (RTT)	• For 26/27, there is a large emphasis in RTT transformation to deliver sustainable improvements in RTT performance. • The number of long waiters remains a challenge within south east London. Following the reduction in 65 week breaches at the end of 2025/26, there has been a shift in focus to 52 week waiters, which has not met the planned trajectory during the current year. • Patient Tracking List (PTL) size reduction is a new ICB specific target for 2026/27. There has been a gradual reduction in size during 2026/27 in line with the planned trajectory. July, however, was marginally off plan. • Strategic Investment Funds are being used to support delivery of this.
Diagnostics	• Diagnostic performance remains an area of significant system challenge. Waits for non-obstetric ultrasound, MRI and audiology continue to be the most challenged modalities during the current year. • SEL wide demand and capacity work is underway for imaging as part of system sustainability. • There continues to be a focus on maximising the available capacity in the SEL Community Diagnostic Centres (CDC), reviewing the consistency of the direct access offer across SEL and CDC first for appropriate referrals. Provider developed plan for a CDC located in the Lambeth/Southwark area is in progress.

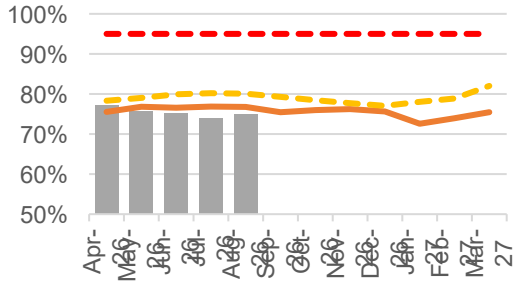
Summary of YTD position – November 2026 (2 of 3):

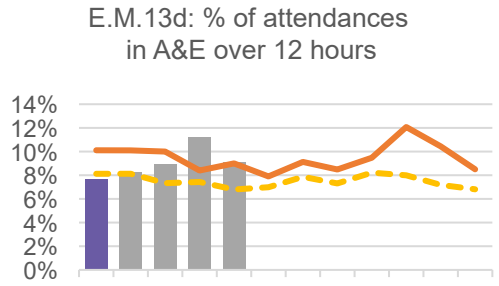
Area	YTD summary and key issues
Mental health including crisis and flow	• Mental health services continue to experience significant pressure, particularly across crisis pathways, with high mental health presentations to EDs and demand for admissions • As previously reported, a data quality (DQ) issue was identified that was inflating the SEL Out of Area Placements (OAPs) position and this has now been rectified by the relevant provider. The number of active OAPs has stabilised and has consistently met the planned trajectory during 2026/27. • The urgent referral Children and Young People (CYP) Eating Disorders waiting time standard has consistently been met during the current year. The system has also performed well against the routine referral standard, noting that there has been some monthly fluctuations in performance. • Service level delivery/implementation plans are in place to support improved performance for CYP access through Mental Health Support Teams (MHST), Individual Placement Support (IPS) access and Talking Therapies (completed courses of treatment and improvement/recovery metrics).
Primary care access	• Appointment levels have exceeded plan during 2026/27, noting some variation in performance above and below monthly planned trajectories. Appointments totalled743,756 in August 2026 against the operating plan target of 688,139. • Boroughs are engaged in actions to better understand and target support for practices showing variation in access levels. Capacity pressures and rising demand continue to impact patient experience in some areas. • Practices are increasing GP capacity to improve access by claiming reimbursement for new GPs under the GP reimbursement scheme. At the end of Q1, 37.9 whole time equivalent GPs were claimed for under this scheme. The scheme has been extended from the 1 October to include locums and salaried GPs which will enable further increased capacity.
Community pharmacy: pharmacy first clinical consultations, hypertension and oral contraception	• Uptake of Pharmacy First, hypertension and contraception services has been strong across most SEL boroughs during 2026/27, with 92.8% of community pharmacies providing all three services as of July 26. • There has been strong engagement across SEL through the Community Pharmacy Neighbourhood Leads programme, supported by ongoing stakeholder and public awareness activity for all three services.
Learning disability and autism	• There has been an increase in admissions during quarter 2 of 2026/27. There has been a large increase in the number of children and young people (CYP) admitted to hospital and work is taking place to fully understand trends and patterns: The number of CYP admissions that were not known or on Dynamic Support Registers (DSRs) and the number that are 17+ have been identified. SEL and borough teams are working to understand the reasons for any delays to discharge and with providers to ensure Care Education Treatment Reviews (CETRs) are undertaken in a timely manner in the community and during hospital admissions. • Annual Health Check performance has remained strong. At the end of July, SEL had completed 2,163 health checks compared to a planned 1,980.

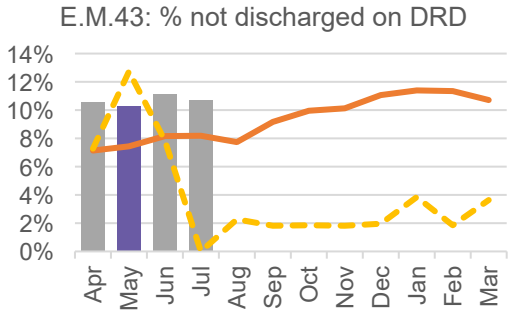
Summary of YTD position – November 2026 (3 of 3):

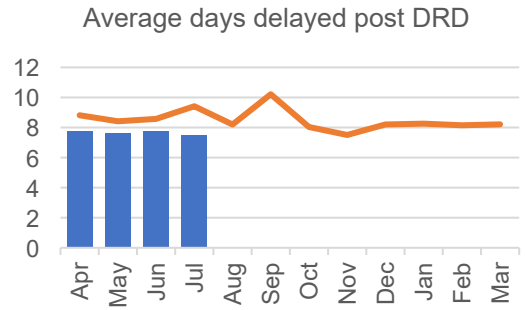
Area	YTD summary and key issues
Community waits and urgent community response (UCR)	• Waiting lists fell by over 3,400 patients in June 2026, with substantial reductions in both 52-week and 18-52-week waits. Performance has been maintained in July and SEL continues to deliver against the 52 week and 18 week community wait trajectories. This improvement has largely been driven by additional assessment capacity within one provider and changes to clock-stop recording within Community Paediatrics at another provider. • UCR referral numbers have increased in 2026/27 compared to the previous year but remains below the national target rate of 200 per 100,000 population. • Benchmarking work led by the SEL Community Provider Network (CPN) has been completed with providers to review service models and identify all eligible community data to understand variation between providers and determine the requirements for SEL to achieve the new national target of 200.
Virtual Ward	• Reported Virtual Ward capacity has reduced during 2026/27 and is now below trajectory, primarily reflecting the removal of capacity from one provider submission following review against NHS England's Virtual Ward classification requirements. • Reported occupancy has also been below the planned trajectory during 2026/27. • Providers have been been requested to review data reporting to ensure accuracy where potential data quality issues have been identified. • Service reviews and self-assessments against the national operating framework have taken place and will inform a system-wide improvement plans, highlighting priority areas for action and investment. This will support the continued maturation of Virtual Ward and UCR services across South East London.
Continuing healthcare (CHC)	• SEL did not meet the 80% national target for assessments within 28 days in the quarter 1 statutory reporting. Local reporting, however, showed an improved position in July to 86%, which is above target. SEL is consistently achieving the target for zero incomplete referrals over 12 weeks reported. • Boroughs continue to work to agreed trajectories to reduce the number of patients waiting for Standard CHC, fast track and Funded Nursing Care Reviews.A significant number of reviews are overdue particularly with FNC reviews which increased to 870.

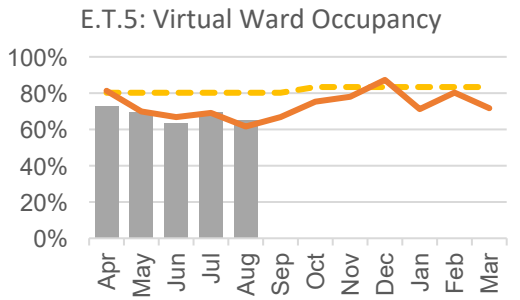
Urgent & Emergency Care

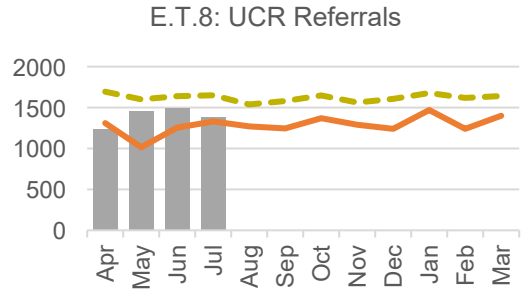












2026/27 - Plan met
2026/27 - Plan not met
2026/27 - No plan
2025/26
Plan
Target

Notes and Issues

- The performance areas detailed here are given to provide context and indication of the pressures within the SEL Urgent and Emergency Care (UEC) system.
- ICBs have submitted trajectories for Urgent Community Response (UCR) and Virtual Ward Occupancy levels which are seen as supporting metrics in the UEC space.
- Published performance for the SEL footprint (including standalone Urgent Treatment Centre (UTC) activity) for August was 74.9% against a combined Trust plan of 80.1%
- The percentage of 12 hours waits (from arrival) decreased in August.
- The percentage of patients not discharged on their Discharge Ready Date (DRD) was 10.71% in July. The average number of delayed days post DRD was 7.49 compared with 7.73 in June.

Recovery Actions

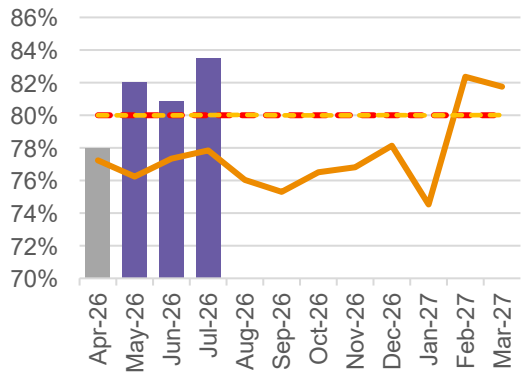
- Local systems/providers have plans in place for 2026/27 to support the delivery of agreed improvement trajectories. Improvement actions continue to focus on:
    - Front door management: use of alternatives to ED, ED triage and streaming, redirection, use of admission avoidance, MH crisis pathway, hospital handovers.
    - In-hospital management: same day emergency care, length of stay improvement
    - Continued focus on reducing discharge delays. Borough level Better Care Fund (BCF) plans are in place to support effective, timely and safe discharge.
- Further detail on UCR and Virtual Ward Occupancy is included on pages 17 and 18 of this report.

Linked to Risk: SEL 663

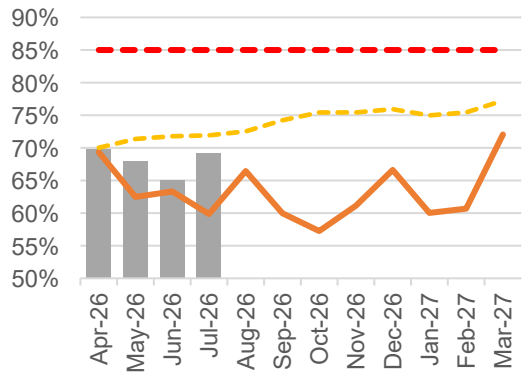
Cancer

2026/27 - Plan met
2026/27 - Plan not met
2026/27 - No plan
2025/26
Plan
Target

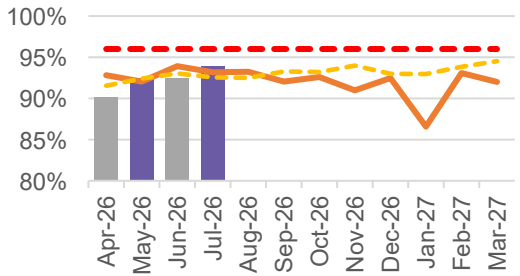
E.B.27: FDS



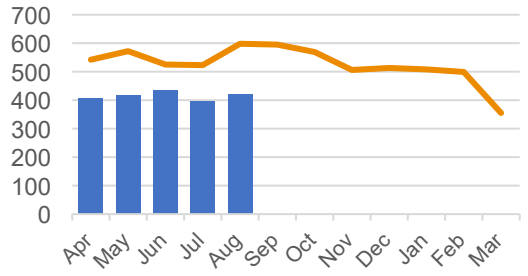
E.B.35: 62 Day Performance



E.B.38: 31 Day Performance



Backlog



Cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral at the end of the reporting period

Please note that this is the only metric on this page that is not included in the Systems operational plan for 26/27. We have included this for information purposes.

Notes and Issues

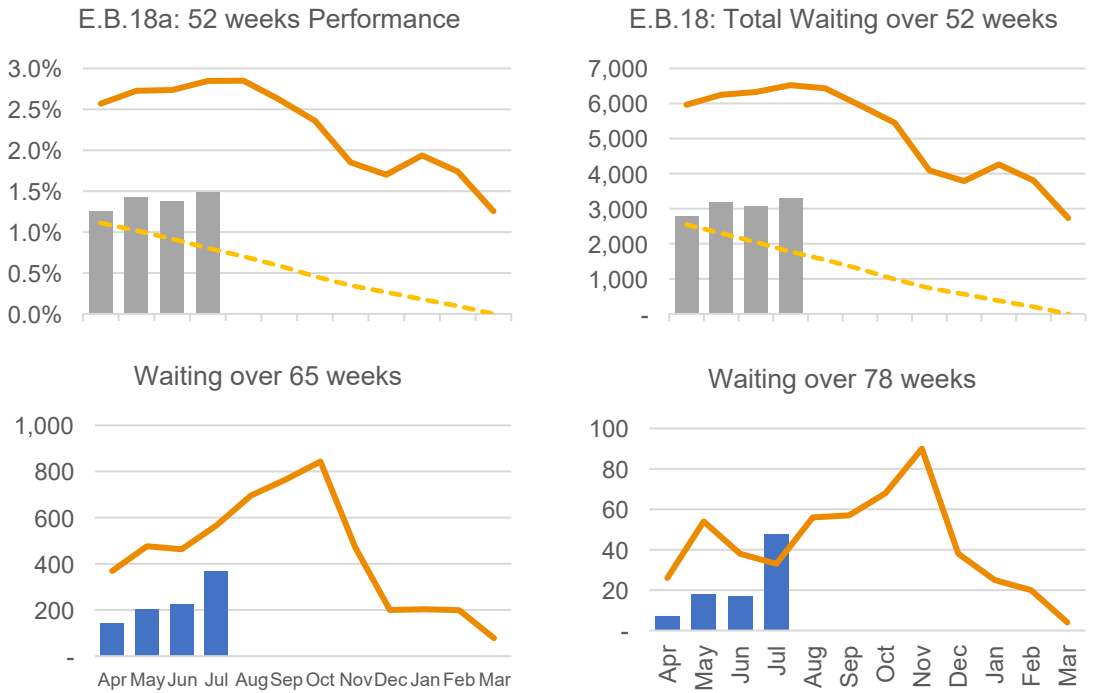
- Faster Diagnosis Standard (FDS) performance exceeded the 2025/26 trajectory and is expected to be maintained during 2026/27.
- 62-day performance remains a challenge for the system but has improved consistently over the past 12 months. Timely and effective Inter-Trust Transfer are a critical focus to improve performance, along with treatment capacity. Lung and urology pathways are specific drivers.
- 31-day performance is broadly in line with the planned trajectory, although some months are challenged. The key driver is surgical capacity.
- Backlog position has reduced in line with national expectations.
- An NHSE system oversight group brings all Providers in SEL together for regular performance reviews. Providers work to an aligned system improvement plan.

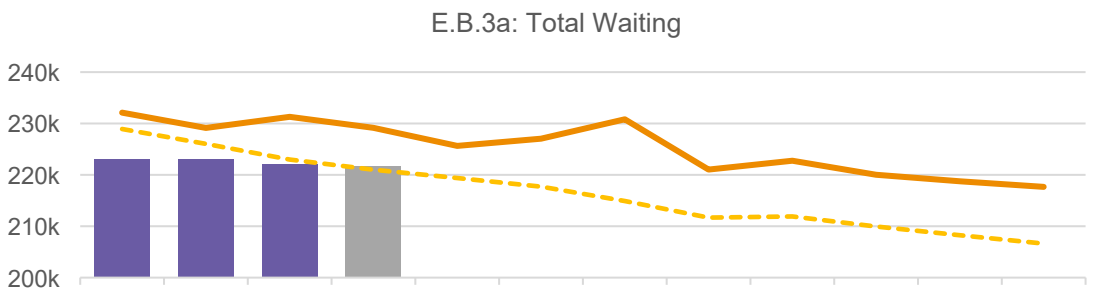
Recovery Actions

- Streamline cancer pathways and optimise diagnostics.
- Ensure timely communication of diagnoses and rule-outs within 28 days.
- Promote utilisation of rapid diagnostic clinics, Faecal Immunochemical Test (FIT) testing, teledermatology, and personalised stratified follow-up.
- Improve early diagnosis, patient experience, and resource utilisation.
- Mitigate potential risks related to workforce, technology systems, and industrial action.
- Support delivery though allocation of necessary funding to support key actions, Patient Tracking List (PTL) validation and clinical review, and increased theatre capacity.
- Cancer recognised as priority pathway for available capacity.
- Participate in national trials and programs to contribute to advancements in cancer detection and management.

Linked to Risk: SEL 663

Referral to Treatment: Long Waiters





2026/27 - Plan met
2026/27 - Plan not met
2026/27 - No plan
2025/26
Plan
Target

Notes and Issues

- The main focus for 2026/27 is delivering improvement in the overall 18-week performance, with the intention to return to constitutional standards of 92% by March 2029
- Alongside this, oversight of long waiters continues with a shift in focus to 52-week waiters.
- While 65 week wait breaches improved significantly at the end of 2025/26, there has been an increase in waiters at the beginning of 2026/27.

Recovery Actions

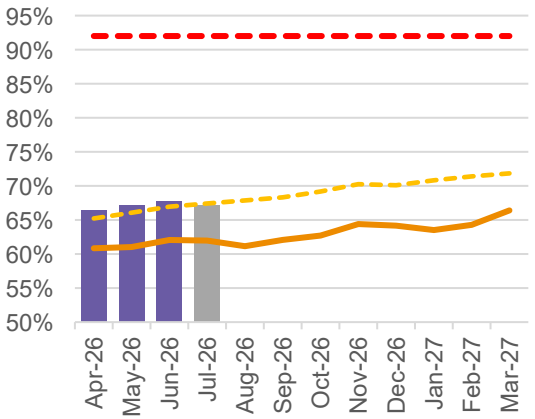
- Service transformation will need to be embedded in services over the course of 2026/27 to make constitutional standards deliverable and sustainable.
- Reductions are expected in overall Patient Tracking List (PTL) size through
    - Validation
    - Pathways changes
    - Additional capacity through outsourcing and insourcing
- Strategic Investment Funds are being used to support delivery of this.

Linked to Risk: SEL 663

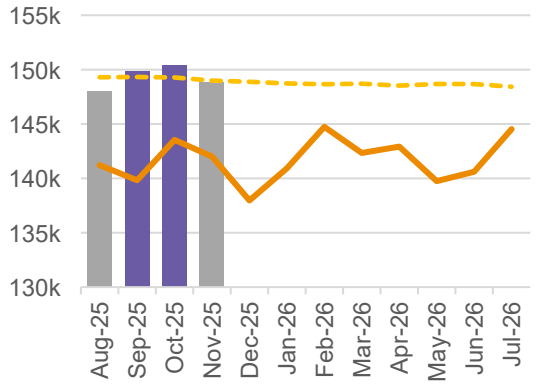
Referral to Treatment: Demand Management

2026/27 - Plan met
2026/27 - Plan not met
2026/27 - No plan
2025/26
Plan
Target

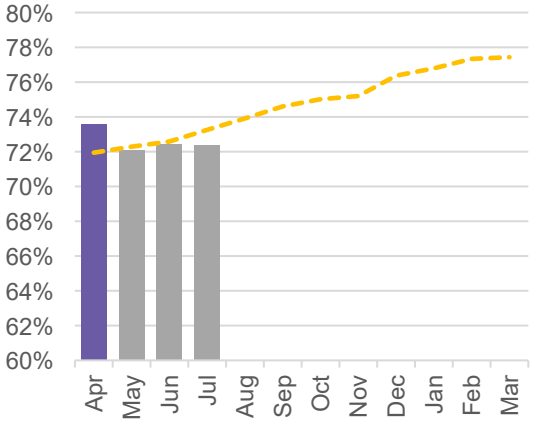
E.B.49: 18 week Performance



E.B.40: Waiting less then 18 weeks



E.M.42: Time to first appointment



DEMAND MANAGEMENT METRICS	Current	Mar-25	National	Trend
eRS Advice & Guidance				
Provision	42%	40%	nk	▲
Responded in <7days	89%	86%	65%	▲
Diversion Rate	73%	79%	65%	▬
Consultant Connect				
Provision	67	69	n/a	▼
Answer Rate (calls)	53%	43%	64%	▲
Answer Rate (messages)	99%	99%	99%	▲
Diversion Rate (calls)	19%	20%	61%	▬
Diversion Rate (messages)	69%	68%	50%	▬
Referral Triage				
Provision	39.4%	27.9%	16-68%*	▲
Responded in <7days	81%	85%	nk	▼
Diversion Rate	15%	13%	14%	▲

*range of London systems. SEL is 2nd highest in London

Notes and Issues

- Trusts have been set organisation-specific improvement targets for 18-wk performance as milestones to delivering the 92% constitutional standard by March 2029.
- Reductions in total Patient Tracking List (PTL) size is an ICB target within the Medium Term Plan.
- Advice and Guidance (A&G) continues to perform well, with improved provision and turnaround time. However, the diversion rate has continued to decline, potentially reflecting changes in referral or triage behaviour.
- There is an ongoing focus on triage which is required to improve provision and identify opportunities for improving the rate of diversion.

Recovery Actions

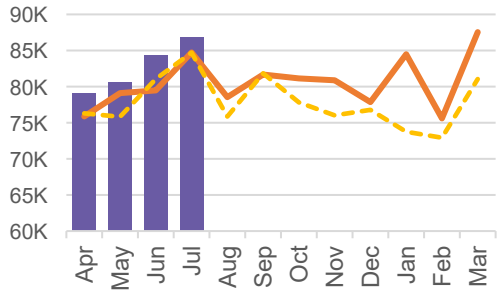
- PTL validation is expected to continue during 2026/27.
- Improved use of advice services and a priority focus on increasing and improving triage, as the most evidence-based intervention for demand management.
- Outpatient transformation, including straight to test, to improve waiting times at the beginning of Referral to Treatment (RTT) pathways.
- A focus on Advice and Guidance (A&G), triage, booking processes, reducing the number of Did Not Attends (DNAs) and scaling Patient Initiated Follow Ups (PIFU).

Linked to Risk: SEL 663

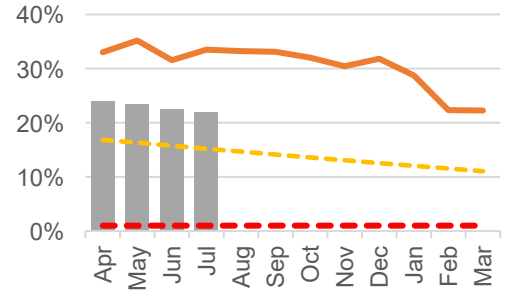
Diagnostics



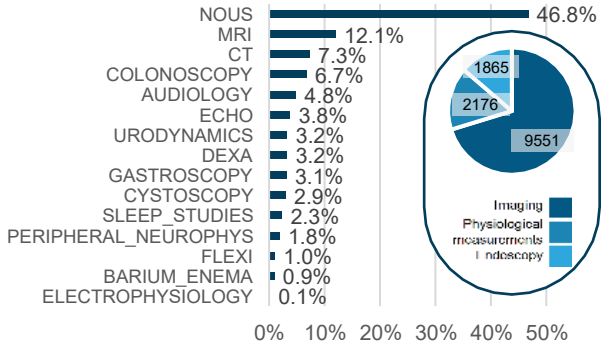
E.B.26x: Total Activity

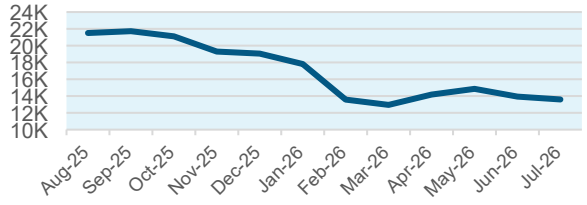


E.B.28x: % Waiting over 6 weeks

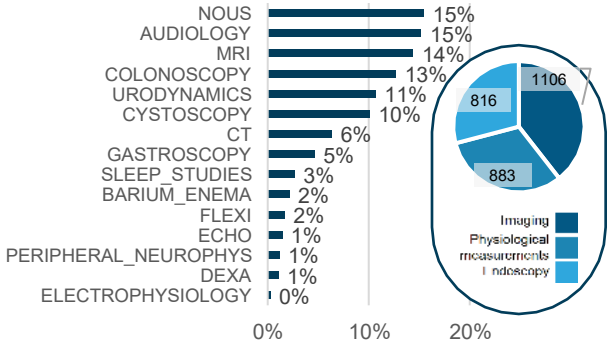


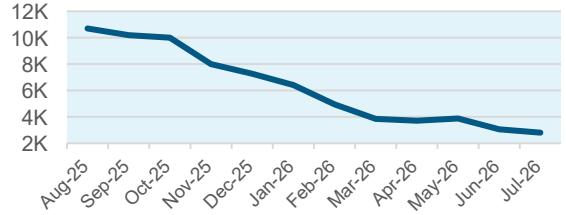
Current 6+ waiters 13,592





Current 13+ waiters 2,805





Notes and Issues

- Interim targets have been set for trusts as milestones to delivering the constitutional standard of less than 1% of patients waiting more than 6 weeks for diagnostic by March 29.
- In addition, ICBs have been set activity targets for diagnostic activity to support the delivery of the diagnostic target, UEC and 18-week performance.
- Key modalities that remain challenged include non-obstetric ultrasound (NOUS), MRI and audiology.
- There have been reductions in the number of patients waiting more the 13 weeks. However further improvement is required in this area.

Recovery Actions

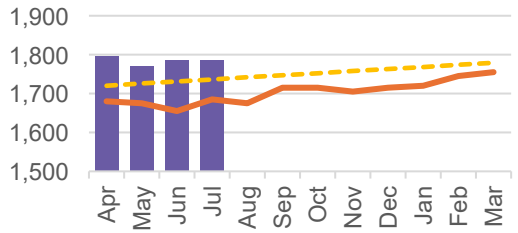
- Clinical and administrative validation of the overall diagnostic PTL.
- Implementing a clinical decision support tool to support demand optimisation.
- Additional capacity through maximising on-site provision, insourcing and outsourcing.
- As part of the operational planning process local trajectories for further reducing 13-week waiters were agreed.
- SEL wide demand and capacity reviews for imaging led by the Acute Provider Collaborative as part of their work on system sustainability.
- Maximising the available capacity at the Community Diagnostic Centres (CDCs) and reviewing the consistency of the Direct Access offer across SEL, implementing CDC first for appropriate diagnostic referrals.

Linked to Risk: SEL 663

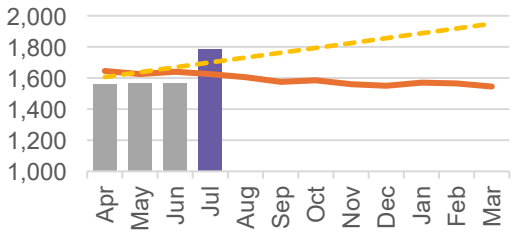
Mental Health

2026/27 - Plan met | 2026/27 - Plan not met
2026/27 - No plan | 2025/26
Plan | Target

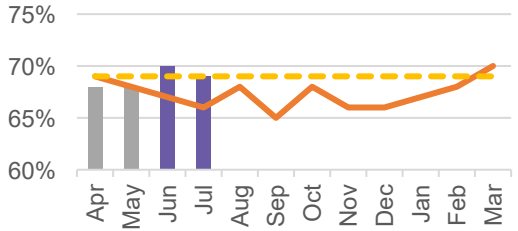
E.H.15: Number of people in contact with perinatal services



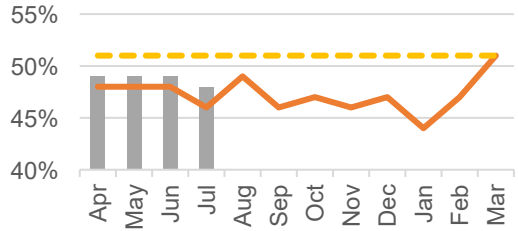
E.A.34: Individual Placement and Support (IPS)



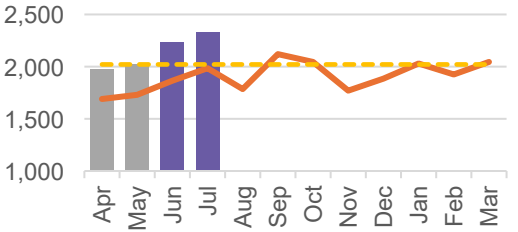
E.A.4b: Talking Therapies Improvement Rates



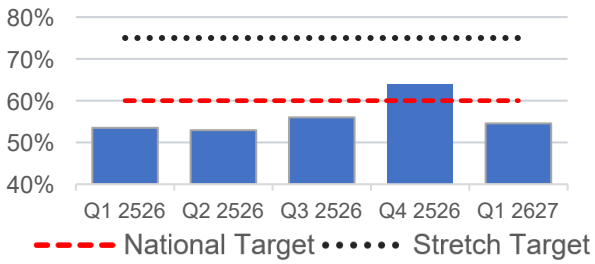
E.A.4a: Talking Therapies Recovery Rates



E.A.4: Talking Therapies Numbers Discharged



Physical Health Checks SEL



Notes and Issues

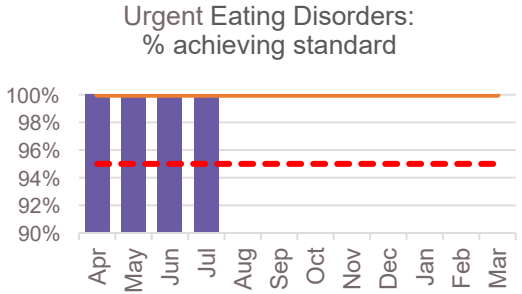
- Quarter 1 Serious Mental Illness (SMI) Physical Health Check performance showed a decrease in the number of completed health checks compared to the end of 2025/26. Performance is below the national standard of 60% and systems are required to work towards a target of 75%.
- Perinatal access increased in July and is now performing above the restated 2026/27 trajectory with reported performance of 1,785 against target of 1,736.
- The number of people completing a course of Talking Therapies treatment increased in July with reported performance of 2,330 against a monthly target of 2,021. The improvement target was met but the target for reliable recovery was missed for the fourth consecutive month
- Individual Placement Support (IPS) access performed above target for the fist time in a year.

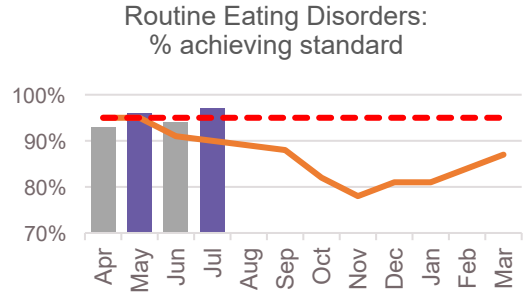
Recovery Actions

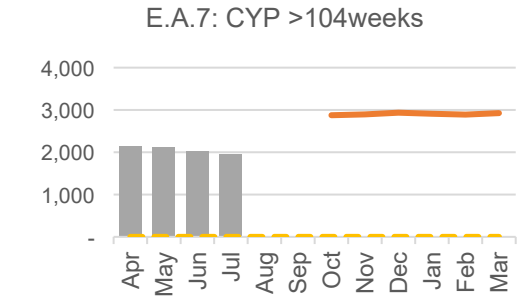
- Data Quality Improvement Plans (DQIPs) are embedded in the contracts for the main providers and plans have been refreshed for 2026/27. The DQIPs are reviewed and updated regularly.
- Local improvement plans will be reviewed to ensure actions are in place to increase the number of Physical Health Checks undertaken for people with SMI.
- All Talking Therapies and IPS services are implementing delivery plans to support performance improvement against the targets set for 2026/27. These plans have been reviewed in support of the national deep dives.

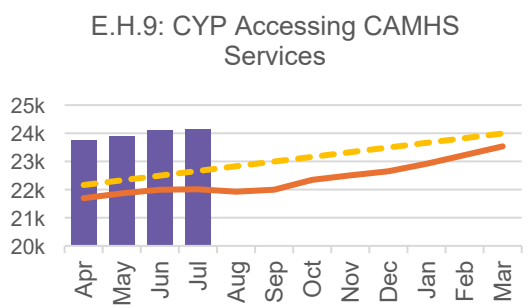
Linked to Risk: SEL 663

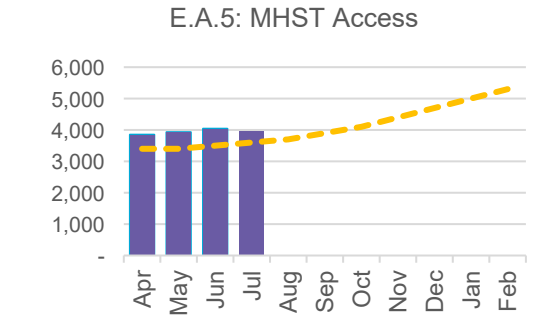
Mental Health: Children and Young People

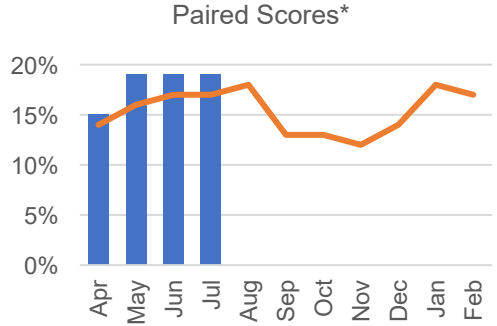












*% of closed referrals for CYP with at least 2 contacts and any perspective paired score in the previous 12 months



Notes and Issues

- The waiting times target for both routine and urgent Children and Young People (CYP) eating disorder referrals were met in July.
- Children and Young People with community mental health related waits of over 104 weeks is a new metric that has been added as part of the ICB NHS Oversight Framework (NOF). The target is to have zero 104-week waits.
- Children and Young People's Mental Health services (CAMHs) access performance improved in July and continues to perform above the restated trajectory set for 2026/27.
- Mental Health Support Team (MHST) access is performing above target so far this year.
- Paired scores for CYP is a new measure introduced in the ICB NOF for 2026/27. This indicator supports routine use and recording of outcome measures at discharge, to strengthen measurement of outcomes and quality. In July, 19% of closed referrals, with at least 2 contacts, had a perspective paired outcome score in the previous 12 months.

Recovery/Improvement Actions

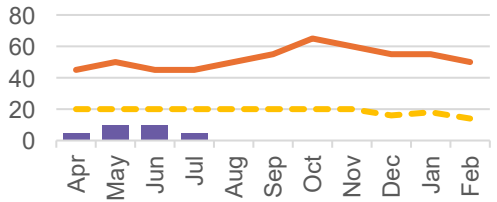
- Providers have plans in place to reduce the number of 104ww and this is being monitored through regular assurance meetings with NHS England.
- The ICB has worked with providers and commissioners to develop a SEL delivery model for MHSTs that provides a greater level of consistency but can be flexed to deliver the needs of individual boroughs. Each borough has an implementation plan in place to support delivery of the very ambitious national targets for increased access and coverage.
- Further work is underway to determine 'what good looks like' for the paired scores metric.
- All ICB and provider NOF metrics are reviewed alongside operational planning metrics at the monthly provider contract monitoring meetings.

Linked to Risk: SEL 663

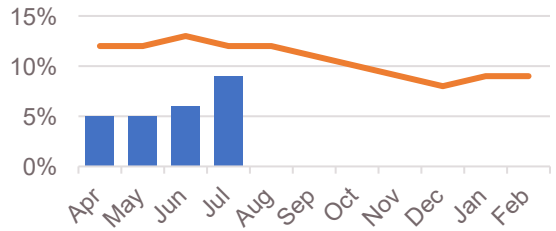
Mental Health Crisis & Flow



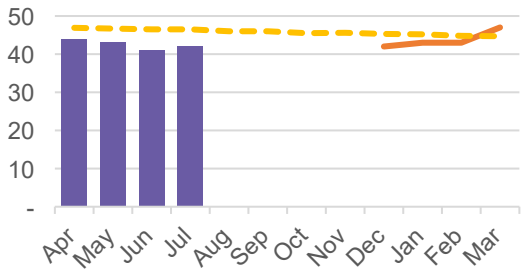
E.A.5: Active Inappropriate Adult Acute OAPs



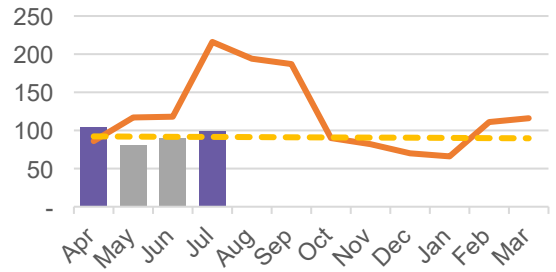
Inpatient - no contact



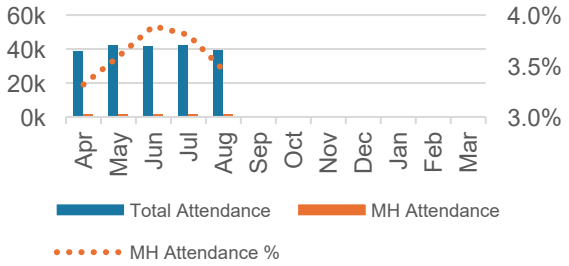
E.H.38: LOS Adults &PICU



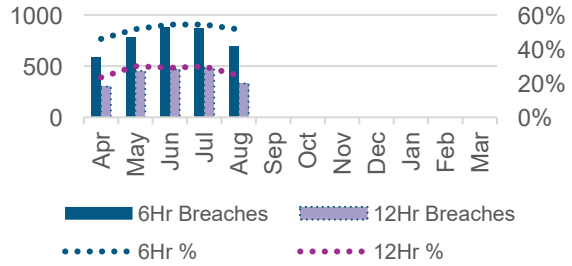
E.H.39: LOS Older Adults



A&E Attendance



A&E Breaches



Notes and Issues

- Mental Health (MH) emergency pressures continue with some very challenging days for providers reported over recent months.
- A significant reduction in Out of Area Placements (OAPs) was reported in March and April, but a small increase was seen in May and June. The July position for SEL is 5 active placements against a plan of 20.
- A&E data for August shows that the proportion of MH presentations in EDs was approximately 3.5%. 51.5% of MH patients waited more than 6 hours in ED and 24.4% more than 12 hours. A&E breaches remain disproportionately high for MH patients.
- Inpatient – no contact is a new metric on the ICB NOF which measures the percentage of acute mental health admissions with no contact with community mental health services in the previous year.
- For 2026/27 the average length of stay metrics have changed to include Adult & PICU and Older Adults. The targets for Older Adults was missed in July.

Recovery Actions

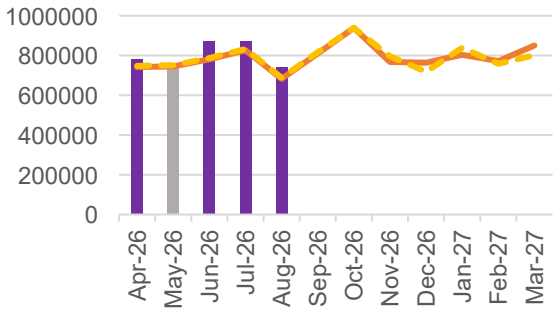
- Continued focus from all system partners on supporting the timely discharge for those patients that are clinically ready for discharge.
- Mental health providers continue to deliver their internal flow improvement plans, focusing on reducing length of stay, purposeful admission, stepping down patients and providing alternatives to admissions where appropriate.
- Continued focus on reducing the number of long delays in ED for MH patients.
- Enhanced monthly monitoring of Out of Area Placements (OAPs) at regional/national level continues.

Linked to Risk: SEL 663

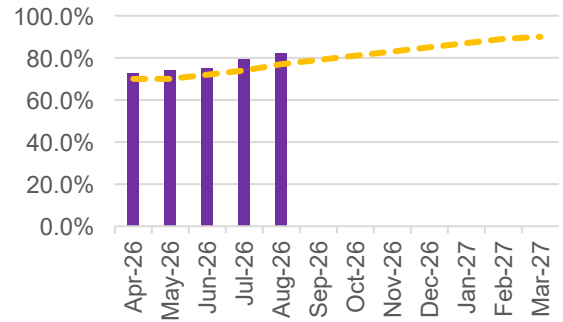
Primary care access



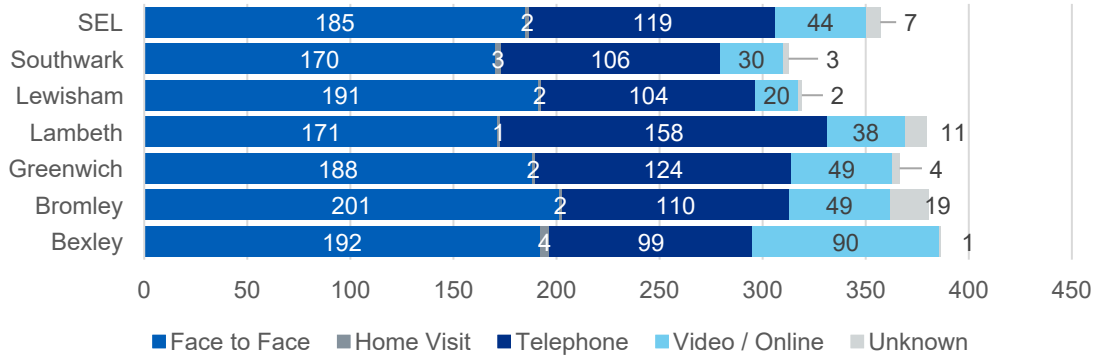
E.D.19: Appointments in general practice



E.D.27: Percentage of clinically urgent appointments seen on the same day



Rate of access per 1,000 population (August 26)



Notes and Issues

- Appointments totalled 743,756 in August 2026 against the operating plan target of 688,139.
- The analysis of the latest available patient experience data has been completed, and practices with the highest levels of unwarranted variation have been identified. Place-based teams continue to lead on this work, prioritising which practices require support and agreeing targeted interventions. Support may be delivered via the Training Hub or through locally agreed programmes and initiatives.

Recovery Actions

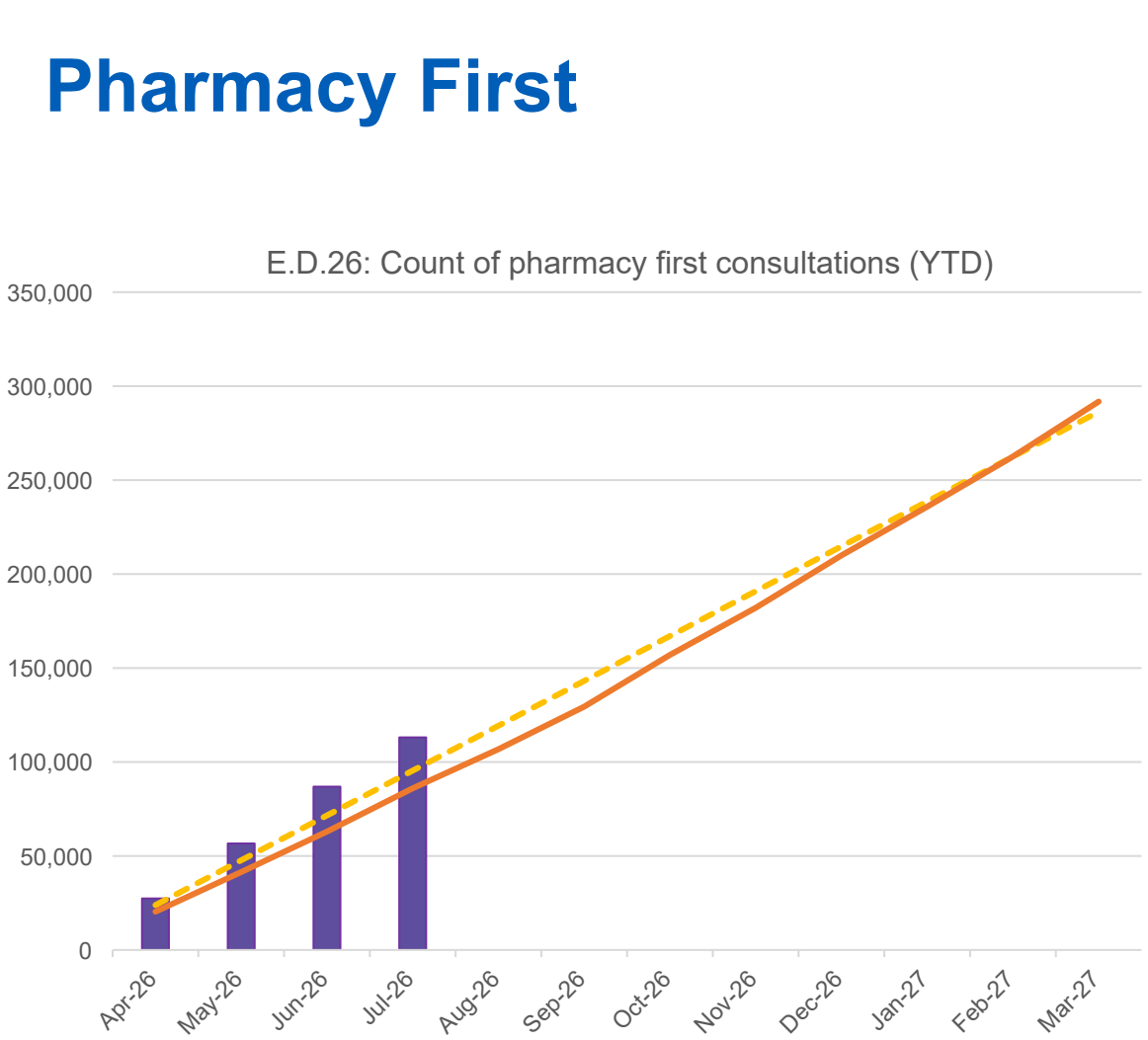
- Support for practices to meet online consultation requirements and to deliver total triage is ongoing. This helps ensure that patients are directed to the right appointment, in the most appropriate setting, with the most suitable practitioner to meet their needs.
- A focused support and training offer is being developed in collaboration with the Workforce Development Hub to help practices meet the national contractual target of ensuring 90% of clinically urgent appointments are seen on the same day within the practice. This will be delivered through a programme of webinars and targeted learning opportunities, supporting practices to understand the requirement and how to demonstrate compliance through appropriate recording and coding.
- Practices are increasing GP capacity to improve access by claiming reimbursement for new GPs under the GP reimbursement scheme. At the end of Q1, 37.9 whole time equivalent GPs were claimed for under this scheme. The scheme has been extended from the 1 October to include locums and salaried GPs which will enable further increased capacity.

Note on data source: All charts use the nationally published PCN level GPAD data to calculate borough level reporting: Appointments in General Practice - NHS England Digital

*Percentage of appointments mapped to a national category of 'general consultation acute' which took place on the same day

Linked risk: SEL 664 Lew 528

Pharmacy First



Notes and issues:

- There were 322 registered pharmacies in July. 313 opted in to provide Pharmacy First Service, 310 Hypertension Case Finding Service and 306 Oral Contraceptive service.
- Year-to-date, SEL community pharmacies delivered 38,960 clinical pathway consultations, 48,612 hypertension consultations and 25,539 contraception consultations.
- Broadly, activity is concentrated within more deprived communities across SEL. There is, however, variation in some boroughs.
- Acute sore throat and uncomplicated UTI remain the highest-volume clinical pathways, with some seasonal variation observed in other conditions (e.g. insect bites).

Antimicrobial Stewardship:

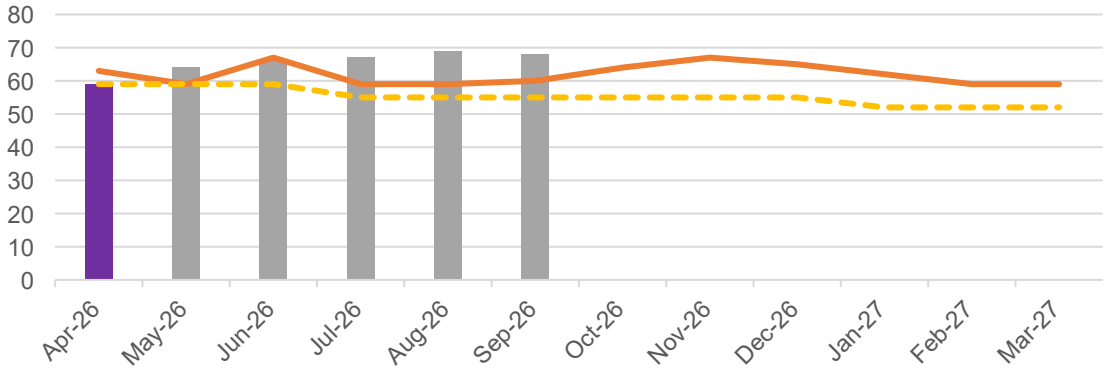
- 62% of clinical pathways (February 24 to June 26) resulted in an antibiotic supply, 7% resulted in antibiotic sparing medicines supply and 30% no medicine but advice and self care guidance was given. These percentages have remained stabled over recent months.
- No concerning increase in overall antibiotic supply for UTI treatment across SEL ICB has been identified following the introduction of Pharmacy First.
- Data suggests a shift in patient access for the treatment of uncomplicated UTI from General Practice to Community Pharmacy. There has been a slight decline on FP10 whilst supply from community pharmacy shows an increase

Thresholds Achieved:

- In July 2026, 302 pharmacies were providing all 3 advance services and qualified for additional monthly threshold payments. The number of Pharmacies achieving monthly threshold payments for Clinical Pathway Conditions has been increasing. June saw the highest number achieving threshold payment at 77%. In July 26 this fell marginally to 73%.

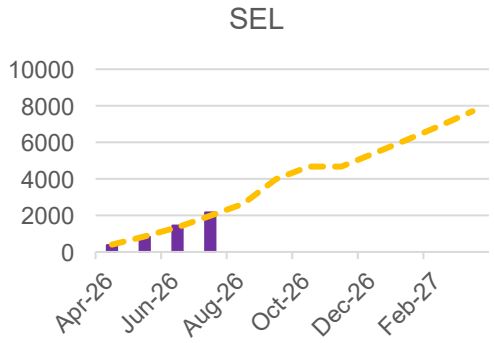
Learning disability and autism

Reliance on mental health inpatient care for autistic adults and children and people with a learning disability (combined metric)



Note: Data correct as of 10 September 2026.

Patients on GP learning disability registers to receive a full physical health check and action plan



	Jul 26 performance		Jul 26 Target	2026/27 Plan
	%	Count		
Bex	21%	273	266	1036
Bro	18%	244	276	1074
Gre	21%	369	362	1406
Lam	21%	379	369	1436
Lew	24%	510	426	1658
Sou	28%	388	280	1090
SEL	22%	2,163	1980	7700

Linked risk: SEL 389, SEL 390, SEL 391, Gre 615, Gre 635, Bex 642, Bro 509, Lam 129, Lew 644, Sou 520

Notes and Issues

- At the end of August, there were 58 adults (28 autism only) in non-secure and secure units, and 11 children and young people. Overall, this was 14 over the Q2 inpatient target.
- Adult inpatient numbers have remained broadly stable. An increase in CYP admissions has driven the overall rise in numbers; a trend not seen in the past two years. Work is underway to understand the reasons for CYP admissions, transition arrangements, appropriateness of admission and completion of Care Education Treatment Reviews (CETRs).
- As part of the SEL Mental Health, Learning Disability and Autism Inpatient Quality Transformation Plan (MHLDA QTP), Out of Area Placements are being reviewed to ensure patients are repatriated to SEL or discharged into the community.
- Demand for autism assessments continues to increase across adult and CYP services. Addressing this is a key focus of the SEL Neurodiversity Transformation Programme

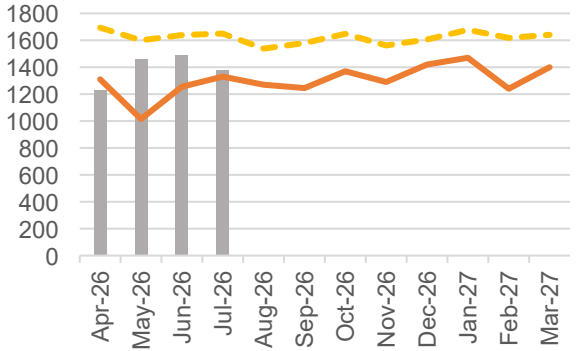
Recovery Actions

- Providers are working towards mobilising community autism specialist services for autistic only people. Along with existing services commissioned from MH providers, these services will support the continued reduction in admission rate**.** Recruitment for Intensive Support Teams (ISTs) (for people with an LD) commenced in Q3, ensuring there is IST coverage in all boroughs to support discharge and prevent admissions. Housing, care and support work is in development to support discharge and prevent admissions.
- Working with providers to identify an action plan to address the high numbers of people on waiting lists/long waiting times for autism assessment as well as requirements to meet demand in the longer term, includes work on Right to Choose and accreditation of services.
- Digital Dynamic Support Registers (DSRs) are supporting admission prevention and utilisation of CETRs and capture case notes for Keyworking and Case Management.
- Specialist prescribing services, including the One Stop STOMP clinic, continue to support patients, primary care, annual health checks and the LeDeR programme.

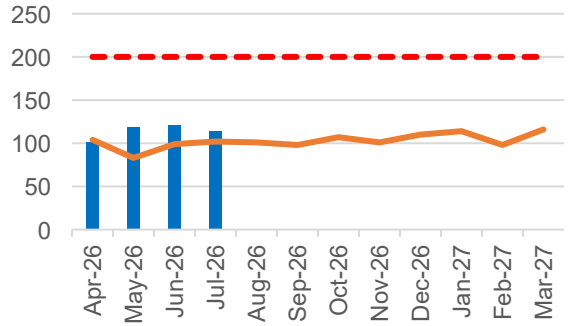
UCR and community waits



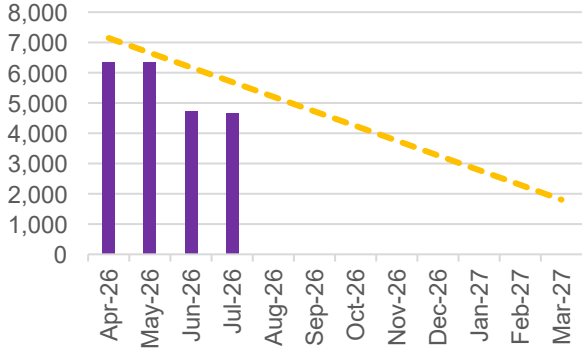
E.T.8: Total UCR referrals



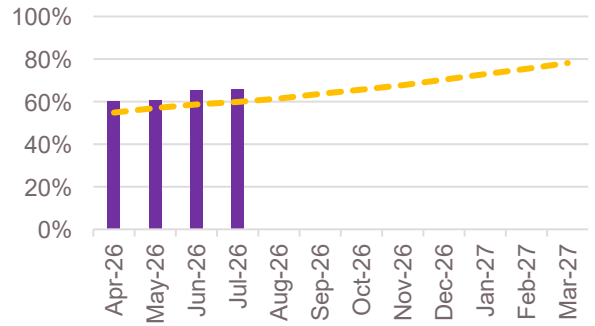
UCR standardised referral rate per 100,000 population



E.T.9: Community waits over 52 weeks



E.T.12: % community waits under 18 weeks



Notes and Issues

- UCR referral numbers have increased this year but remains below the 200 target rate.
- The Community Services waiting list decreased by 3,403 to 32,850 in June 2026. There was a reduction of 1,600 waiting >52 weeks and 1,278 18-52 weeks. The position in July has remained similar with a total waiting list of 32,434.
- Services contributing most to overall wait numbers are Community Paediatrics (35%), MSK (11%), Podiatry/Podiatric Surgery (13%), Paed Audiology (5%) and Paed SLT (6%). 96% of patients waiting >52 weeks were in Community Paediatrics and a small number were in Looked After Children, SLT, audiology and physiotherapy.
- In adult services, 158 were in Podiatry/ Podiatric Surgery, with a small number in Dietetics and LTC Nursing –Continence.

Recovery Actions

- SEL Community Provider Network (CPN) has undertaken a benchmarking exercise to bring potential 2-hour data sets together from each provider.
- Reductions in community paediatric waits has been driven by provider level actions to reduce the size of their lists and provide additional assessments.
- Additional service specific actions include: addressing DNAs by training patients to use MyChart to reschedule their own appointments, use of AI scheduling tool and continuing reminder calls to patient.
- A data quality issue has negatively impacted reported neuro-rehab performance. Actions are being taken by the relevant provider to address this.

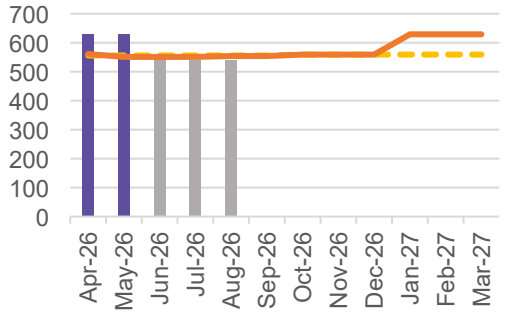
Note: Some service data is only published at national level to prevent risk of disclosing sensitive information.

Linked to Risk: SEL 663

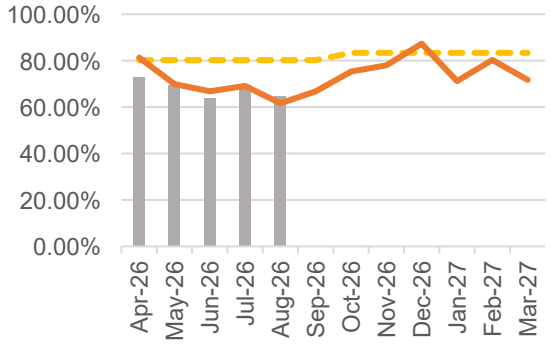
Virtual Wards



Capacity (beds) vs plan at month end*



Occupancy vs plan at month end*



End of August 2026 snapshot*

July 2026	Capacity	Utilisation
SEL actuals	539	65%
SEL Plan	556	80%

*All charts on this page are based on the nationally published ICB and provider level data.

*Providers have been requested to review data reporting to ensure accurate reporting where potential data quality issues have been identified.

Notes and Issues

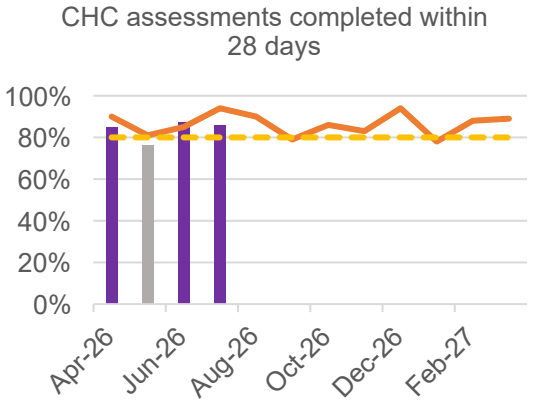
- SEL Virtual Ward (VW) capacity was below plan at 439 beds versus a target of 556, with utilisation at 65% against an 80% target. Further investigation has been requested from the services reporting lower utilisation or where potential errors in reporting have been identified.
- Reported Virtual Ward capacity has reduced during 2026/27 and is not achieving the planned trajectory. This reflects a change in one provider submission following confirmation that the service does not meet NHS England's Virtual Ward classification requirements and will therefore no longer be reported as Virtual Ward capacity.

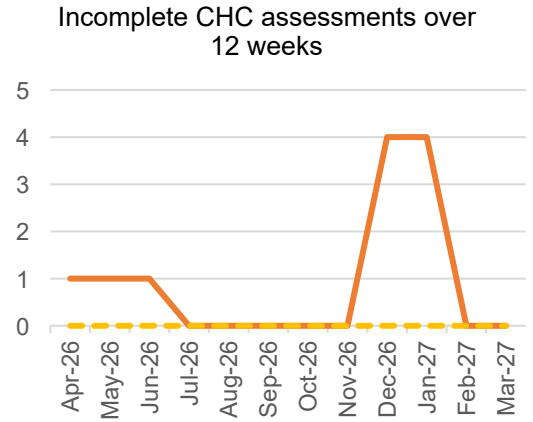
Recovery Actions

- A baseline mapping exercise has been undertaken following a series of site visits to VW services across South East London as part of a comprehensive review of Virtual Ward and Urgent Community Response (UCR) pathways. This assessed the current service model alignment with the requirements of the NHS England National Operating Frameworks for VW and UCR services. The review examined key components of service delivery, identifying variation across providers and opportunities for greater consistency across the system.
- All providers also completed self-assessments against the National Operating Framework. This will provide a systematic and evidence-based assessment of compliance with national standards and support the identification of development needs to strengthen service delivery and improve alignment with national expectations. It also identified examples of innovation and good practice to supporting service improvement, reduce unwarranted variation, and promoting a more consistent approach to Virtual Ward delivery.
- The findings from the service reviews and self-assessments will inform a system-wide improvement plans, highlighting priority areas for action and investment. This will support the continued maturation of Virtual Ward and UCR services across South East London.

Linked risk: Gre 474

NHS Continuing Healthcare







Quarterly statutory reported position

	CHC assessments in an acute setting		% assessments completed in 28 days		Incomplete referrals over 12 weeks	
	Q1	Target	Q1	Target	Q1	Target
Bexley	0%	0%	74%	80%	0	0
Bromley	0%	0%	85%	80%	0	0
Greenwich	0%	0%	82%	80%	0	0
Lambeth	0%	0%	88%	80%	0	0
Lewisham	0%	0%	48%	80%	0	0
Southwark	0%	0%	79%	80%	0	0
SEL	0%	0%	76%	80%	0	0

Note: monthly reporting is in place as an 'early warning' and means that data issues can be identified and addressed within the quarter. Monthly and quarterly data may not align.

Notes and Issues

- July performance (local reporting) against the number of referrals completed within the 28-day time frame was 86%. This is above the national target of 80%.
- SEL reported zero 'long wait' over 12 weeks in July meeting the national requirement.
- The quarter 1 statutory reported position for SEL was 76% for 28-day performance which is below the national target. There were zero incomplete referrals over 12 weeks which meets the national target and zero assessments completed in an acute setting.
- There is variation in the number of overdue standard CHC and fast track reviews across the six boroughs. The number of individuals waiting for a Standard CHC review increased to 246 from 238. There are 92 overdue fast track reviews.
- The number of Funded Nursing Care Reviews (FNC) increased from 832 to 870 in July.

Recovery Actions

- Boroughs continue to work to agreed trajectories to reduce the number of patients waiting for Standard CHC, fast track and Funded Nursing Care Reviews, as a significant number remain overdue.
- An improvement plan will be developed following the review of all 2025/26 Independent Review Cases recommendations.

Linked to Risk: SEL 468

NHS
South East London

Strategic Investment Fund and Commissioning Intentions Approach, and Medium Term Financial Strategy

Agenda item: 5.1.3 & 5.1.4

Executive Lead: Ed Waller

Report by: Ed Waller

Paper type: Discussion

Conflicts of Interest: None identified

Chair: Richard Douglas CB

CEO: Andrew Bland

1. Purpose and recommendation

The purpose of this paper is to seek the Board's support for South East London ICB's proposed 2027/28 commissioning intentions, and the associated approach to aligning investment and resource allocation through the Medium Term Financial Strategy (MTFS) and Strategic Investment Fund (SIF).

The paper sets out how the ICB will build on the first year of delivery of its five-year Strategic Commissioning Plan, with a continued focus on the delivery priorities set out in the five year strategic commissioning plan; national shifts of treatment to prevention, hospital to community and analogue to digital, alongside improving the sustainability of acute and specialised services. It proposes a more targeted approach to strategic investment in 2027/28, concentrating the SIF on fewer priorities where investment at sufficient scale can deliver material change.

The Board is asked to:

- endorse the proposed commissioning intentions for 2027/28 and their alignment with the five-year Strategic Commissioning Plan;
- support the proposed financial and resource allocation approach
- support the proposed approach to the 2027/28 Strategic Investment Fund, including concentrating investment on fewer, higher-impact priorities; and
- note the further work required during Q3 to finalise SIF investment priorities ahead of mobilisation in Q4 and implementation from April 2027.

2. Background and context

SEL ICB finalised its first five-year Strategic Commissioning Plan in February 2026, setting out how it will fulfil its role as a strategic commissioner to improve population health, reduce health inequalities and improve access to consistently high-quality services. The plan was informed by population health analysis, resident and patient insight, review of existing commissioned services and consideration of the system's financial sustainability.

During 2026/27, £30m was invested through the SIF to begin delivery across four strategic areas: sickness to prevention, hospital to community, analogue to digital, and sustainability of acute and specialised services. As many schemes only began delivery during Q2 or Q3, it is too early to make definitive judgements about their impact. The proposed 2027/28 approach therefore builds on rather than restarts this work, scaling promising models and increasing population coverage.

The commissioning intentions are also framed within the MTFS and the need to address SEL's underlying financial deficit while responding to demographic change and increasing complexity of need. This requires the ICB to maintain investment in transformation while improving productivity and value from existing expenditure.

3. Analysis and evidence

The proposed commissioning intentions are grounded in SEL's population health needs analysis, resident insight and the priorities established through the five-year Strategic Commissioning Plan. This identified particular opportunities to improve outcomes for children and young people with complex needs and those living in more deprived neighbourhoods; working-age adults with rising health risks; and people with frailty, multiple long-term conditions and dementia.

The analysis also identifies significant inequalities in access, experience and outcomes, alongside long-standing performance pressures in acute and mental health pathways and increasing demand associated with demographic change. The 2027/28 proposals respond through a combination of prevention, proactive neighbourhood care, improved community access, digital enablement and more responsive alternatives to hospital care.

Investment is proposed to be assessed consistently against five criteria: strategic alignment; improved population health outcomes; reduced inequalities; value for money and affordability; and deliverability. The paper proposes strengthening the assessment of financial and non-financial benefits, with measurable KPIs and baselines and monetisation only where benefits can credibly be translated into financial savings.

4. Options and trade-offs

The central choice is how the ICB uses its limited discretionary investment while maintaining delivery of the broader commissioning intentions. Based on current financial planning assumptions, the paper anticipates £45m of new recurrent SIF investment in SEL in 2027/28, subject to affordability and final planning decisions.

The proposed approach represents a move away from spreading investment across a relatively large number of individual initiatives towards concentrating investment on fewer priorities at sufficient scale to achieve material change. This involves balancing:

- continuity and scaling of 2026/27 investment against investment in new opportunities;
- short-term financial recovery against longer-term investment in prevention and service transformation;
- investment in alternative models of care against the transition and potential double-running costs required before existing capacity can safely reduce;
- local flexibility against greater consistency and scale across SEL; and
- ambition against the practical commissioning and provider capacity available to mobilise change during 2027/28.

5. Implications, impacts and risks

The proposals are intended to improve population health outcomes, reduce inequalities, improve access and experience and support longer-term financial and operational sustainability.

The paper identifies several risks and dependencies, including:

- changes arising from national planning guidance and allocations;
- transition, double-running and stranded costs as activity shifts between settings;
- the interaction between payment mechanisms and the intended strategic shift away from hospital-based activity;

- the possibility that identifying unmet need and improving access initially increases rather than reduces expenditure;
- the longer-term consequences of delaying investment and transformation

6. Engagement and approvals

The five-year Strategic Commissioning Plan underpinning these proposals was developed in partnership with system partners and incorporated previous engagement with residents and patients on their experience of and access to care. The paper also describes a number of areas being developed collaboratively with provider, primary care, VCSE and integrator partners.

For the SIF specifically, the proposed timetable includes discussion and review of proposed strategic investment areas by the Strategic Commissioning Committee in December, followed by ICB Board consideration in January, with mobilisation during Q4.

7. Next steps and oversight

Work will continue during Q3 to refine the commissioning intentions and identify the proposed priority areas for strategic investment, assessing potential investments for strategic alignment, population health impact, inequalities, value for money, affordability and deliverability.

The current proposed timetable is:

- December 2026: Strategic Commissioning Committee discussion and review of proposed strategic investment priorities.
- January 2027: ICB Board consideration/sign-off.
- Q4 2026/27: mobilisation of agreed investment priorities.
- April 2027: implementation of funded priorities, maximising the opportunity for full-year impact during 2027/28.

Delivery will be supported by measurable outcomes and KPIs, with investment decisions informed by evidence of population health impact, inequalities, productivity and financial and non-financial benefits. The intention is that evidence of delivery informs subsequent decisions to continue, adapt or stop investment, as well as informing future planning cycles.

Appendices and supporting information

Appendix 1: Board Paper: Commissioning intentions, SIF, MTFS

South East London Integrated Care System

SEL ICB 2027/28 Commissioning Intentions

Status: **FOR BOARD DISCUSSION**

Context and Background

- **The NHS 10 Year Plan sets a clear ambition to change the way in which the NHS organises, delivers and funds services**. In response to this ambition, all NHS organisations have been asked to shift their focus towards a rolling five-year planning horizon and to prepare integrated five-year plans which support transformational change, deliver the three shifts set out in the NHS 10 Year Plan and demonstrate how financial sustainability will be secured over the medium term.
- The **role of ICBs within planning is one of strategic commissioners** with a core focus on improving population health, reducing health inequalities and improving access to consistently high-quality services.
- In February 2026 **SEL ICB finalised its first five-year strategic commissioning plan,** which sets out how the ICB will secure improvements for its population in line with its key responsibilities as a strategic commissioner.
- The plan was **developed in partnership with our system partners** and incorporated the findings from previous engagement work with residents and patients on their access and experience of care. In developing the plan and determining our commissioning priorities for the next five years, we:
    - **Undertook a population health needs analysis** to understand local need and in doing so, identified the healthcare interventions that will have the biggest impact on our population both now and in the future.
    - **Brought together insight and intelligence on our existing commissioned health care services** to ensure we continue to focus on the delivery of consistent, equitable and high quality services.
    - **Reviewed our current strategy and financial sustainability plans** to ensure our approach is fit for purpose for the next five years and supports delivery of our commissioning priorities.
- Our **five-year strategic commissioning plan remains a current document in terms of the ambitions and outcomes SEL ICB want to achieve for our population**. We are currently progressing work in 26/27 aligned to this strategy and **our commissioning intentions for 27/28 build on this.**
- This is in the context that we have **not yet received the draft national planning guidance for 2027/28**, which will **include a number of operational planning asks of ICBs and providers** that we will need to work through
- **This pack is designed to support discussion on our commissioning intentions for 27/28**. The pack summarises the priorities set out in our five year strategic commissioning plan, activities in progress in year 1 of plan delivery and our commissioning intentions as we move into 2027/28.

South East London
Integrated Care System

A summary of our five year strategic commissioning plan

Summary of our five year strategic commissioning plan

South East London Integrated Care System

4-9 years
Life expectancy gap, least vs most deprived areas

21-27%
Black communities across our four most diverse boroughs

1 in 5
Children in SEL live in low-income households

12.5-15.3%
Growth in older people in the next decade

57%
Of £5.93bn budget current spend on acute hospital care

- SEL is a vibrant and ethnically diverse region; however, there is **marked deprivation and intersectional inequalities** (e.g. LGBTQIA+, unpaid carers, those in temporary accommodation).
- The SEL **population is predicted to grow by 4% each decade; but the age profile is shifting**, **and this can mask risk of rising health demand and inequalities.** For example, while the proportion of CYP is projected to shrink from 22.7% to 18.3%, CYP in SEL are more likely to be living in deprivation with risk of intensified health need. And people over 65+ will increase by around 63,000 individuals which will result in increasing demand for healthcare without change in how we respond to this proactively.
- **Vital 5 risk factors (alcohol harms, high blood pressure, poor mental health, tobacco dependency and unhealthy weight) are causing greatest loss of years of life** due to disability or premature death and disproportionately impact those from underserved communities.
- There is **unwarranted variation in access, experience and outcomes for underserved communities** as evidenced by vaccination rates, cancer screening rates, poor experiences of pre-pregnancy, maternity and post-natal care, rates of access to unplanned care (e.g. emergency admissions, A&E attendances), elective waiting lists and mental health detentions.
- Healthcare services span primary, secondary and tertiary care plus an increasing range of voluntary and community sector providers and several independent providers. **Most resident's access care within SEL**, **with some also accessing care in other parts of London and into Kent and Medway**. The specialist nature of our NHS Trust service provision means that **SEL is a net importer of patients into our sector.**
- While there have been pockets of improvement, SEL has some **long-standing performance challenges across acute and mental health pathways and timely access to care remains a key challenge**. There are notable opportunities to improve quality, productivity, and efficiency and to transform care through changes to pathways and models of care – however, this requires a shift in investment toward primary, community and preventative care alongside targeted efforts to secure more sustainable acute and specialised services.

What our residents have told us is important to them:

- Rebuild trust – too many feel unheard, unseen or stigmatised
- Simplify access, connectivity between services, and cut waiting times
- Target resources to highest need and deliver greater continuity of care where needed
- Use plain, jargon-free communication that is tailored to our diverse communities
- Community-based education that is built on trusted relationships and is culturally sensitive

Summary of our five year strategic commissioning plan

South East London Integrated Care System

4 cross cutting ambitions

- **Population health:** Increased focus on prevention, early detection and intervention, with targeted efforts for those most at risk of poorer health outcomes
- **Resident experience:** Demonstrable progress in addressing key themes from community engagement and insights by commissioning more tailored and culturally appropriate services
- **System sustainability:** Deliver productivity, pathway and model of care transformation opportunities with collective understanding of benefits to ensure system is financially and operationally sustainable
- **Access and outcomes:** Enhanced focus on improving access and waiting times – improving access to and knowledge of available services, working with community organisations to build trust, and targeted actions alongside wider population strategies to improve access, quality and safety.

3 population cohorts for initial priority focus

- **Children and Young People with complexity and living in our most deprived neighbourhoods** – to address growing risk of complexity given demographic profile
- **Working age adult population who have rising health risks –** including targeted work to address leading drivers of premature death and disability (eg. cardio-vascular risk, diabetes and severe mental illness)
- **Frailty, multiple long-term conditions and dementia care** – ensuring services for older people enable them to stay living healthy and well for longer given predicted growth

As we develop our population based approaches, we will expand this approach to further population cohorts.

4 programmes of work to transform care

- **Hospital to community –** bringing more care into local communities, including people's homes and doing so in a way that applies population management approaches to ensure we are meeting the needs of our communities.
- **Sickness to prevention** – moving the focus from treating existing illness to proactively preventing poor health, addressing health concerns and issues before they arise and addressing health inequalities.
- **Analogue to digital –** enabling the adoption of digital tools and technologies to enable patients to manage their care online and support staff in releasing time to direct care.
- **Sustainable acute and specialised services –** exploring and identifying solutions to long-standing financial and performance challenges.

15 population health outcomes

- The **SEL Strategic Outcomes Framework** sets the direction of travel for population health, providing an integrated view of how commissioning activity is contributing to outcomes that matter.
- It enables a **structured way to support strategic commissioning decisions** for prioritisation and resource allocation.
- We will take steps to **embed the SEL ICB Strategic Outcomes Framework in our work;** aligning commissioning decisions around prioritisation and resource allocation to the outcomes and testing approaches for using the outcomes within our commissioning approaches.

Our strategic outcomes framework

This is the strategic outcomes framework SEL ICB have developed, showing what we ultimately want to achieve for our population . We will take steps for 27/28 to **embed the SEL ICB Strategic Outcomes Framework in our work;** aligning commissioning decisions around prioritisation and resource allocation to the outcomes, and testing approaches for using the outcomes within our commissioning approaches.

Extend healthy life expectancy of South East London residents by delaying the onset of preventable long-term conditions and proactively addressing health issues and illness.
Impact 1.

Reduce health inequalities for South East London residents across the life course by targeting those at greatest risk of poor health (including those in the Core20PLUS groups)
Impact 2.

	Start well	Live well	Age well
Proactive-support focused	**Children and young people with long-term and / or complex conditions lead active, engaged lives, supported by a system that actively manages their needs.** Outcome 3.	**Adults with physical and mental health conditions live confident, independent lives, achieving equity with others.** Outcome 6.	**Older people with frailty or complex needs stay safe, well, and in control of their own health and care.** Outcome 9.
Thriving focused	**Children and young people thrive in their physical, mental and emotional health, able to seize opportunities.** Outcome 2.	**Adults navigate their life and work with confidence, enabled by a responsive system that identifies health issues early and delays progression of long-term conditions.** Outcome 5.	**Older people maintain their quality of life through the early detection and holistic clinical management of acute illness and long-term conditions.** Outcome 8.
Prevention focused	**Every mother, baby and family enjoys a safe and healthy pregnancy and the very best start in life.** Outcome 1.	**Adults live healthier lives for longer, avoiding premature long-term conditions** Outcome 4.	**Older people are safe and independent, living in their own homes for longer.** Outcome 7.

All residents experience dignity, comfort, and respect at the end of their lives.
Outcome 10.

All residents possess the capability and confidence to sustain healthy lifestyles and manage their own health and wellbeing at every stage of life.
Outcome 11.

Commissioned services in South East London are accessible, sustainable, effective and deliver value for our population.
Outcome 12.

There is strong alignment of commissioning activities across partners with joint endeavours on tackling the wider determinants of health
Outcome 13.

South East London Integrated Care System

Progress in year 1

Overview

- **SEL ICB finalised our first five year strategic commissioning plan in February 2026.** This plan sets out how the ICB will secure improvements for its population in line with its key responsibilities as a strategic commissioner over the next five years.
- Through the 26/27 planning round, **we created a £30m strategic investment fund**, which was the primary enabler of delivering strategic interventions to support year 1 delivery of our five year strategic commissioning plan
- **Our SIF funding was aligned to the delivery priorities set out in our commissioning plan**; sickness to prevention, hospital to community, analogue to digital and acute and specialised sustainability
- Over the course of Q1, **robust delivery plans have been produced for funded schemes**, alongside development of **approaches to evaluating impact** with quarterly monitoring of KPIs established
- This section of our pack **summarises what we are currently delivering as part of year 1**
  - The majority of our SIF funding was embedded in contracts for the start of 26/27, with associated expectations about delivery requirements. Funding that wasn't allocated for the start of the financial year has been allocated over the first part of the financial year. As such, all of these priorities should now be seen as "commissioned" for 26/27
  - Due to timelines, it was agreed through the 26/27 planning round that a part-year effect would be required for the agreed priority schemes, to ensure time for mobilisation. Most schemes started delivery in Q2, with some slipping to Q3
  - It is therefore too early to say whether the schemes are showing the expected impact. Reporting will start from Q3 but this will still only give an initial view.

Sickness to Prevention

South East London Integrated Care System

We have started implementation of the **SEL Prevention Framework**, which sets out an evidence-based approach to optimise resources around prevention so that people remain in the best health they can be for as long as possible, reducing disparities in healthy life expectancy.

We invested **£8m through the Strategic Investment Fund (SIF)** on prevention interventions and models of care that address key population health and burden of disease challenges.

What we commissioned:	Progress since April 26:	Expected impact/monitoring:
£3m Neighbourhood-based preventi offer targeted to communities most at risk of health inequalitie	Integrator partnerships are mobilising tailored neighbourhood offers in line with agreed delivery plans across 10 of our most deprived neighborhood's in SEL with full service delivery expected for 27/28	- Each partnership has a logic model with measurable impact which is being monitored with oversight through integrator partnerships and the neighbourhood operational delivery group
£1m SEL-wide CYP tier 3 obesity moc with a 'whole families' pathway approach	GSTT have developed a high-level model which is being further refined with input from key partners, including public health and will be mobilized during Q4	- Number of CYP and families enrolled in service - Number/% enrolled from high-risk groups - Number of completers and numbers maintaining weight at agreed levels after 12 months
£1m Additional funding to reduce variation in access to adult specialist obesity services and GLP1s	KCH in the process of expanding specialist medical weight management service to increase access for those patients who are eligible for weight loss drugs	- Number of patients initiated on GLP-1 medications - Number of patients attending group sessions and accessing wraparound care - Outcome data, including weight-related and clinical outcomes
£3m Neighbourhood-based identification and optimization of CVKM risk factors	Integrator partnerships are mobilizing provision to increase identification and optimasation of populations at-risk of cardiovascular kidney metabolic (CVKM) conditions (e.g. atrial fibrillation, heart failure, blood pressure, lipids, diabetes and chronic kidney disease)	- Improvement in condition-specific management indicators across CVKM with agreed trajectories - More people appropriately identified, coded and recorded - Modifiable CVKM risk factors are systematically identified and addressed for people at risk with reductions in variation

Hospital to Community

South East London Integrated Care System

We have continued **development of our neighbourhood health model**, improving collaboration, coordination and transforming how our system operates. This is a key priority through which we will deliver what our population want, as well as enabling us to deliver a more integrated model of preventative and proactive care, through a population health management approach, which supports our residents to stay well for longer, and contributes to overall sustainability of our healthcare system.

We invested **£12m through the Strategic Investment Fund (SIF)** on further development of our neighbourhood health model.

What we commissioned:	Progress since April 26:	Expected impact/monitoring:
£3.5m Achieving consistency across IN in segmentation, stratification, cohort size and functional mode	Ensured non recurrent funding provided in 2025/26 is made recurrent for 2026/27 onwards (led via Integrators) to achieve consistency across INTs in SEL in segmentation, stratification, cohort size and functional model, aligned to requirements document	- Success will be measured through the Neighbourhood outcomes framework with a set of 26/27 metrics that track early signs of delivery
£2m Core baseline provision to support integrated neighbourhood care – starting to level up primary care funding	The focus for year one is to start to move towards a more consistent set of additional general practice services by initially addressing some of the historic variation in the level of GP premium funding available within each borough. Approach to funding agreed and seven areas of focus for the funding; Places have the authority to decide which of these recommended areas they would like to prioritise	- Places will develop their local proposals and take them through their local governance processes to sign off the schemes during August and September to ensure delivery starts on the 1st October.
£5m Development of our CYP INT model and investment in mental health neighbourhood development	CYP INT Phase 1 roll out, each borough has identified a cohort of CYP to focus on in the core 20 populations or living in deprivation. Plans developed and signed off for MH neighbourhood development, with a focus on dedicated mental health support into existing adult INTs and expansion of the multi-morbidity model to include SMI, with a focus on the long acting injectable cohort	- Success will be measured through the Neighbourhood outcomes framework with a set of 26/27 metrics that track early signs of delivery
£1.5m Pushing the boundaries of neighbourhood care – testing new approaches	Proposals submitted, reviewed and decisions about which models to test in 26/27. Areas being progressed.	- Range of metrics associated with the particular approach being tested - Each scheme will be evaluated at the end of 12 months of operation, with future funding decisions taken at that point

Analogue to Digital

We have continued to strengthen the core digital offer whilst preparing SEL for a more connected and data-driven model of care.

Core & mandated digital GPIT services

Continued delivery of core infrastructure, digital platforms, support, assurance and mandated national capabilities for general practice aligned to the primary care (GP) digital services operating model

Primary care EPR migration

Mobilised an assurance-led programme to support GP practice clinical system / electronic patient record (EPR) migrations from EMIS to Medicus, including readiness, interoperability and governance requirements.

NHS App and patient messaging

Local NHS App registration target exceeded and currently at 75.5% registrations across SEL and expanded individual NHS App messaging across SEL practices.

London Care Record (LCR) expansion

Expanded shared care record access, helping more professionals view relevant information across care settings. Work commenced to enable GP records to flow to LCR via GP connect and Greenwich children social care data flow to LCR adding to the richness of LCR

Universal Care Plan (UCP) adoption

Continued expansion and adoption of the UCP to support personalised care information across health and care settings. Raising awareness across our residents about the capabilities available to amend their own care plan via NHS plan

Responsible AI and automation

Rollout of Copilot across primary care and corporate staff, blood-test automation and evaluation of ambient scribe across SEL practices. Additionally provided clinical safety, information governance and cyber assurance support for Ambient AI in primary care

Population Health management (PHM)

London Data Service (data infrastructure) and baseline integrated datasets now in place. Agreement reached to host SEL PHM data at Guy's and St Thomas' (GSTT) to support analytics across SEL. Workshops organised to agree PHM analytic joint working across SEL, to support INT decision support

Foundations for Neighbourhood

Agreed core digital enablement priorities for integrated neighbourhood teams. Decision support and digital platform requirements gathering progressed and 5 year digital, data & technology milestones are defined.

Digital inclusion and workforce support

Embedded laptop donation activity and community co-design activities with our residents, alongside practical training and support for our staff adopting new digital tools to improve digital maturity

Analogue to Digital

In addition to areas set out on the previous slide, we have invested additional funding through the SIF in areas which support new ways of working in priority areas and embed digital technology within our pathways.

We invested **£2.5m through the Strategic Investment Fund (SIF)** on further development of digital initiatives.

What we commissioned:	Progress since April 26:	Expected impact/monitoring:
£0.8m Population Health Management	To secure population health driven planning and provision, as per system business case/ identified investment needs.	- Delivery: Track progress against the agreed data engineering, system administration and infrastructure functions. - Quality and assurance: Monitor data quality, platform performance, security and regulatory compliance.
£0.7m Remote monitoring	Plans to optimise self and community-based care, including roll out of LTC/prevention, digital self management platforms. Three areas of focus around diabetes remote monitoring in community nursing, strategic remote monitoring infrastructure and scale enablement and scale up of COPD remote monitoring models.	- Areas focused on quantifying the productivity gain and the return on investment.
£1m CYP mental health digital access	Digital platform to improve access and outcomes through two routes: • Testing a universal early support offer • Development of community CAMHS pathways to include digital interventions across both mental health trusts.	- Access and waiting times: Reduce the time CYP wait to receive an effective intervention - Clinical outcomes: Improvements in symptoms and reduced severity of need - Uptake and engagement: Proportion of CYP offered digital support who take it up and engage - Implementation and sustainability: Assess how effectively digital interventions are embedded into routine care

Acute and specialised services

We invested **£7.5m through the Strategic Investment Fund (SIF)** on acute and specialised services interventions, which included pump priming to secure agreed care pathway transformation across adults and CYP, with a particular focus on national requirements around Single Point of Access / Advice and Refer and commissioning of new pathways/services to support sustainable operational and performance delivery

What we commissioned:	Progress since June 26:	Expected impact/monitoring:
£4m Delivery of Single Point of Access / Advice and Refer as part of outpatient transformation programmes	Progress towards universal triage across SEL providers in 10 high volume specialties, offering and high quality responses to referral/advice to reduce volume of avoidable outpatient first appointments.	- 100% Wave 1 specialties triaging - 80% first response within 48hrs - Reduction in discharge after OPFA no IX/PX
£1.5m New or expanded community services to support left shift	Piloting community gastroenterology model, investment in community dermatology services, investment in MSK single points of access as front door to orthopaedic services, and expansion of women and girls health hubs to test a single point of access model	- Range of metrics across areas covering activity delivered in community services, % onward referral, waiting times
£1m New or expanded cancer services to improve performance and outcomes for people with cancer	Expansion of the Cancer Risk Assessment Service and Endocrine Risk Reduction services to ensure equality of access across SEL for women with moderate/high familial risk, investment in cancer MDTs, ensuring TP biopsy model is delivered across SEL and testing a head and neck triage model	- Range of metrics across areas covering tumour group performance and activity
£1m Other areas; homecare prescribing, piloting digital technology in UEC pathways, weight management services	• Piloting point of care testing within the Emergency Department, AI enabled screening of ECGs in the Emergency Department environment, Ambient Voice Technology within the Urgent Treatment Centre environment • Levelled up acute pharmacy homecare staffing resource to ensure capacity to provide high value medicines recommended on the NHS for our population. • A SEL single point of access for tier 3 and 4 weight management services and waiting well offer which will go live during Q4 with GSTT as lead provider	- Homecare ; range of metrics covering access to medicines, medicines value and medicines delivery

South East London Integrated Care System

Our commissioning intentions for 27/28

Overview

- Our **five-year strategic commissioning plan remains a current document in terms of the ambitions and outcomes SEL ICB want to achieve for our population**.
- As we move into 27/28, we will **focus on further developing our strategic commissioning approaches**. This will include:
  - Work to **embed the Strategic Outcomes Framework** in our work, including how we start to use this within our contracting approaches
  - **Further developing our approach to population health commissioning**, focussing on population cohorts and how we commission in line with improving health outcomes and reducing health inequalities
  - **Exploring new contracting approaches** and how they could enable us to go further, faster, on achieving better outcomes for our population cohorts
- This section of our pack sets out our commissioning intentions for 27/28, building on work in 26/27 and aligned to our five year strategic commissioning plan**. A summary of our approach is shown on the next slide with more detail in the following pages.**

Summary of CI approach

Problem identified in five year strategic commissioning plan	What are our commissioning intention for 27/28?	How will this solve the problem?
Working age adult population with rising health risks - analysis shows that we have the most substantial opportunity to improve health and wellbeing in adults aged between 19 – 64 years of age. This includes targeted work aimed at the leading drivers of premature death and disability in south east London including cardiovascular risk factors (particularly tobacco use and obesity), diabetes and severe mental illness (SMI).	• Expansion of targeted neighbourhood prevention core offer, building on initial roll out in 26/27 • Expansion of initiatives targeting obesity and weight management; GLP-1s alongside weight management expansion • Implementation of digital self-management support tools e.g. LTC self management platform and expansion of MSK tool	The SEL prevention core offer targets evidence based interventions designed to avoid or delay escalation into more complex needs; proactive identification and support for those at risk of poorer outcomes due to "vital 5 plus" factors – an evidence based approach to areas of health focus alongside an integrated approach to ensure local alignment with financial security, employment, housing and social connectivity through "making every contact count". Roll out to increased number of neighbourhoods will increase scale of impact.
Children and young people with complexity and in living our most deprived neighbourhoods – our future demographic projections demonstrate that although the total number of children and young people living in south east London will decrease over the next 10 years, the complexity within this age range will increase. Children and young people will account for higher proportions of our Core20 populations, where outcomes are known to be worst. **Frailty, multiple long term conditions and dementia care –** the projected growth and expansion of our older population could overwhelm our health and social care system. We therefore need to focus on reducing health risks in our working age adult population as set out above, but also ensuring our services for older people enable our population to stay living healthy and well	• Continue expansion of integrated neighbourhood teams, building on 26/27 roll out • Incorporate expectations around a neighbourhood "reactive" care model, alongside preventative and proactive elements that were the focus of 26/27 • Continued roll out of a mind and body approach to integrate mental health support into INTs and coverage of the SMI cohort • Expand the capability of INTs to provide greater reach and impact e.g. incorporating respiratory into mLTC INT and testing a neighbourhood based approach to aspects of maternity care, to identify and support those at risk of poorer outcomes from pregnancy, which can impact across the life course • Establish a targeted SEL remote monitoring programme that spreads and scales where evaluation demonstrates impact and value and extends to additional priority	Continued roll out of the INT approach will lead to greater impact, through greater scale and population reach. Incorporating reactive elements into the neighbourhood care model should deliver impact on acute demand, alongside the longer term benefit of preventative / proactive elements of the care model
Initiatives focused on **continued delivery of the four programmes of care set out in our strategic commissioning plan:** sickness to prevention, hospital to community, analogue to digital and sustainability of acute and specialised services	• Range of initiatives targeted at sustainable improvements within cancer, planned care and diagnostics through new models and community services • Sustainable model of care for adult and CYP ND assessment and ongoing pathways • Implementation of new 111 model, aligned to neighbourhood working	Initiatives which focus on new solutions to long standing challenges which impact access and experience for our population. A focus on learning from what has worked elsewhere and expanding this across SEL e.g. learning from community ENT service and expanding to other specialties, roll out of proven approaches to delivering cancer care

Babies, Children and Young People

South East London Integrated Care System



A family-centred pathway that prevents avoidable ill health, coordinates need proactively, makes routes into care accessible, and responds outside hospital wherever safe.

Prevention Give every child and family the best start	**Proactive** Find priority cohorts and coordinate support earlier	**Accessible** Create clear digitally enabled routes	**Responsive** Rapid advice, transition support and alternatives to hospital
Family healthy-weight programme Pregnancy through early and primary years **Antenatal and postnatal healthy-weight support** Parenthood, development and healthy choices	**Year 2 CYP INT expansion (mind and body approach)** LCHT plus priority cohorts **Maternity INT design and test** Scale into two further areas	**CYP Modern Service Framework and AI triage** Placeholder including AI-enabled ED triage **ADHD model of care** New model of care	**SEL maternity telephone triage / SPoA** Midwife-led urgent advice **Neonatal outreach** Transition home across King's and LGT **CYP Urgent Care Response** ED navigation, high-intensity users and Hospital@Home

Cross-cutting enablers: PHM | Primary Care Capacity | Neighbourhood OD and System Development | Digital | VCSE Capacity Building

Babies, Children and Young People

Pathway Stage	Scheme	Brief description of scheme	SEL Outcome Framework	Interconnections
Prevention	Family healthy-weight programme	Targeted family support beginning in pregnancy and continuing through early and primary years	Children and young people thrive in their physical, mental and emotional health, able to seize opportunities.	Antenatal and postnatal healthy-weight support
Prevention	Antenatal and postnatal healthy-weight support	Provision of an evidence based targeted family support programme that starts in pregnancy with women with a high BMI and continues into the early and primary age years reducing the risk factors associated with infant, child and adult obesity. The programme should deliver preparation for parenthood, child development and infant and child and family education on healthy weight management, including support for food choices and preparation.	Every mother, baby and family enjoys a safe and healthy pregnancy and the very best start in life.	• Family Weight Management Services • Weight Management SPoA for tier 3 and tier 4
Proactive	Year 2 CYP INT expansion	Development of INTs to incorporate LCHT into the INT model and at least 2 of the following areas (list to be confirmed at later date) • High intensity users • Teen health – Teen health and wellbeing check • Obesity and/or maternal obesity • STAMP • Prevention elements of the framework • CYP palliative care/complex needs	Children and young people thrive in their physical, mental and emotional health, able to seize opportunities.	Maternity INTs
Proactive	Maternity INT (Design and Test)	Following evaluation of L&S proof of concept, scale Maternity INT into two more areas.	Every mother, baby and family enjoys a safe and healthy pregnancy and the very best start in life.	CYP INTs

Babies, Children and Young People

Pathway Stage	Scheme	Brief description of scheme	SEL Outcome Framework	Interconnections
Accessible	CYP MSF (and AI enabled triage)	CYP MSF Placeholder – including AI ED triage	Children and young people thrive in their physical, mental and emotional health, able to seize opportunities.	UEC Pathway Digitalisation AI triage
Accessible	ADHD model of care	Based on outputs of system work, move towards new service model for ADHD assessment and treatment	Children and young people thrive in their physical, mental and emotional health, able to seize opportunities.	
Responsive	SEL maternity telephone triage / SPoA	System-wide midwife-led telephone triage and clinical advice for maternity urgent and emergency support, potentially with LAS hosting support.	Every mother, baby and family enjoys a safe and healthy pregnancy and the very best start in life.	UEC Pathway Digitalisation SPoAs
Responsive	Neonatal outreach	Roll out a multidisciplinary outreach model for King's and LGT to support transition home.	Every mother, baby and family enjoys a safe and healthy pregnancy and the very best start in life.	
Responsive	CYP Urgent Care Response	ED Front Door Navigation, Support for High Intensity Users, development of a consistent integrated community offer to support CYP and prevent hospital attendance (Virtual ward/hospital at home)	Children and young people with long-term and / or complex conditions lead active, engaged lives, supported by a system that actively manages their needs.	Integration of UCR, Hospital@Home and acute services and SPOA (Adults)
Proactive / accessible / responsive	Primary Care Strategic Commissioning and Capacity Building	• Defined focus on ensuring that general practice providers have sufficient capacity to underpin our neighbourhood care models in each place • Building the capacity, capability and infrastructure required for community pharmacy to play a greater role in prevention, long-term condition management and delivery of care closer to home	Range of outcome measures	

Working Adults with Rising Risk

South East London Integrated Care System



A connected pathway that prevents avoidable ill health, manages emerging risk proactively, makes community care accessible, and responds to complex or escalating need.

Prevention Reduce risk and delay progression	**Proactive** Enable early action and personalised management	**Accessible** Coordinated community routes and specialist advice	**Responsive** Respond to severe or escalating need
Targeted Neighbourhood Prevention Expand into high-deprivation neighbourhoods **Medicines optimisation for CKRM including GLP-1 medicines** Sustainable pathway for eligible patients **Community Pharmacy Prevention Offer** Vital 5 checks, reducing inequalities	**GetUBetter MSK** SEL-wide digital self-management, including mental health support **LTC self-management** Universal support with condition content, including mental health support **CVKM Modern Service Framework** Earlier diagnosis, medicines and treatment optimisation	**Weight Management SPoA** SEL-wide referral and triage **MSK pathway expansion** Specialist physiotherapy capacity	**Integrated Alcohol Inpatient Detox** Dedicated SEL pathway for severe dependence and complex need

Cross-cutting enablers: PHM | Primary Care Capacity | Neighbourhood OD and System Development | Digital | VCSE Capacity Building

Working Adults with Rising Risk

Pathway Stage	Scheme	Brief description of scheme	SEL Outcome Framework	Interconnections
Prevention	Expansion of Targeted neighbourhood prevention core offer	We propose expanding the neighbourhood-based prevention core offer via integrator partnerships at place to 11 further neighbourhood areas with high levels of deprivation.	Adults live healthier lives for longer, avoiding premature long-term conditions	
Prevention	GLP-1 and medicines optimisation for CKRM	Build the capacity and capability required to deliver an effective, sustainable pathway for eligible patients. Using medicines optimisation, case-finding and evidence-based treatments to improve outcomes for priority CVKM cohorts and reduce health inequalities.	Adults live healthier lives for longer, avoiding premature long-term conditions	Medicines Optimisation
Proactive	GetUBetter MSK	Expand GetUBetter across the remaining boroughs (Bromley & Greenwich) to establish a consistent South East London digital self-management offer for MSK conditions.	Adults navigate their life and work with confidence, enabled by a responsive system that identifies health issues early and delays progression of long-term conditions.	Other digital self-management schemes
Proactive	LTC self-management	Universal self-management support applicable across multiple long-term conditions, with condition-specific content tailored to individual conditions, including mental health support	Adults navigate their life and work with confidence, enabled by a responsive system that identifies health issues early and delays progression of long-term conditions.	Self-management of Frailty GetuBetter MSK and Gynae
Proactive	CVKM Modern Service Framework	Accelerate delivery of MSF across South East London, supporting a more joined-up cardiovascular, kidney and metabolic (CVKM) system focused on prevention, earlier diagnosis, proactive management, treatment optimisation and care closer to home	Adults live healthier lives for longer, avoiding premature long-term conditions	GLP and related therapies Medicines Optimisation

Working Adults with Rising Risk

Pathway Stage	Scheme	Brief description of scheme	SEL Outcome Framework	Interconnections
Accessible	Weight management SPoA expansion	Establish a SEL-wide Single Point of Access (SPOA) for specialist weight management services (Tier 3 and Tier 4), creating a networked model that coordinates referrals, triage, assessment and access across existing providers.	Adults navigate their life and work with confidence, enabled by a responsive system that identifies health issues early and delays progression of long-term conditions.	Medicines optimisation and access to weight management medicines.
Prevention and accessible	Community Pharmacy Prevention Offer	Develop community pharmacy as a key delivery partner for the SEL Prevention Framework, including health improvement, opportunistic case finding and targeted support for communities experiencing the poorest outcomes.	Adults live healthier lives for longer, avoiding premature long-term conditions	
Accessible	MSK pathway expansion	Increased capacity of MSK services, with additional specialist physiotherapy capacity to manage rehabilitation and follow-up activity	Adults with physical and mental health conditions live confident, independent lives, achieving equity with others.	
Responsive	Alcohol Detox	Establish an Integrated Alcohol Inpatient Detox (IPD) Unit for South East London, providing a dedicated pathway for patients with severe alcohol dependence and complex physical, mental health and social care needs.	Adults with physical and mental health conditions live confident, independent lives, achieving equity with others.	

People with Multiple Long Term Conditions, Frailty or approaching the End of Life

South East London Integrated Care System



A connected ageing well model that prevents deterioration, identify and manage need proactively, make support accessible, and respond quickly as complexity or acuity increases.

Prevention Support independence, activation and healthier ageing	**Proactive** Identify risk and coordinate holistic care earlier	**Accessible** Provide diagnostics, treatment and medicines closer to home	**Responsive** Escalate, de-escalate and support people at home
Ageing-well self care and self management (physical and mental health) AI enabled platform with universally accessible resources	**Ageing-well INT Expansion** Full frailty spectrum, dementia, age well hubs and sensory assessment **MLTC INT Expansion** Respiratory **Integrated neighbourhood mental health care** Continued development of integrated approaches **Structured medication review and reduction of inappropriate polypharmacy**	**Community Respiratory Diagnostics** Spirometry and FeNO through community hubs **Enhanced Respiratory Diagnostics** FeNO, N-TIDAL and expanded local diagnostics **COPD Biologics** **Access to Palliative Medicines out of hours**	**SEL urgent community SPoA and Hospital@Home** MDT triage, coordination and higher-acuity support **Sleep Medicine**

Cross-cutting enablers: PHM | Primary Care Capacity | Neighbourhood OD and System Development | Digital | VCSE Capacity Building

Multiple LTC, Frailty and End of Life

Pathway Stage	Scheme	Brief description of scheme	SEL Outcome Framework	Interconnections
Prevention	Ageing well self-care and self-management	AI-enabled Living and Ageing Well Platform, providing a digital self assessment and tailored self-care / self-management support across physical and mental health	Older people are safe and independent, living in their own homes for longer.	MLTC self-management platform GetuBetter MSK and Gynae
Proactive	Ageing Well Neighbourhood Expansion	• Expand proactive care model across full frailty spectrum (into moderate and mild), Roll-out age well hubs across SEL • Sensory assessment: Testing of expansion of MDT with appropriate partners, at scale, within 1 borough to support complex /extended sensory assessments (housebound residents), linked in with frailty INT	Older people maintain their quality of life through the early detection and holistic clinical management of acute illness and long-term conditions.	
Proactive	mLTC INT respiratory expansion	Extend neighbourhood mLTC teams to respiratory conditions, increasing expertise and caseload capacity.	Adults with physical and mental health conditions live confident, independent lives, achieving equity with others.	
Proactive	Integrated neighbourhood mental health care	Continued development of integrated neighbourhood mental health care with primary care, social care and VCSE partners—supporting proactive SMI care, prevention and "mind and body" pathways, building on 26/27 work	Adults with physical and mental health conditions live confident, independent lives, achieving equity with others.	
Accessible	Community Respiratory Diagnostics Service	Bromley Community Respiratory Diagnostic Hubs, delivering quality-assured spirometry and FeNO testing closer to home through a hybrid model of physiologist-led diagnostics and Primary Care support.	Adults navigate their life and work with confidence, enabled by a responsive system that identifies health issues early and delays progression of long-term conditions.	MLTC INT Respiratory Expansion COPD Biologics Pathway Medicines Optimisation
Accessible	Enhanced Respiratory Diagnostics	Expand FeNO, N-TIDAL, community respiratory diagnostics	Adults navigate their life and work with confidence, enabled by a responsive system that identifies health issues early and delays progression of long-term conditions.	MLTC INT Respiratory Expansion COPD Biologics Pathway Medicines Optimisation

Multiple LTC, Frailty and End of Life

Pathway Stage	Scheme	Brief description of scheme	SEL Outcome Framework	Interconnections
Accessible	COPD Biologics	To improve COPD care by leveraging biologics delivered through an integrated SEL pathway. This pathway combines a population health OPTIMISE approach delivered through local COPD services in partnership with neighbourhoods and primary care, with formal oversight and decision-making on biologic initiation and treatment through the regional secondary care hosted Complex COPD MDT.	Adults with physical and mental health conditions live confident, independent lives, achieving equity with others.	MLTC INTs respiratory expansion Community respiratory diagnostics Enhanced respiratory diagnostics Medicines Optimisation
Accessible	Out of hours medications	Ensuring appropriate access to out of hours medication for patients who are at the end of life.	Older people with frailty or complex needs stay safe, well, and in control of their own health and care.	Medicines Optimisation and Community Pharmacy
Responsive	Sleep Medicine			
Responsive	SEL urgent community SPoA and integrated hospital@home pathways	• SEL-wide SPoA that will function as a multi-disciplinary triage and coordination hub aligning with Hospital@Home teams • Optimise Hospital@Home services so that they are fully compliant, meet demand and manage increased levels of acuity	Older people with frailty or complex needs stay safe, well, and in control of their own health and care.	
Proactive	Structured Medicines Review and reduction of inappropriate polypharmacy	• SEL wide targeted medicines optimisation, structured medication review and reduction of inappropriate polypharmacy for people with frailty, multiple long-term conditions and complex needs.	Older people with frailty or complex needs stay safe, well, and in control of their own health and care.	MLTC and Frailty INT Medicines Optimisation
Proactive / accessible / responsive	Primary Care Strategic Commissioning and Capacity Building	• Defined focus on ensuring that general practice providers have sufficient capacity to underpin our neighbourhood care models in each place • Building the capacity, capability and infrastructure required for community pharmacy to play a greater role in prevention, long-term condition management and delivery of care closer to home	Range of outcome measures	

South East London Integrated Care System

Cross-cutting Enablers

Primary Care Strategic Commissioning, Capacity Building

South East London Integrated Care System

- **General practice** services are under increasing strain to meet increasing same day demand whilst supporting high-quality proactive care for patients at increasing risk of poorer health outcomes. The GP national contract is increasingly geared towards ensuring effective same day provision, with enhanced services commissioned locally focussing more on meeting the needs of patients with long-term conditions and increasing complexity. Enhanced service provision varies across SEL leading to variation in access, experience and outcomes for our patients.
- In 2026-27, the ICB worked across its 6 places to undertake a first step in levelling up provision (covered earlier in this slide pack around 26/27 delivery). In 2027-28, we will continue this journey moving to a more defined focus on ensuring that general practice providers have sufficient capacity to underpin our neighbourhood care models in each place. Below we have set out at a high-level what our expectations would be of general practice. Work will be undertaken across our 6 places to develop this into a commissioned service for 27-28, ensuring that there is no duplication with existing schemes.
- **Community pharmacies** are experiencing sustained workload pressures driven by increasing demand, workforce challenges and the expansion of clinical services delivered closer to home. In 2026/27, we invested in developing the foundations for a neighbourhood community pharmacy model. In 2027/28, our focus will be on building the capacity, capability and infrastructure required for community pharmacy to play a greater role in prevention, long-term condition management and delivery of care closer to home.

General Practice		Community Pharmacy
High need (Frailty, cancer, MLTC, complex CYP and end of life)	**Moderate need (1-2 Conditions, Rising Risk)**	**1-2 conditions, Rising Risk, mLTCs and end of life**
• Practices use population health tools to identify patients with high need • Patients are appropriately flagged as requiring continuity (with a named GP) and this is built into triage flows • Longer appointments are offered where required • Patients have holistic review appointments at least every 6 month (covering full need) • Patients are offered a Structured Medication Review annually • Frailty is identified earlier and coded appropriately • Care plans are co-produced with patients, families and carers and are updated after planned reviews and admissions • Patients with escalating need are appropriately identified and discussed at complex care MDTs, with engagement from the lead GP • Practices provide coordinated support following discharge from hospital • Practices ensure that patients receive earlier discussions around palliative and end of life preferences and support early planning	• Practices use population health tools to identify patients with moderate need • Patients are appropriately flagged as requiring coordination of care (with a named care coordinator) and this is built into triage flows • Group consultations are offered for patients with similar need • Patients are offered a Structured Medication Review annually • Education sessions are offered to improve self-management • Practices support outreach activity within their local community settings to identify unmet need • Enhanced screening, vaccination and call/recall working with partners • Lifestyle, wellness and prevention assessments offered annually to adults with rising risk	• Increase uptake of national community pharmacy clinical services to release capacity within other parts of primary care and improve timely access to care. • Strengthen community pharmacy leadership and engagement within neighbourhood and Integrated Neighbourhood Team arrangements. • Expand the contribution of community pharmacy to prevention, health improvement and management of long-term conditions, particularly for populations experiencing poorer outcomes and health inequalities. • Improve digital connectivity and information sharing between community pharmacy, general practice and wider health and care partners. • Support workforce and prescribing capability development to enable more clinical care to be delivered through community pharmacy settings

Enabler: Digitalisation

South East London ICB has articulated a digital strategy that works towards rationalisation and integration of tools to support improved patient care

A variety of the SIF proposals for 2027/28 require new or enhanced digital functionality. The summary below sets out the key functionalities required. Proposal leads will work with the digital team to access the best solutions to meet those digital functionalities that maintains our strategic direction to rationalise and integrate the digital tools that we use across our system.

Area	Brief description of functionality	Which schemes are requesting this functionality	Connections
Self-Management	A single AI-supported platform that enables residents to access structured content and support for self-care and self-management across a range of pathways, covering physical and mental health	Long Term Condition Self-Management CVKM Modern Service Framwork Weight management proposals (ante and post natal and family) Ageing well self-management	Needs to work with GetUBetter system (MSK and Gyanae)
Point of Care Testing	Enables front-line teams to undertake diagnostic tests at the point of care delivery (including non-clinical settings) with integration of results into EPRs.	Primary Care Capacity Building Neighbourhood Teams SPOA/Hospital@Home CVKM Modern Service Framework UEC Pathway Improvement	
Call and Recall	Enables patients to be identified and called in for screening, vaccinations and review without human interaction across multiple settings	Neighbourhood INTs (Frailty, MLTC, CYP and Maternity) CVKM Modern Service Framework Cancer Screening	
LTC management and responsive care pathways	Consistent ability to monitor key health markers remotely to support both chronic condition management and responsive care.	Integration of hospital@home pathways Neighbourhood INTs (Frailty, MLTC, CYP and Maternity) CVKM Modern Service Framework GLP1	
Simplification of access routes	Ensures patients and professionals are routed to the most appropriate team/setting through a single call when care needs are escalating	SPOA/Hospital@Home Maternity SPOA CYP SPOA	Potential connection with elective SPOAs

Enabler: Digitalisation

Area	Brief description of functionality	Which schemes are requesting this functionality	Connections
AI Triage	Patient accessible AI-led triage of need with automated routing to the most appropriate service.	UEC Pathway Improvement (below) CYP Digital ED Front Door Primary Care Access Improvement	
Tele-dermatology	Digitally-enabled diagnosis and treatment of dermatology conditions	Tele-Dermatology	Opportunities to connect to wound care
UEC Pathway Digitalisation	• **Navigation** - Use NHS App functionality to help residents identify the most appropriate urgent care option based on need • **Streaming & redirection** - Expansion of digital front doors and NHS App access to urgent care services. • **Scheduling and booking** - Direct booking into alternatives to ED (and direct booking into ED) • **Identify, trial, and scale emerging technologies as they arise in the market, to support ED–** e.g.point of care testing, remote monitoring, wearable technology, building on 26/27 pilots	UEC Pathway Improvement	
New NHS 111 service	In 2027/28 we plan to mobilise our new South East London 111 Service. The future model for SEL is designed to be much more than a telephone triage service. The overarching aim is to support neighbourhood-based care, improve access, and ensure patients are directed to the right service first time. Key changes and ambitions include: • Aligning with the Fuller recommendations and neighbourhood health agenda, moving from a centralised service to more localised teams that understand the needs of their residents and local services. This will be delivered through the separation of the call handling service from the clinical assessment service which will be delivered locally through Integrated Delivery Units. • More patients increasingly being booked directly into the most appropriate care setting, including GP, community and specialised services, reducing unnecessary attendances to high acuity emergency services. • Reducing inequalities and improving patient experience by supporting people whose first language is not English, people with disabilities, mental health needs and other groups who may experience barriers to access.		Community Pharmacy First pathways and integration.

Enabler: digitalisation

Alongside the digital areas covered on previous slides, the ICB will progress wider digital work building on delivery in 26/27 which focuses on the delivery of practical capabilities building on existing platforms that support access, safer information sharing, productivity and neighbourhood working approach. In 27/28 we will move from pilots and technical foundations to scaled adoption, pathway transformation and outcomes.

Reliable digital foundations

Core GPIT delivery, device and platform modernisation, cyber resilience and clearer assurance routes.

Adoption of infrastructure across partner organisations for seamless access such as GovRoam and Federated Active Directory.

Migration from legacy system EMIS to Medicus - a new GP practice clinical system / electronic patient record (EPR)

Connected records and pathways

Widening usage of London Care Record, Universal Care Plan, GP Connect, supported data flow and access across the systems - essential for continued seamless care provision.

Integration programmes such as Dovetail and Epic Care Link supporting enhanced interoperability and integration between primary and secondary care EPRs.

Data-driven care

Delivery of SEL PHM data and architecture, PHM analytics and emerging INT decision support requirements.

This provides the platform to move from technical and analytical foundations to delivered solutions, at scale analytics and scaled adoption, leading to more targeted and preventative care delivery.

Productivity and innovation

Delivery of ambient voice technology across Primary Care – based on outcomes of local evaluation of existing scribe solutions across SEL.

Delivery of Copilot across all settings including corporate staff to support productivity and efficiency.

Enabling multi-disciplinary team access to data and digital tools to support integrated neighbourhood working.

Digital Inclusion and workforce support

Partnering with wider stakeholders across SEL to enhance existing digital inclusion foundations and grow further opportunities to support residents and staff alike with training and access to digital pathways, NHS App and wider tools.

Cyber Security, Assurance and Compliance

Maintaining and enhancing assurances of compliance of key cyber security resilience including:

Cyber Assurance Framework aligned to Data Security Protection Toolkit (DSPT) compliance.

Maintaining Cyber Essential Plus accreditation to support cyber security resilience and assurance

Resident and workforce impact: easier digital access • more complete information • reduced duplication • stronger resilience • improved assurance

Enabler: digitalisation

Through our commissioning intentions for 27/28, we will continue core delivery while scaling adoption, prevention, connected care and secure data capabilities.

1	**Core and mandated digital GPIT**	Continue to provide core and mandated digital capabilities and GPIT services, infrastructure, cyber, including safe Electronic patient record (EPR) migration
2	**Connected care and Single Patient Record**	Scale shared care records and neighbourhood interoperability; improve interoperability between new primary care EPR Medicus and existing national and London level digital platforms, work with the national and regional teams on initial scoping and architecture for the Single Patient Record.
3	**NHS App, prevention and self-management**	Increase adoption and usage of NHS App features, giving targeted access to Vital 5 health checks, remote monitoring and self-management support
4	**Secure data and proactive care**	Continue working with London Partners on greater "at scale" data integration and availability. Supporting access to PHM data, for Integrator Hosts and INTs. Supporting analytic team joint working which enables adoption of consistent decision support tools and the delivery of targeted and proactive care.
5	**Responsible AI and innovation**	Scale proven AI and automation in proactive care, patient triage, long term condition management, and point of care testing with benefits tracking, while embedding clinical safety, cyber, privacy, and ethical controls.
6	**Digital inclusion and workforce support**	Continue partnering work with integrators and community organisations including charities to grow digital inclusion opportunities to benefit citizens and staff alike including: Digital Hub – Mind in Bexley, Digital Support – Link Age Southwark,Support for over-60s to online confidently – RB of Greenwich,Clear Community Web – digital confidence and training for accessing MyChart and NHS App

YEAR 2 COMMISSIONING CHECKLIST

- ✓ Does it improve access or outcomes in patient care?
- ✓ Is it interoperable and reusable?
- ✓ Does it reduce inequalities?
- ✓ Are benefits and adoption measurable?
- ✓ Does it promote at-scale working and reduce silos?
- ✓ Is it clinically safe, digitally secure and affordable?

Enabler: Organisational and System Development

The 10 Year Plan sets out an ambitious redesign of the way that NHS care is delivered. This sort of transformation needs to be underpinned by organisational and system change. In South East London, we have been developing strong foundations to support this through the introduction of integrator partnerships that will lead the implementation of neighbourhood care models.

As we scale and expand neighbourhood care, we need to continue to invest in the organisational and system development required to support that change. The three areas below are our priorities for 2027/28 to support this.

Neighbourhood Thrive

- In 2026/27 we introduced Primary Care Thrive which provides universal, targeted and bespoke improvement support for general practice with the aim of reducing unwarranted variation in access, experience and outcome. We would ensure this is sustainably funded from 2027-28
- Provide new universal access to digitally hosted training, education and development for all staff working within neighbourhood teams (including primary care, VCSFE and social care staff)
- Enable staff working with neighbourhood models to assess their neighbourhood working skills, set own Personal Development Plan and build their skill
- Provide a personal development budget for each neighbourhood team to support group training / action-learning set approaches based on bespoke needs of the team.

Integrator Partnership Maturity and Capability

- During 2027/28, our neighbourhood roadmap set expectations that we would expand the role of the Integrator Partnership role in alignment with the Maturity Matrix. Continuing to develop the maturity of the local provider-led partnerships is fundamental as we move towards implementing new population health commissioning and contracting approaches.
- We propose to give each partnership further recurrent funding to support them to expand their capabilities and drive their maturity development plans.

Population Health Management

- In 2026/27 we worked with our partners, and contributing a share of investment, to develop a Population Health Management Service to support our Integrator Partnerships. This service is delivered through a network of the ICB, GSTT and LGT. In 2027/28, we propose to increase our investment in this service to deliver improved population health capabilities that will support:
    - Case Identification
    - Population Health Improvement
    - Direct care provision
    - Integrated Neighbourhood Team population cohort oversight and management

South East London Integrated Care System

Contracting approaches

VCSFE Strategic Commissioning and Capacity Building

- **The SEL VCSE Charter, developed in 2025, responds to persistent challenges in collaboration** between the Voluntary, Community and Social Enterprise (VCSE) sector and the Integrated Care System (ICS), with a focus on tackling health inequalities, strengthening prevention and health creation, and bolstering collaborative system planning
- The charter was co-developed and agreed between the SEL Integrated Care System and the VCSE sector to signal **shared commitments** to equitable strategic and operational partnership, shared leadership and innovation.
- It sets out **high-level commitments and principles** for collaboration, co-planning, and mutual accountability.
- **As part of delivery in 2027-28 we plan to work with the VCSFE Strategic Alliance to build on the charter and apply the principles and commitments to our commissioning approach**
- We would like to invest money in the Strategic Alliance, to work with VCSFE partners to identify offers that could be scaled across SEL to support the outcomes aligned to our commissioning intentions, and then work with our Integrator Partnerships to scale those offers and embed them into local delivery models.
- The aim of the approach is to:
    1. Enable a more strategic outcomes-based commissioning approach to VCSFE provision across South-east London
    2. Build the capacity of the sector to work with integrator partnerships in each place
- The Strategic Alliance would be responsible for:
    - Identifying services that could be scaled, aligned to the outcomes expected and population need
    - Working hand in glove with VCSFE representatives on local integrator partnership and VCSFE infrastructure organisations to continue to build capacity across each place
    - Distributing and monitoring funding, using a proportionate monitoring approach
    - Supporting VCSFE partners to engage with integrator partnerships so that services are embedded in local delivery models

Neighbourhood contracting approaches

During 2027/28 we will start to **evolve our current contracting approach**.

- **Integrator hosts would be commissioned through their main contract** to be the host and **support the Integrator Partnership** – receiving infrastructure funds to support this.
- **Integrator hosts would also receive investment for neighbourhood care to hold on behalf of the partnership** Again this would be contracted through their main contract with a requirement that investment was delivered in-line with an agreed investment and delivery plan agreed through the Integrator Partnership. **The host remains accountable to commissioners for that investment**.
- **The Integrator Partnership in each place would be asked to develop and sign off their delivery plan**, ensuring parity of voice across partners. The Integrator Partnership would be expected to have **clearly defined accountable persons for each delivery areas**.
- Delivery arrangements would be **underpinned by an MoU**, **alliance agreement** or **sub-contracting**

During 2027/28, we would also aim to **test how we can move towards whole population commissioning approaches**. We would aim to test shadow approaches to:

- An approach focussed on the **frailty population**
- **In one place** where the current community and acute commissioning boundaries align closely to the registered population.
- **All four elements of our model of care** (preventative care, proactive care, reactive care and accessible care).
- **Think through benefits of new contractual arrangements** available to ICBs
- **Commissioner and provider capabilities** to support population health contracts.
- **Population-level budgeting** (across health and care)

The learning from this would inform expansion of approaches for 2028/29.

How our financial strategy supports our 2027/28 commissioning intentions

Our financial strategy in support of our commissioning intentions

South East London Integrated Care System

Our Medium Term Financial Strategy (MTFS) sets out how we intend to use our resources to improve population health, reduce inequalities and achieve financial sustainability. It provides the financial framework for delivering our strategic commissioning priorities, guiding how we allocate resources, prioritise investment and make decisions about the services we commission as reflected in annual commissioning intentions and annual operating plans.

1. Our MTFS aims, approach and 3 key enablers

Our aims

Deliver the three strategic shifts
- From treatment to prevention.
- From hospital to community.
- From analogue to digital.

Improve outcomes and reduce inequalities
Improve population health, reduce inequalities and improve the quality and performance of services.

Achieve financial sustainability
Deliver year-on-year improvements in productivity and efficiency, alongside sustained improvements in our underlying financial position.

Our medium-term approach

- We will continue to **improve productivity and efficiency** across existing services while **protecting investment** in prevention, care closer to home and digital.
- Initially, we will use the **Strategic Investment Fund** to develop alternative models of care, alongside directing a greater proportion of funding growth towards our strategic priorities.
- **Acute funding will continue to increase**, but its share of overall spending will reduce.
- Over time, **larger transfers of resources will be possible** as changes in care allow hospital capacity and costs to reduce. The pace of these changes will depend on delivery, affordability and transition.

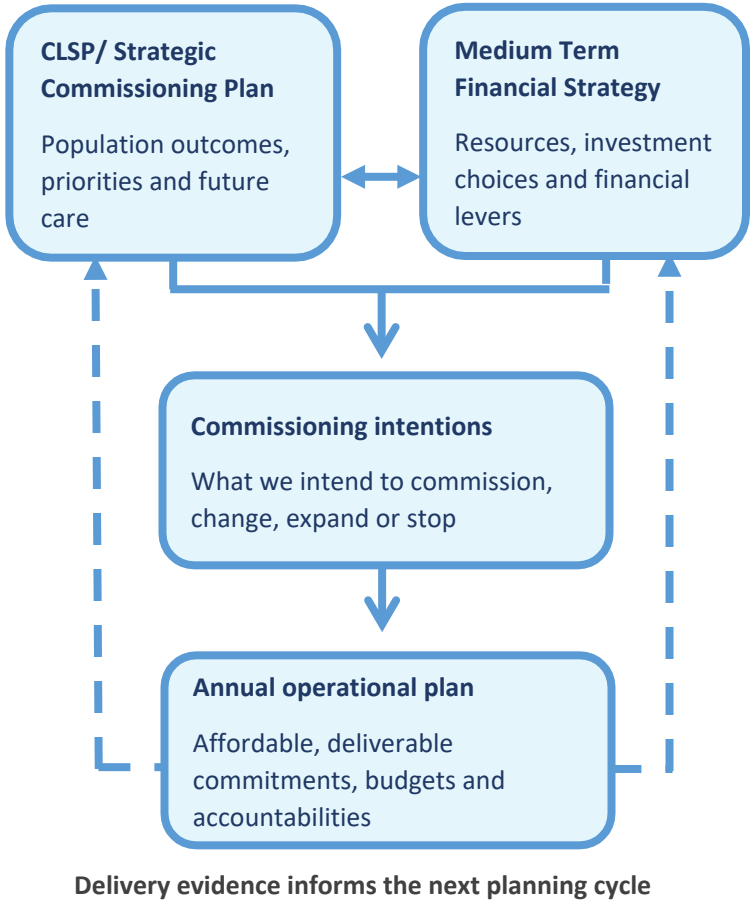
3 key enablers to support our objectives

Enabler 1. ICB Allocative Strategy
- Update our financial planning assumptions and approaches.
- Review growth funding and deconstructing-block adjustments.
- Protect investment through the Strategic Investment Fund and manage the financial consequences of changing services.

Enabler 2. Commissioning Approaches and Provider Models
- Strengthen how we prioritise investment, assess its value and evaluate the benefits delivered.
- Review existing expenditure to ensure effective use of resources.
- Develop and test neighbourhood and provider arrangements.

Enabler 3. Contract and Payment Approaches
- Develop contractual approaches that support our strategic priorities and financial sustainability.
- Review the implications of national payment arrangements and incentives for local services.
- Explore and test alternative payment approaches.

2. How strategies becomes delivery



Delivery evidence informs the next planning cycle

ICB allocative approach

In reflecting the direction of our financial strategies in our plans for 2027/28, we are proposing to adopt **common resource allocation principles** across SEL and SWL, while allowing local decisions to reflect need, performance and existing commitments with alignment to our **commissioning intentions and affordability**. A tiered approach is set out below:

National requirements and recovery funding
Apply national allocations, planning guidance and performance funding, including elective recovery and deconstructing blocks

Ringfenced commitments
Deploy MHIS and other ringfenced funding within the national guidance, using discretion to align with our financial strategies

Evidenced BAU growth
Recognise population and incidence growth where the activity basis is clear, subject to opportunities for pathway transformation — including hospices, CHC, prescribing and ADHD.

Quality and safety priorities
Address material risks such as maternity through an explicit and transparent prioritisation process.

Strategic Investment Fund
support for prevention, neighbourhood services, digital and transformation against deliverable benefits and outcomes with close alignment to 10 Year Health Plan priorities

Our resource allocation will be supported by a proportionate, staged process to demonstrate **return on investments** to strengthen the connection between investment decisions and outcomes and to **support prioritisation**. This will be particularly key for the allocation of our Strategic Investment Funds, which are currently planned to total £45m in SEL, subject to affordability and final planning decisions
We will also need to consider our options regarding **contractual form and approaches to their agreement** to ensure that these most closely incentivise performance delivery, agreement of contracts, facilitate left shifts and the development of integrator functions, our ability to ringfence our Strategic Investment Funds and the delivery of financial balance. Given our respective financial positions and history, this may require differences in approach across providers and/ or the two ICBs.

Strategic Investment Fund and Financial Sustainability

Financial sustainability is a central objective of our MTFS. We face two related challenges. First, we need to **address the SEL system's underlying financial deficit**. Second, demographic changes, including an ageing population and increasing numbers of people living with multiple long-term conditions, mean that **demand for services and the costs of providing care are expected to grow faster than the funding available** . We therefore need to improve the productivity and value of existing services while changing how we deliver care to meet future demand more effectively. This requires us to protect investment in our strategic priorities, alongside continued financial recovery, and to manage the financial consequences of changing services.

Our approach brings together priorities to support financial recovery while investing in future care, as set out below:

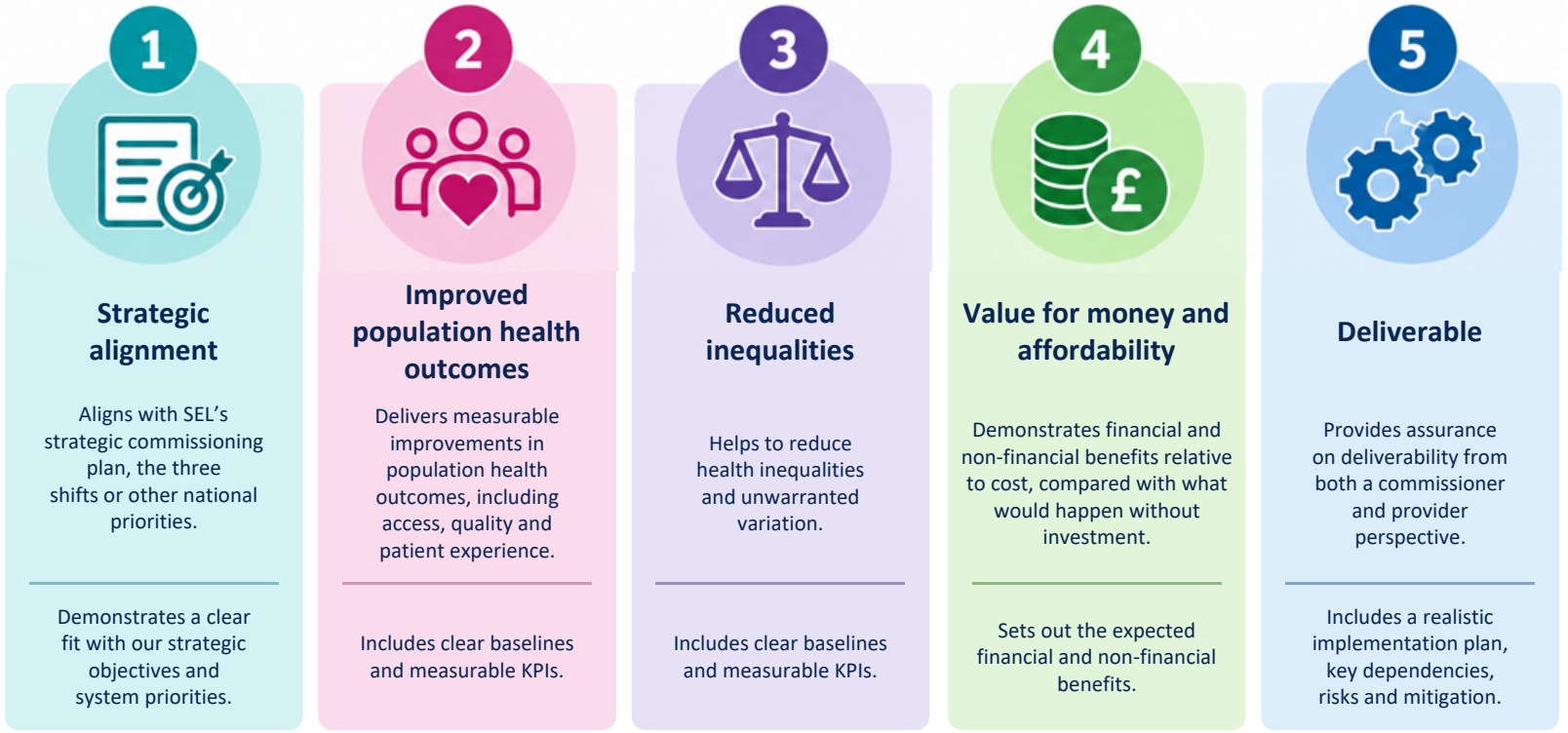
- **Protecting investment in our strategic priorities**
  Financial pressures have historically meant that short-term financial delivery has often taken precedence over investment in longer-term service change. Our SIF provides a means of protecting investment in prevention, neighbourhood care, digital development and acute & specialised service transformation. We need to maintain this investment while strengthening how we prioritise schemes and assess the benefits they deliver. These benefits may include better outcomes, reduced inequalities, improvements in productivity and avoided future costs, as well as cash-releasing savings.
- **Continuing financial recovery across existing services**
  Investment in new models of care does not replace the need for organisations to improve productivity, deliver recurrent efficiencies and address the SEL system's underlying financial deficit. We also need to look critically at our existing expenditure, identifying opportunities to reduce duplication, improve services and change or stop spending that no longer represents the best use of our resources.
- **Connecting investment to changes in demand and costs**
  Investment in prevention and alternatives to hospital care should help us improve outcomes and moderate the growth in demand for more expensive services over time. However, we need to be clear about what we expect each investment to deliver, including the impact on demand, activity and costs across different services. Moving activity out of hospitals does not automatically release equivalent savings. We need to distinguish between avoiding future costs, releasing capacity and making actual reductions in expenditure that can be reinvested.
- **Managing the transition within available resources**
  We will often need to invest in alternative services before existing hospital capacity and costs can be reduced. This may require periods of double-running, and some costs will take longer to remove than others. Our annual financial plans will therefore need to test the impact of investment, efficiency requirements and changes in resource allocation on the ICB and providers. We will need to review the pace of change against evidence of delivery and affordability, recognising both the risks of moving too quickly and the longer-term consequences of repeatedly delaying investment.

Affordability and return on investments

We will maintain affordability by prioritising investment within available financial envelopes, improving productivity across existing services and testing whether investments deliver their expected benefits. In particular we will focus on:

- **Prioritisation:** approve schemes within the available envelope through proportionate business cases and governance, allowing for recurrent commitments and transition costs.
- **Productivity:** improve the value of existing spending, reduce duplication and review lower-value provision.
- **Return on investment:** assess outcomes, inequalities, productivity and financial benefits against what would happen without investment. Count cash savings only where expenditure can genuinely reduce.

We will prioritise investments that best deliver value for our population and support shared ambitions for a healthier South East London



How we will measure delivery and outcomes

We will assess each investment against the financial and non-financial value it is expected to create, compared with its cost and what would otherwise have happened. This can be linked to broader health outcomes as set out in our Strategic Outcomes Framework. Every investment must demonstrate measurable value—but benefits should only be monetised where this can be done credibly. This will broaden the assessment of value beyond immediate cash-releasing savings and will provide a consistent basis for comparing investments, tracking benefits and evidence will inform decisions to continue, adapt or stop investment.

Financial risks and dependencies

Delivery of the 2027/28 commissioning intentions depends on managing demand, transition costs and system financial risk within the available funding envelope.Our plans offer opportunities to improve care and financial sustainability; however, delivery depends on managing the following financial risks and developing the information, capabilities and agreements needed to support change, alongside risks to manage as we test and deliver changes.

- **National guidance changes current assumptions.** Our plans are based on national 3-year allocations plans, beginning in 2026/27. Should guidance and allocations change significantly, we will need to rapidly agree changes to our plans accordingly, whilst maintaining our strategic direction.
- **Underlying financial position across the system**. SEL's legacy underlying deficit requires continued financial recovery through system transformation and recurrent organisational efficiencies. Allocation and pathway changes must support this recovery while maintaining quality. Financial pressures may constrain investment, and provider income may fall before costs reduce. We should assess combined ICB and provider impacts, including double-running and stranded costs, distinguish cash-releasing savings from avoided future costs, and avoid simply transferring deficits. Affordability testing should allow for smaller or later benefits, with review points to adapt or stop investment.
- **Payment reform and our strategic direction.** Payment reform must support the left shift and its population benefits but could reward income generation in services we aim to shift care away from. We need to test national and local arrangements together to ensure they incentivise agreed delivery and better outcomes while managing financial risk across the ICB and providers.
- **Unmet need and inequalities.** Earlier identification and better access could reach people whose needs are poorly met and reduce avoidable deterioration. This may initially increase demand and expenditure rather than release savings. Plans should allow for this, assess who benefits and monitor access and outcomes, so pressure to demonstrate savings does not discourage appropriate care or widen inequalities.
- **Information and capacity.** We need substantially better information to support strategic commissioning, linking spend by patient cohort across settings to need, activity and outcomes. Robust, efficient business-as-usual finance, contracting and reporting must free strategic capacity without weakening operational controls, but also developed to address the complexity of national and local information requirements. We need a clearer picture of current spending, service use and outcomes for different patient groups, so we can judge whether investment delivers the expected benefits.
- **Agreement on resource changes.** Joint working offers opportunities to use resources more effectively across organisational boundaries. However, individual organisations may agree the strategic direction without agreeing the changes to budgets and costs needed to deliver it. We will need agreement on the financial consequences for each organisation, including transition funding and how benefits and risks are shared. Delays could defer savings or prolong additional costs.
- **Consequences of delaying change** will need robust assessment including continued lower-value spending and unmet need, so short-term financial pressures do not repeatedly displace investment in prevention and longer-term improvement.

South East London Integrated Care System

SEL ICB 2027/28 Strategic Investment Fund

Strategic Investment Priorities

- The 2027/28 **commissioning intentions proposed in this paper, translate the direction set out in our five year strategic commissioning plan into a broader programme of work.**
- The question for 2027/28 is therefore not whether the wider commissioning intentions remain priorities, but **where the ICB should use its limited discretionary investment to make the greatest difference**. As set out in the MTFS, the current financial planning assumption is £45m of new recurrent SIF investment in SEL in 2027/28, subject to affordability and final planning decisions.
- The 2026/27 SIF was spread across prevention, neighbourhood care, digital and acute/specialised transformation. The current assessment is that the **portfolio is relatively fragmented and brings a significant overhead** in developing, commissioning and managing individual investments. It is therefore proposed that the 27/28 SIF should aim to concentrate funding on fewer priorities to allow investment at sufficient scale to deliver material change.
- It is proposed that the **following principles inform selection of the priority areas for investment**;
    - **Alignment to our 5yr strategic commissioning plan and commissioning intentions**. Our 5yr plan was signed off in February 2026 and set out strategic priorities around particular population cohorts, overarching delivering priorities focussed around the three shifts in the national plan, and the sustainability of our acute and specialised services. This document remains our strategic guide, so investment priorities should directly link to delivery of the areas set out.
    - **2027/28 should build on, rather than restart, the work begun in 2026/27**. Much of the 2026/27 investment has only recently mobilised, with many schemes beginning delivery during Q2 and some during Q3. The proposed approach provides continuity, allowing the ICB to scale promising models and extend population coverage rather than continually establishing new pilots and areas of focus.
    - **Deliverability needs to be a more explicit part of prioritisation**. The ICB's new organisational structure, the increasing role of integrator partnerships and providers, and the scale of the overall commissioning intentions mean that the system cannot realistically mobilise every potential investment simultaneously. Relative deliverability of initiatives is therefore an important consideration in identifying investment priorities.

Strategic Investment Priorities

- **Work is ongoing to identify and propose priority areas for strategic investment and this will continue over Q3**. Through this process we will ensure interventions are strategically aligned to the five year strategic commissioning plan, deliver a clear improvement in population health outcomes, reduce inequalities, are deliverable and that there is clear return on investment.
- For 26/27, use of the SIF was not agreed until February / March 2026 which led to an element of slippage in funding and impact. We aim to address this for 27/28 by working to the **following timeline to confirm and mobilise investment priorities**:
  - **Strategic commissioning committee in December** – discussion and review of proposed areas for strategic investment
  - **ICB Board meeting in January** – sign off of proposed areas for strategic investment
  - **Over Q4** – mobilisation of agreed areas for investment
  - **April 2027** – Go-live of funded priorities to maximise in year impact in 27/28

NHS
South East London

Committee Update – Audit, Risk & Assurance Committee

Agenda item: 5.2

Executive Lead: Dinah McLannahan

Report by: Mike Parkinson, Committee Chair

Paper type: Information

Conflicts of Interest: None identified

1. Purpose and recommendation

The purpose of this report is to provide to the Board an update on the activity of the Audit, Risk and Assurance Committee, including decisions made, since the last Board meeting.

The Board is asked to:

- **Note** the discussions and assurance received by the Audit, Risk and Assurance Committee.
- **Note** the decisions and outcomes detailed in section 5 of this report, including the decision made by the Auditor Panel, under its delegated authority, in relation to auditor contract extensions.

2. Background and context

Since the Board meeting on 22 July 2026, the Audit, Risk and Assurance Committee (ARAC) has met once, on 27 October 2026. This was the first meeting of the Committee with the new membership and remit set out in the Terms of Reference agreed by the Board in July.

The Committee comprises three non-executive directors. Standing attendees include the Chief Finance and Compliance Officer (CFCO), the Director of Corporate Affairs, and representatives from the partner agencies: Grant Thornton (external audit), RSM UK (internal audit) and TIAA (counter fraud services).

3. Activity undertaken

The October 2026 meeting covered the following items:

Future planning and response to the new governance arrangements
The committee considered and acknowledged the contents of the revised Terms of Reference.

Discussion took place on proposals for the future risk management framework, noting work was required with the Board to agree a risk appetite statement, ensure risks were linked with corporate objectives, and to ensure the framework supported the Board in giving its focus to the principal risks genuinely requiring Board attention.

The Chief Finance and Compliance Officer (CFCO) updated the Committee on plans to review and revise the ICB's Freedom to Speak Up (FTSU) arrangements, maintaining FTSU visibility while providing proportionate support to staff.

Partner reports
Reports were received from external audit, internal audit and counter fraud partners. All three partners confirmed their audit workplans were on schedule.

RSM highlighted the reasonable assurance assessment received from a recent cyber security audit noting the ICB had established a strong cyber security control environment but emphasising the need for ongoing vigilance by the ICB teams. Some additional areas of opportunity were identified around privilege access to infrastructure, management of user access following staff changes, and alignment of password standards to current National Cyber Security Standard recommendations. The one medium priority area was noted as immediately addressed by management during the audit with only one low action outstanding at the point of the reports production.

A discussion took place on the prioritisation of internal audit work between ADHD and Section 117 processes, following a management proposal to replace the ADHD review with a Section 117 review. The committee requested further explanation on the rationale for the decision to provide assurance that the focus was correctly prioritised.

RSM also highlighted a paper on the approach to ensuring internal audit work between SEL and SWL was not duplicated.

TIAA promoted international fraud awareness week and the current work on mental health activity.

Governance and assurance
The CFCO presented proposed further amendments to the Scheme of Reservation and Delegation (SoRD), distinguishing these from the version approved by the Board in July 2026. The amendments were described as largely legislative or clarificatory. The Committee agreed escalation to the Board for final approval. The version for approval is included as part of the Governance Report presented to Board.

The Committee received the financial governance report, recognising the achievements of the finance team to meet its Key Performance Indicator targets and reporting any write offs, special payments, bad debts and tender waivers. The members discussed the highest aged debtors and what was required to resolve these. Given the majority of oldest debts related to partner organisations it was proposed that the finance team work with the Place Executive Leads to contact local partner colleagues to identify and

resolve any blockers to payment. Four tender waivers were noted as being approved in the reporting period.

4. Part 2 meeting (Auditor Panel) – contract extensions

In Part 2, with external partners excluded, members considered a proposal to extend the Grant Thornton, RSM UK and TIAA contracts to align their end dates across SEL and SWL. The proposal was approved. It was confirmed that the members, acting in their capacity as Auditor Panel, had authority to approve the appointment of the auditors for the extension period, as per the current Scheme of Reservation and Delegation, without the need for onward referral to Board.

5. Decisions and Outcomes

The following outcomes were agreed by the Committee:

- Committee responsibilities as laid out in the Terms of Reference were **noted and accepted.**
- The proposed risk management operating model and approach to exploring risk appetite was **endorsed.**
- Amendments to the Scheme of Reservation and Delegation were **noted and agreed** for escalation to the Board for final approval.
- Actions to follow up on aged debtors were **agreed**.
- Extensions to the Grant Thornton, RSM UK and TIAA contracts were **approved** by the Auditor Panel.

NHS
South East London

Committee Update – Patient Safety Committee

Agenda item: 5.3

Executive Lead: Elaine Clancy, Chief Nursing and Quality Officer

Report by: Anu Singh, Committee Chair

Paper type: Information

Conflicts of Interest: None identified

1. Purpose and recommendation

The purpose of this report is to provide to the Board an update on the activity of the Patient Safety Committee, including decisions made, since the last Board meeting.

The Board is asked to:

- **Note** the items of discussion
- **Note** the outcomes of the discussions by the Committee members.

2. Background and context

Since the last meeting of the Board on 22 July 2026, the Patient Safety Committee (PSC) has met once. This was the first meeting of the committee since its terms of reference were agreed by the Board at its July meeting.

Membership comprises two non-executive directors, the ICB Chief Nursing and Quality Officer, and the ICB Medical Director, with standing attendance by the Deputy Chief Nurse and Director of Quality.

3. Activity undertaken

The November 2026 meeting covered the following items:

Future planning and response to the new governance arrangements
The Committee members discussed the terms of reference, particularly the membership detailed. In alignment with the discussion at the SWL Patient Safety Committee, it was proposed that some additional members were added to ensure representation from medicines optimisation and system partners. The terms of reference were adopted with a note that further amendments may be required as arrangements mature.

Annual reports
The members received the Safeguarding annual report, noting good evidence of partnership working despite a partial assurance outcome. Compliance on statutory and training responsibilities was noted and key risks and emerging issues discussed. Challenges presented by less resources were noted and the Chief Nursing and Quality Officer highlighted the importance of Board colleagues remaining curious around Thirlwall recommendations.

Thirlwall Update
The committee received an update on the outcomes of the Thirlwall Inquiry, which identified learning from the Lucy Letby case. The implications for the ICB from the recommendations were discussed especially the need to connect learning from deaths and Freedom to Speak Up work, with an emphasis on a system response rather than it being seen as a safeguarding only issue.

Subject matter updates
The committee received updates from the Quality and Nursing teams as follows:

- Local Maternity and Neonatal Service – noting recent media attention on maternity, and the expected publication of a national action plan. All providers had been benchmarked against a 10 point plan, with an audit on maternity triage underway. The member discussed any challenges concerning the increased rate of c-sections and impact on theatre capacity.
- Learning Disabilities and Autism LeDeR – the members were updated on the reviews completed in quarter 2 and the resultant learning. Positive practice was noted around patient centred care. Key themes of focus had been identified in the annual report with escalation at a local level having best effect to embed and share learning. Work on education, awareness and training to reduce missed opportunities on flu vaccination, key screening and early intervention was needed.
- The quality and safety report noted provider winter challenges and completion of a paediatric audiology report. Never events were highlighted, and any infection, prevention and control issues raised. The importance of ensuring quality governance was incorporated in commissioning cycle discussions was emphasised. It was agreed that patient experience, clinical effectiveness and system working also needed to be included. The committee chair emphasised the need to ensure patient voice was included on the committee.

4. Decisions and Outcomes

The following outcomes were agreed by the Committee within their own scope of responsibility:

- Committee responsibilities as laid out in the Terms of Reference were **noted.** Membership would be reviewed and amended for recommendation to the Board.

NHS
South East London

Committee Update – Neighbourhoods Strategic Delivery Committee

Agenda item: 5.4

Executive Lead: Ed Waller, Chief Commissioning Officer

Report by: Paul Najsarek, Committee Chair

Paper type: Information

Conflicts of Interest: None identified

1. Purpose and recommendation

The purpose of this report is to provide to the Board an update on the activity of the Neighbourhoods Strategic Delivery Committee, including decisions made, since the last Board meeting.

The Board is asked to:

- **Note** the items of discussion
- **Note** the outcomes of the committee discussions

2. Background and context

Since the last meeting of the Board on 22 July 2026, the Neighbourhoods Strategic Delivery Committee (NSDC) has met once. This was the first meeting of the committee with the new membership and remit determined in the terms of reference (ToR) agreed by the Board at its July meeting.

Membership comprises one non-executive director (as co-chair), a local authority representative (as co-chair), the ICB partner member for primary care, the ICB medical director, the Chief Commissioning Officer (proposed as an addition in revised ToR), Director of Delivery for Neighbourhoods and Population Health, and other colleagues representing strategic commissioning, public health, mental health, and the VCSE.

3. Activity undertaken

The October 2026 meeting covered the following items:

Future planning and response to the new governance arrangements
Committee members considered the terms of reference for the committee and the scope of their responsibilities, noting their accountability to the Board and residents, and the importance of ensuring neighbourhood working was effective. The members also discussed the importance of the relationship between the committee, strategic commissioning, place-based decision making and the work of the Health and Wellbeing Boards. The committee proposed seven place representatives should be members, with four from integrator organisations and three ICB Place Executive Leads (PEL). From this cohort, a minimum of four, of which one should be a PEL, should be the quoracy requirement.

The committee chair will be meeting with relevant local authority members of the Committee separately to discuss who is best placed to co-chair the Committee, and whether further development of local authority membership is needed.

Ways of working for the Committee were also discussed, recognising the importance of a proactive approach to the Committee's work. There was an acknowledgement that this would evolve over time.

Programme planning
The committee received an overview of the national, London and south east London context for neighbourhood health; the system journey and decisions to date; current delivery arrangements, priorities and enablers; and the proposed direction for 2026/27 and 2027/28. Noting that delivery was currently moving from pilots to systemic spread, this aimed to establish a common baseline for the Committee and to support an initial discussion on priorities, the Committee's role, its forward plan and the shared leadership and accountability required to accelerate delivery. Securing a collaborative approach across all partners at the Committee was a key theme of the discussion and it was agreed the future agendas could be used to support this.

Delivery report
A regular report to be delivered to the Committee will be the delivery and insights report. The first iteration was presented at the October committee, with members providing input to help develop future reports. The members noted the credible progress made in line with expectations, although there was some significant variance across boroughs.

It was noted that performance on key in year metrics was often very different across boroughs and neighbourhoods. The Committee agreed for Place recovery plans to be developed where necessary.

Currently the committee has data to inform assurance on the short-term objectives of neighbourhood care but has more work to do to offer assurance on strategic objectives.

4. Decisions and Outcomes

The following outcomes were agreed by the Committee within their own scope of responsibility:

- Committee responsibilities as laid out in the Terms of Reference were **noted and accepted.**
- Progress with programme planning and delivery was noted.

NHS
South East London

Committee Update – Joint Transition Committee

Agenda item: 5.5

SRO Lead: Ben Luscombe, Director of Corporate Services

Report by: Georgina Fekete, Committee Chair

Paper type: Information

Conflicts of Interest: None identified

1. Purpose and recommendation

The purpose of this report is to provide to the Board an update on the activity of the Joint Transition Committee, including decisions made, since the last Board meeting.

The Board is asked to:

- **Note** the items of discussion.
- **Note** the outcomes of the discussions.
- **Note** that the Board took a decision based on the Committee's recommendation on 30 September to approve the transfer of the estates function from the SEL ICB to Guys and St Thomas's NHS Foundation Trust (GSTT) and Oxleas NHS Foundation Trust.
- **Consider the decision,** based on the Committee's recommendation, regarding delegation of Lewisham neighbourhood development functions to Lewisham and Greenwich NHS Trust (LGT).

2. Background and context

Since the last meeting of the Board on 22 July 2026, the Joint Transition Committee (JTC) has met four times.

Membership comprises three non-executive members, the ICB Chief Finance and Compliance Officer, and the ICB Chief People Officer, with standing attendance by the Director of Corporate Services as joint ICB change programme SRO.

3. Activity undertaken

4 August 2026

The August meeting discussed the transfer of the Lewisham Neighbourhood team to Lewisham and Greenwich NHS Trust (LGT), staff appeals, and programme updates.

Key assurance issues to **note** were:

LGT transfer

- The report gave assurance on the proposed timeline for transfer, the sign off process, and mitigation of risks.
- Agreement of KPIs and identification of consistent and complete documentation across transfers for integrators was discussed, and the Committee asked for some insight into the improvements or different ways of working that would evolve as a result of the new arrangements.

Staff Concerns

- The Committee received an update on Employee Relations cases specifically resulting from the Change Programme and received assurance that these cases were being progressed in line with organisational policy. The themes driving the appeals were also discussed.
- The SROs confirmed a lessons learned process had been adopted within this phase which identified consistency of policy, use of subject matter experts and impact of clustering as key themes.

Programme update and risks

- Progress against the programme plan was confirmed, with a request for risk scores to be reviewed and consolidated across the SEL and SWL cluster.

1 September 2026

The Joint Transition Committee discussed the status of the change programmes which were reported as being on track, noting risks relating to the payroll provider and HR capacity that are being mitigated. The Committee discussed the transition plan and the learning review, including suggesting a dedicated Board lessons learned session on the change programme.

Key assurance issues to **note** were:

Programme update and risks

- SEL and SWL change programmes were reported as being on track, with ring-fenced interviews taking the place at the time of the Committee.
- The main risks outlined were: i) the risk of a gap in provision of payroll by NECS CSU which the CPOs were working to mitigate; ii) shortage of HR capacity to manage the change programme - additional support has been secured for SWL and was under discussion for SEL and iii) a small number of grievances that were being reviewed.

Transition Plan

- A transition plan was shared focusing on the phased implementation of team structures, support to staff and knowledge capture.

- Following a discussion, the Joint SRO confirmed that amendments to contracts for those staff in joint posts would be needed to ensure legal certainty in terms of management responsibilities (both financial and staffing wise).
- The Committee also asked for assurance regarding knowledge transfer between current and future HR hosted functions.

Lessons Learned Review Process

- A proposal for capturing lessons learned during the change programme was shared, which will aim to understand stakeholder experiences, success factors, barriers, unintended consequences and put forward practical recommendations and a "playbook" for future change management programmes.
- The Committee welcomed a focus on learning, and sought clarification on the rollout, timing, qualitative data and suggested holding Board lessons learned session.

29 September 2026

Committee members discussed transition of workforce data and received change programme and operating model design updates.

Key assurance issues to **note** were:

Programme update and risks

- Programme remained on track with ringfencing and transfer of functions processes commenced. VSM at risk business cases had been approved by NHSE and compulsory redundancy for Agenda for Change staff would be going to Remuneration Committees at the end of October.
- The risk for payroll provision was discussed, with assurance that mitigations were appropriate and residual risk sat with the previous provider.

Operating Model

- The Committee noted a joint Board session was planned for 7 October 2026 to discuss the proposed operating model for the SEL/SWL cluster, with the approach that cluster first/ strategic commissioning would be at the centre of the organisation.
- The Committee discussed the principles of the operating model, clarity on what clustering means in practice, and the importance of landing decision making at the right level and achieving a cultural shift to achieve that.
- The Committee noted that engagement with Trade Unions was ongoing.
- No objections had been received from members concerning the management response to the CoSOP consultation on the transfer of the estates function to GSTT and Oxleas NHS Foundation Trust. It was therefore recommended to the Board.
- Note that the Board subsequently met on 30 September 2026 and approved the recommendation to transfer the estates function from SEL ICB to GSTT and Oxleas NHS Foundation Trust.

3 November 2026

The November meeting had a focus on the delegation of Lewisham neighbourhood development functions to LGT, plus a consideration of the Equality Impact Assessment (EIA), the financial impact of the transition programme, as well as the usual programme update.

Key assurance issues to **advise**, to support a recommendation for Board approval, were:

LGT transfer

- The Committee received the formal documentation to review the proposed delegation of budget and staff from the Lewisham neighbourhood team to LGT, acting as host integrator for Lewisham. Functions were noted as intending to transfer on 1 April 2027 and the Committee were asked to consider progression to the next stage of CoSOP.
- Additional assurance was sought around capacity and performance risks, and arrangements for monitoring performance and intervening if delivery was not effective, as well as LGT's capacity and capability and the current NHS oversight framework position and provider maturity assessment.
- Progression of the delegation to CoSOP was recommended, subject to some amendments and receipt of capacity evidence before referral to the Board for decision.

Key assurance issues to **note** were:

Financial review

- The committee received an update on the financial effect of the change programmes, noting sufficient non-recurrent mitigations for 2026/27 and assurance on funding to cover the compulsory redundancy stage of the change programme. Work on establishment costs and comparison to the nationally mandated ICB running cost limit was ongoing.

Equality Impact Assessment

- The committee received confirmation an equalities impact assessment had found no evidence of systemic disproportionate impact or unlawful discrimination associated with protected characteristics on the workforce across the change programmes.
- The Committee discussed that there were very small shifts in the proportion of global majority, disabled and female staff and particular age groups in SEL ICB which reflect the new structure of the ICB to fulfill its functions. Continuing monitoring was requested with further analysis and assurance on reasonable adjustments and support provided to disabled staff and those on maternity/paternity leave. A final EIA was requested once the change programme has been completed.

Programme update and risks

- The Committee received programme and HR updates, confirming the programme was progressing on timetable with compulsory redundancy business cases submitted to NHS England for approval and outplacement and colleague-support arrangements in place. Mitigations for any approval delays were in place. Comparative sickness absence data, pre and post change, was requested.

Appendices and supporting information

Appendix 1: Lewisham delegation function transfer checklist

South East London Integrated Care System

Transfer of Functions workstream: Process, Timeline, Transfer Checklist & Transition Committee ToR questions

[SEL ICB Lewisham delegation to Lewisham and Greenwich Trust (LGT)]

3rd November 2026

Version 5

Purpose

The purpose of this document is to

1. Update the Joint Transition Committee on recommendations in relation to the updated transfer of functions checklist. Recommendations include

    - Approve – low risk
    - Approved – medium to high risk with mitigations
    - Not approved

2. To seek the Joint Transition Committee's approval to proceed with the Lewisham delegation and initiate the Cabinet Office Statement of Practice (COSoP) process, and to provide assurance that the necessary due diligence, governance and transition arrangements are being progressed to support a safe and controlled transfer.

Following recommendations from Transition Committee held on 4th August 2026, the following activities have been updated or since undertaken.

- **Transfer of Functions Checklist**
- **Delegation Agreement**
- **Service Specification**
- **Evaluation & KPIs**
- **Lessons Learnt**
- **Audit Legacy Requirements**
- **Formal letter confirmation from CEOs Andrew B & Ben T**
- **Implications for Lewisham Population**
- **Key Lines of Enquiry (KLOE)**
- **COSoP Operational Plan and staff consultation plan**
- **Equality Impact Assessment**

Transition Committee Recommendations – 4th August 2026

Following review of the checklist by the Transition Committee on 4th August 2026, the following recommendations were made.

1) **Undertake an Equality Impact Assessment (EIA) –** Completed and approved. This will be reviewed again in Q4 ahead of submission to the ICB Board.

2) **Ensure Information Governance / DPIA and Digital, Data and Information (DDI) requirements in place and progressing**

- A task and finish group with leads across ICB and LGT has been established and is meeting bi-weekly.
- A joint Digital, Data and Information mapping / due diligence exercise has been undertaken to identify all data, system, access and information governance dependencies.
- A DDI migration plan will outline agreed migration, access, testing and contingency arrangements to be implemented prior to delegation to maintain business continuity and ensure appropriate information governance.
- The draft DPIA will be finalised and approved in Q4 ahead of submission to the ICB Board.

Key stages for transfer of Lewisham NHD Team and its delegated functions

South East London Integrated Care System

Stage 1
(Jan-Apr'26)

Scope and initiation

- Initiate process for agreeing in principle the transfer of the Lewisham Neighourhood team and its functions to the integrator host LGT
- Set up working group for overseeing the delivery of the delegation programme

Stage 2
(May-Sept'26)

Engagement and Development

- Engage with key stakeholders across the partnership to develop a shared understanding of the delegated functions, how the transfer will work in practice and how the functions will be evaluated and monitored effectively as a partnership.
- Engage with key leads (HR, contracting and procurement, finance, Communications) to determine scope key requirements
- Develop service specification and delegation agreement detailing the staff and functions to be delegated based on engagement.
- Submit to ICB Transition Committee a completed checklist for review on 18 Aug'26 to consider proposed transfers / give recommendations.

Stage 3
(Oct-Dec'27)

Approval and Sign off

- Transition Committee (3rd Nov) to review final checklists ahead of formal sign off.
- Finalise and seek formal approval of the Delegation Agreement, associated schedules and service specification
- Ensure overarching staff transfer (CoSoP) principles are understood and COSoP initiation documentation is approved.
- Agreement across ICB and LGT confirmed
- Initiate COSoP process following formal approval.
- Staff consultation

Stage 4
(Jan-Apr'27)

Mobilisation & Transfer

- COSoP management response report completed (Jan'27)
- Mobilise operational requirements for transfer of staff (Jan-Mar'27)
- Final approval of delegation agreement and agreement to transfer (Feb-Mar'27)
- Transfer complete (31st Mar'27)

GOVERNANCE

Timeline (overview)

South East London

2026

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec

2027

Jan	Feb	Mar	Apr

Initiation and project scope

Legal support

Service Specification Development & function requirements

Partnership engagement / Workshops

Approval

Approval to proceed

1. **Delegation Agreement**
2. **Service Specification**
3. **Evaluation & KPIs**
4. **Lessons Learnt**
5. **Audit Legacy Requirements**
6. **Formal letter confirmation from CEOs Andrew B & Ben T**
7. **Implications for Lewisham Population**
8. **Key Lines of Enquiry**
9. **COSoP Operational Plan and staff consultation plan**
10. **Equality Impact Assessment**

Mobilisation / Implementation

COSoP process

- Compilation of consultation documents/materials, including 'measures' from receiver organisations
- Staff engagement (pre-during, post consultation)
- Staff consultation (30th Nov'26 – 8th Jan'27)
- Consultation outcomes, appeals, formal correspondence to in-scope staff

Finalise / implement Operational requirements (BAU functions. estates, IT requirements (emails, assets, access to receiver IT infrastructure etc)

- Maintenance of BAU through transfer and post-transition arrangements for running of service, line management etc.
- Engagement with staff and interdependent services
- Governance requirements, including (but not limited to) EIAs, DPIAs, IARs
- Practical staff and service transfer requirements e.g. transfers of service files, integration/transfer of systems, double/parallel running of systems, physical transfers of equipment/assets etc.

Approval

ICB Board in public

LGT Board in public

Delegation Agreement Signing

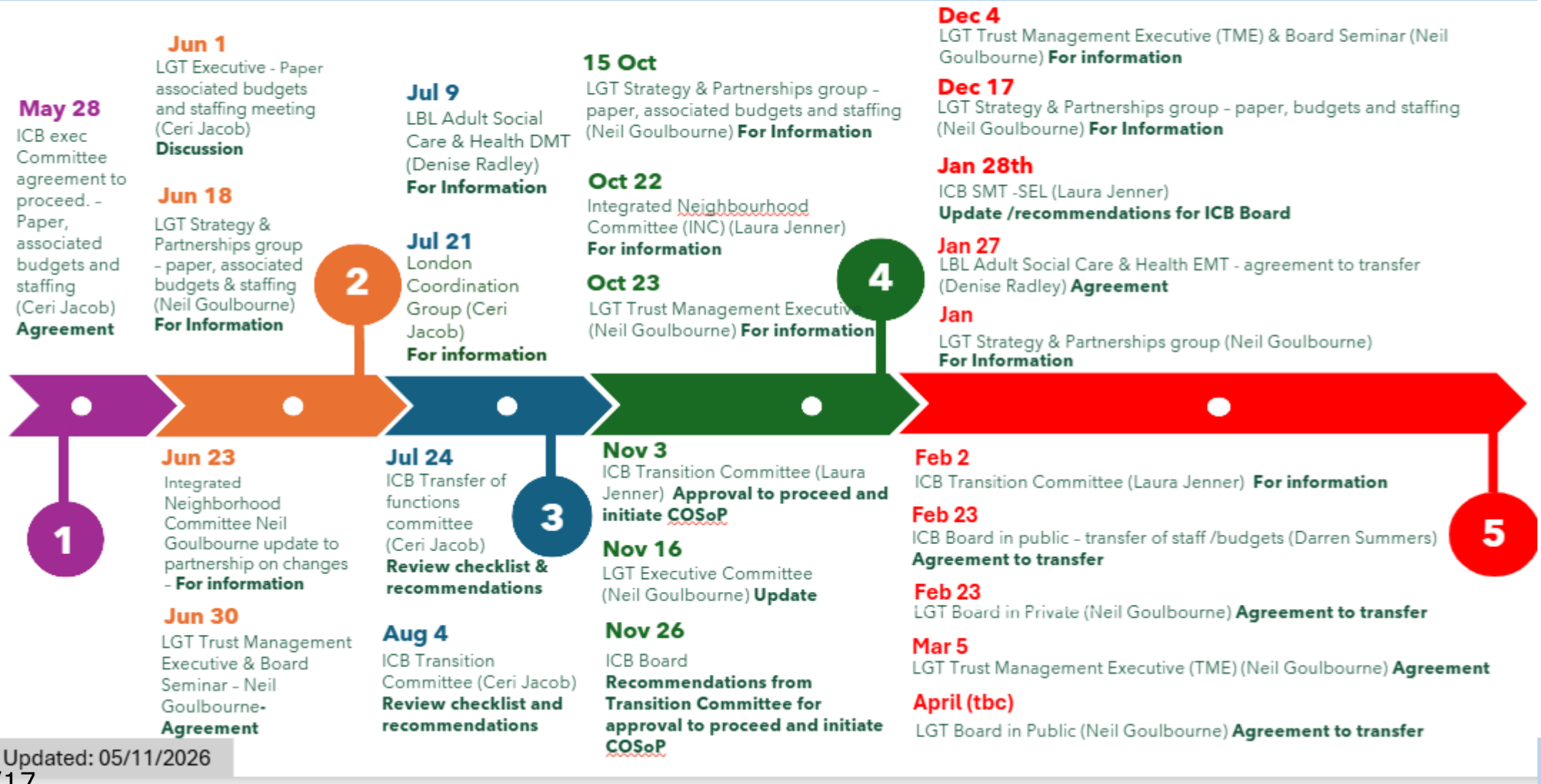
Go Live

Communications (Staff, Partnership, Stakeholders and population)

Lewisham Delegation - Governance Process

South East London Integrated Care System

Governance timeline Sign off Delegation – ICB Neighbourhood team and associated budgets (May 2026-April 2027)



Updated: 05/11/2026

Lewisham Neighbourhood Development Team - function transfer checklist (page 1 of 8)

Question	Response	Recommendation to the Transition Committee
Does the function being transferred fall within the list set out in the 2025 ICB Blueprint?	Yes, this aligns with the 2025 ICB Blueprint strategic commissioner model and the transfer of primary care development/ neighbourhood and place-based partnership functions to providers. The London Target Operating Model has identified **the need for an "integrator" function** to support neighbourhood-level collaboration and coordination The 10-Year Health Plan has set out plans to move care closer to people's homes through **neighbourhood-based, preventative and coordinated care models**	Approve – low risk
Has the function specification, including the operating model and associated resources, been agreed as deliverable with the lead director in both the sender and the receiver organisation?	• The service specification sets out the scope, operating model, outcomes, governance and resources for hosting the Lewisham Neighbourhood Development Team and budgets. • Provider lead is LGT, commissioner lead is SEL ICB. Total value of transfer is £2,898,018 (based on 2026/27), including £1,828,662 budget costs and £1,069,356 staffing costs. • Staff transfer (approximately 11 staff) is subject to COSoP transfer process including staff consultation; only SEL ICB-employed staff transfer to LGT. • Function review is via agreed KPIs, delegation agreement reporting, regular commissioner/partnership reporting and contract/governance meetings via an agreed evaluation framework. • A delegation agreement will outline roles and responsibilities of LGT as the host supported by detailed schedules across function areas to provide clarity on roles of LGT, strategic commissioners and the wider partnership. • Formal letter confirmation from CEOs Andrew Bland (SEL ICB) and Ben Travis (LGT) received	Approve – low risk
Does the value of the function achieve the savings target assigned to it?	Not applicable	Not applicable

Lewisham Neighbourhood Development Team - function transfer checklist (page 2 of 8)

Question	Response	Recommendation to the Transition Committee
What are the benefits to the ICB of transferring the function?	The ICB Blueprint strategic commissioner model enables ICBs to focus on population health strategy, resource allocation, outcomes, and system leadership, while transferring operational transformation functions to organisations closer to delivery. The transfer of primary care development, neighbourhood development and place-based partnership functions to provider-hosted integrator arrangements supports the development of a Neighbourhood Health Service, strengthens partnership working across providers and local authorities, improves support to general practice, and creates clearer accountability for delivery while allowing the ICB to retain strategic oversight and assurance 1. **Delivery closer to patients and communities -** Provider-hosted teams are embedded within neighbourhoods and can work directly with GP practices, PCNs, community services, mental health providers, local authorities and VCSE organisations. This enables faster implementation of neighbourhood health models and more responsive service redesign 2. **Stronger integration across organisations -** In Lewisham, the proposed Integrator model brings together LGT, General practice and PCNs, LBL, SLaM and VCSE partnerships that form the Lewisham Partnership. This creates a single delivery infrastructure capable of coordinating neighbourhood transformation across organisational boundaries 3. **Improved primary care support -** Neighbourhood development teams can work directly with practices on Access improvement, Workforce resilience, Digital transformation, Population health management, Local contracts and primary care development allowing support to be more operationally responsive and aligned to local need. 4. **Better delivery of the Neighbourhood Health Service -** The transfer is explicitly linked to the NHS 10-Year Plan and the establishment of a Neighbourhood Health Service. Provider-hosted neighbourhood teams are expected to be better positioned to Coordinate multidisciplinary teams, Reduce avoidable hospital use, Support frailty pathways, Improve proactive care and address health inequalities at neighbourhood level 5. **Clearer accountability for operational delivery** The model separates**:** Strategic commissioning responsibilities (ICB) and Operational delivery responsibilities (providers), reducing duplication and clarifies who is responsible for planning versus implementation. 6. **Greater local partnership convening power -** benefits include strengthened delivery through the Lewisham Integrator partnership, Closer alignment with neighbourhood priorities, Improved convening of local partners, Better support for integrated care and GP access improvement, Stronger focus on population health and health inequalities. 7. **Benefits for residents and patients** - the main benefit is that services become more organised around the needs of local people rather than around NHS organisational boundaries including better access to care closer to home, more joined up services, improved access and primary care resilience, reduced health inequalities, more preventative and proactive care, better outcomes for frail and vulnerable residents,	Approve – low risk

Lewisham Neighbourhood Development Team - function transfer checklist (page 3 of 8)

Question	Recommendation to the Transition Committee	Recommendation to the Transition Committee
What interfaces with other functions have been identified, have the associated risks been identified and are mitigations in place?	**Key interfaces** are critical to the successful operation of the transferred neighbourhood and primary care development functions • **SEL ICB strategic commissioning and primary care teams** – retaining responsibility for strategy, commissioning decisions, resource allocation and assurance • **Lewisham and Greenwich NHS Trust (LGT)** – as the host provider organisation responsible for operational management of the transferred function. • **London Borough of Lewisham** – particularly in relation to neighbourhood development, population health and integrated care planning. • **General Practice and PCNs** – supporting primary care development, access improvement, workforce resilience and neighbourhood delivery. • **Voluntary, Community and Social Enterprise (VCSE) organisations** – supporting population health and community-based service delivery. • **South London and Maudsley NHS Foundation Trust (SLaM)** – particularly around integrated neighbourhood and mental health pathways. • **Public Health teams** – supporting prevention, health inequalities and population health management. • **Urgent and Emergency Care, Virtual Ward and Home First programmes** – ensuring alignment with wider community-based care transformation. • **Supporting corporate functions** including business intelligence, digital, estates, workforce and finance teams. • **Lewisham Integrator Partnership governance arrangements** – providing place-based oversight and coordination across the partnership. **Risks** • Unclear responsibilities and accountabilities following transfer. • Loss of strategic alignment between provider-led delivery and ICB commissioning intentions. • Disruption during transition, including staff transfer and programme continuity risks. • Potential gaps in governance and reporting arrangements if responsibilities are not clearly defined. • Dependencies on multiple partners across health, local authority and voluntary sector organisations requiring effective coordination **Mitigations** • A formal service specification and delegation agreement setting out scope, outcomes, responsibilities and resources. • Regular commissioner-provider oversight meetings, governance meetings and performance reporting arrangements • Agreed KPIs and assurance mechanisms to monitor delivery and outcomes. • Continued strategic commissioning oversight by SEL ICB, including responsibility for resource allocation and strategic planning. • Partnership governance through the Lewisham Integrator arrangements, ensuring collaborative decision-making across organisations. • A requirement to maintain integrated pathways of care and operate within the SEL ICS Neighbourhood Development Framework. Committee-Ready Response • Will have identified staff members with honorary contracts in place to enable joint working with the commissioning teams.	Approve – low risk

Lewisham Neighbourhood Development Team - function transfer checklist (page 4 of 8)

Question	Response	Recommendation to the Transition Committee
What risks to delivery of the function have been identified and are mitigation actions in place?	**The primary risk relates to contracting and procurement and associated Standing Financial Instructions (SFI).** • **Risk:** Currently, differences between LGT and ICB Standing Financial Instructions would require additional procurement processes for General Practice and VCSE arrangements, creating potential delays and disproportionate administration for short-term, low-value service provision. • **For context,** The arrangements associated with the delegated budgets comprise a range of relatively small-scale and developmental funding arrangements, including MOUs, SLAs and other agreements with General Practice, PCNs and other partners. Funding is non-recurrent with a short-term duration. Examples include primary care training and development, Protected Learning Time, health inequalities initiatives, primary care transformation, workforce development/flexible staffing and digital change support. These arrangements are often established to support time-limited or developmental activity rather than as substantive recurrent commissioned services and are non-health services. Current arrangements are generally made through direct award, as they predominantly relate to non-healthcare services where there is typically only one provider with the capability, local infrastructure or established role to deliver the required activity e.g. Lewisham Practices / PCNs or local Voluntary organisations. • **Mitigating Action**: SEL ICB and LGT leads are reviewing processes, LGT are willing to adopt a similar approach to the ICB, final process being developed **Additional risks relate to** • unclear roles, budgets, delegated authority roles and responsibilities, data/IG, interfaces with primary care/secondary care/LBL, and continuity during transfer .**Mitigations** are addressed through the delegation agreement, governance arrangements, KPIs, finance reporting, partner governance and transition planning. • maintaining continuity within available resources, dependency on partner contributions to shared capacity, developing KPIs and governance, budget management/process, staff transfer/induction, evolving reporting requirements. **Mitigations** include agreed scope and service standards, regular KPI and impact reporting, quarterly budget monitoring, Partnership Board/contract governance, COSoP compliance, and ongoing agreement with LGT and the wider partnership. • The transfer of staff from the ICB to LGT may create a gap in strategic commissioning capacity and expertise at place, potentially impacting the ICB's ability to maintain strategic oversight, system planning and commissioning responsibilities. **Mitigations:** Transferred staff will continue to be co-located with the remaining ICB Place team and attend relevant ICB meetings, supporting continuity, shared intelligence and close working relationships. Additional ICB priorities that may be requested will be supported by the Neighbourhood Team. Several transferred staff will retain access to relevant ICB systems and continue to work in a joint capacity across LGT and the ICB, helping to maintain strategic commissioning knowledge, relationships and continuity at place. Regular meetings between the **ICB and LGT** will provide a formal mechanism to identify any emerging gaps in strategic commissioning capacity or provision and agree appropriate action where required.	Approve – medium risk with mitigations (see response column)

Lewisham Neighbourhood Development Team - function transfer checklist (page 5 of 8)

Question	Response	Recommendation to the Transition Committee
Have all risks to delivery of the function during transfer been identified and mitigated?	Risk register in place and reviewed by Lewisham Transfer Group – see below examples	Approve – medium risk with mitigations (See response column)

Ref	Risk	Category	Ongoing controls	Assurances
R1	If the primary care team and the primary care development budget are transferred to the Trust, there is a risk that partners—particularly general practice—may perceive this as a shift in ownership and influence away from the wider system. This could lead to a loss of confidence in the INT partnership model, reduced engagement from primary care, and a weakening of collaborative working across the neighbourhood teams.	Primary Care	• Co-design a shared governance framework with all INT partners—including PCNs and practices—prior to any transfer. • Provide transparent communication on roles, accountability, and how primary care voice will be preserved. • Maintain clear separation between operational delivery and strategic primary care development oversight • Regular partnership assurance reviews to monitor trust and engagement levels	• Primary Care invited to workshop to go through detail • LJ to hold regular meeting with PC leads re the transfer
R2	There is a risk that **Lewisham & Greenwich Trust (LGT) governance processes**, which can be highly bureaucratic and require multiple approval steps, may **delay budget sign-off** for primary care or INT-related work. This could slow delivery, create operational bottlenecks, and reduce the ability of the programme to respond flexibly to system needs.	Governance	• Delegate the budget to the INC Committee, with clear delegated financial authority to approve spend within the agreed development envelope. • Require a short, light-touch business case for each allocation to ensure transparency, auditability, and alignment with system priorities. • Establish a streamlined approval route that avoids duplication between Trust and system governance. • Maintain regular monitoring and reporting to ensure compliance with financial controls.	• LJ and AOS meeting with governance and finance leads at LGT to ensure that the funding is ringfenced and decisions are delegated to execs
R3	There is a risk that payments to providers could be delayed as a result of LGTs internal processes	Finance	• Review of contracts to be transferred over in a phased approach to minimise impact • Finance leads invited to TP meetings to discuss processes SEL team included in group discussions	• Regular working group between finance (LGT and ICB) to review the contract line by line and determine the payment methods

Lewisham Neighbourhood Development Team - function transfer checklist (page 6 of 8)

Question	Response	Recommendation to the Transition Committee
Has a function review/contract review approach been agreed?	• Bi-weekly Delegation transfer group to ensure delivery of delegation programme. • Workshop with partnership organisations and wider stakeholders to engage on developing a shared understanding of the delegated functions and how the transfer will work in practice; and to explore how we evaluate and monitor the delivery of those functions effectively as a partnership. • Reviews will be undertaken through agreed KPIs and reporting requirements using the agreed evaluation framework detailed in the delegation agreement. • Frequent progress and impact reports will be submitted to ICB commissioners, the Health and Wellbeing Board, partner Boards and the Lewisham population. Finance review includes quarterly budget monitoring to the Neighbourhood Contracting Meeting and annual value review/uplift. • **2027/28 will be treated as a transition year**, with the delegation arrangements monitored regularly by the ICB to ensure the safe and effective transfer of functions, identify emerging risks or gaps, and agree corrective action where required. • **LGT will develop and maintain a transition and delivery plan** setting out how the delegated functions will transfer and be delivered, including key milestones, responsibilities, workforce arrangements and governance. Progress against the plan will be reviewed jointly by the ICB and LGT throughout the transition year. • **Performance and financial oversight will be maintained through the Integrated Neighbourhood Committee (INC), chaired by the ICB.** LGT will provide regular reporting against the agreed service specification and KPIs, alongside financial returns, enabling the Committee to monitor delivery, expenditure, performance and any areas requiring further assurance or action. • **The delegation will remain subject to ongoing review.** Where significant concerns arise that cannot be satisfactorily addressed, the ICB will retain the ability, **in accordance with the terms of the delegation agreement**, to pause or terminate the delegation and put alternative arrangements in place to ensure continuity of the functions.	Approve – low risk
Is there a safe and assured COSoP process planned for staff?	• Cabinet Office Statement of Practice (COSoP) applies for staff transfer and that the provider must comply with COSoP principles throughout the delegation, including expiry or termination. • Only SEL ICB-employed staff transfers to LGT. • HR will lead on managing the process including staff consultation process and ongoing employment support arrangements. • Union Engagement: Andrew Bland formally wrote to unions in July 2026 informing of the proposed delegation. Further engagement is undertaken with unions pre, during and post the staff consultation process • HR leads = Hannah Clarke (SEL ICB), Helen Baker (LGT)	Approve – low risk

Lewisham Neighbourhood Development Team - function transfer checklist (page 7 of 8)

Question	Response	Recommendation to the Transition Committee
Is the receiving organisation a suitable and capable provider of/for the transferring function?	• Yes, Lewisham and Greenwich NHS Trust (LGT) is the provider lead and host for the Lewisham Integrator and will provide the Organisational home and enabling infrastructure for the partnership to operate effectively. This has been agreed across the partnership via agreed approval routes (ICB and LGT Boards). An NHS trust possesses the scale, financial stability, and established governance required to coordinate care across complex local health systems and is CQC registered. • Under the NHS Oversight Framework, Lewisham and Greenwich NHS Trust (LGT) is classified as a Segment 3 provider, and its overall corporate Care Quality Commission (CQC) rating remains Requires Improvement (RI) however this is an aggregate score; core divisions show varying performance. • LGT has undergone further assessment and has a confirmed regional maturity assessment rating in the green/amber range. Additionally, an external PA Consulting well-led review has supported this confirming that the Trust can demonstrate strong performance across the majority of the CQC domains. Culture, visible leadership, and positive staff engagement are highlighted in the report as strengths. The report also acknowledges the Trust is working to address challenges in cross-site working, governance efficiency, accountability, and embedding improvement and sustainability. • LGT has focused relentlessly on improving quality over the last 8 years. This has been a whole-organisation effort encompassing culture, workforce stabilisation and optimisation, targeted investments (both revenue and capital), process and pathway improvements, patient and resident engagement, work to improve inequalities and population health. This has resulted in steady and sustainable improvements across our services, which have been recognised by the CQC. • Documentation and oversight updates regarding LGT's strategic trajectory and maturity level adjustments are frequently annexed within the **South East London Integrated Care System (SEL ICS) Board Papers** or sub-regional governance packs. • It is not anticipated that there will be any direct implications for delivery of the delegated functions	Approve – low risk

Lewisham Neighbourhood Development Team - function transfer checklist (page 8 of 8)

Question	Response	Recommendation to the Transition Committee
Where a function is deemed complex, has NHSE endorsement been received and is the approach to monitoring delivery proportionate?	• Meeting held with NHSE and ICB Lewisham Place to confirm if NHSE endorsement and agreement to continue. No issues identified. • Contracting and Finance/budgets have been identified as complex areas as part of the delegation agreement however no identified complex functions that require NHSE endorsement.	Approve– low risk
Have all legal issues been fully addressed and accounted for?	• Legal advice has confirmed that the proposed transfer can be lawfully delivered through a delegation of functions under the NHS Act 2006, rather than through a contractual outsourcing arrangement as follows. • *The proposed delegation transfers neighbourhood development functions, staff and associated budgets to LGT as host Organisation, while statutory accountability, strategic commissioning responsibilities and primary care contracting responsibilities remain with South East London ICB.* • Legal, governance, workforce, finance and assurance issues are actively managed through the transfer programme with legal review throughout the process. Final legal review and confirmation of the delegation documentation will be undertaken prior to implementation.	Approve – low risk

Lewisham Neighbourhood Development Team (page 1 of 3)

Section 1: what are we changing, and why?

Question	Response
Are the proposed changes **aligned** to the strategic vision for the future i.e. ICB blueprint in SEL?	**Yes.** The specification explicitly links the transfer to the 2025 ICB Blueprint, which redefines ICBs as strategic commissioners, and to the NHS 10-Year Plan requirement to establish a Neighbourhood Health Service. The function transfers neighbourhood development, primary care development and associated transformation functions into provider-hosted Lewisham Integrator arrangements.
Is there an evidence-based **rationale** for the decisions being taken at a local SEL level?	**Yes**. The rationale is based on national policy, the London Target Operating Model for Integrators, and SEL ICB's approach that each Place identifies an Integrator to support delivery of a Neighbourhood Health Service. In Lewisham, the provider host is LGT within a partnership arrangement with London Borough of Lewisham, general practice, VCSE and SLaM.
Are the proposed changes meeting the requirements of national and regional directions?	**Yes**. The transfer supports national and regional requirements: ICB Blueprint, NHS 10-Year Plan, London TOM, SEL ICS Neighbourhood Development Framework and SEL ICB strategic commissioning plans. The specification also requires compliance with NHS Constitution principles, relevant legislation/regulation, CQC/employment law, IG/GDPR, confidentiality and clinical governance policies.
Is the required saving achieved through the proposed changes?	Not Applicable

Section 2: how are we delivering the change?

Question	Response
Is the change being **implemented** as fairly, transparently and effectively as possible given the high levels of uncertainty in the national process?	Co-development of documentation, partnership engagement and frequent meetings and communications regarding changes have been undertaken with the aim to be transparent, shared timelines and aligned governance structures, opportunities for challenge to be made openly and feedback concerns. The specification sets out transition governance covering clear transfer governance, defined roles and responsibilities, escalation, contracting/procurement, budget accountability and HR/workforce arrangements. It also requires COSoP-compliant staff transfer, staff support/induction, reporting and governance through ICB, LGT and partnership routes.
Are relevant national, regional and local policies being adhered to for example, HR policies	Relevant policies and requirements are referenced: COSoP for staff transfer; NHS Constitution; relevant legislation, guidance and regulatory requirements including CQC and employment law; IG/GDPR and confidentiality; national and SEL ICB clinical governance; and delegation agreement requirements. HR, legal, data protection and equality appendices should be confirmed as part of final assurance.

Lewisham Neighbourhood Development Team (page 2 of 3)

Question	Response
Are transfers of functions to other organisations taking place safely and in a way that meets national rules and guidelines for transferring services or functions?	• The transfer is structured through a service specification, delegation agreement and transition governance. The specification identifies LGT as host/provider, requires COSoP compliance for staff transfer, and sets out governance over contracting/procurement, budgets, HR/workforce and ongoing management of the delegation. Final schedules/appendices should be completed to evidence full compliance. • An engagement workshop with Lewisham stakeholders was held in July 2026 to develop the evaluation framework and KPIs supported by PPL. • The ICB have put in a strong project support process being overseen by the SRO and Director of System Development and Programme manager. • Ongoing governance for managing the delegation was co-designed with the Lewisham Partnership.
Will this transfer involve processing new or existing personal/identifiable data in a way that is different, new, innovative, or likely to result in a high risk to individuals' privacy? If so, has a data protection impact assessment (DPIA) been undertaken and what are its outcomes?	• The service specification includes IG/GDPR, confidentiality and clinical governance compliance requirements, and the function includes PHM, dashboards, data-led strategy, case finding and KPI reporting. Because existing or new identifiable data processing may be involved, a DPIA/IG will be completed. • Data, Digital and Information (DDI) mapping is underway with a mitigating proposal being developed which will inform the DPIA. • Data sharing agreements already in place for PHM between ICB and LGT. • Bi-weekly DDI task and finish group established.
Are we identifying, assessing and mitigating **risks** in proportion to their impact?	Yes – a proportionate, risk-based approach is in place. Risks are identified and assessed across each transition workstream, with mitigating actions, owners and escalation arrangements applied according to their significance. High or critical risks must be mitigated to an acceptable level or formally accepted through ICB governance before delegation proceeds. LGT will maintain and manage operational risks following transfer, with significant risks escalated to SEL ICB through the agreed governance and assurance arrangements

Lewisham Neighbourhood Development Team (page 3 of 3)

Section 3: for whom are we working - *within the constraints of nationally set timelines?*

Question	Response
Are we 'doing the right thing' by patients, staff, partners and the wider community?	Yes. The transfer is intended to maintain continuity and strengthen delivery of neighbourhood health, INTs, primary care development, health inequalities, PHM, urgent care, virtual ward/Home First and partnership development. The specification emphasises improving population health, reducing inequalities, improving GP access/resilience and supporting care closer to home. An 'Impact on the Lewisham population' has been undertaken. • **More joined-up care** by strengthening the infrastructure for integrated neighbourhood working across primary care, community services, local authority, mental health and • **More proactive and preventative support**, using population health data, risk stratification and local intelligence to identify residents who would benefit from earlier intervention rather than waiting until needs escalate. • Stronger local accountability for outcomes, through agreed KPIs, quarterly performance and financial reporting, while strategic commissioning and statutory accountability remain with the ICB. • A stronger partnership approach, rather than LGT acting alone. Priorities and delivery will continue to be collectively shaped through the Lewisham partnership, involving the NHS, Council, primary care and voluntary and community sector
Are we communicating, consulting and listening throughout the process?	Yes. • Service specification development – engagement with partners at workshop held in July 2026 with Lewisham Partnership stakeholders • Comms and engagement plan developed • Staff engagement with the NHD team has commenced and formal consultation will be delivered through the COSoP process and HR timetable. • Regular updates to the Primary Care Leadership Forum is undertaken for Primary Care input. • Further engagement required with Lewisham population /residents will be supported via the communication and engagement plan.
Are diverse voices being heard and included, including Equality Impact Assessments (EIA)?	The specification includes equality-related aims through reducing health inequalities, targeting underserved communities, population health approaches and use of resident feedback. EIA has been completed and approved and will be repeated post COSoP process and ahead of board approval.

NHS
South East London

Committee Update – Remuneration Committee

Agenda item: 5.6

Executive Lead: Dinah McLannahan, Chief Finance and Compliance Officer

Report by: Anu Singh, Committee Chair

Paper type: Information

Conflicts of Interest: None identified

1. Purpose and recommendation

The purpose of this report is to provide to the Board an update on the activity of the Remuneration Committee, including decisions made, since the last Board meeting.

The Board is asked to:

- **Note** the items of discussion
- **Note** the decisions made by the Committee.

2. Background and context

At the last Board meeting held in public on 22 July 2026, the Board approved revised terms of reference for the Committee, effective from 1 October 2026. This included an amendment to Committee membership from two non-executive members and two partner members, to three non-executive members only. This aligns with the NHS South West London ICB model.

Since this meeting, the remuneration committee has met twice – once in its previous committee member composition, and once under the new terms of reference. In addition, two decisions were agreed by email, as permitted in section 9 of the terms of reference.

3. Activity undertaken

The remuneration committee met on two occasions in the period:

- 2 September 2026 – at this meeting the Committee considered two requests:
  - approval of two redundancy payments relating to fixed term contracts where the post holders had been in post for over two years (meaning redundancy payments were due).
  - Approval of two compulsory redundancy payments – one payment was agreed whilst the committee requested additional information on the other proposal before a decision was made.
- 28 October 2026 – approval of redundancy payments submission to NHS England for final approval, relating to compulsory redundancy of individuals whose roles were substantively deleted as part of the ICB organsational change programme.

Decisions made by email were:

- 3 August 2026 – approval of acting up pay to one VSM role for a period of 3 months.
- 15 September 2026 – approval of redundancy payment for one post discussed initially at the meeting of the Committee on 2 September 2026, but where a request for additional information was requested. The decision was made following receipt of additional information which the committee members considered sufficient to enable the payment approval to be given.

4. Decisions and Outcomes

Under its delegated authority stated in the Scheme of Reservation and Delegation, the Committee approved the payments requested above.

NHS
South East London

Board Assurance Framework

Agenda item: 6

Executive Lead: Ben Luscombe, Director of Corporate Services

Report by: Kieran Swann, Deputy Director of Risk and Assurance

Paper type: Approval

Conflicts of Interest: No specific conflicts identified.

1. Purpose and recommendation

This paper presents the SEL ICB Board Assurance Framework (BAF) for approval at the November Board meeting, reflecting the risk position recorded on Datix on 5 November 2026. It seeks agreement to proposed closures and sets out the planned BAF refresh.

The Board is asked to:

- Approve the current SEL Board Assurance Framework.
- Approve closure of Risks 601 and 602 relating to the ICB Change Programme, as the transition is substantively complete, with residual risks to be managed on Joint Transition Committee and ICB risk registers in line with the ICB's risk management framework.
- Endorse closure of the six place BAF entries on autism and ADHD waiting times and consolidation of the SEL-wide exposure into an updated version of Risk 391.
- Note the planned BAF refresh and risk appetite development, with aligned BAFs targeted for April 2027 subject to the necessary approvals.

2. Background and context

The BAF supports oversight of risks to delivery of the ICB's objectives. Seven SEL risks currently remain above tolerance and six place entries remain recorded pending Board agreement to the proposed closures. Reported risk scores are unchanged and no new risk is proposed for escalation.

The current SEL BAF remains in use while an aligned SEL and SWL approach is developed over Q4 26/27.

3. Implications, impacts and risks

Risk and assurance: Risks remain above agreed tolerance despite existing controls; unchanged scores do not indicate resolution. Closing the place entries would change the level of oversight, not resolve the underlying autism and ADHD waiting-time risks. Risk 391's existing controls and reported score remain unchanged pending review of its proposed extended scope.

Residual risk management: Place Executive Leads to arrange local assessment of residual place-led delivery risks to autism and ADHD services without duplicating updated risk 391. Residual risks relating to ICB change management would be included on Joint Transition Committee risk register.

Other implications: No separate financial or resource decision is requested. There are no sustainability implications or EIA requirements for this item. THE BAF does not separately assess quality and safety, safeguarding, legal duties or wider impacts on residents and communities.

4. Engagement and approvals

The Audit, Risk and Assurance Committee (ARAC) approved the future risk operating model on 27 October 2026. Patient and public engagement is not required for this BAF item.

5. Next steps and oversight

The decisions sought are set out in section 1.

Entries remain on the BAF pending agreement. Following agreement, residual risks would be managed through the arrangements in section 3.

The refresh is planned over Q3/4 2026/27 and will reflect the Boards' work on corporate objectives in November 2026. Initial changes are expected in January 2027 alongside a Board seminar on risk appetite, with aligned BAFs targeted for April 2027, subject to revised objectives, testing and the necessary committee and Board approvals.

Appendices and supporting information

Appendix 1: SEL ICB BAF for Board – November 2026
Appendix 2: Full SEL BAF risk register – November 2026

SEL ICB Board Assurance Framework

Prepared for SEL ICB Board, 24 November 2026

Context and latest updates

A reminder on ICB risk governance

- The ICB's risk appetite matrix is used by the ICB Board to set risk tolerance levels for various categories of risk across the organisation. This approach is designed to promote and support local ownership of risk across the ICB's governance and delegation arrangements. It also means that the Board will receive a view on those risks that have been assessed as exceeding the tolerance levels set.

- The ICB Board retains ultimate responsibility for the Board Assurance Framework (BAF). In July 2026, the Board approved revised governance arrangements under which the Audit, Risk and Assurance Committee (ARAC) took over the Executive Committee's role in reviewing the status of risks, including the draft BAF, and recommending the BAF to the Board for approval.

- The ICB also operates with a corporate risk register, which includes risks which are material and are assessed as having some likelihood of impacting objectives or the ability of the ICB and/or wider system to deliver business objectives. The Board Assurance Framework (BAF) document represents the full range of ICB risks from the risk register that sit above the permitted level of risk tolerance.

Development of new BAF

- On 27 October 2026, SEL's Audit, Risk and Assurance Committee approved the future risk operating model to support improved and consistent risk management processes between SEL and SWL as an ICB cluster. Each ICB will in future retain its own BAF and statutory accountability, but will adopt a common methods and reporting learning from the best parts of each of the current approaches to risk. The new clustered ICB risk function will work with risk owners with a sharper focus on principal strategic risks, an approach which seeks a clearer separation of risks from issues and proportionate escalation of operational and place partnership risks to risk registers and the BAF.

- This update remains a version of the current SEL BAF while the aligned refresh develops. Both Boards' work on corporate objectives in November 2026 will inform the refresh. We expect initial changes in the January 2027 BAF update and aligned BAFs for the April 2027 Board cycle, subject to testing and committee and Board approvals. Further development of risk appetite will include a planned Board seminar in January 2027.

- As a first step towards the updated clustered ICB arrangements, this pack asks the Board to endorse closing the six place BAF entries on autism and ADHD waiting times. Risk 391 would cover the ICB-wide exposure, with residual place delivery risks held locally through Place Executive Leads (PELs). This would reduce duplication while maintaining oversight (see slides 4 and 8). In addition, it is proposed that BAF risks 601 and 602, relating to the ICB Change Programme are closed by the Board given that the transition is substantively complete.

Structure of the BAF

- All risks on the SEL and place risk registers have been updated by designated risk owners working with their teams. Full details of SEL BAF entries are included as **Appendix 1**.
- The six place entries remain in this draft pending Board endorsement of the proposed closure and consolidation into Risk 391.
- Risks 601 and 602 relating to the ICB Change Programme also remain on the BAF and are also proposed for closure subject to the Board agreement.
- The detailed descriptions of risks in the appendices, include the following information:
    - risk owners and sponsors
    - the risk category that the risk falls into
    - the risk appetite for that category of risk
    - a description of the risk
    - controls that are in place to mitigate the risk
    - assurances
    - initial and residual risk scores.

Key points and summary of changes

Key points to note

- Risks reflect the assessed position as recorded on the ICB's Datix system for risk management on 5 November 2026.
- The current draft retains 7 SEL risks above threshold and 6 place risks (Bexley, Bromley, Greenwich, Lambeth, Lewisham, Southwark), pending Board endorsement of the proposed place closures.
- Risks 601 and 602 relating to the ICB Change Programme, given that this transition has been substantively completed and residual areas of risk will be managed on Joint Transition Committee and ICB risk registers in line with the ICB's risk management framework.
- Subject to agreement, this would leave the 5 SEL BAF risks, with local delivery risks managed on partnership or local registers. The Board should note the development work on the BAF planned over the next quarter as described on page 2.

Escalation and de-escalation of risks

- No new risk above the risk appetite threshold is proposed for escalation onto the BAF.
- The Board is asked to endorse closing all six place BAF entries on page 8 and incorporating their SEL-wide autism and ADHD waiting-time exposure into Risk 391. This changes the level of oversight to align with updated clustered ICB governance and avoid duplication. It does not mean the underlying risks have resolved.

Risk score changes

- There have been no changes to the reported BAF risk scores.

Proposed closure and local follow-up

- Risks 601 and 602 relating to the ICB change programme are proposed for closure.
- The 6 place risks relating to autism and ADHD services are proposed to be closed on the BAF. Subject to endorsement, Place Executive Leads (PELs) will be asked to use place partnership and local registers to assess risks to delivery of the place-led components of improvement plans for ADHD and autism services, including any residual mitigating actions. New local risk entries should capture these responsibilities where needed, with clear ownership and escalation. Local entries should avoid duplicating the SEL-wide exposure in Risk 391.

Summary of SEL risks exceeding tolerance levels (1 of 3)

Risk Category	Risk ID	Risk title / summary of risk	Key controls include	Max tolerance score	Residual risk score
Data and Information Management	**651**	Significant disruptions to the ICT and digital systems across out provider and/or supply settings.	Up-to-date incident response plan in place. DSPT compliance indicates that monitoring is in place to detect potential security problems and to track the ongoing effectiveness of protective security measures. SEL ICB has various mechanisms in place to ensure security defences remain effective and to detect cyber security events and incidents which may potentially impact essential functions.	9	12
Operational: relating to the effective day to day running of the ICB organisation (MCR)	**601**	ICB Change Programme – workforce capacity risks **PROPOSED FOR CLOSURE**	Agreement to cease some non-priority work to focus on must do areas, reappraisal of consultation timeline aligned to national guideline, and programme governance structure in place.	15	20
	602	ICB Change Programme – impact on staff **PROPOSED FOR CLOSURE**	Weekly CEO-led all staff briefings in place, dedicated intranet and MS Teams space for transparent communication, regular “ask HR” sessions in place.		20

Key: Primarily system risk Primarily ICB risk

Summary of SEL risks exceeding tolerance levels (2 of 3)

Risk Category	Risk ID	Risk title / summary of risk	Key controls include	Max tolerance score	Residual risk score
Clinical, Quality and Safety	404	New and emerging High Consequence Infections Diseases (HCID) & pandemics.	Staff offered vaccines, HCID and pandemic plans in place, collaboration with system to minimised impact on the workforce, hybrid working in place, process for re-deployment established.	9	12
	468	Risk of variation in performance across SEL with FNC (funded nursing care) reviews.	Monthly assurance pack reviewed at CHC meeting, tracking FNC reviews, and individual borough plans set out how boroughs will clear overdue reviews.		12
	391**	Increased waiting times for autism diagnostics assessments.	Backlog clearance to reduce waiting times includes development of services to meet demand, clinical leads recruited to focus on autism across all ages. Autism strategy approved and launched, and core offer for CYP autism assessment developed and agreed.		16

**Proposed scope extension, subject to Board endorsement: Risk 391 would incorporate the SEL-wide autism and ADHD waiting-time exposure from all six place BAF entries on slide 8. PELs would arrange separate local assessment of residual place-led delivery risks. The existing controls and reported score remain unchanged pending review.

Key: Primarily system risk; Primarily ICB risk

Summary of SEL risks exceeding tolerance levels (3 of 3)

Risk Category	Risk ID	Risk title / summary of risk	Key controls include	Max tolerance score	Residual risk score
Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	**663**	Implementation of ICB strategic commitments, approved plans, and delivery priorities	Mitigating controls include delivery of agreed operational plan trajectories for cancer performance, supported by system wide oversight through the SEL Cancer Alliance, Cancer Executive and regional performance review arrangements. Targeted support and assurance are provided through NHSE oversight, diagnostics and UEC programmes, quality surveillance and harms reviews, alongside investment through Strategic Investment Fund to support recovery and operational plan delivery. These arrangements are complimented by the ICB's five-year strategic commissioning plan and ongoing partnership working with providers to monitor progress, address delivery issues and support the shift from hospital to community care.	12	16

Key: Primarily system risk | Primarily ICB risk

Place risks proposed for closure and consolidation

Risk Category	Risk ID	Risk title / summary of risk	Key controls include	Max tolerance score	Residual risk score
Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities **Proposed closure into Risk 391, subject to Board endorsement. Residual place delivery risks: local registers via PELs (see slide 4).**	**Bex 642**	Residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments.	SEL-wide neurodevelopmental improvement programme established under the CYP MH and Wellbeing Partnership Board to oversee ASD and ADHD diagnostic pathways, waiting times, and consistency of the core offer across SEL boroughs / places. New integrated diagnostic pathway from April 2025 enabling movement between ADHD and Autism assessments, reducing duplication and re-referral delays. Targeted capacity investment including non-recurrent and recurrent funding to providers to expand assessment capacity, weekend clinics, and workforce recruitment initiatives. SEND Improvement Board oversight with joint leadership from local authorities and Directors of Children's Services to drive delivery of local improvement plans and monitor performance trajectories. Exploring the opportunity to join arrangements with other boroughs to ensure residents have equity of access to medication and review pathways	12	16
	Bro 509	Residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments.			16
	Gre 635	Residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments.			16
	Lam 129	Waiting time targets for children and young people waiting for an autism or ADHD assessment is unacceptably long.			16
	Lew 644	Residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments.			16
	Sou 520	Residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments.			16

Key: Primarily system risk | Primarily ICB risk

‘Heat Map’ of BAF risks

Current BAF likelihood and impact scores, distinguishing primarily ICB and system risks. The six place entries remain shown pending Board endorsement of their proposed closure and consolidation into Risk 391 (see slides 4 and 8). Risks 601 and 602 are shown whilst pending Board’s decision to close these as BAF risks.



ID	Summary risk descriptions
602	ICB Change Programme – impact on staff
663	Implementation of ICB strategic commitments and priorities
391	Increased waiting times for autism diagnostics assessments
601	ICB Change Programme – workforce capacity risks
642	Residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments.
509	
635	
129	
644	
520	
404	ICB oversight of new & emerging HCID & pandemics
468	Variation in performance with funded nursing care
651	Significant disruptions to the ICT and digital systems across out provider and/or supply settings.

Appendices: risk scoring matrices

Risk scoring matrices (1 of 3)

The matrices below are taken from the ICB's Risk Management Framework and represent the possible combined risk scores based on a measurement of both the likelihood (probability) and severity (impact) of risk issues. A combination of likelihood and severity score provides the combine risk score.

Likelihood x Severity = Risk Score

			Likelihood				
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost certain
Severity	5	Catastrophic	5	10	15	20	25
	4	Major	4	8	12	16	20
	3	Moderate	3	6	9	12	15
	2	Minor	2	4	6	8	10
	1	Negligible	1	2	3	4	5

Likelihood Matrix:

Likelihood (Probability) Score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Frequency Time-frame	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Frequency Will it happen or not?	<0.1%	0.1 to 1%	1 to 10%	10 to 50%	>50%

Risk scoring matrices (2 of 3)

Severity matrix

Severity (Impact) Score	1	2	3	4	5
Descriptor	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Service Business Interruption	Loss interruption of 1-8 hours Minimal or no impact on the environment /ability to continue to provide service	Loss interruption of 8-24 hours Minor impact on environment / ability to continue to provide service	Loss of interruption 1-7 days Moderate impact on the environment / some disruption in service provision	Loss interruption of >1 week (not permanent) Major impact on environment / sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked	Permanent loss of service or facility Catastrophic impact on environment / disruption to service / facility leading to significant “knock on effect”
Personal Identifiable Data [Information Management Risks]	Damage to an individual’s reputation. Possible media interest e.g. celebrity involved Potentially serious breach Less than 5 people affected or risk assessed as low e.g. files were encrypted	Damage to a team’s reputation. Some local media interest that may not go public. Serious potential breach and risk assessed high e.g. unencrypted clinical records lost. Up to 20 people affected.	Damage to a service reputation. Low key local media coverage. Serious breach of confidentiality e.g. up to 100 people affected.	Damage to an organisations reputation. Local media coverage. Serious breach with either particular sensitivity e.g. sexual health details or up to 1000 people affected.	Damage to NHS reputation. National media coverage. Serious breach with potential for ID theft or over 1000 people affected.

Risk scoring matrices (3 of 3)

Severity matrix (contd.)

Severity (Impact) Score	1	2	3	4	5
Descriptor	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Complaints / Claims	Locally resolved complaint Risk of claim remote	Justified complaint peripheral to clinical care e.g. civil action with or without defence. Claim(s) less than £10k	Below excess claim. Justified complaint involving lack of appropriate care. Claim(s) between £10k and £100k	Claim above excess level. Claim(s) between £100k and £1 million. Multiple justified complaints	Multiple claims or single major claim >£1 million. Significant financial loss >£1 million
HR / Organisational Development **Staffing and Competence**	Short term low staffing level temporarily reduces service quality (< 1 day)	Ongoing low staffing level that reduces service quality.	Late delivery of key objectives/service due to lack of staff. Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory / key training.	Uncertain delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory / key training	Non-delivery of key objectives / service due to lack of staff Ongoing unsafe staffing levels or incompetence Loss of several key staff No staff attending mandatory training / key training on an ongoing basis
Financial (damage / loss / fraud) **[Financial Risks]**	Negligible organisational / financial loss (£< 1000	Negligible organisational / financial loss (£1000- £10000)	Organisational / financial loss (£10000 -100000)	Organisational / financial loss (£100000 - £1m)	Organisational / financial loss (£>1million)
Inspection / Audit	Minor recommendations Minor non-compliance with standards	Recommendations given Non-compliance with standards Reduced performance rating if unresolved	Reduced rating Challenging recommendations Non-compliance with core standards Prohibition notice served.	Enforcement action Low rating Critical report. Major non-compliance with core standards. Improvement notice	Prosecution. Zero rating. Severely critical report. Complete systems change required.

SEL ICB Open Full Register - SEL BAF

Risk ID	Risk Owner	Risk Sponsor	Risk Title	Opened Date	Risk Description	Risk Type	Risk Subtype	Initial Likelihood	Initial Consequence	Initial Rating	Current Likelihood	Current Consequence	Current Rating	Target Likelihood	Target Consequence	Target Rating	Control Summary	Gaps in Control Summary	Assurance in Place	Gaps in Assurance	Next Review Date
391	Carol-Ann Murray	Elaine Clancy	Increased waiting times for Autism diagnostic assessments	26/09/2022	There is a risk of increased waiting times for a diagnostic assessment for Autistic Spectrum Disorder (ASD) for adults and children and resulting non-contracted activity costs due to patient choice referrals to private providers. This is caused by increased demand for assessments combined with historical waiting lists. The impact on the ICB will be on its ability to meet statutory obligations and increased spend due to non-contracted activity. Achieving timely access to assessment will reduce diagnosis waiting times and ensure support can be put in place earlier and help improve patient outcomes.	Clinical, Quality and Safety	Other	3	4	12	4	4	16	4	4	16	Backlog clearance achieved with waiting times reduced in boroughs served by Oxleas. service funded to meet the demand and maintain waiting times within 6 -8 months, All age autism strategies in all six boroughs and recurrent funding of £80k provided to each to support non- medical needs and provide support in the community., Core offer for CYP Autism assessment developed and agreed with stakeholder. Set up of Community of practice to share best practice and find solutions to ongoing issues. Exploring options for assessment of 16-17 to 18 year olds before adulthood to prevent longer waits in adult services. - Piloting SEL CYP Neurodiversity Hub for diagnostic assessments and medication pathways., Waiting list validation undertaken in SLaM for Lambeth and Lewisham., Providers funded to undertake assessments 17 to 18 year olds before adulthood to prevent longer waits in adult services., Piloting SEL CYP Neurodiversity Hub for diagnostic assessments and medication pathways.	Demand for assessments increasing and difficult to predict if and when it will level out.	SEL LDA Strategic Executive Group Agenda and Minutes List the assurance evidence., SEL LDA Operational Board Agenda and Minutes. to be relaunched during 2025/26, Minutes from the quarterly Joint Region and System LDA Health Partnership meeting.	No gaps on assurances	30/11/2026
404	Simon Beard - Associate Director Corporate Governance	Elaine Clancy	New and emerging High Consequence Infectious Diseases (HCID) & pandemics	05/10/2022	There is a risk that new and emerging HCID & pandemics could occur at any time and are likely to occur in one or more waves. This could cause disruption to the operation of the ICB with staff illnesses/absence and reprioritisation of workload which could lead to a detrimental effect of communities and staff within SE London.	Clinical, Quality and Safety	Infection risk	4	4	16	4	3	12	4	2	8	Staff are offered flu and covid-19 vaccines to mitigate as far as possible the impact on the workforce., HCID & pandemic plans in place. Antiviral plan in place for SEL system., Collaboration with organisations across the system through forums such as Borough Resilience Forums enables the ICB to horizon scan for potential emerging HCID issues and put mitigating actions in place early to minimise impact to the workforce and ICB operations., Hybrid working arrangements are in place, supported by cloud-based access to IT systems, which enables the ICB to reduce face to face interactions between staff should this be necessary as a measure to reduce spread of infections., The ICB has an established process for considering staff redeployment to focus on business critical services., Employee assistance is available - e.g. mental health first aiders; occupational health and employee assistance programme., During the 2024-25 year there are plan to run tabletop and workbook exercises with the primary care teams and GPs to test and exercise the ICB plans for HCIDs. A national exercise - Op Pegasus - is planned to be run in 2025 to test plans.	UK HSA have published updated communicable disease outbreak management guidance which will be used in London to develop a pan London MoU for managing complex infectious disease outbreaks. Once completed, the ICB HCID response plan will need to be reviewed for alignment.	SEL ICB - System approach utilised and implemented for HCIDs (P), EPRR Practitioners network is in place enabling early sharing of information/ horizon scanning in relation to HCIDs, which will ensure organisations can take early mitigating actions (P), HCID plan reviewed and updated in 2024. Refreshed plan has been endorsed by ICB AEO and approved for publication by ICB Executive Committee (P), SEL ICB Head of EPRR and the Bromley PEL Angela Bhan, have been involved in the initial scoping discussion for the pan London MoU and are engaged in the ongoing development work.	No gaps in assurance	12/11/2026
468	Jane Waite - Head of CHC/CYPCC Governance Assurance and QIPP	Elaine Clancy	There is a risk of variation in performance across SEL with the FNC (Funded Nursing Care) reviews.	20/07/2023	There is a risk of variation in performance across SEL with the FNC (Funded Nursing Care) reviews. This is due to a significant number of reviews over the required time frames (National Standard). This is impacting on the ICB's ability to meet statutory requirements. This is a clinical risk which impacts on financial control across the system and patient experience.	Clinical, Quality and Safety	Reduced quality of care	4	4	16	3	4	12	2	4	8	This risk is monitored at the NHSE assurance meeting monthly, The SEL Head of CHC/CYPCC governance assurance and QIPP has oversight of this risk., There is a monthly assurance pack produced which goes to the CHC review meetings. The CHC monthly assurance report tracks FNC reviews., There are monthly meetings held at place level where this risk is discussed except Southwark. In Southwark key risks and issues are escalated to the head of Age Well Integrated Commissioning at bi-weekly meetings and issues are escalated to more senior colleagues as required., There are individual borough plans setting out how boroughs will clear the overdue reviews., Monitoring of outcomes is through the quality and performance committee in Bromley.	no gaps., No gaps in controls	There are minimal vacancies across the place based teams., Individual borough plans in place and teams are working towards reducing the backlogs	Place CHC leads have been asked to provide individual borough trajectories where necessary, The CHC monthly performance report shows that overdue FNC reviews have been increasing overall	25/09/2026
601	Ben Luscombe	Andrew Bland	ICB Change Programme – Capacity risks	22/05/2025	There is a risk that the ICB will face significant and increasing capacity challenges throughout implementation of the ICB change programme. A cautious approach to recruitment throughout a prolonged period of uncertainty then a lengthy change programme, plus the impact of staff leaving through voluntary redundancy across April and May has/will have a tangible effect on ICB workforce capacity. This increases the risk of burnout for staff covering extended portfolios and threatens delivery of statutory responsibilities, ICB objectives and priority areas of work.	Operational: relating to the effective day to day running of the ICB organisation (MCR)		5	4	20	5	4	20	4	4	16	Programme governance structure in place (SMT, Transition Committee, Operations Group), Proposals tested through scenarios with a detailed transition plan being developed, Agreement to cease some non-priority work to focus on statutory and "must-do" areas., Reappraisal of consultation timeline aligned to issue of national guidance and review by ICB Board and the ability to more easily secure fixed term contracts and secondments for additional time-limited capacity., Change Programme Group with joint SROs meets weekly, Participation in London Transition Group to ensure safe transfer of functions., Directors have confirmed how they will manage gaps resulting from the first round of VR; outputs of this exercise have been reviewed collectively to identify interface issues. Directors will be asked to review again given the numbers of staff leaving via VR in April and May., Feedback from staff across the change programme and consultation has flagged anxieties around capacity gaps,. Alignment in structures and ways of working with South West London ICB may give some additional capacity in some areas,. Development of future ICB operating model and supporting OD programme programme., Paper outlining the process for preserving organisational knowledge to be agreed with the Transition Working Group,. Clear leaver management process for staff leaving through the transition programme, including line manager responsibilities, return of equipment, deactivation of ID passes, removal of system access and completion of handover activity, supported by a central tracker,. Leadership Forum briefed on leaver and knowledge-capture processes.	None	Programme governance structure in place (SMT, Transition Committee, Operations Group).	None	19/10/2026
602	Ben Luscombe	Andrew Bland	ICB Change Programme – Staff morale and wellbeing	22/05/2025	There is a risk of low staff morale, health and wellbeing impacts, and wider disengagement as a result of the ICB change programme. Increased uncertainty around future structures, consultation length, and job security has led to a potential for increased staff anxiety and change fatigue. This may lead to higher sickness absence, reduced productivity, disruption to business as usual delivery, and disengagement from the consultation process.	Operational: relating to the effective day to day running of the ICB organisation (MCR)		5	4	20	5	4	20	5	4	20	Weekly CEO-led all-staff briefings with executive team in attendance., Dedicated intranet and MS Teams space to support transparent communications., Access to HR/OD support, including psychological support and wellbeing offers., Regular "Ask HR" sessions and targeted staff training/support., Change Programme Group (MCR Ops Group) meeting weekly; monitors feedback received through consultation and has requested measures of morale and wellbeing i.e. long-term sickness rates, use of EAP., Ongoing monitoring of staff feedback through HR channels., Analysis of consultation feedback from staff has noted some issues of morale; to be addressed., Long-term sickness absence has not increased significantly through the change programme., Directors are actively planning for capacity gaps arising from voluntary redundancy and ensuring appropriate cover arrangements were in place, Implementation of a new operational model and organisational development programme across the whole organisation., Clear mandatory selection guidance published to all managers and staff to support a fair, unbiased and transparent selection process.	None	Joint Change Programme Operational group meeting weekly - chaired by Joint SROs, Regular reporting into the Joint Transition Committee	None currently identified	19/10/2026
651	Pin Bhandal	Nisha Wheeler	Digital - Disruption to ICT/Digital systems affecting the providers data, systems and essential services which may impact the ICB. (supply chain)	03/03/2026	There is a risk of significant disruptions to the ICT and digital systems across our provider and/or supply settings. This may be caused by external factors such as cyber attacks, gaps in security controls, human factors (including phishing and social engineering) or change initiatives implemented by the NHS, healthcare and service providers. The consequences of this occurring is significant disruption or delay to the provision of clinical services potentially affecting patients health and care. This may cause financial and reputational damage, particularly if a data breach leads to penalties from the Information Commissioners Officer or service user negligence claims. Subsequently resource levels would likely be significantly impacted by this level of disruption.	Data and Information Management	Cyber attacks	4	4	16	4	3	12	3	3	9	Accessible and secured current backups of data and information needed to recover operation of your essential function(s) following an adverse impact to network and information systems, Up-to-date incident response plan that is grounded in a thorough risk assessment that takes account of network and information systems supporting the operation of your essential function(s) and covers a range of incident scenarios, DSPT compliance indicates that monitoring is in place to detect potential security problems and to track the ongoing effectiveness of protective security measures,, NHS SEL ICB Data Protection Impact Assessment process includes capturing details of any new flows as new projects, systems and changes are implemented throughout the ICB., Using and sharing information - use and share information for direct care. B = You lawfully and appropriately use and share information for purpose outside of direct care,. SEL ICB has various mechanisms in place to ensure security defences remain effective and to detect cyber security events and incidents which may potentially impact essential functions, Such controls are in place that it limits the access to the designated area/files/premises or incorporates different levels of accessibility. Access controls are monitored or revoked where necessary, change advisory board process is in place to support review of any proposed system changes proposed by partners or digital solutions providers which are then risk and impact reviewed with necessary mitigation actions identified and / or rollback process agreed as necessary prior to any approvals taking place. Secure design, configuration and management processes have been established. Vulnerability Management Processes are in place to track, manage and prioritise activity., Systems are designed to ensure appropriate levels of resilience and recovery plans are in place,. Supply Chain- DSPT compliance indicates that for some organisations processes to risk assess the supply chain are in place and there is an understanding of how suppliers may impact the delivery of our essential functions,. Asset Management – DSPT compliance indicates that assets underpinning essential services are identified, prioritised and have clear ownership assigned,. SEL ICB have implemented information assurance policies, processes and procedures, Security Culture - processes are in place to ensure staff have appropriate awareness, knowledge and skills to carry out their roles., Relevant committees oversee information risk. There is clear direction, roles and responsibilities, and decision making with respect to information risk.,.	Inclusion of Digital /ICT risk management approach to be linked into Corporate Risk management framework	2024-25 DSPT/CAF compliance, Cyber Essentials and Cyber Essentials Plus accreditation achieved, Governance structure and policies in place (IG Framework and suite of policies and procedures), DCB1596 - NHS Email Security Standard, Cyber Security Operation Centre members - 24/7 Monitoring capabilities, ICT disaster recovery and cyber incident planning exercise completed, SEL ICB Risk management framework (Updated to incorporate information and security risk), Internal audit assessment completed in May 2026, 2025-26 DSPT/CAF submission completed End June 2026 - Standards met	Revised Digital risk management framework to be completed	08/02/2027
663	Sarah Osborn	Annabel Appleby	Operational Planning Performance Targets	15/05/2026	There is a risk that the ICB is unable to deliver its 2026/27 operational plan commitments in relation to •Cancer access and waiting times standards, particularly 62-day treatment standard •Referral to Treatment times (RTT) for elective care •Patient Tracking Lists (PTL/Waiting List) size reductions •Diagnostic activity levels, to support cancer, and elective performance •Community health waiting list reductions •Mental health, particularly Talking Therapies outcomes, access to IPS and reducing the number of out of area placements •General Practice activity and urgent appointments seen on the same day •Urgent and Emergency care - urgent community response Failure to achieve these performance standards may result in delays to diagnosis and treatment, leading to poorer clinical outcomes for patients, increased system pressure, and reputational and regulatory risk for the ICB and partner organisations. Similarly, failure to meet performance/activity targets could result in our inability to achieve medium term planning targets in 3 to 5 years,	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	Delivery of strategic commitments	4	4	16	4	4	16	3	3	9	The 2026/27 operational plan includes agreed system-wide trajectories to improve cancer performance, including the Faster Diagnosis Standard (FDS) and the 62-day treatment standard,. System oversight is provided through the South East London Cancer Alliance and SEL ICB Cancer Executive, alongside regular regional performance review meetings. Targeted support arrangements remain in place, NHSE London oversight for RTT, diagnostics and UEC at local acute trusts. Quality and safety are monitored through ongoing surveillance, including harm reviews for patients impacted by delays. SEL has used part of the Strategic Investment Fund (SIF) as a resource to support the trust's in delivering the PTL reductions for the SEL population. However it should be noted that some ICB patients will be waiting at trusts outside SEL. SEL has developed a 5-year strategic commissioning plan which sets a clear course of action for all care pathways across the ICB. All areas have targeted work in the 3 fundamental areas set out in the NHS 10-Year Health Plan focusing on Hospital to Community, Analogue to Digital and Sickness to Prevention. 8h Plan focusing on Hospital to Community, Analogue to Digital and Sickness to Prevention. The Strategic Investment Fund will be used across the ICB to support the delivery of our operational plans. The ICB is reliant on providers for delivery of many operational planning targets and works closely with partners to understand progress and support resolution of issues.	Whilst plans are in place, the 26/27 operational targets are stretching and significant work is required across all areas to achieve targets. The ICB has limited influence on how non local trusts deliver on these expectations, as they will be receiving their steer from their host ICB.	Our plans have been signed off by the Board and approved with conditions by NHSE. ICB will continue to be assured through NHSE oversight arrangements in year.	none	31/12/2026

NHS
South East London

Organisation Report

Agenda Item: 7

Executive Lead: Andrew Bland, CEO SEL ICB

Report by: Ben Luscombe, Director of Corporate Services

Paper type: Information

Conflicts of Interest: Not applicable for this report

1. Purpose and recommendation

The Board is asked to note this report which provides an overview and update to the Board on specific issues in South East London (SEL).

2. Background and context

This report provides an operational update from NHS South East London Integrated Care Board (SEL ICB), regarding matters of interest to members of the Board that are not noted in other papers.

3. Background and context

Thirlwall Inquiry

The Thirlwall Inquiry was established following the convictions of former neonatal nurse Lucy Letby to examine events at the Countess of Chester Hospital between 2015 and 2018 and their wider implications for NHS patient safety. Its final report, published in September 2026, identified profound failures in management, governance and safeguarding, including failures to act quickly enough on concerns raised about the safety of babies.

The findings have prompted a national programme of action to strengthen neonatal safety, safeguarding, leadership and accountability. NHS England has asked every trust and ICB Board to consider the findings, seek assurance that appropriate safeguards and escalation arrangements are in place, and promote a culture in which staff feel able to speak up, challenge and raise concerns.

NHS SEL Change Programme

Since the beginning of March this year, the ICB has undertaken a major organisational change programme in order to realise the Government’s commitments made through the Model ICB Blueprint and the vision and aspirations of the NHS 10-year plan.

Our new structures were implemented across October and November and are now operational meaning that we are entering into the final stages of the programme. During this stage a number of ICB staff will be issued with notice of Compulsory Redundancy, and we expect to have completed this stage of the programme by the end of March, in line with the timetable agreed with NHS England. Comprehensive support packages for all staff affected by these changes have been put in place.

Moving forward we have started to discuss new Ways of Working with the organisation to ensure that we become an effective, efficient and resilient Strategic Commissioner delivering improved health outcomes across South London.

Special Educational Needs and disability (SEND) Reviews

A child or young person has special educational needs and disabilities if they have a learning difficulty and/or a disability that means they need special health and education support,

Against a backdrop of the implementation of the Model ICB and the associated changes in the ICB's workforce, the planned SEND reforms in England will involve major planned changes to Education, Health and Care Plans (EHCPs), a new tiered support system, stronger inclusion in mainstream schools, and early-intervention measures, with full implementation expected by September 2029. Inspections of current SEND Partnerships and Local Plans occur throughout the year, and 2026 has been a busy one for the ICB's.

Ofsted and the Care Quality Commission (CQC) jointly inspect the arrangements in local areas for children and young people with special educational needs and/or disabilities. Across SWL and SEL Boroughs there have been several inspections during 2026 (listed below).

- **Croydon Local Area Partnership**, October 2026
- **Lambeth Local Area Partnership**, October 2026.
- **Bromley Local Area Partnership**, October 2026
- **Kingston upon Thames Local Area Partnership**, June 2026
- **Sutton Local Area Partnership**, January 2026
- **Richmond upon Thames Local Area Partnership**, last inspected October 2023, with a recently announced Thematic Review of The Local Offer (this is the provision available across education, health and social care for children and young people with SEND, and their families, in a local area).

Inspection outcomes for local SEND services in England are published by Ofsted and the Care Quality Commission (CQC). Outcomes are categorised as:

- **Positive experiences and outcomes:** Local arrangements typically lead to good support for children and young people with SEND. (19%)
- **Inconsistent experiences and outcomes:** Local arrangements require improvement to ensure consistent support. (56%)
- **Widespread or systemic failings:** Significant concerns exist, requiring urgent action and submission of a priority action plan. (25%)

Nationally in 2025, positive outcomes rating has reduced, inconsistent outcomes have increased and widespread or systemic failings outcomes remains similar to overall rates since 2023.

In both SWL and SEL, inspections have provided outcome reports in all three domains and local Borough teams all have partnership plans in place (including when found to have widespread and/or

systemic failings, when Boroughs are required to produce a priority action plan). There are a range of *areas which the ICB's are progressing as key areas of development, in addition to previous* programmes of work already underway:

- **Strengthening partnership** and shared governance across LA, ICB and Providers including scrutiny around SEND partnership board risk registers
- **Joint commissioning arrangements** in each area are different and this is an opportunity to develop greater consistency
- **Improvement work** required on service specifications to include key metrics to demonstrate compliance with statutory processes
- **Strategic commissioning and development** of Local Area responses whilst children and young people are awaiting neurodevelopmental assessment
- **Therapies demand and capacity work** extension of this work to consider a future for the increased provision of therapies which link with the SEND Reform "Experts at Hand" model
- **Health contributions** indicate further work required on some elements of the Education, Health and Care Needs Assessment (EHCNA) process – the first stage in obtaining an EHCP – and annual reviews
- **Alignment of programmes** related to SEND, including All Age Learning Disability and Autism, Mental Health.

Appointments

Elaine Clancy formally took up her role as Chief Nurse and Quality Officer for the cluster on 7 September 2026. Elaine has returned from a secondment at St George's, Epsom and St Helier University Hospitals and Health Group (GESH) where she has been the Group Chief Nurse. Elaine has more than 30 years' experience in the NHS. A trained adult, paediatric and A&E nurse, Elaine has worked on the frontline of the NHS - as well as holding a range of senior roles at hospitals and community providers across London.

Ed Waller took up his role as Deputy Chief Executive and Chief Commissioning Officer for the cluster on 7 September 2026. Ed joins us from NHS Kent and Medway ICB where he was the Deputy Chief Executive and Chief Commissioning Officer. In this role he led the development of the organisation to become a strategic commissioner, implementing commissioning change in a challenged system through planning and strategy as well as playing a major role in the ongoing ICB change process.

London Maternity and Neonatal Excellence Awards 2026

The SEL Local Maternity and Neonatal System (LMNS) has won the Quality and Safety category at the London Maternity and Neonatal Excellence Awards 2026 for its Perinatal Optimisation Programme. The programme has strengthened collaboration across maternity and neonatal services and improved access to specialist care for extremely preterm babies. Key outcomes include a 38% reduction in in-utero transfer refusals, a 50% improvement in successful transfers for women in threatened extremely preterm labour, and the lowest transfer refusal rates in London. The successful improvement model is now being adopted more widely, recognising the significant contribution of teams across SWL to improving outcomes for babies and families.

Bexley Place

Supporting Our Diverse Communities

South Asian Heritage Month

More than 100 residents attended the 28 July 2026 event at Crayford Community Centre. The Mentor Ring, Bexley's Staying Together team and Bexley Wellbeing Partnership combined cultural celebration with diabetes, carer and social prescribing advice. GPs answered questions; Hayshine Pharmacy provided checks and advice, sharing these with GP practices.

Black History Month

Bexley Wellbeing Partnership and the Global Majority Group hosted Let's Talk Your Health at The Family Hub, Erith, on 23 October 2026. Residents discussed menopause, sexual and reproductive health, young people's services and cancer awareness, alongside GP advice, blood pressure checks and support information.

Diwali

The same partners hosted a Diwali celebration at The Family Hub on 24 October 2026. Talks, food, music, dancing and henna brought communities together, with Councillor Rags Sandhu MBE reflecting on light, hope and togetherness.

Delivering Neighbourhood Services

Breast Cancer Awareness

Albion Surgery's Patient Participation Group, working with Geddes Place United Reformed Church, led a breast cancer awareness evening in Bexleyheath on 8 October 2026. General practice, cancer and breast screening specialists, and Breast Cancer Now covered signs and symptoms, early detection, screening, risk reduction and support for people living with and beyond cancer. Patients asked questions and shared experiences, highlighting a need for clearer information about access to breast screening for women over 71.

Bexley System Leadership Health & Care Summit

The Summit on 28 October 2026 brought together senior representatives from the London Borough of Bexley, acute and community trusts, GP practices, community pharmacy, social housing and voluntary and community organisations. A public health overview and partners' written submissions informed discussion of system pressures, how decisions affect partner organisations and opportunities for collective action. Partners focused on residents whose overlapping health, care, housing and social needs fall outside established pathways or eligibility criteria, exploring links between housing, unpaid caring, hospital discharge and workforce pressures. Prevention, children and young people, future population needs and community strengths were also highlighted, with neighbourhood working offering a way to connect services and community support. The proposed next step is to consolidate findings into shared priorities, building on existing activity: clearer access and referrals, better recognition of unpaid carers, more effective information use and stronger coordination across organisations.

Big Bus Week

The Big Week Bus provided flu, COVID-19 and RSV vaccinations alongside Vital 5 checks at Abbey Wood Station on 12th November 2026, from 2pm to 7pm. Reported as the week's busiest session so far, its commuter-friendly location and timing were valued by residents. Bexley Community Champions promoted the offer and signposted residents to smoking cessation and wellbeing support. The Abbey Arms Pub supported delivery and provided an alternative vaccination space for a wheelchair user unable to access the bus, highlighting the importance of accessible facilities and local partnerships. Residents expressed interest in more frequent provision. The next borough visit is planned for 28 November 2026 at Welling United's Park View Road stadium.

Bromley

Establishment of the One Bromley Integrator Board

Bromley held its first Integrator Board earlier in November. The multi-agency board, currently chaired by the Director of Adult Services, aims to

- oversee delivery against neighbourhood priorities
- unblock cross organisational dependencies
- ensure Strategic Investment Fund (SIF) resources are connected to deliver plans and assurance
- create a learning loop from neighbourhood delivery to strategic commissioning and resource decisions
- receive a quarterly update on outcomes, variations and benefits

The Board aims to meet monthly and agreed to develop a programme of organisational development commencing in early 2027.

Update on Neighbourhood (NH) Development

Bromley is moving from programme mobilisation to a consistent four neighbourhood delivery programme with the following achievements:

- Appointment of four neighbourhood GP leads, alongside a manager lead.
- Completion of a 40 patient south west neighbourhood Long Term Conditions (LTC) pilot, with standardised multi-morbidity assessment model across all neighbourhoods.
- Residents with long term conditions identified through population health management, general practice case finding and hospital discharge referrals.
- Establishment of frailty Multi-Disciplinary Teams (MDTs), with comprehensive geriatric assessment undertaken by community matrons (and strengthening implementation of universal care plans and personalised care planning). This will result in more consistent recording of patients' Clinical Frailty Scales – leading to better case management of severe frailty. Named geriatrician, palliative care links and Allied Health Professional input through the community teams.
- Mobilisation commenced of population health management Hub bridging analytical insight with front line delivery
- Development of and adult pathway workforce model, moving to recruitment

- Children and Young People (CYP) delivery is building on the Bromley Child Health Integrated Partnership (BCHIP) model with asthma and allergy pathways development. This aligns with the Families First programme and pathways being co-designed with young people and families.
- Strengthening social care, Voluntary, Community and Social Enterprise (VCSE), mental health, secondary care and community pharmacy participation
- Cardiovascular, Renal and Metabolic (CVRM) prevention programme commenced with pathway development for surveillance and management of women post partum, who had gestational diabetes and/or hypertension in pregnancy.

Challenges identified include ensuring that additional standalone services are not created, and that we have clear clinical ownership and safe escalation processes in place.

Winter Plans 26-27

Following our review of last winter and an assessment of what needs to be in place, additional services to support patients and organisations are now up and running, or due to start at the beginning of December:

- Approximately 10,000 additional GP appointments
- New model of social work to support discharge with social workers working more close in person with wards in the hospital
- Frailty Single Point of Access (SPoA) expansion - now a seven-day service running from 9am to 6pm, with additional expert clinical decision maker available during these hours. We are very grateful to the Princess Royal University Hospital (PRUH) Gerontology team who volunteered for the weekend rota. Open access to this service is available for all care homes as well as London Ambulance Service and South East Coast Ambulance Service.
- Enhanced virology testing for care homes with same day results.
- Additional support to increase uptake of vaccination in care home residents.
- Additional capacity for a number of different organisations.
- Weekly winter update on current pressures and circulating viruses available for all partners.
- Two weekly system touchpoints instituted.

Greenwich

SEND Reforms

Greenwich's Local Special Educational Needs and Disability (SEND) Reform Plan has been approved by the Department for Education. Significant work is taking place to implement it locally and in September as part of that plan the borough launched its new Experts at Hand Service supporting greater inclusion within Childcare and Education settings in the borough. The implementation of the plan is overseen by the jointly ICB and Local Authority chaired SEND Reform and Partnership Board, which includes representation from the local Parent/Carer Forum. Greenwich's Annual SEND Engagement Meeting takes place in December with the CQC and Ofsted and provides an opportunity for the ICB and Local Authority to feedback to both regulators on the work that is happening at Place.

Neighbourhood Social Investment Partnership

Greenwich has been selected alongside Lewisham for the trailblazer social investment programme. This is a significant achievement and testament to the local partnership we have in place. This will be building on our existing Integrated Neighbourhood Teams model to make it cancer inclusive, demonstrating to other sites nationally what can be achieved through transforming community offers. Social investment partnerships enable new innovation to be delivered by a model which is based on assessing the impact of local services on the outcomes they deliver for the target population, as well as key metrics related to system impacts. An investor shares the risk by investing in local delivery (Macmillan in this case), an outcome payer shares the risk by paying the investment back subject to the outcomes being delivered. A strong place-based partnership is required to ensure integrated local services, including those in the public and VCSFE sectors, can be commissioned to deliver improved impact for local target populations using the investment. Between now and March 2027 we will continue our work to develop the business case and secure up to £9m for the Greenwich model we put forward.

Digital Health and Care Technology Service (DHACT)

The Local Government Chronicle award winning service has also now been shortlisted for a Health Service Journal award, *Driving Efficiency through Technology*. This service is already integrated as it was jointly commissioned as a strategic innovation partnership with health staff referring in for devices in our community pathways as well as those supporting people to be discharged from hospital. Current impact analysis is showing that the services is positively impacting length of stay and outpatients metrics for the NHS as well as delivering over 5m of evidenced impact for ASC. Health financial benefits were phased to be accrued as the service continued to evolve. With the full implementation in Virtual Wards we expect this to ensure the core offer for remote health monitoring is met via the service before expanding in to more proactive care pathways as we continue to establish INTs.

Neighbourhood health and care

Greenwich has now agreed and signed off investment of £1.4m as part of the Flexible Funding package to 'level up' Premium (non-core) funding across SEL. Investment of £3.33 per weighted patient will now be made recurrently into Greenwich general practice for participation in the LTCs INT proactive care pathway, and a further £1 per weighted patient will be paid for wound care in general practice.

Greenwich's proactive care INT pathways for Frailty and LTCs are both now launched in all four Neighbourhoods. These are delivering proactive, multi-disciplinary input into identification and coordinated health and wider wellbeing care for vulnerable and 'rising risk' patients within these cohorts.

General Practice

The safe closure of Eltham Palace Surgery took place on 18th September, following the cancellation of the GP partners' registration by the CQC in March 2026. Patient and politician engagement has been ongoing throughout and we are now in the final stages of allocating the final ~500 patients to new GP practices (where they have not re-registered themselves).

All 28 Greenwich GP practices are now signed up to the Safer Surgeries scheme, making a commitment to ensure healthcare is accessible to everyone, including migrants, refugees, asylum seekers, and people experiencing homelessness. This has risen from 14 practices signed up two years ago.

Lambeth

*'*Our Health, Our Lambeth' Health and Care Plan 2023 to 2028

Delivery of *Our Health, Our Lambeth* continues to progress, with a focus on strengthening neighbourhood-based care, prevention and reducing health inequalities. The six-month review of Alliance and Programme activity has been completed, highlighting achievements and areas for further improvement. Integrated Neighbourhood Teams continue to support residents with more complex needs, supported by a new care coordinator function, while community mental health services have been remodelled to provide more joined-up, neighbourhood-based support. Prevention activities include expanded sexual health services, targeted flu vaccination outreach and additional support for rough sleepers ahead of winter. The annual winter plan is also now complete and is being enacted, with Lambeth supporting six additional winter schemes to help manage demand, strengthen capacity and improve flow. A substance misuse needs assessment has been completed, with the latest data showing continued improvement in the number of residents accessing drug and alcohol treatment. Findings from the six-month review will inform priorities for the remainder of 2026/27 and the refresh of the action plan for 2027/28.

Work in the Community

Neighbourhood and Wellbeing Delivery Alliance (NWDA) - Lambeth has made good progress in developing and improving its neighbourhood health model. Key achievements include establishing the Integrator Delivery Board, launching three Integrated Neighbourhood Teams across five neighbourhoods.

Living Well Network Alliance (LWNA) - Lambeth's community mental health services have transitioned to neighbourhood focused Mental Health Teams, supporting more person-centred care and closer working with GP practices, VCSE partners and Integrated Neighbourhood Teams. Services will continue operating from the existing Living Well Centres, with most service users retaining their current care arrangements. Around 160 people will transfer to a new Living Well Centre with support and engagement in place to manage the transition.

Children and Young People Alliance (CYPA) - The Alliance continues to strengthen joint working across Families First, SEND Reform, Best Start Family Hubs and Integrated Neighbourhood Teams, aligning delivery plans and support pathways across health, education and social care. Building on early successes, Lambeth are exploring more proactive ways of identifying children and families who may benefit from coordinated support before their needs escalate. This includes innovative work to bring together information on repeat social care contacts, school attendance and SEND to identify children whose needs may not be fully addressed through existing services.

Key Programme Updates and Achievements

Primary Care Thrive and the Lambeth Offer - launched in September, strengthening general practice skills, resilience and wellbeing through training and tailored support.

Estates – leases signed for long-term premises at Graphite Square, Vauxhall for Lambeth Walk Group Practice and for Gray's Inn Medical Group, expected to open summer 2027.

Lambeth Can Move System Network - launched in September with nearly 100 partners to tackle physical activity inequalities, ahead of a planned Sport England funding bid in January.

Carers Awards - around 100 attendees celebrated 15 awards in September, recognising unpaid and young carers, professionals and community organisations.

HIV Confident - Lambeth became the first council nationally to achieve HIV Confident Organisation status for tackling stigma and discrimination and promoting inclusion.

Inspire Black Communities Health Inequalities Small Grants Programme launched in October, supporting black-led organisations to improve wellbeing, tackle inequalities and isolation, and strengthen community support and service access.

SEND - Lambeth's joint Ofsted/CQC inspection of local SEND services took place in October, involving partners across health, social care, education and the voluntary sector, alongside children, young people and families. The findings will be shared once the final inspection report is published.

Lewisham

Lewisham – Long Term Conditions (LTC) - Integrated Neighbourhood Team

Lewisham has successfully established its Long-Term Conditions (LTC) Integrated Neighbourhood Team (INT) model across all four neighbourhoods, providing proactive, coordinated care for residents living with three or more long-term conditions. To date, approximately 4,000 eligible residents have been identified, with around 1,200 patients receiving support The teams provide holistic assessments, personalised care plans, pharmacist reviews, lifestyle medicine interventions, and support from the voluntary, community sector, with plans to strengthen mental health provision.

Early outcomes have been positive, including improvements in blood pressure and cholesterol levels**,** alongside support to address wider social needs and improve overall wellbeing. The model has also strengthened collaboration and integration between primary care, community health services, and the voluntary sector. The Lifestyle Medicine programme which is part of the INT offer has also been shortlisted for a Health Service Journal (HSJ) Award this month, recognising its innovative approach to supporting residents with long-term conditions, promoting healthier lifestyles and improving health outcomes.

Neighbourhood Social Investment Partnership

Lewisham and Greenwich have been selected as one of six national sites for the Trailblazer programme with expected investment from Macmillan, as detailed above in paragraph 2 of the Greenwich section.

Primary Care

Lewisham has now agreed and signed off additional investment of £481,099 for 2026/27, as part of the Flexible Funding package to 'level up' Premium (non-core) funding across SEL. This equates to investment of £2.82 per weighted patient which will be made into Lewisham general practice to support the priority areas of diabetes prevention, Universal Care Plans (UCPs) and frailty. The scheme was successfully launched to practices in advance of the 1st of October 2026 go live date and all practices have now signed up to the scheme and commenced delivery.

HIV prevention, testing and care

Lewisham and the ICB are strengthening the HIV pathway, with a focus on earlier diagnosis, improved access to prevention and reducing inequalities in HIV outcomes. Developments include extending Pre-Exposure Prophylaxis (PrEP) into primary care and digital provision, introducing opt-out HIV testing in general practice, and recommissioning community HIV and PrEP outreach through trusted VCSE partners. These approaches particularly aim to improve access for communities currently under-represented in PrEP and testing, including Black African and Caribbean residents, women and heterosexual men.

This is complemented by ICB-supported joint commissioning across South East London, including Lewisham's participation in recommissioning HIV care and support across Lambeth, Southwark and Lewisham. Together, the programme is developing a more integrated pathway across primary care, community, digital and specialist NHS services, supporting progress towards fewer undiagnosed and late HIV diagnoses, increased prevention uptake and more equitable access and outcomes.

Substance misuse reconfiguration

Lewisham is moving into mobilisation of a new integrated drug and alcohol treatment model from April 2027, following a whole-system review and recommissioning programme. The redesigned service will strengthen integration across primary care, mental health, housing, social care and other partners, with neighbourhood-based delivery, outreach and dedicated links into Integrated Neighbourhood Teams. The accompanying redesign of GP shared-care provision will consolidate the current eight practices into five more sustainable hubs, while explicitly developing closer alignment with Integrated Neighbourhoods and specialist treatment.

For the ICB, this creates an important opportunity to embed substance misuse treatment within the wider neighbourhood health model, improving earlier access, reducing fragmented pathways and strengthening support for people with co-occurring physical health, mental health, housing and social needs. The new model has a strong inequalities focus, targeting poorer access and outcomes among women, ethnically diverse communities, younger adults, people experiencing multiple disadvantage and people with co-occurring mental health needs. The intended outcomes are greater engagement

and retention in treatment, reduced drug and alcohol-related morbidity and mortality, improved recovery and more equitable outcomes, alongside reduced pressure on urgent and emergency NHS services.

Ending Rough sleeping strategic approach

Lewisham Council and the ICB are developing an increasingly integrated housing, health and care response to rough sleeping, recognising the significant inequalities experienced by people with multiple mental health, substance misuse, physical health and social care needs. The ICB has secured continued investment in START specialist dual-diagnosis mental health outreach, alongside primary care and homeless-health provision. This is now being complemented by £932k of new Ending Rough Sleeping investment, developed jointly through the Rough Sleeper Steering Group, to strengthen rapid access to accommodation, small-scale intensive supported housing, Housing First, outreach, VCSE support and dedicated Adult Social Care input. Together, this provides a stronger platform for the Council and ICB to integrate housing with health and care, improve access and outcomes for one of Lewisham's most disadvantaged populations, prevent repeat rough sleeping and crisis, and reduce avoidable pressure on urgent and emergency services.

Southwark

Partnership priorities

The September Health and Wellbeing Board considered the 2026 JSNA, approved the 2026/27 Better Care Fund plan and agreed an approach to the 2027/28 Neighbourhood Health Plan which will include a small number of cross-cutting priorities, prevention and neighbourhood-specific delivery. Other business covered health equity, financial support, maternity and sexual and reproductive health.

Neighbourhood delivery

Most Integrated Neighbourhood Team leads are in place. VCSE anchors are confirmed in each neighbourhood, coordinated by Pembroke House. Strategic Investment Fund proposals are moving into mobilisation for cohorts with frailty, long-term conditions and children. In all these areas activity data is increasing month on month to cover 1.5% of the population this year. Southwark and Lambeth secured funding for four "Pushing the Boundaries" initiatives covering maternity, children and young people, high-intensity service users and reactive care.

Primary care and recognition

All Southwark GP practices have signed the refreshed GP Premium contract, running from 1 October 2026 to 31 March 2029 with existing investment maintained. The independent prescribing hypertension project is shortlisted for an HSJ award, with the ceremony on 19 November.

Performance and assurance

Community waiting times, SEND and learning disability health checks show progress; Continuing Health Care assessment timeliness has recovered. Key concerns include Talking Therapies

outcomes, SMI physical health checks, hypertension control, childhood and flu immunisation, and urgent same-day GP access. GP activity and access comparisons remain affected by data-quality issues which are being worked through.

Finance

Month 4 forecasts breakeven, with mental health and community service overspends offset by CHC underspending. ADHD/autism assessment demand and mental health placement costs remain the primary financial risks.

Governance and team changes

Gabi Darby has joined as Place Executive Lead. The Neighbourhood Team posts are filled through the ICB change programme. Staff capacity risks have escalated for integrated commissioning. In line with ICB changes to governance, the Partnership Southwark Strategic Board will no longer meet as a Committee of the ICB. The members have agreed to continue to meet bi-monthly as a Partnership Southwark Neighbourhood Board to oversee delivery of Neighbourhood health in line with the national framework.