Bexley Wellbeing Partnership Committee meeting held in public

Thursday 22nd January 2026, 14:00 – 16:00

Venue: Council Chambers, Ground Floor, Civic Offices, Bexleyheath DA6 7AT

Agenda

No.	Item	Encl.	Presenter	Time
Opening Business and Introductions				
1.	Introductions and apologies		Chair	14:00
2.	Declarations of Interest	Encl. A	Chair	14:03
3.	Notes from 27th November 2025 and matters arising	Encl. B	Chair	14:04
Decision				
4.	Five Year Strategic Commissioning Plan: *Bexley Neighbourhood Delivery Plan*	Encl. C	Diana Braithwaite/ Dr Nicole Klynman	14:05
5.	Joint Prevention & Early Intervention Grants Programme	Encl. D	Gita Prasad	14:25
Assurance				
6.	Better Care Fund: Quarter 3 2025/26 NHS England Return	Encl. E	Steven Burgess	14:40
7.	Finance Report: Month 8	Encl. F	Asad Ahmad	14:55
8.	Risk Register	Encl. G	Rianna Palanisamy	15:05
Public Forum				
9.	*Public Questions*			15:15
Let's Talk				
10.	New Year, New You		Chair	15:17
Closing Business				
11.	Any other business		Chair	15:55
For Information				
12.	Glossary	Encl. H		
13.	Date of the next meeting: Thursday 26th March 2026, Council Chambers, Civic Centre.			

ITEM: 2

ENCLOSURE: A

Declaration of Interests: Update and signature list

Name of the meeting: Bexley Wellbeing Partnership Committee **Date:15.01.2026**

Name	Position Held	Declaration of Interest	State the change or 'No Change'	Sign
Dr Sid Deshmukh*	Chair- Bexley Wellbeing Partnership	1. Senior Partner Sidcup Medical Centre PMS Contract - Financial Interest Materiality 50% 2. Shareholder of GP Federation 3. Shareholder Frogmed Limited (Dormant company) 4. Chair - Frognal Primary Care Network GP Lead 5. Wife (Dr Sonia Khanna-Deshmukh) is Frognal PCN Clinical Director 6. Non-financial personal interest in Inspire, Father-in-law Mr Vinod Khanna is Chief Executive. Community Trust; a) Wheelchair service; b) Joint Equipment Store; c) Personal Health Budgets; d) Information and service support for people with physical and sensory impairment. 7. Chairman, Bexley Health Neighbourhood Care CIC 8. Clinical Lead, Frognal Local Care Network		
Diana Braithwaite*	Place Executive Lead (Bexley), NHS South East London Integrated Care Board	Nothing to declare.		
Dr Nicole Klynman*	Director of Public Health London Borough of Bexley Council	1. Salaried GP at Leyton Healthcare		
Yolanda Dennehy*	Director of Adult Social Care, London Borough of Bexley Council	Nothing to declare.		
Raj Matharu*	LPC Representative	1. Superintendent Pharmacist of MAPEX Pharmacy Consultancy Limited.		

		2. Wife is lead pharmacy technician for the Oxleas Bromley medicines optimisation service (indirect interest) 3. SEL Community Pharmacy Fed Ltd/SEL Pharmacy Alliance – MAPEX Pharmacy Consultancy Ltd is a member of SEL Pharmacy Alliance. (financial interest) 4. Conclusio – Consultancy work with respect to primary care community pharmacy services (financial interest) 5. Chief Executive Officer – South East London Local Pharmaceutical Committee/Community Pharmacy South East London (financial interest) 6. Chair of Community Pharmacy London 7. Editorial Board Member – PM Healthcare (financial interest) 8. Son is Pharmacist at Westchem Pharmacy is Community Pharmacy Neighbourhood Lead (CPNL) for Bromley.		
Keith Wood	Lay Member, Primary Care (Bexley)	Nothing to declare.		
Jennifer Bostock*	Independent Member (Bexley)	1. Independent Advisor and Tutor, Kings Health Partners (financial interest) 2. Patient Public involvement Co-Lead, DHSC/NIHR 3. Independent advisor and Lay Reviewer, UNIS 4. Lay co-applicant/collaborator on an NIHR funded project 5. Independent Reviewer, RCS Invited Review Mechanism 6. Lay co-applicant, HS2		
Dr Pandu Balaji*	Clinical Lead – Frognal Primary Care Network	GP partner, Woodlands Surgery (financial interest)		
Dr Miran Patel*	Clinical Lead – APL Primary Care Network	1. GP Partner, The Albion Surgery (financial interest) 2. Clinical director, APL PCN (financial interest)		
Dr Nisha Nair*	Clinical Lead – Clocktower Primary Care Network	1. GP Partner, Bexley Group Practice (financial interest) 2. Clinical director, Clocktower PCN (financial interest)		
Dr Surjit Kailey*	Clinical Lead – North Bexley Primary Care Network	1. GP Partner, Northumberland Health Medical Centre (financial interest)		

		2. Co-director of BHNC (financial interest) 3. Co-clinical director, North Bexley PCN (financial interest) 4. Co-medical Director Grabadoc (financial interest)		
Abi Mogridge (n)	Chief Operating Officer, Bexley Health Neighbourhood Care CIC	Nothing to declare.		
Jattinder Rai (n)	CEO, Bexley Voluntary Service Council (BVSC)	Nothing to declare.		
Rikki Garcia (n)	Chair, Healthwatch Bexley	Nothing to declare.		
Kate Heaps (n)	CEO Greenwich and Bexley Community Hospice	1. CEO of Greenwich & Bexley Community Hospice – financial interest 2. Chair of Share Community - a voluntary sector provider operating in SE/SW London with spot purchasing arrangements with LB Lambeth – non-financial professional interest		
Andrew Hardman	Chief Commercial Officer, Bromley Healthcare	Nothing to declare.		
Stephen Kitchman	Director of Services for Children and Young People, London Borough of Bexley Council	Nothing to declare.		
Sarah Burchell	Director Adult Health Services, Bexley Care	Nothing to declare.		
Iain Dimond*	Chief Operating Officer, Oxleas NHS Foundation Trust	Nothing to declare.		
Dr Sushantra Bhadra	Clinical Director, North Bexley Primary Care Network (deputising for Dr Kailey)	1. GP Partner, Riverside Surgery – financial interest 2. Member of the Londonwide LMC – financial interest 3. Clinical Director, North Bexley PCN – financial interest		
Deborah Travers	Associate Director of Adult Social Care (deputising for Deputy Director of Adult Social Care)	Nothing to declare.		
Dr Sonia Khanna	Clinical Director, Frognal PCN (deputising for Dr Pandu Balaji)	1. GP Partner, Sidcup Medical Centre – financial interest 2. Practice is member of Bexley Health Neighbourhood Care – financial interest 3. Joint Clinical Director, Frognal PCN – financial interest		

		4. Husband, Dr Sid Deshmukh, is Frognal PCN chair, BHNC Director, Clinical lead – Urgent Care, Senior Partner at Sidcup Medical Centre, shareholder of Frogmed Ltd (dormant company) and Chair of Bexley Wellbeing Partnership – indirect interest 5. CYP and Families Clinical Lead – Bexley – non-financial professional interest 6. Father, Mr Vinod Khanna, is Chief Executive Officer of Inspire Community Trust – non-financial personal interest. 7. Member of Bexley LMC – non-financial professional interest. 8. GP Appraiser for south east London – non-financial personal interest.		
Dr Adefolake Davies	Clinical Director – Clocktower Primary Care Network	1. Clinical Director, Clocktower PCN – Financial Interest 2. Shareholder, Bexley Health Neighbourhood Care – Financial Interest 3. Shareholder, Bexley Health LTD – Financial Interest 4. GP Principal, Dr Davies and Partner – Financial Interest		
Ellie Thomas	Associate Director, Planning and Partnerships, Dartford & Gravesham NHS Trust	Nothing to declare.		
Spencer Prosser	Chief Finance Officer, Lewisham and Greenwich NHS Trust	###		

***voting member.**

members who have not made the annual declaration for 2025/26 will be requested to make a verbal declaration within the meeting.

Agenda Item: 3
Enclosure: B

Bexley Wellbeing Partnership, Meeting in Public

Minutes of the meeting held on Thursday, 27th November 2025, 14:00hrs to 16:00hrs
Venue: Council Chamber, Ground Floor, Civic Offices, Bexleyheath DA6 7AT

(and via Microsoft Teams)

Voting Members

Name	Title and organisation
1. Dr Sid Deshmukh	Chair, Bexley Wellbeing Partnership
2. Jennifer Bostock (JB) – (via MS Teams)	Vice-Chair, Independent Member
3. Diana Braithwaite (DB)	Strategic Director, Integrated Health & Care/Place Executive Lead (Bexley), NHS South East London Integrated Care Board (NHS SEL ICB)
4. Dr Nicole Klynman (NK)	Director of Public Health, London Borough of Bexley (LBB)
5. Deb Travers (DT)	Associate Director, Adult Social Care (LBB)
6. Bhaval Patel (via MS Teams)	Local Pharmaceutical Committee
7. Iain Dimond (ID)	Chief Operating Officer, Oxleas NHS Foundation Trust
8. Dr Miran Patel (via MS Teams	APL Primary Care Network
9. Dr Sonia Khanna (via MS Teams)	Frognal Primary care Network
10. Dr Folake Davies (FD) (via MS Teams)	Clocktower Primary Care Network
11. Dr Surjit Kailey (via MS Teams)	North Bexley Primary Care Networ

In attendance

Dr Nisha Nair (via MS Teams)	Clocktower Primary Care Network
Sarah Burchelll	Director, Integration & Neighbourhoods, Oxleas NHS Foundation Trust
Keith Wood (KW) (via MS Teams)	Lay Member for Primary Care (Bexley), NHS SEL ICB
Abi Mogridge (AM)	Chief Executive Officer (CEO), Bexley Health Neighbourhood Care CIC (GP Federation)
Andrew Hardman (AH)	Chief Commercial Officer, Bromley Healthcare
Dr Clive Anggiansah (CA)	Clinical & Care Professional Lead, Community Based Care, Bexley, NHS SEL ICB
Alison Rogers (AR)	Director of Integrated Commissioning (Bexley), NHS SEL ICB
Gita Prasad (GP)	Interim Director of Integrated Commissioning (Bexley), NHS SEL ICB
Tracey Jenkins (TJ) (via MS Teams)	Director of Strategic Transformations and Partnerships, Dartford & Gravesham NHS Trust
Graham Tanner (GT)	Associate Director, Primary & Community Care (Bexley), NHS SEL ICB
Asad Ahmad (AsA)	Associate Director of Finance (Bexley), NHS SEL ICB
Kallie Heyburn (KH)	Bexley Wellbeing Partnership Programme Director, NHS SEL ICB

Steven Burgess (StB)	Policy and Strategy Officer, London Borough of Bexley
Patrick Gray (PG)	Community Voice Manager (Bexley), NHS SEL ICB
Aysha Awan (AyA)	Head of Communications and Engagement (Bexley), NHS SEL ICB
Rianna Palanisamy (RP) *(Presenter)*	Partnership Business Manager (Bexley), NHS SEL ICB
Nazima Bashir (NB) *(Minutes)*	Corporate Business Manager (Bexley), NHS SEL ICB

Apologies

- Stephen Kitchman (StK), Director of Children's Services, London Borough of Bexley
- Pandu Balaji (PB), Frognal Primary Care Network
- Yolanda Dennehy (YD), Director of Adult Social Care & Health, London Borough of Bexley
- Kate Heaps (KH), Chief Executive Officer, Greenwich & Bexley Community Hospice
- Raj Matharu (RM), Chief Executive Officer, Local Pharmaceutical Committee
- Jattinder Rai (JR), Chief Executive Officer, Bexley Voluntary Service Council
- Jim Beale (JB), Deputy Director Adult Social Care, London Borough of Bexley

		Actioned by
1-2	**Welcome, apologies and declarations of interest** **Dr Sid Deshmukh (SD), Chair, Bexley Wellbeing Partnership Committee, NHS South East London Integrated Care Board (NHS SEL ICB)** opened the meeting and welcomed all present. Apologies were noted and the meeting was confirmed as quorate. No further declarations of interest were made other than those stated in the Register of Interests.	**SD**
3.	**Draft minutes of the public meeting held on 25th September 2025** Bexley Wellbeing Partnership agreed that the draft minutes of the public meeting held on 25th September 2025 were a true and accurate record of that meeting and approved them on that basis **Matters Arising** Nil. *02.12.2025: A post-meeting correction was identified regarding the job title of Diana Braithwaite (DB). This has now been amended within agenda items 4 and 5 of the minutes.*	**SD**
4.	**Health & Care Reforms: Neighbourhood Health Plan Development** **Diana Braithwaite (DB), Strategic Director, Integrated Health & Care/Place Executive Lead (Bexley), NHS South East London Integrated Care Board (NHS SEL ICB) and Kallie Heyburn (KH), Bexley Wellbeing Partnership Programme Director, NHS South East London Integrated Care Board** jointly talked the group through the salient points of the item. DB talked the group through the changing role of the Health and Wellbeing Board and KH talked through the 2026/27 neighbourhood plan requirements and the approach to its development this year. Outlined the national reforms set out in the NHS 10-Year Plan, the strengthened role of Health & Wellbeing Boards and the new requirement to develop neighbourhood health plans. Summarised Bexley's proposed approach for developing the 2026/27 Neighbourhood Health Plan, including alignment with existing strategies, the role of current pilot workstreams and the timetable for producing a draft plan. The Chair (SD) then invited questions and comments from the group. Questions/Comments: • JB asked for clarification regarding the comment made about the shift to digital • KH explained that the reference was in relation to the exercise of looking at the requirements set out in the NHS 10-year plan and comparing them to our existing Joint Local Health and Wellbeing Strategy and Joint Forward Plan. The national priority of moving away from analogue to digital is not strongly articulated in our current plans.	**DB/KH**

	• KH advised that this would include items such as the NHS App, on-line triage and consultations and collecting patient feedback digitally. • KH noted that there could be a risk of creating inequalities through digital exclusion and this would be an important consideration in the development and delivery of the plan next year. • JB queried the ease of making the changes set out in the 10-year plan • KH advised that some elements were more straightforward than others with some challenges being worked through. However, she stressed that the Bexley Partnership is committed to working together to improve outcomes for our population and referenced the ageing well/frailty work as an example of bringing partners and stakeholders together to codesign a model of care. • KH mentioned that the ability to share data will take longer to resolve although interim work arounds are in place to enable progress to be made and ensure we are successful. No further questions were raised **The Bexley Wellbeing Partnership Committee:** **(i) Noted** the proposed governance review across the Bexley Health & Wellbeing Board and Bexley Wellbeing Partnership Committee for implementation in 2026/27. **(ii) Endorsed** the approach and timelines for reviewing and health strategies and plans in the immediate term (during 2025/26), including developing the Local Neighbourhood Plan as aligned to the Joint Health & Wellbeing Strategy.	
5.	**Joint Forward Integrated Plan 2025/26: Progress Report** **Kallie Heyburn (KH), Bexley Wellbeing Partnership Programme Director, NHS South East London Integrated Care Board** talked the group through the salient points of the progress update on the Integrated Joint Forward Plan 2025/26. KH summarised delivery across priority workstreams and Local Care Networks, noting key successes, challenges and learning from April to September 2025. The Chair (SD) then invited questions and comments from the group. Questions/Comments: • JB commended the work to date but queried the absence of any reference to homelessness and addiction. • KH confirmed that this was identified as a gap in the read across exercise referenced earlier and would be built into the 2026/27 neighbourhood plan • NK confirmed Bexley Public Health will be co-hosting four workshops at the halfway point of the Integrated Health and Wellbeing Plan, hopefully in July 2026, to review achievements and what they want to do in the second half of the plan. No further questions were raised. **The Bexley Wellbeing Partnership Committee:**	**KH**

	(i) **Reviewed** the progress made on delivering the Bexley Wellbeing Partnership Integrated Forward Plan.	
6.	**Better Care Fund (BCF): Quarter 2 2025/26 NHS England Return** **Steven Burgess (StB), Policy and Strategy Officer, London Borough of Bexley,** talked the group through the salient points of the item. He outlined that the purpose of the paper was to present the Better Care Fund Quarter 2 Return 2025/26 for information and assurance, noting that the return had been submitted to the BCF National Team and that all national conditions had been met. StB provided a summary of performance across the core BCF metrics, including emergency admissions, discharge delays, care home admissions, and outcomes from short-term support. StB highlighted areas of strong performance, such as high same-day discharge rates, reduced long-term care admissions and improvements in discharge to usual place of residence alongside areas requiring continued focus, including discharge complexity, falls related admissions and rising care package complexity. The group was also updated on key system learning and improvement actions, including winter planning preparations, joint work on complex discharges, strengthened reablement capacity, dementia pathway support, neuro-rehabilitation reviews, improved mental health engagement and upcoming service transformation initiatives expected to enhance system flow. The Chair (SD) then invited questions and comments from the group. No questions were raised. **The Bexley Wellbeing Partnership Committee:** (i) **Noted** the report for information and assurance.	**StB**
7.	**Local Care Partnership Assurance Report** **Graham Tanner (GT), Associate Director, Primary and Community Based Care (Bexley), NHS South East London Integrated Care Board,** talked the group through the salient points of the item. He explained that the report provides an overview of Local Care Partnership (LCP) performance metrics, highlighting areas of achievement and those requiring additional focus to meet national targets and agreed trajectories. GT outlined key areas of strong performance, including mental health metrics (Dementia diagnosis, Talking Therapies and Severe Mental Illness (SMI) Health checks), Continuing Health Care, learning disabilities (LD) and Autism Annual Health Checks and Bowel Cancer screening. Areas where performance is below trajectory were also highlighted, including childhood immunisations (MMR1 and MMR2, DTaP/IPV/Hib), cervical cancer coverage, hypertension management and adult flu vaccination rates. He detailed mitigating actions and improvement plans, including targeted community engagement, enhanced practice support, operational oversight and investment initiatives to address identified shortfalls. The Chair (SD) then invited questions and comments from the group. <u>Questions/Comments</u>:	**GT**

	• The Chair (SD) asked for clarification regarding the cervical cancer reporting metric, highlighting that the reporting period was from June 2024. • GT explained that the reports are based on the latest available published datasets and that there was a significant lag with some of the cancer date reporting. There is a known data quality issue for cervical cancer reporting for Q2 24/25. • The Chair (SD) thanked GT for the clarification. No further questions were raised. **The Bexley Wellbeing Partnership Committee:** (i) **Reviewed** the report and the mitigations/actions highlighted in Appendix 1 for each of the metrics RAG rated as red based on the latest reporting period.	
8.	**Finance Report: Month 6** **Asad Ahmad (AsA), Associate Director of Finance (Bexley), NHS South East London Integrated Care Board,** talked the group through the salient points of the report. Bexley Place shows a £194k Year to Date (YTD) underspend with forecast breakeven. The NHS SEL ICB is broadly on plan and the NHS ICS system reports a £22.9m YTD deficit, with a year-end breakeven forecast. *Full details are included in the agenda pack shared in advance of the meeting.* The Chair (SD) invited questions or comments from the group. Questions/Comments: • The Chair (SD) asked if one borough overspends does another borough which might have underspend cover the overspend to help achieve a break-even position. • AsA responded, explaining the current financial position and the factors influencing potential variances. • DB noted that Bexley has not been in a challenging financial position for some time. DB highlighted that, as AsA had outlined, the commissioning and primary care teams have managed resources effectively to reach the current position and that this context should be considered by the public. • The Chair (JB) observed that the NHS is under significant pressure, especially following the confirmation of the Chancellor's budget. JB asked how such financial positions could be explained and defended publicly. • PG acknowledged the complexity, noting that public perception is often shaped by headlines. PG emphasised the importance of transparency and engagement, referencing work with community champions over the past few years to help residents understand ongoing programmes and the complexities behind decision making. PG noted that such engagement helps counter misconceptions about funding limitations and ensures informed communication within communities.	**AsA**

	• JB asked whether the predicted break-even position applied only to the current year or also to future years and whether it was convincing given what we have heard about the financial position of the NHS. • AsA confirmed that the break-even position applies solely to the current year due to the one-off funding injection which could not be guaranteed in future and it is this injection of funds which enables the break-even position. • DB reminded the group that the overall financial position reflects the NHS ICS, not specifically Bexley Place or the NHS SEL ICB. • The Chair (SD) thanked the group for the discussion and noted there were no further questions or comments. **The Bexley Wellbeing Partnership Committee:** (i) **Reviewed** the month 6 financial position for Bexley Place. (ii) **Reviewed** the NHS South East London ICB and NHS South East London ICS financial position as at month 6.	
9.	**Risk Register** **Rianna Palanisami (RP), Partnership Business Manager (Bexley), NHS South East London Integrated Care Board** presented the Risk Register and took the paper as read. RP highlighted that the Bexley Borough Risk Register currently contains 14 risks, of which: • 10 are rated as high risk • 3 are rated as moderate risk • 1 is rated as low risk • Two risks have an initial score of 15 or above. RP outlined the key underlying causes, which include concerns about achieving financial targets and the level of funding available at both borough and wider system level, insecure lease arrangements affecting a small number of Bexley GP practices; risks relating to delivery of priority actions following the Special Educational Needs and Disabilities (SEND) inspection and performance against targets for SMI health checks, flu vaccination uptake and hypertension management referenced earlier in the meeting. Further risks include the need to embed recommendations from the Better Care Fund (BCF) support programme (March 2025), the challenge of integrating and coordinating services effectively across system partners, delays in delivering Joint Forward Plan goals, and concerns about long waits for autism and Attention Deficit Hyperactivity Disorder (ADHD) diagnoses for children and young people in Bexley. RP noted that the full risk register, including controls and assurance summaries, is included in the meeting papers and confirmed that risks are reviewed monthly by SMT. She invited any questions/comments. The Chair (SD) then invited questions and comments from the group. <u>Questions/Comments</u>: • The Vice-Chair (JB) asked for clarification regarding the risk related to increased patient demand for self-care items being prescribed. She queried why such items are being prescribed if they are not intended to be.	**RP**

	• The Chair (SD) responded that a clear list exists of items considered self-care, such as paracetamol, which should not normally require a prescription or an appointment. However, practical considerations arise for example, following operations or where patients face financial difficulty. While guidance is followed in most cases, clinicians must often balance individual patient circumstances with wider system expectations and decision making is not always straightforward. • The Chair (JB) acknowledged the explanation and noted her concern about the broader impact on NHS resources and potential word-of-mouth expectations that might see self-care items being requested even more through GPs. No further questions were raised. **The Bexley Wellbeing Partnership Committee:** (i) **Noted** the report is for information and assurance to the Bexley Wellbeing Partnership Committee setting out the risks and associated mitigations.	
10.	***Public Questions*** *No questions had been received at this time.*	**PQs**
11.	**Let's Talk 'Diabetes'** The Chair (SD) opened the agenda item, outlining the purpose of the session and highlighting the growing impact of diabetes across the UK. He noted that currently around 5.8 million people are living with diabetes, an all-time high. He confirmed that today's scheduled speakers, all providers of diabetes services, would present. Before their presentations, he invited Dr. Nicole Klynman (NK), Director of Public Health, to provide an overview of diabetes prevalence and noted there will be an opportunity to ask questions following the presentations. **Dr. Nicole Klynman (NK), Director of Public Health, London Borough of Bexley (LBB)** talked the group through the salient points of the key public health insights, highlighting Bexley's comparatively high diabetes prevalence and mortality, increasing modifiable risk factors and the influence of deprivation and demographic change NK emphasised the need for prevention, early identification and targeted support for higher risk residents. **Julie Page, (JP) Bexley Community Diabetes Team Lead**, provided an overview of diabetes and the role of the team. JP explained that diabetes is a long-term condition affecting insulin production or usage, which can lead to high blood glucose and complications over time. JPoutlined the common symptoms and the main types of diabetes, highlighting that type 1 requires insulin treatment and type 2 can be managed with lifestyle changes, medication and sometimes insulin. JP then described the Bexley Community Diabetes Team, part of Oxleas NHS Foundation Trust, which provides specialist support for people living with diabetes. The team includes diabetes specialist nurses, a dietitian, clinical psychologists, a consultant diabetes doctor and community practitioners, offering both clinic based and home visits. JP explained how referrals are made primarily from GP practices or secondary care, based on	

specific clinical criteria and encouraged GP colleagues to contact the team for advice or questions.

PG handed over to Malsa Ibrahim, to provide further information on diabetes prevention.

Malsa Ibrahim (MI), Engagement & Partnership Manager for the National Diabetes Prevention Programme (NDPP), Thrive Tribe, provided an overview of the diabetes prevention service in South London. She summarised the programme's purpose in supporting individuals at the pre-diabetic stage to adopt lifestyle changes through structured interventions covering nutrition, movement, mind, sleep and behaviour change. MI outlined the different delivery options, including face-to-face group sessions, digital access via an app and tailored remote programmes for individuals with specific needs, including language support or accessibility requirements. MI also described eligibility criteria, referral routes through GP practices, expected waiting times and population specific adaptations. MI noted strong feedback from participants and highlighted that many completing the programme achieve a return to normal HbA1c levels. She emphasised the importance of raising awareness of the programme among healthcare professionals and patients and confirmed her contact details for further advice or support.

PG thanked MI for the comprehensive presentation. He introduced the next segment, explaining that Mei Wells, Peter Bellingham and Linda Bellingham would share their experiences of living with diabetes and their work in establishing a peer support group.

Mei Wells (MW), a former diabetes specialist, shared how the Bexley Diabetes Peer Support Group began over 25 years ago following a request from the Community Health Council for patient input on service improvements. After gathering feedback from patients and carers, the group formed to provide ongoing support. MW described how the group initially met at the United Reform Church and was supported by volunteers, including a secretary, treasurer and other stable members. Various healthcare professionals, such as diabetes specialists, eye specialists and vascular surgeons, have contributed their expertise voluntarily. She acknowledged the ongoing contributions of group members, including Peter and his wife Linda, in sustaining the group's activities.

Peter Bellingham (PB) outlined his 10-12 years as Secretary. PB noted that financial support including a £10,000 donation from Cllr Alan Downing helped sustain the group. He described the development of the group's website, which includes high quality Diabetes UK videos on HbA1c, hypo management and self-care for newly diagnosed patients. PB referenced structured education programmes available locally: X-PERT (led by Natasha Collette, Preventative Services Manager & Freedom to Speak Up Guardian, Bexley Health Neighbourhood Care CIC, GP Federation) and DAFNE (Dose Adjustment for Normal Eating), noting that both require strong patient commitment but produce excellent outcomes. PB also reflected on diabetes technology and paid tribute to longstanding member Sheila Burstyn, MBE, who recently passed away. PB described community events, fundraising activities and the group's annual Christmas gathering.

MW encouraged GPs to actively recommend the peer support group, noting that although it has operated for 25 years, attendance remains low despite

the breadth of support available. She reminded colleagues that meetings take place monthly at the United Reformed Church.

Service User Comment - A long-term diabetes patient highlighted the importance of peer support not only for those with diabetes but also for partners and family members and offered to provide additional leaflets to GP practices to support signposting.

The Chair (SD) thanked the speakers and provided the opportunity for questions/comments.

Questions/Comments:

The Vice-Chair (JB) thanked the speakers, describing the presentation as inspirational. She acknowledged the funding support from the Council and highlighted the importance of partnership working in Bexley's 10-year health plan, noting how it addresses prevention, the transition from hospital to community care, and the move from analogue to digital services. She commented on the relevance of the presentation to real world challenges in managing a growing health concern and praised the clarity and effectiveness of the session.

CA, thanked the speakers for their presentation and noted the growing prevalence of diabetes, highlighting that approximately one in 20 people in England are affected. He emphasised the importance of patients attending regular reviews for blood glucose, blood pressure and cholesterol management to help reduce future complications. CA welcomed the peer support group initiative and expressed interest in receiving further details to engage more patients.

MW invited CA to meet with patients, which he welcomed. He also highlighted the importance of prevention, echoing JB's earlier comments, and stressed the need to encourage patients, particularly those with pre-diabetes, to participate in the Diabetes Prevention Programme (DPP), including those who may not have taken up the offer initially.

AM thanked the speakers and emphasised the importance of a strong focus on prevention and early diagnosis. She highlighted two further services: NHS health checks, which in Bexley are effectively identifying pre-diabetic and undiagnosed diabetic patients and directing them to appropriate services and the X-PERT programme (led by Natasha Collette, Preventative Services Manager & Freedom to Speak Up Guardian,) offered within Bexley Health Neighbourhood Care CIC (GP Federation), which is well received by patients. She noted that ongoing follow-ups and collaboration with Oxleas NHS FT services and the peer support group help to integrate and connect the range of diabetes services available.

DB thanked the contributors. DB emphasised the importance of understanding what support is needed and highlighted the role of the local health and care system in promoting available services and peer support groups. DB stressed the focus on prevention, particularly for individuals with pre-diabetes and recognised the work of specialist services in Bexley. DB reiterated the value of early intervention to prevent progression to diabetes and thanked everyone for their contributions, noting the system's commitment to communicating these messages effectively to patients.

Question (on behalf of Dr Sonia Khanna): The Chair (SD) asked whether local data was available on Type 2 diabetes reversal programmes.

	DB confirmed that this can be explored further and noted ongoing work under the long-term conditions programme, including partnerships with the voluntary sector and health and wellbeing coaches. NK reminded colleagues that Bexley offers weight management services, face-to-face and digital which support wider lifestyle change and diabetes prevention. MW reiterated her concern that many residents remain unaware of the support available across the system. PG confirmed that he will bring additional leaflets and information to the next meeting to support wider promotion. There was no further questions or comments. The Chair (SD) thanked all presenters and contributors and closed the item.	
12.	**Any other business** **Diana Braithwaite (DB), Strategic Director, Integrated Health & Care/Place Executive Lead (Bexley), NHS South East London Integrated Care Board** shared with the group that Alison Rogers (AR), Director of Integrated Commissioning, NHS South East London Integrated Care Board (NHS SEL ICB), who has previously served with the clinical commissioning group (CCG), primary care trust (PCT) and the London Borough of Bexley (LBB), will be retiring in a couple of weeks. DB and the group expressed sincere and heartfelt thanks to AR for her many years of outstanding dedication to Bexley, recognising her pivotal role in maintaining strong partnerships with the local authority and wished her a very happy and fulfilling retirement. AR expressed her gratitude to DB and colleagues and reflecting on her enjoyment of working in Bexley. The Chair (SD) also expressed his sincere thanks to AR and thanked everyone for their contributions and closed the meeting.	**DB**
13.	**Glossary** These glossary terms were noted.	**SD**
14.	**Date of the next meeting** Thursday 22nd January 2026, Council Chambers, Bexley Civic Centre.	**SD**

Bexley Wellbeing Partnership Committee

Thursday 22nd January 2026

Item: 4

Enclosure: C

Title:	**Five Year Strategic Commissioning Plan: *Bexley Neighbourhood Delivery Plan***
Author/Lead:	Kallie Heyburn, Bexley Wellbeing Partnership Programme Director, NHS South East London Integrated Care Board
Executive Sponsor:	Diana Braithwaite, Strategic Director, Integrated Health & Care/Place Executive Lead (Bexley), NHS South East London Integrated Care Board Dr Nicole Klynman, Director of Public Health, London Borough of Bexley

Purpose of paper:	The purpose of this paper is to provide the Bexley Wellbeing Partnership Committee with an overview of the Bexley 5-year strategic Neighbourhood Delivery Plan. This plan summarises Bexley's population health needs and outlines the high-level local actions to address those needs in 2026/27 and beyond.	**Update / Information**	
		Discussion	***X***
		Decision	***X***
Summary of main points:	The 2025 **NHS 10-Year Health Plan** and subsequent **Medium-Term Planning Framework** set out the requirement for systems to accelerate the shift towards prevention and neighbourhood-based care, supported by place-based neighbourhood plans aligned to Integrated Care Board priorities. Whilst detailed national neighbourhood planning guidance is still to be published, places are required to contribute high-level neighbourhood plans to the Integrated Care Board (ICB) strategic plan for submission to NHS England in early February 2026. This paper outlines Bexley's Five-Year Neighbourhood Delivery Plan, developed to inform and align with the South East London Integrated Care Board's 5-Year Strategic Commissioning Plan and Bexley's population health improvement ambitions. Developed collaboratively with the Partnership through a series of multi-agency working groups, the plan reflects a shared understanding of population needs, agreed priorities and defined deliverable actions, demonstrating Bexley's commitment to partnership-led, locally owned transformation The Neighbourhood Delivery Plan responds directly to national expectations to shift care from hospital to community, from treatment to prevention, and from analogue to digital, and to strengthen delivery at neighbourhood level through Integrated Neighbourhood Teams (INTs). It reflects Bexley's transition from piloting neighbourhood-based models to delivery and scale, building on existing INT development and integration across primary care, community health services, adult social care, voluntary sector and secondary care.		

	The plan is structured in two connected parts: • **Part A: Population Health Improvement Plan**, which incorporates a summary of Bexley's Joint Health and Wellbeing Strategy and sets out the overarching population health priorities and outcomes. • **Part B: Neighbourhood Delivery Plan**, which translates these priorities into a programme of actions and deliverables across a five-year timeframe. Across the five-year period, actions are explicitly aligned to the seven national priorities of: 1. **Develop neighbourhoods around natural communities** 2. **Ensure good access to high quality general practice** 3. **Continue to improve the primary-secondary care interface** 4. **Agree a multi-neighbourhood urgent care plan** 5. **Establish Integrated Neighbourhood Teams (INT) focused on people with complex needs** 6. **Improving planned care in the community** 7. **Improving care for children and young people** Within this framework, Bexley's previously agreed priorities of **Children and Young People, Mental Health, Healthy Weight** and **Ageing Well/Frailty** are embedded across the relevant national priority areas, ensuring continued focus on local population needs whilst meeting national requirements. The Neighbourhood Delivery Plan has been developed in advance of the publication of detailed national neighbourhood planning guidance, expected later this month, and will be further refined and strengthened once this guidance is issued.	
Potential Conflicts of Interest	There are no conflicts of interest as a consequence of this report	
Other Engagement	Equality Impact	The approach to developing the neighbourhood plan addresses inequalities and ensures that those most affected by poor health outcomes receive proportionate support by focusing on at-risk and rising-risk groups. This approach strengthens equity by aligning resources with need.
	Financial Impact	There are no immediate financial impacts. New models of care will be developed with the aim of utilising existing resources.
	Public Engagement	Engagement undertaken during the development of the initial draft models of care has informed the immediate actions. Further engagement will be built into the next phase as the models evolve and are scaled across the borough as well as when new models emerge aligned to the priority areas.
	Other Committee Discussion/ Engagement	The plan has been developed iteratively with the Partnership through a series of working groups and virtually.

Recommendation:	The Bexley Wellbeing Partnership Committee is recommended to: (i) Approve the 5-Year Neighbourhood Delivery Plan. (ii) Provide feedback on any key areas to support its successful implementation.

NHS
South East London

Five Year Strategic Commissioning Plan: Bexley

Agenda Item: 4
Enclosure: C(i)

DRAFT V8.0

Population Health Improvement Plan (1/3)
Bexley

NHS South East London

Ambition

Working with our communities and partners, we will help people in Bexley stay healthier for longer by making care more preventative, more local, and easier to understand and access.

What do we know about our local population and residents?

Population: Bexley's population is projected to grow by a further 14,700 by 2035. The borough has a higher proportion of children and older people than the London average, with a 21.9% increase expected in the 65+ population and rising frailty. Bexley has a comparatively high number of care homes (18; a total of 1,247 beds), attracting people into the borough and increasing demand on community provision.

Growth and need are uneven, with higher deprivation in north Bexley. The population is increasingly diverse, with minority ethnic groups increasing by 9.9% over the past decade. Around 1 in 10 residents are from a Black African background and 1 in 10 from an Asian background, with diversity greatest in younger age groups and in the north of the borough

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Life expectancy and quality of life: Life expectancy is 80.1 years for males and 83.3 for females. On average, residents spend between 15.9 and 19.5 years in poor health, often with multiple long-term conditions, with outcomes varying significantly between neighbourhoods. 5.5% of the population live in a Core20 area: Thamesmead and Erith.

Causes of death: The main causes of premature death is cancer followed by CVD. On average, 276 preventable deaths occur in Bexley each year. Mortality rates are higher in the most deprived fifth of the borough, particularly for cardiovascular disease, respiratory conditions and cancer, highlighting the need for targeted prevention across the life course.

What outcomes are we looking to secure over the next five years?

Fewer preventable illnesses and more years lived in good health *Measured by:* lower preventable mortality (under 75), longer healthy life expectancy, improved management of long-term conditions, and reductions in tobacco dependency, obesity, and undetected hypertension.

Narrower health inequalities between neighbourhoods. *Measured by: a* reduction in the life expectancy gap between the most and least deprived areas, lower preventable mortality rates in Core20 or the most deprived quintile, and increased uptake of prevention and screening services in deprived neighbourhoods.

Residents are supported and empowered to manage their health and wellbeing. *Measured by*: increased patient activation scores, increased uptake of self-management programmes, social prescribing and prevention offers, improvements in health literacy and digital access where available, and more positive patient-reported experiences of involvement in care decisions.

Care is more accessible, joined-up and delivered closer to home. *Measured by*: reduced emergency admissions for ambulatory care–sensitive conditions, fewer A&E attendances and non-elective admissions among people aged 65 and over, shorter delayed discharges and overall length of hospital stay, and improved patient-reported experiences of care coordination and access.

Population Health Improvement Plan (2/3)
Bexley

NHS South East London

Priority Area	What are we aiming to achieve?	Why does this matter?
Supporting **Children & Young People** *throughout life*	Every child has the best start in life, with reduced inequalities, better mental health, strong family and community support, and smoother transitions into adulthood.	• Giving every child the best start has lifelong benefits for health, education and opportunity. • Early intervention and prevention reduces inequalities seen from pregnancy through adolescence, particularly in the north of the borough. • Improving mental health, safety and resilience now shapes stronger, healthier adults in the future.
Supporting people living with **Mental Health** challenges	Improved mental wellbeing across all ages, with earlier support, better access to community-based care and reduced crises.	• Poor mental health affects people of all ages and is closely linked to deprivation, discrimination and poorer life outcomes. • Early help and community-based support prevent crises and reduce demand on emergency and inpatient services. • Good mental wellbeing improves physical health, productivity, relationships and long-term life chances.
Supporting people to maintain a **Healthy Weight**	Healthier weight across the population, especially children, by creating environments that support active living and healthier diets.	• Obesity is one of Bexley's biggest health challenges, driving higher risk of diabetes, heart disease, cancer and poor mental health. • Rates are highest in our most deprived communities, widening health inequalities. • Creating healthier environments in childhood prevents illness in adulthood and improves lifelong wellbeing.
Supporting older people living with **Frailty**	More older residents living independently for longer, with fewer falls, slower progression of frailty and dementia, and better support for carers and end-of-life care.	• Our population is ageing and more residents are living with dementia, frailty and long-term conditions. • Preventing falls, slowing decline and supporting independence improves quality of life and reduces avoidable hospital use. • Carers and families play a vital role and need support to stay well themselves.

Population Health Improvement Plan (3/3)
Bexley

NHS South East London

How will these priorities contribute to the NHS three shifts?

Our population priorities drive how we expand care into the community, prevent illness, and use digital tools to reach more people effectively.

- **Hospital to community:** our plan will bring services closer to home for people of all ages, ensuring timely access to care and reducing the need for hospital visits. We will strengthen community-based support for children, mental health, and ageing well by integrating primary care, social care, and voluntary sector resources.
- **Sickness to prevention:** the focus is on early intervention across all life stages, preventing illness through targeted initiatives, such as healthy lifestyle programmes, social prescribing, vaccination campaigns, and proactive management of long-term conditions, empowering residents to make informed choices about their health.
- **Analogue to digital:** incorporating digital tools in our care pathways alongside improved digital literacy will support residents with access, engagement, and self-management.

How will our priorities improve access to high quality, safe care?

- **Children and young people** – Bexley will see more services delivered closer to home, reducing waiting times, preventing complications, and supporting joined-up multi-professional and multi-agency care, with a focus on reaching children and families in underserved communities.
- **Healthy weight** – we are providing community-based programmes and early lifestyle interventions, helping people access support for diet, exercise, and long-term condition prevention, empowering residents to manage their health and reduce future illness.
- **Mental health** – we are expanding local mental health services, integrating support across health, social care, schools, and voluntary sectors, improving timely access, crisis support, and safety, while using local data to monitor and improve outcomes.
- **Ageing well / frailty** – we are strengthening proactive community care, home-based assessments, and multidisciplinary teams to manage frailty, prevent avoidable hospital admissions, and help older adults maintain independence safely and die well.

How will we monitor and share progress?

We will monitor progress through:

- Tracking against our success metrics and outcome measures
- Embedding robust governance processes and frameworks, including oversight via the Bexley Executive Leadership, Health and Wellbeing Board and the Bexley Community Based Care Delivery Board

We will share progress by:

- Monitoring and oversight via our existing Programme Boards/Partnerships including flagging risks, issues and barriers as well as sharing lessons learnt
- Utilising agreed communication channels to ensure alignment and visibility

Bexley Neighbourhood Delivery Plan (1/4)

NHS South East London

	Local Actions In Year 1	Local Actions In Year 2	Local Actions In Years 3 -5
Develop neighbourhood footprints around natural communities	• **Map system assets** including digital maturity, shared care records, and neighbourhood resources • **Establish integrator governance and workforce framework** for strategic commissioning leadership and training • **Use Population Health Management (PHM) to align commissioning priorities** to children & young people, people with multiple long-term conditions and frailty in line with SEL frameworks • **Build shared infrastructure** across estates, digital tools, and PHM analytics • **Launch system-wide quality improvement programme**	• **Scale digital tools and PHM infrastructure** for proactive, preventative care • **Embed INT leadership and workforce development** with competency frameworks • **Expand PHM cohorts** and deliver preventative interventions in line with SEL frameworks • **Scale system-wide quality improvement programme** and embed Quality Improvement collaboratives • **Align contracts, incentives, and workflows** to support coordinated delivery	• **Embed shared leadership**, culture, and integrated workforce • **Use advanced PHM and interoperable systems** for proactive, population-based care • **Optimise estates and enablers**, with neighbourhoods contributing to system planning and outcomes • **Commission for outcomes through value-based care contractual frameworks**, with aligned incentives and prevention investment • **Implement unified outcomes framework** with real-time reporting
Ensure good access to high quality general practice	• **Stabilise access** through the Care Sustainability Programme, including reducing variation and expanding Pharmacy First/ independent prescribers. • **Map estates and digital capability**; increase uptake of national and local digital tools • **Baseline vulnerable groups** and **high-frequency users** to inform MDT model	• **Implement neighbourhood estates plans** and strengthen digital access to support delivery of primary care at scale • **Scale MDT approaches** for high-risk cohorts, informed by risk stratification and early population insights • **Broaden deployment** of pharmacy independent prescribers and maximise benefit of community pharmacy	• **Embed integrated access models delivering primary care at scale** with fully developed MDTs • **Deliver optimised estates** and **digital infrastructure** enabling seamless access, coordination and improved outcomes • **Scale and spread community pharmacy independent prescribers** supporting people with multiple long-term conditions

Bexley Neighbourhood Delivery Plan (2/4)

NHS South East London

	Local Actions In Year 1	Local Actions In Year 2	Local Actions In Years 3 -5
Continue to improve the primary-secondary care interface and implement the recommendations of the Red Tape Challenge (RTC) and 'Bridging the Gap'	• **Strengthen joint working across all interface pathways,** aligning with INTs and embedding interface actions to improve timeliness and quality of discharge notices • **Stabilise and expand Advice & Guidance**, electronic referrals and Consultant Connect • **Commence work on resident optimisation** to support people 'waiting well' prior to surgery	• **Implement consistent interface standards**, supported by neighbourhood teams and shared governance • **Work with providers to scale optimised diagnostics**, Same Day Emergency Care and urgent care processes to reduce variation and unblock flow • **Embed integrated digital** and referral processes across all neighbourhoods to promote and support waiting well	• **Achieve a fully integrated interface** with consistent cross-pathway standards, shared decision-making and mature neighbourhood collaboration to include shared estates, workforce and training • **Optimise availability of community diagnostics** to support integrated working and provide care closer to home • **Use population insights and continuous improvement** to refine pathways and reduce avoidable demand
Agree a multi-neighbourhood urgent care plan which includes ensuring the teams supporting urgent community response, and home-based intermediate care have the right capacity and work seamlessly in partnership with ambulances, acute care and are linked to INTs	• **Maximise virtual wards**, **intermediate care**, **and same-day emergency** care focusing on people with complex needs • **Strengthen shared pathways** and escalation across physical and mental health; continued Universal Care Plan quality improvements • **Deliver deep-dive actions** (eg call-before-convey), workforce skills assessment, and workforce capacity development • **Improve vertical integration** via urgent treatment centres and primary-care redirection; support basic digital interoperability across all pathways	• **Manage high risk cohorts in the community** by implementing a multi-neighbourhood urgent care plan, including strengthened urgent community response and out-of-hours provision • **Establish 111 integrated delivery units,** aligned with local community urgent care pathways, integrated neighbourhoods, and local urgent care response functions • **Standardise shared handovers**, access routes and MDT processes across physical and mental health urgent care • **Use digital tools to support remote triage**, **virtual clinical review** and streamlined communication across teams	• **Commission a fully integrated urgent care** offer across neighbourhoods to include primary care, urgent community response, hospital at home/virtual wards and intermediate care • **Embed seamless coordination and delivery across INTs with interoperable data** and shared decision-making • **Use system intelligence to optimise capacity**, reduce avoidable admissions and improve same-day community-based support • **Expand digitally enabled community pathways** to divert demand from UEC and support safer, earlier discharge

Bexley Neighbourhood Delivery Plan (3/4)

NHS South East London

Establish Integrated Neighbourhood Teams (INT) focused on people with complex needs at higher risk of hospital admissions (people living with frailty, care home residents, housebound and people at end of life).

Local Actions In Year 1

- **Consolidate existing initiatives** (3+Long Term Conditions and Frailty) into a single INT framework
- **Prioritise redesigned adult weight-management** pathways, including access to future medications, to tackle obesity's impact on outcomes and LTCs
- **Scale Ageing Well Community Hub and Frailty INT** borough wide and phased roll out of Bexley Frailty end-to-end /end of life model incorporating district nursing service review and care home deep dive actions
- **Codesign neighbourhood health centre model** with focus on complex needs
- **Embed holistic, integrated working** across organisational boundaries and establish personalised care planning and support for self-management and carers
- **Continued co-design,** drawing on relationships with community champions, to introduce 'no wrong door' for integrated care
- **Implement Bexley GP Premium** to support consistent, preventative and digitally supported integrated delivery

Local Actions In Year 2

- **Evaluate and scale the INT model** across all neighbourhoods with consistent multi-disciplinary team processes (involving adult social care, voluntary and community sector and carers) and digitally supported coordination
- **Strengthen shared governance**, data flows and community resource mapping to avoid duplication and improve early intervention with 'prevention-first' approaches
- **Embed shared holistic assessments** and care coordination across partners to support anticipatory, preventative and digitally enabled care
- **Strengthen Population Health Management improvement cycles** to target 'at risk' cohorts and address local inequalities.
- **Continue proactive support to unpaid carers** across neighbourhoods
- **Embed personalised care** as standard practice across all cohorts through co-designed models of care
- **Strengthen digital interoperability** between organisations and enable improved digital support for self-care

Local Actions In Years 3 -5

- **Embed predictive analytics**, advanced risk stratification, and digital coordination to anticipate needs, manage high-risk cohorts, and deliver prevention-first, person-centred interventions beyond initial priority cohorts
- **Seamlessly collaborate** across health, adult social care, and community partners to provide holistic care, reduce duplication, and improve outcomes using INT evaluation insights
- **Commission neighbourhood services via a value-based care framework,** focused on measurable population health outcomes, linking provider payments to quality, prevention, and integration outcomes
- **Embed engagement with residents, carers, and communities in co-design**; address health inequalities; and enable self-management and digital literacy to support inclusive, preventative care
- **Optimise workforce capacity and skills,** leverage interoperable digital tools, monitor performance via clear KPIs, and embed learning cycles to adapt services and scale successful innovations

Bexley Neighbourhood Delivery Plan (4/4)

NHS South East London

	Local Actions In Year 1	Local Actions In Year 2	Local Actions In Years 3 -5
Improving planned care in the community (linked to work to redesign outpatient care)	• **Map community physical/mental health pathways** to identify gaps & prevention opportunities, including elective/diagnostic access • **Develop a neighbourhood planned care model** for high-volume, high-impact conditions, aligned to SEL-wide work • **Strengthen links** with adult social care, carers, voluntary sector, and community networks to support early help and prevent escalation	• **Implement redesigned pathways** for priority conditions with optimised elective/diagnostic access and integrating physical health, MH, social care, and community support • **Standardise referral routes**, shared assessments, and multi-disciplinary links with neighbourhood teams • **Expand early intervention**, self-management, and carer/community support programs	• **Commission fully integrated neighbourhood planned-care model** with consistent elective/diagnostic pathways to reduce waits • **Embed shared dashboards** and neighbourhood led initiatives to optimise high-volume pathways and reduce outpatient demand • **Strengthen prevention, proactive carer support,** and community-led approaches to reduce long-term demand
Improving care for children and young people as part of neighbourhood working	• **Evaluate current initiatives** and develop plan for scaling based on insights • **Map CYP physical and MH service gaps**, including neurodiversity, transition, out-of-hours mental health and SEND. • **Support development of a family-based tier 3 weight-management** service and prevention offer. • **Develop integrated transformation** plan based on outputs from joint workshops and the SEL CYP Framework focusing on inequalities and workforce capability.	• **Scale integrated child health initiatives** across all neighbourhoods, including MDT for complex cases • **Implement redesigned CYP pathways** for priority needs (neurodiversity, transition, obesity and MH) integrated with neighbourhood teams aligned to SEL CYP Framework • **Improve access, signposting, waiting times** and coordinated support for CYP, families, and carers across neighbourhoods • **Deliver the joint transformation plan**	• **Commission a fully integrated CYP model across neighbourhoods**, aligned to the SEL CYP Framework • **Use shared data and proactive outreach** to improve outcomes • **Embed prevention** and joint working with education, social care, and voluntary partners with inclusive practice for CYP with SEND • **Integrate new digital tools** and neighbourhood platforms to support coordinated care and communication with families

Bexley Wellbeing Partnership Committee

Thursday 22nd January 2026

Item: 5

Enclosure: D

Title:	**Voluntary Sector Prevention and Early Intervention Grants: Future Arrangements**
Author/Lead:	Gita Prasad, Interim Director of Integrated Commissioning, NHS South East London Integrated Care Board (Bexley)
Executive Sponsor:	Diana Braithwaite, Strategic Director, Integrated Health & Care/Place Executive Lead (Bexley), NHS South East London Integrated Care Board

Purpose of paper:	London Borough of Bexley Adult Social Care (ASC) and the NHS South East London Integrated Care Board (Bexley) provide jointly funded Prevention and Early Intervention grants to a range of voluntary sector organisations to the value of £1.03m. The grants were issued for five years from 2020 to 2025. The decision to renew these grants for a three year period has been made jointly between the London Borough of Bexley and NHS South East London Integrated Care Board. This paper is for information about the Prevention Early Intervention grants and future arrangements.	**Update / Information**	***X***
		Discussion	
		Decision	***X***
Summary of main points:	The Prevention Early Intervention (PEI) grants support local organisations with infrastructure costs to enable them to prevent escalation to statutory services and provide support after adverse events. These grants were extended for a year, during 2024/25 to allow for a review to take place and they are due to expire in March 2026. Following a review of the grants and light touch monitoring the following proposals were made to the London Borough of Bexley and NHS South East London Integrated Care Board: 1. That new grants are issued for a three-year period from 1 April 2026 to 31 March 2029. 2. That grant funding is made available to widen access and address the needs of residents with or awaiting an Autism diagnosis and allow the Autism Partnership to oversee and award these grants. 3. That the grant award amounts are adjusted by the Commissioning Team, working with BVSC, Public Health and other colleagues, to enable a grant award to the Autism Partnership 4. During the three-year period a roadmap is developed to review the requirements of the market for health, Adult Social Care (ASC) and Children's Social Care and to determine a full programme of either commissioned or grant-funded services. The London Borough of Bexley and the NHS South East London Integrated Care Board (Bexley) are committed to PEI and value the wide range of		

	services provided by voluntary sector partners. In reviewing the effectiveness of the grants programme, one of the main findings was the positive return on investment. The funding of organisations' infrastructure supports them to bid for external funding and contracts, from bodies which do not as a rule fund the core costs of an organisation. Our intention is that the award of grants for a three-year period will maintain stability for the sector whilst allowing for a fully integrated health and social care review of the economic case for prevention, and consideration of the possibility of a bidding process at the end of the next grant period. We are also keen to map the delivery of the PEI grants against Bexley's three neighbourhoods (Clocktower, Frognal and North Bexley) and align to Bexley's Neighbourhood Plans, in line with the NHS 10 Year Plan. The London Borough of Bexley and Bexley Voluntary Services Council (BVSC) entered into a new Compact agreement in December 2024. The Bexley Wellbeing Partnership Committee approved the adoption of the South East London Integrated Care System's Voluntary, Community and Social Enterprise Sector Charter in March 2025. The proposal to issue new three-year grants is line with the commitments and principles set out in both the Compact and the Charter.	
Potential Conflicts of Interest	There are no conflicts of interest as a consequence of this report.	
Other Engagement	Equality Impact	The PEI grants positively support people with protected characteristics. In particular, supporting people with learning disabilities, people with mental health issues, carers, autistic people, people who are deaf and have hearing needs, people who are blind and partially sighted, older people, people with dementia, families in need and people who have suffered a bereavement.
	Financial Impact	NHS South East London Integrated Care Board (Bexley) contributes £396,000.00 per annum to the grant programme.
	Public Engagement	The decision to renew the PEI grants was published by the London Borough of Bexley, via the Council's website on 19.12.25 Engagement with the PEI grant holders, the VCSE sector and BVSC has taken place as part of this review.
	Other Committee Discussion/ Engagement	Place Executive Lead (Bexley), NHS South East London Integrated Care Board: December 2025 London Borough of Bexley: September – December 2025
Recommendation:	The Bexley Wellbeing Partnership Committee is recommended to:	

	(i) Endorse the renewal of the PEI grants as agreed by the Place Executive Lead and the intention to widen access to include the Autism Partnership, and that this aligns with the South East London Integrated Care System's Voluntary, Community and Social Enterprise Sector Charter. (ii) Support the future arrangements of the PEI grants to include prevention and early intervention for children and families (iii) Note the intention to align the delivery of the PEI grants to Bexley's Neighbourhood delivery planning.

Voluntary Sector Prevention and Early Intervention (PEI) Grants: Future Arrangements

1. Introduction

The London Borough of Bexley Adult Social Care (ASC) and the NHS South East London Integrated Care Board (SEL ICB) (Bexley) provide jointly funded Prevention and Early Intervention (PEI) grants to a range of voluntary sector organisations to the value of £1.03m on approximately a two thirds/one third split, respectively. The grants were issued for five years from 2020 to 2025 and extended for a further year till March 2026 to allow for a review to take place.

The grants support the organisations with core costs or fund specific services to enable them to prevent escalation to statutory services and provide support after adverse events. These grants are monitored on a regular basis and grant recipients provide both qualitative and quantitative data regarding the outcomes achieved via this funding.

The grant recipients are key partners in many of the Council and NHS SEL ICB's programmes of work and the stability and continuity of these key partners proved the most valued outcome of the last recommissioning process. Our relationship with the voluntary sector was noted in the recent Care Quality Commission Assurance process of ASC as being mature and they also noted the strong community response to people's needs, which these grants contribute to. In reviewing the effectiveness of the grants programme, one of the main findings was the positive return on investment.

The funding of organisations' infrastructure supports them to bid for external funding and contracts, from bodies which do not, as a rule, fund the core costs of an organisation. This enables organisations to do several things:

a) Develop and gain external funding for services which residents can access. Council funding has enabled organisations to access up to 4.6 times more[1] income from external sources, than provided through the grants. This supports the local economy and jobs, as many staff live locally.
b) Develop networks across local authority and health boundaries, with some working in other local authority areas which also brings in a wider range of opportunities for local people.
c) Add capacity into the local health and social care system, directly providing services for local people, with services and support that is developed based on the knowledge of what residents need.
d) Support the Council and the local health system to gain the views of the community and those with lived experience and feed into the various Partnership Boards. Partner organisations contribute many hours each week to these important collaborative groups and contribute significantly to the addressing health and social inequalities in Bexley and the delivery of neighbourhood health services in line with the NHS 10 Year Plan.
e) Deliver activities which are led and influenced by people with lived experience, with sustainability woven into the projects.
f) Support the Council with the distribution of the Household Support Fund (which is due to become the Crisis and Resilience Fund from April 2026).
g) Enable the delivery of Social Prescribing in Bexley.

2. Key outcomes

The PEI grants have enabled organisations to sustain their offer in Bexley to their target populations.

While there have been some changes in central government policy, these have only been to focus more on the use of prevention, particularly in health with the development of neighbourhood health services. Therefore, the key outcomes are still valid today and align with the shared approach to

[1] **NHS Confederation.** Paving a new pathway to prevention: leveraging increased returns on our collective investment 7th October 2024 Paving a new pathway to prevention | NHS Confederation

prevention in the Council's 2050 Vision. They also mirror the Care Act Responsibilities which remain unchanged.

To reflect the changing demographics of the borough and the need to serve all our communities, the outcomes set out below have been reordered to give a stronger focus to supporting under-served communities. This aligns with the work of the Bexley Wellbeing Partnership in devolving recommendations for the Health Inequalities Programme to the three Local Care Networks. This gives grant recipients the opportunity of working across organisations, to gain knowledge and expertise from those that have better access to these communities.

2.1 Key Strategic outcomes for the grants programme to remain unchanged

a) Reduce health inequalities by providing support and services for vulnerable, at-risk or under-served communities.
b) Support Bexley residents to live independent, healthy, fulfilling lives for as long as possible, in line with the Council's Adult Social Care vision and to enable opportunities for each person to be an active citizen in a community in which they feel they belong.
c) Prevent, delay or manage the progression of physical or mental health conditions that lead to illness, disease or frailty.
d) Prevent, delay or manage the need for medical or social care services, primary care services, or admission to hospital.
e) Support people through adverse life events, including disease, illness and injury.

2.2 Voluntary and Community Sector Compact

The London Borough of Bexley and the Bexley Voluntary Services Council (BVSC) entered into a new Compact agreement in December 2024.

2.3 South East London Integrated Care System Charter for partnership with the voluntary, community and social enterprise sector

Bexley Wellbeing Partnership approved the adoption of the South East London Integrated Care System's Voluntary, Community and Social Enterprise Sector Charter (VCSE) at its committee meeting in public on the 27th March 2025.

The Charter set out four high level commitments to provide clear direction for the local health and care system, which would be implemented in a way that respects the democratic and organisational mandates:

1. *We will treat the VCSE sector as a full strategic partner in setting strategic direction and system planning, in addition to its role in delivering services.*
2. *We will increase funding provided for the VCSE sector across our partnership and secure its services in ways that deliver greater social value and support health creation and prevention.*
3. *We will ensure proportionate procurement and contract monitoring processes that will reduce the transactional burden for commissioners and providers and ensure a level playing field for VCSE organisations.*
4. *We will invest in strengthening the VCSE sector's infrastructure so that it can play an effective role in the strategic leadership of our system and service delivery.*

The proposal to issue new three-year grants is line with the commitments and principles set out in both the Compact and the Charter.

3. Areas for consideration and options considered

Options reviewed by the London Borough of Bexley and NHS South East London Integrated Care Board included:

a) Run a bidding process for the wider sector.
b) Cease the grants and move to a standard commissioning approach.

c) Cease the grants entirely.
d) Issue new grants for a period of up to five years.

During the review detailed discussions were undertaken with the current grant recipients and colleagues to identify areas of need that were not being addressed by the current grant programme.

2.1 Grant recipients feedback

a) Those that receive core funding said it gave them:

- The financial stability which supports them to fully engage with system partners, allowing them the time to contribute in a meaningful way.
- The stability which made them more attractive to external funders/ commissioners of services, particularly when coupled with the length of the programme.
- These factors have been key in their ability to engage and be an active part of the *One Bexley* Consortium.

b) The demand for expert advice and information is outstripping capacity, with several organisations holding waiting lists. This is particularly in relation to welfare benefit applications and review processes. This is a complex area to provide advice on, exacerbated increasingly by the digital exclusion of some residents.

c) Those grant recipients that provide a service in return for the grant consistently stated that the level of the grant did not meet their costs which represents a risk to the Partnership of them withdrawing. In the discussions it became clear that as the grant levels have not risen for many years if we were to commission those services under a contract, they would in most cases cost us more.

d) Grant recipients also raised the need for consideration of an annual review of the grant amount. This would enable them to keep up with the various increases in their overall costs, such as pay increases, National Insurance increases and inflation, as most have funded these out of their reserves recently.

e) *One Bexley* partners stated that the PEI grant enabled them to signpost people to local services (including their own) funded by the grants, and other support that they have been able to develop with external funding.

2.2 Gaps in Provision

A working group, overseeing this review, has discussed the gaps in the provision of the grants and the key challenges facing adult social care and health budgets. After some reflections, the working group identified one main group, where we need to do more, and there was evidence to support this:

- 4,624 people have a diagnosis of autism in Bexley (1.8%), which is higher than the South East London (SEL) average.
- Adult Social Care reviewed 35 young people who were referred to them after their 18th birthday in crisis. The review identified that the young people would have benefited from earlier support as part of their preparation for adulthood which could have reduced or avoided the need for statutory support later.
- The recent Autism Needs Assessment also set out several recommendations which the Autism Partnership Board is working to implement, one of which is to identify areas for earlier invention and prevention support to reduce the need for crisis intervention. A menu of options has been co-designed.

Given the identified benefits of prevention, the return on investment, the part that the VCSE plays in the health and social care partnership and the gaps identified it is proposed that the Council and NHS SEL ICB continue to issue PEI grants.

Feedback has also been received as this report has been through the Council's governance, that opportunities to take a life course and Think Family approach to prevention and early intervention going forwards should be incorporated into the next commissioning cycle.

3.3 Bexley Voluntary Services Council

In 2024/25 Bexley Voluntary Services Council's (BVSC) grant was extended for two years to enable them to support with this process. They have been involved in the working group which has supported these recommendations, hosted one-to-one meetings with grant holders to elicit individual views and fed back themes from discussions. BVSC are working with around 40 grass roots organisations in the Borough. None of these small organisations would, at the present time, be able to bid to deliver the grant outcomes at the required scale.

4. Preferred option and related matters

It is recommended that the following proposal is endorsed:

1. That new grants are issued for a three-year period from 1 April 2026 to 31 March 2029.
2. That grant funding is made available to widen access and address the needs of residents with or awaiting an Autism diagnosis and allow the Autism Partnership to oversee and award these grants.
3. That the grant award amounts are adjusted by the Commissioning Team, working with BVSC, Public Health and other colleagues, to enable a grant award to the Autism Partnership
4. During the three-year period a roadmap is developed to review the requirements of the market for health, Adult Social Care (ASC) and Children's Social Care and to determine a full programme of either commissioned or grant-funded services.

4.1 Citizens Advice (CA)

The grant for the Citizens Advice is separate to the PEI grant programme, but ASC has also taken over the commissioning and has extended it to 31 March 2026, so it can be aligned with the timeline of the PEI grants. It is therefore recommended that CA are also issued with a new three-year grant.

4.2 Bexley Voluntary Services Council

BVSC's grant expires on 31 March 2027. A decision on the future of this grant will need to be made by partners during the calendar year 2026.

4.3 Consultation with Overview and Scrutiny Members

An informal briefing for elected members of the Adult Social Care & Health Overview and Scrutiny Committee and the Finance and Resources Overview and Scrutiny Committee took place on 16th December 2025.

5. Legal implications

a) Summary of Legal Implications

The grants provided to a range of voluntary sector organisations jointly by Adult Social Care, London Borough Bexley and NHS South East London Integrated Care Board (Bexley) enable the statutory duties of the Council and the ICB to be discharged effectively.

NHS South East London Integrated Care Board covering London boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark was established on 1 July 2022 to build upon existing health and care partnerships established by the Integrated Care System (ICS).

The Council is required under the Health and Care Act 2022, Section 26(6)(1) to have regard to the integrated care strategy when exercising any of their functions.

The Care Act 2014 requires the Council in discharging its statutory duty, to promote the well-being of individuals, which includes the following matters:

(a) personal dignity (including treatment of the individual with respect).

(b) physical and mental health and emotional well-being.
(c) protection from abuse and neglect.
(d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided).
(e) participation in work, education, training or recreation.
(f) social and economic well-being.
(g) domestic, family and personal relationships.
(h) suitability of living accommodation.
(i) the individual's contribution to society.

The Local Authority should continue to operate within the above legislative framework as failure to do so can result in complaints and legal challenges. If complaints and legal challenges are not resolved promptly, there are reputational risks to the Local Authority. The Local Authority should be mindful of complaints which escalate to the Local Government and Social Care Ombudsman and the Parliamentary and Health Service Ombudsman as this can result in compensation being ordered.

The London Borough of Bexley and the NHS South East London Integrated Care Board should ensure that all grant agreements comply with the relevant legislation which includes GDPR and the Data Protection Act 2018. There should be regular monitoring and audits to ensure that funds are not misused. Failure to implement these measures could expose the Local Authority and their partners to legal, financial and reputational consequences.

6. Financial Implications

a) Summary of Financial Implications

The current grants are set out below. These are joint funded by the London Borough of Bexley and NHS South East London Integrated Care Board (Bexley) on a proportion of approximately two thirds to one third respectively. NHS South East London Integrated Care Board's contribution of **£396,000.00** per annum to the grant programme.

The grant distribution as set out in Table 1 below will be adjusted in line with Recommendation 2 which will result in some reductions of current grants.

Table 1: 2025/26 Current Distribution

Provider	**Current Grant Budget Distribution £'s 2025/26 (subject to rounding)**
Mind in Bexley	£35,000
Mencap	£103,000
Bexley Crossroads	£82,000
Carers Support Bexley	£226,000
Advocacy for All	£16,000
Bexley Deaf Centre	£69,000
Kent Association for the Blind	£18,000
Age UK	£175,000
Alzheimer's Society	£194,000
Choice Support	£47,000
Family Matters	£23,000
Cruse	£13,000
Currently allocated	£34,000
Total	**£1,035,000**

The Citizen's Advice Bureau CAB grant is £216,000 per year and is not included in the PEI grant allocation.

7. Risks and mitigation measures

Risk	Mitigation
Providers which have indicated they may be unable to continue on the current grant may have to cease operating or reduce provision.	This has already happened in one instance. It is proposed to redirect freed up resource to support others
This may impact disproportionately on specific groups with disabilities	As above will redirect freed up resource to mitigate as far as possible.
There is no opportunity for diversifying the market.	We will develop an offer for people waiting or with an Autism diagnosis which will offer some diversification.
Some providers may publicly voice disappointment at the lack of inflationary increase to accompany the grant extension and/or may object to a reduction in their grant.	The positive message is that grants will continue despite the very difficult current financial circumstances.
Providers may reject the reduced offer resulting in reduced provision and risk of escalation to statutory services.	We will closely monitor the impact and. direct risk of service reductions and identify potential cost-effective solutions
The Council or NHS SEL ICB may need to review or withdraw grants during the five-year period due to budget reductions or the need to re-prioritise expenditure.	The grant agreements include a three-month notice period for each party. The clause will be reviewed and strengthened if required.
If grants are not re-issued there is a risk that demand on statutory services will increase with an associated impact on the finances of Council and the ICB.	The recommendation is to re-issue three-year grants.
The fact that some of the PEI providers are part of *One Bexley* creates an interdependency between grant and contract periods.	The *One Bexley* contract is 5 + 2 years starting in October 2024. Three-year grants will avoid a re-granting and re-tendering process in the same year.

8. Summary of other implications

These are covered above, as we try to find a balance between the Council and NHS SEL ICB's position financially, getting value for money from this funding, as well as the need we have to reach residents and communities as we develop and co design services and policy in line with government direction of travel for health and adult social care services.

NHS South East London Integrated Care Board (Bexley) has supported this decision via the Place Executive Lead (Bexley).

9. Recommendations

The Bexley Wellbeing Partnership Committee is recommended to:

(i) Endorse the renewal of the PEI grants as agreed by the Place Executive Lead and the intention to widen access to include the Autism Partnership, and that this aligns with the South East London Integrated Care System's Voluntary, Community and Social Enterprise Sector Charter.

(ii) Support the future arrangements of the PEI grants to include prevention and early intervention for children and families

(iii) Note the intention to align the delivery of the PEI grants to Bexley's Neighbourhood delivery planning.

Bexley Wellbeing Partnership Committee

Thursday 22nd January 2026

Item: 6

Enclosure: E

Title:	Better Care Fund: Quarter 3 2025/26 NHS England Return
Author/Lead:	Gita Prasad, Interim Director of Integrated Commissioning, NHS South East London Integrated Care Board/London Borough of Bexley Steven Burgess, Policy and Strategy Officer, London Borough of Bexley
Executive Sponsor:	Diana Braithwaite, Diana Braithwaite, Strategic Director, Integrated Health & Care/Place Executive Lead (Bexley), NHS South East London Integrated Care Board Yolanda Dennehy, Director of Adult Social Care and Health, London Borough of Bexley

Purpose of paper:	**To report on the Better Care Fund (BCF) Quarter 3 Return 2025–26**	**Update / Information**	***X***
		Discussion	
		Decision	

Summary of main points:

Introduction:

- This report presents the Draft BCF Quarter 3 Return 2025 - 26 and is provided to the Bexley Wellbeing Partnership Committee for information and assurance. The return (Appendix A) is due to be submitted to the BCF National Team on 30 January 2026.
- All national BCF conditions have been met in Quarter 3, including joint planning, delivery of agreed objectives, compliance with funding conditions and effective operation of the section 75 partnership arrangements.

Performance against core BCF metrics

- At the time of preparing the BCF Quarter 3 return, some of the data required to assess progress against the BCF metrics was not yet available.
- Performance against the core national BCF metrics so far shows a broadly stable position with some areas of pressure. There is also some initial evidence of improvement, particularly around discharge timeliness and long-term care avoidance.
- Emergency admissions (65+) remain slightly above plan year-to-date with continued system focus on admission avoidance through frailty, virtual wards and Home First pathways.
- Same-day discharge performance fell below the 90% target in September 2025 (86.2%) and October 2025 (86.8%), reflecting higher levels of discharge complexity. However, the average number of delayed days

reduced in October, indicating improved timeliness once patients were deemed ready for discharge.

- Performance to date indicates a lower-than-planned reliance on new long-term residential care placements for people aged 65 and over. This reflects continued progress in supporting older people to remain independent and in their own homes.

Supporting and local metrics:

- Unplanned hospitalisation for chronic ambulatory care sensitive conditions: Early indications suggest modest improvement, although the full Quarter 3 position will be confirmed once final data is available.
- Falls-related admissions (65+): Compared to other boroughs in South East London, Bexley has the second highest number of patients admitted due to falls. This reflects a higher baseline associated with an older population profile and a larger care-home sector. However, recent data shows improvement with the admission rate falling from 176.67 per 100,000 in June to 117.78 in September 2025, which was below the London average (121.02). These trends will continue to be monitored as partners maintain a focus on falls prevention and care-home support.
- Discharge to Usual Place of Residence: Over 94% of discharges during 2025/26 so far have been to a person's usual residence.
- Inpatient Length of Stay: Based on the available data to the end of November 2025, there has been a reduction in the proportion of inpatients with longer hospital stays (14 days or more and 21 days or more). 14+ day stays improved from 14.7% in September 2025 to 12.5% in November 2025 and 21+ day stays fell from 8.3% to 6.5% over the same period.
- Outcomes following short-term support: Provisional data indicates that the majority of people either require no ongoing support or experience a reduction in care following intervention.

Quarter 3 progress update

System pressures and winter demand

Quarter 3 saw sustained system pressure continuing from late Quarter 2 with higher levels of emergency department attendances and non-elective admissions, increased lengths of stay and a rise in the proportion of patients not meeting the criteria to reside. Pressures remained elevated through October and into early November, coinciding with a seasonal increase in flu cases.

Winter resilience and capacity measures

Winter resilience schemes were mobilised from early December, including additional staffing and the opening of eight temporary interim beds over a 12-week period. Based on an average six-week length of stay, these beds are expected to support approximately 16 interim placements and are intended to relieve pressure on acute capacity during peak winter demand.

Admission avoidance and community support

Rapid Response services continued to prioritise admission avoidance throughout Quarter 3. In addition, Community Care Navigators, employed by Oxleas NHS Foundation Trust, have played a key role in proactive

case-finding, supporting both admission avoidance and timely discharge. The navigators are linked closely to the Transfer of Care Collaborative (ToCC) at Queen Elizabeth Hospital (QEH), supporting engagement and joint work across acute and community services. Their role has been extended over the winter period, including weekend in-reach.

Transfer of Care Hub developments

Plans are in place to launch an integrated Transfer of Care Hub at QEH in Quarter 4. The hub will bring together partners from multiple organisations in a co-located model, improving joint working and real-time decision-making. It will also link with Darent Valley Hospital (DVH), supporting a more joined-up approach across acute sites. The System Lead for the Bexley & Greenwich Transfer of Care Hub started in post in December and the role is hosted by Oxleas NHS Foundation Trust. The postholder will be instrumental in coordinating the ToCC, including co-locating staff and systems.

Multi-Agency Discharge Event (MADE)

A MADE was held at DVH in December 2025, bringing together partners from across health, social care and the wider system to focus on discharge arrangements. The event provided an opportunity to review current pressures, unblock delays and reinforce joint approaches to complex discharges.

Acute pathway improvements

Following the launch of the Acute Medical Unit (AMU) at QEH in November, there are early signs of quicker turnaround and discharge to usual place of residence for patients without the need for additional health or social care support (Pathway 0). Some activity on other discharge pathways is also being generated from AMU referrals, which is being managed within existing teams and system arrangements.

Seasonal urgent care and respiratory response

A seasonal Acute Respiratory Hub for children and adults commenced in mid-November 2025 and will run until mid-February 2026. Funded by NHS South East London Integrated Care Board (Bexley) and delivered by the local GP Federation, the hub provides additional same-day urgent face-to-face assessments for patients presenting with acute respiratory infections. The service operates during core GP hours and accepts referrals from Bexley GP practices and NHS 111, supporting access to timely care and helping to manage demand across urgent and emergency pathways.

Discharge readiness and complex delays

Performance against discharge readiness metrics dipped from September, reflecting a cohort of particularly complex cases. These included housing-related delays, patients in other out-of-borough hospitals (Guy's & St Thomas' and King's College Hospitals) and individuals requiring specialist neuro-rehabilitation. Access to Level 1 and Level 2 neuro-rehabilitation beds remained challenging with waits of four to five weeks in some cases, contributing to prolonged lengths of stay for a small number of high-need patients. Mitigations include the phased reopening of Level 2 capacity on Ontario Ward at Orpington Hospital and continued system escalation. These pressures are being highlighted to system partners to support further planning and pathway development.

Discharge pathways

<table>
<tr><td></td><td colspan="2">As part of the system's "Flowtober" initiative at QEH, the Discharge and Patient Flow Manager and partners undertook focussed case reviews to examine and optimise discharge processes and pathways. This enabled partners to reflect on recent cases together, share learning and clarify expectations, helping to support consistent practice and timely discharge planning.

Following a period of higher non-elective admissions, there has been a concentration of patients becoming medically fit for discharge. This has increased demand for short-term rehabilitation and recovery beds that support people who are not yet able to return home (Pathway 2). The Meadow View Unit at Queen Mary's Hospital, Sidcup, has seen higher referral levels and has recently been operating at full capacity. Despite this pressure, the service continues to deliver effective intermediate care with active discharge planning in place to minimise onward delays.

Care home ambulance conveyance

Using London Ambulance Service data, we have undertaken analysis to understand patterns of emergency activity and ambulance conveyance from care-home settings. Between April 2024 and March 2025, Bexley recorded a higher proportion of falls-related incidents as a chief complaint than other South East London and outer London boroughs, consistent with Bexley's population profile and scale of care-home provision. Over the same period, average monthly falls incidents reduced by around 25% (from 39.2 to 29.3). The analysis also shows that a small number of presentations - including falls, breathing problems, minor head injuries, infections and frailty-related weakness - account for most demand with variation between care homes in the use of community alternatives to hospital. These insights will be used to help inform actions on prevention, earlier clinical input and clearer escalation guidance.

Urgent Care integration and demand management

New integrated urgent care arrangements are in place at Erith & District Hospital and Queen Mary's Hospital, Sidcup, delivered by Lewisham & Greenwich NHS Trust in partnership with Bexley Health Neighbourhood Care CIC. These arrangements bring together Urgent Treatment Centres, NHS 111 out-of-hours provision, primary care, community and mental health services, pharmacy and social prescribing, supporting a more joined-up approach to same-day urgent care.

Demand for urgent and emergency care remained high in Quarter 3, particularly at the start of the week at Darent Valley Hospital and Queen Elizabeth Hospital with a notable number of people attending hospital directly, including walk-ins and people arriving via their own transport. During Quarter 4, partners are continuing to promote appropriate use of Urgent Treatment Centres and alternatives to A&E, alongside public communications to raise awareness of available urgent care services.</td></tr>
<tr><td>Potential Conflicts of Interest</td><td colspan="2">There are no conflicts of interest as a consequence of this report.</td></tr>
<tr><td>Other Engagement</td><td>Equality Impact</td><td>Bexley's BCF Plan sets out local priorities for addressing health inequalities and equality for people with protected characteristics. Services</td></tr>
</table>

		commissioned under the Section 75 agreement are monitored to ensure equalities duties are met.
	Financial Impact	The total value of Bexley's BCF Pooled Fund in 2025-26 is £91.460m, comprising £55.698m from the ICB and £35.763m from the Council. Quarter 3 Year-to-Date expenditure totals £68.618m (75% of the total fund) in line with profiled spend.
	Public Engagement	Public consultation on the section 75 agreement was undertaken in 2020–21, including arrangements for the BCF Pooled Fund.
	Other Committee Discussion/ Engagement	The Quarter 3 return will be considered at the Bexley Health and Wellbeing Board for sign-off on 12 March 2026.
Recommendation:	This report is for information and assurance to the Bexley Wellbeing Partnership Committee.	

Appendix A – Draft Bexley BCF Quarter 3 Return 2025-26
Appendix B – Updated BCF Metrics.

Better Care Fund 2025-26 Q3 Reporting Template

2. Cover

Version 2.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Bexley	
Completed by:	Steven Burgess	
E-mail:	steven.burgess@bexley.gov.uk	
Contact number:	020 3045 5242	
Has this report been signed off by (or on behalf of) the HWB Chair at the time of submission?	No	
If no, please indicate when the report is expected to be signed off:	Thu 12/03/2026	<< Please enter using the format, DD/MM/YYYY

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Expenditure	Yes

For further guidance on requirements please refer back to guidance sheet - tab 1.

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2025-26 Q3 Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Bexley

Confirmation of Nation Conditions			Checklist Complete:
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:**	
1) Plans to be jointly agreed	Yes		Yes
2) Implementing the objectives of the BCF	Yes		Yes
3) Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) and Section 75 in place	Yes		Yes
4) Complying with oversight and support processes	Yes		Yes

Better Care Fund 2025-26 Q3 Reporting Template

4. Metrics for 2025-26

Selected Health and Wellbeing Board: Bexley

For metrics time series and more details: BCF dashboard link

For metrics handbook and reporting schedule: BCF 25/26 Metrics Handbook

4.1 Emergency admissions

Plan		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,950.5	2,014.1	2,058.8	2,082.4	2,193.1	2,075.3	2,183.7	1,886.9	2,011.7	2,011.7	1,882.2	1,818.6
	Number of Admissions 65+	828	855	874	884	931	881	927	801	854	854	799	772
	Population of 65+	42,451.0	42,451.0	42,451.0	42,451.0	42,451.0	42,451.0	42,451.0	42,451.0	42,451.0	42,451.0	42,451.0	42,451.0

Assessment of whether goal has been met in Q3:	Data not available
You may use this box to provide a very brief explanation of overall progress if you wish.	The number of emergency admissions for older people during the year so far (6260 between Apr- Oct 2025) are slightly higher than planned (6180). October saw 981 admissions (above plan of 927). There is a continued focus on admission avoidance through frailty support, virtual wards and Home First pathways. Data for November and December 2025 is not yet available.

4.2 Discharge Delays

Original Plan	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	0.81	0.81	0.78	0.78	0.78	0.74	0.74	0.74	0.78	0.78	0.78	0.81
Proportion of adult patients discharged from acute hospitals on their discharge ready date	87.0%	87.0%	89.0%	89.0%	89.0%	90.0%	90.0%	90.0%	89.0%	89.0%	89.0%	87.0%
For those adult patients not discharged on DRD, average number of days from DRD to discharge	6.25	6.25	7.10	7.10	7.10	7.40	7.40	7.40	7.10	7.10	7.10	6.25

Assessment of whether goal has been met in Q3:	Data not available
You may use this box to provide a very brief explanation of overall progress if you wish.	Same-day discharge rates fell below the 90% target in September (86.2%) and October 2025 (86.8%). Whilst the majority of adult patients continued to be discharged from acute hospitals on their Discharge Ready Date, this dip in performance reflects a rise in more complex discharges. Encouragingly, the average delay from Discharge Ready Date to discharge has improved, reducing from 7.96 days in September to 6.62 days in October, which is better than our planned target of 7.40 days. The overall average delay for all patients, including those discharged on the same day, also fell from 1.10 days to 0.88 days. This brought performance back below the England average (0.92 days) and closer to the London average (0.85 days). Data for November and December 2025 is not yet available.

Checklist

Complete:

Yes

Yes

Yes

Yes

4.3 Residential Admissions

Actuals + Original Plan		2023-24 Full Year Actual	2024-25 Full Year CLD Actual	2025-26 Plan Q1 (April 25-June 25)	2025-26 Plan Q3 (July 25-Sept 25)	2025-26 Plan Q3 (Oct 25-Dec 25)	2025-26 Plan Q4 (Jan 26-Mar 26)
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	601.2	457.0	141.3	117.8	141.3	117.8
	Number of admissions	251.0	194.0	60.0	50.0	60.0	50.0
	Population of 65+*	42451.0	42451.0	42451.0	42451.0	42451.0	42451.0

Assessment of whether goal has been met in Q3:	On track to meet goal
You may use this box to provide a very brief explanation of overall progress if you wish.	Provisional data for April to December 2025 shows that there have been 130 new care home admissions for people aged 65 and over. The BCF target for 2025/26 is to have no more than 220 new admissions over the full year. Based on performance to date, the number of new care home admissions is lower than planned, indicating a reduced reliance on new long-term care home placements funded by the local authority. This reflects the continued focus on community-based alternatives, supporting older adults to remain at home for longer wherever possible.

Yes
Yes

Better Care Fund 2025-26 Q3 Reporting Template

5. Income & Expenditure

Selected Health and Wellbeing Board: Bexley

Source of Funding	2025-26 Planned Income	2025-26 Updated Total Plan Income for 25-26	DFG Q3 Year-to-Date Actual Expenditure	Checklist Complete:
DFG	£3,679,055	£3,940,550	£2,978,458	Yes
Minimum NHS Contribution	£22,953,335	£22,953,335		Yes
Local Authority Better Care Grant	£8,162,090	£8,162,090		Yes
Additional LA Contribution	£23,660,000	£23,660,000		Yes
Additional NHS Contribution	£32,744,434	£32,744,434		Yes
Total	**£91,198,914**	**£91,460,409**		

	Original	Updated	% variance	
Planned Expenditure	**£91,198,914**	£91,460,409	**0%**	Yes

		% of Planned Income	
Q3 Year-to-Date Actual Expenditure	£68,618,352	**75%**	Yes

If planned expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.	The planned expenditure by activity for 2025/26 has changed since the original BCF plan. This change has been agreed through an amendment to the schedules of the section 75 agreement between the Council and ICB. It relates to the carry forward of DFG funding totalling £0.261m from 2024/25 into 2025/26, increasing the DFG allocation from £3.679m to £3.940m. This results in a corresponding increase in total planned income for 2025/26 from £91.199m to £91.460m. For the financial year to date (Quarter 1 to Quarter 3), we completed a total of 192 major adaptations. The total DFG spend is £2.978m, which is broken down into £1.997m mandatory and £0.531m discretionary expenditure. There were also a total of 102 hospital discharge grants completed to the value of £0.018m (part of the discretionary spend total). In addition, DFG expenditure includes a £0.450m staffing allocation for the full year.	Yes

Appendix B

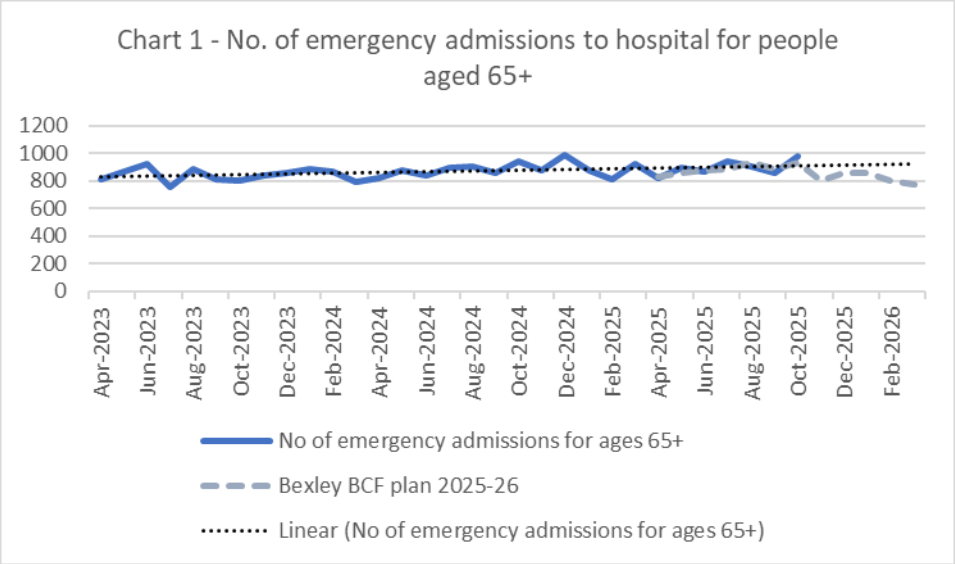
Update on BCF Performance – Quarter 3 2025/26

1. Introduction

This report provides a summary of Bexley's performance against the Better Care Fund (BCF) metrics. It draws on the latest data to assess progress in Quarter 3 2025/26.

2. Emergency Admissions 65+

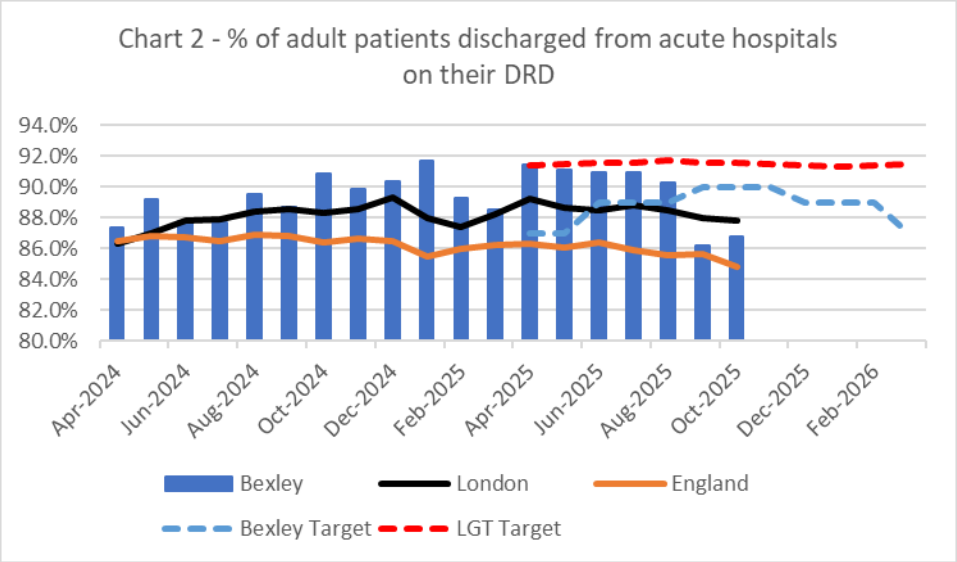
Emergency admissions for older people during the year so far (6260 between Apr- Oct 2025) are slightly higher than planned (6180). October saw 981 admissions (above plan of 927). There is a continued focus on admission avoidance through frailty support, virtual wards and Home First pathways.



Source: NHS SEL ICB Unplanned Care Dashboard

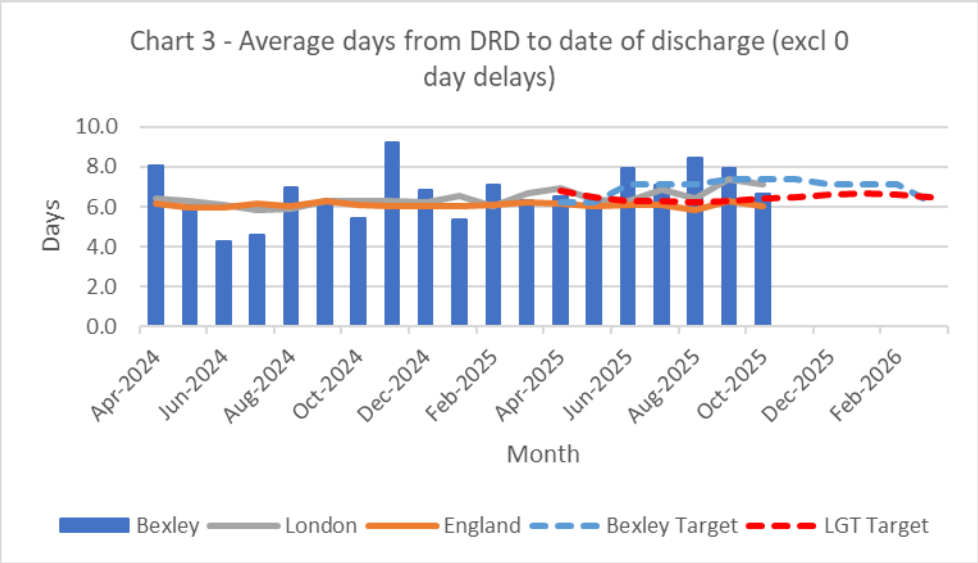
3. Discharge Metrics

Performance on same-day discharge fell below 90% in September 2025 (86.2%) and October 2025 (86.8%). Whilst the majority of adult patients continue to be discharged from acute hospitals on their Discharge Ready Date, the recent dip in performance reflects an increase in complex discharges.



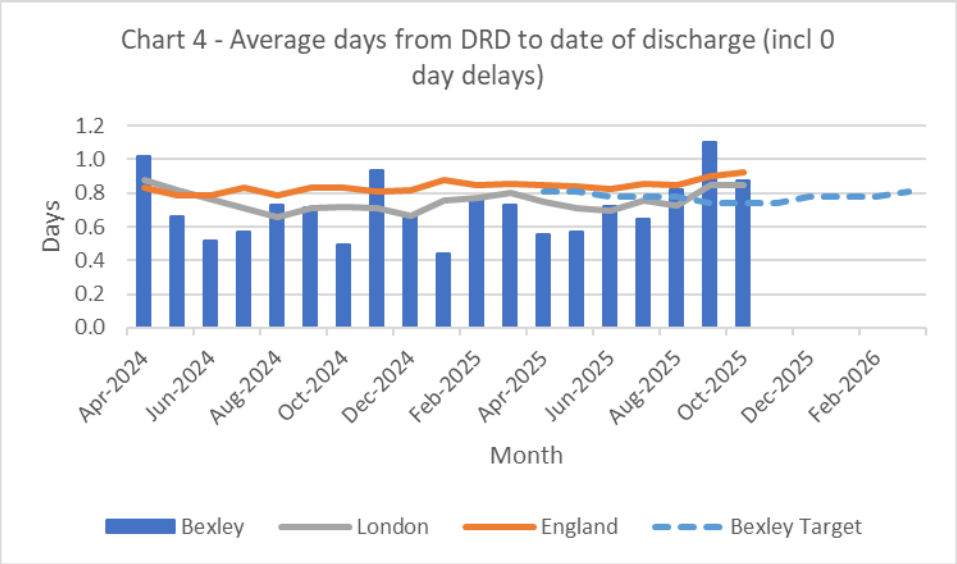
Source: NHS England, Timeliness of Acute Hospital Discharges completed within the month

The average number of days from Discharge Ready Date to discharge (excluding 0-day delays) reduced from 7.96 days in September to 6.62 days in October, below the target of 7.40 days.



Source: NHS England, Timeliness of Acute Hospital Discharges completed within the month

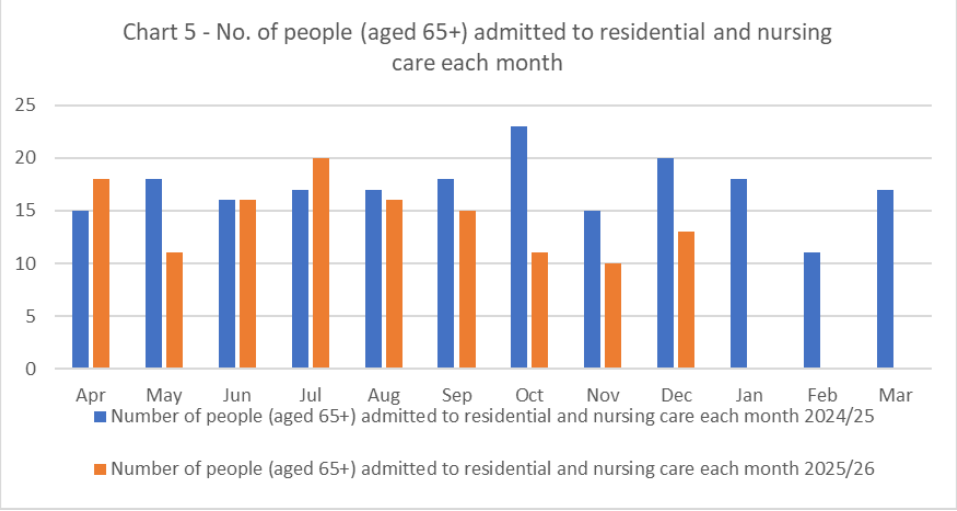
Average delay for all patients, including those discharged on the same day, reduced from 1.10 days in September to 0.88 days in October, bringing this back below the England average (0.92 days) and closer to the London average (0.85 days).



Source: NHS England, Timeliness of Acute Hospital Discharges completed within the month

4. Care Home Admissions (65+)

Provisional data for April to December 2025 shows that there have been 130 new care home admissions for people aged 65 and over. The BCF target for 2025/26 is to have no more than 220 new admissions over the full year. Based on performance to date, the number of new care home admissions is lower than planned, indicating a reduced reliance on new long-term care home placements funded by the local authority. This reflects the continued focus on community-based alternatives, supporting older adults to remain at home for longer wherever possible.

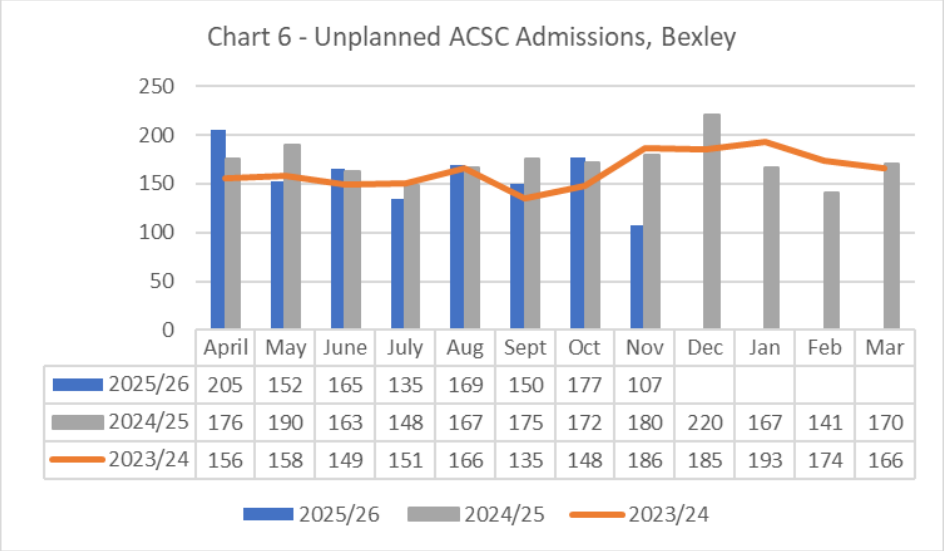


Source: ASCH - Management Information Pack

5. Unplanned hospital admissions for chronic ambulatory care sensitive conditions

Provisional data suggests there were 1153 avoidable admissions between April and October 2025, indicating potential improvement compared to 2024/25 (-1.9%). We will

need to await a further refresh of the NHS SEL Unplanned ACSC Admissions Report to get a full picture of the Quarter 3 position.

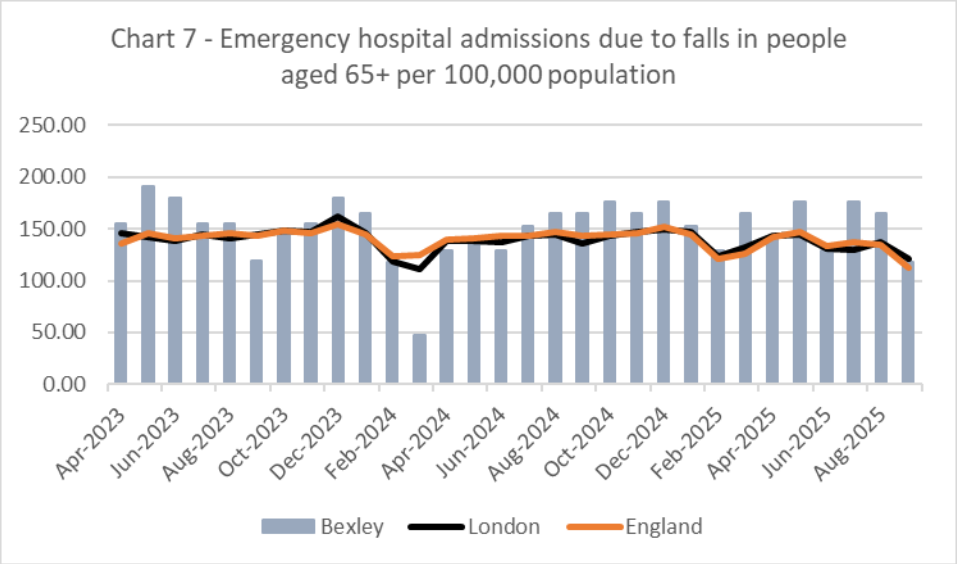


	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2025/26	205	152	165	135	169	150	177	107				
2024/25	176	190	163	148	167	175	172	180	220	167	141	170
2023/24	156	158	149	151	166	135	148	186	185	193	174	166

Source: NHS SEL ICB Unplanned ACSC Admissions Report

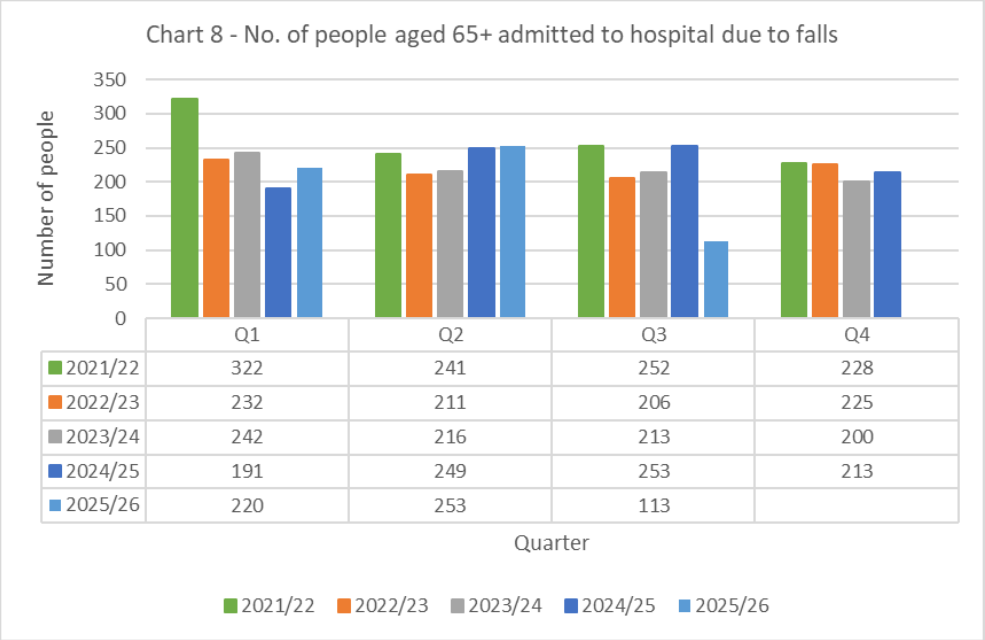
6. Emergency hospital admissions due to falls in people over 65

Provisional data shows progress in reducing emergency hospital admissions due to falls among people aged 65+. The rate per 100,000 fell from 176.67 in June 2025 to 117.78 in September, which is below the London average of 121.02.



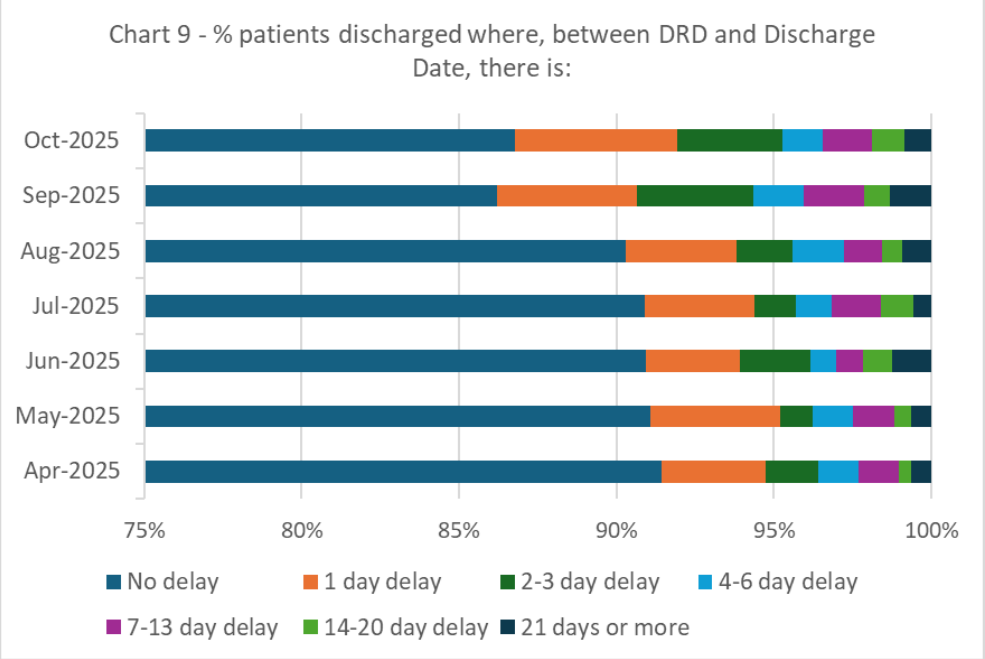
Source: DHSC Better Care Fund & Discharge Dashboard

The total number of falls-related admissions for this age group is 586 in the period April - November 2025. When compared to other boroughs in South East London, Bexley has the second highest number of patients admitted due to falls, highlighting an ongoing need to prioritise prevention initiatives.



Source: NHS SEL ICB Better Care Fund Baseline Dashboard

7. Percentage of patients not discharged on their DRD and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more



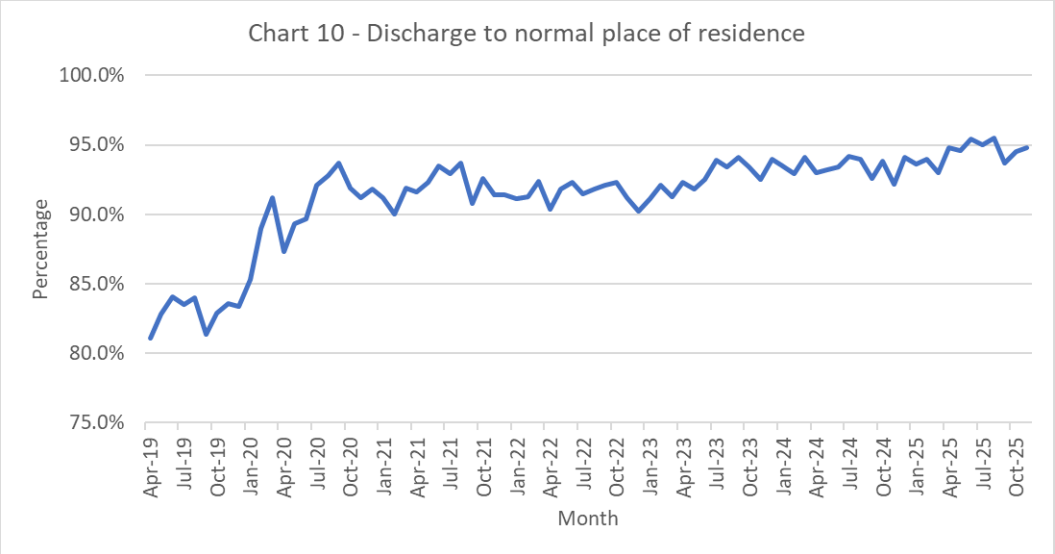
Source: NHS England, Timeliness of Acute Hospital Discharges completed within the month

Most Bexley patients who were not discharged on their Discharge Ready Date were subsequently discharged within one day. Delays of 2–3 days and 4–6 days were also relatively common with some variation from month to month. Delays of 21 days or more

affected a small proportion of patients, but this has operational significance due to the number of associated bed days.

8. Discharge to normal place of residence

This indicator measures the percentage of discharges to a person's normal place of residence. There is evidence that recovery and independence for people who have been admitted to hospital are improved if they are discharged to their own home. Our performance in Bexley in 2025/26 so far shows that over 94% of hospital discharges were to a person's usual place of residence.



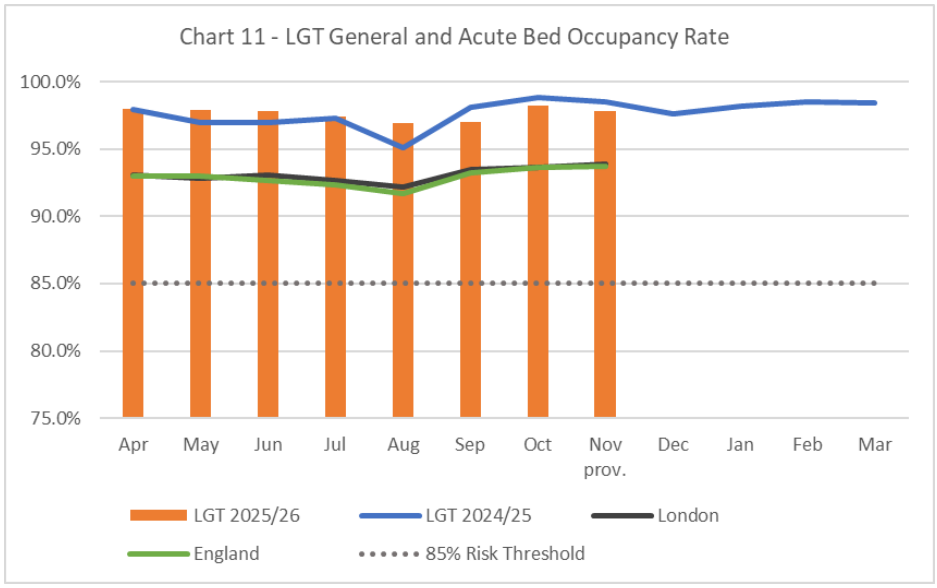
Source: NHS SEL ICB Better Care Fund Baseline Dashboard

9. Inpatient Length of Stay

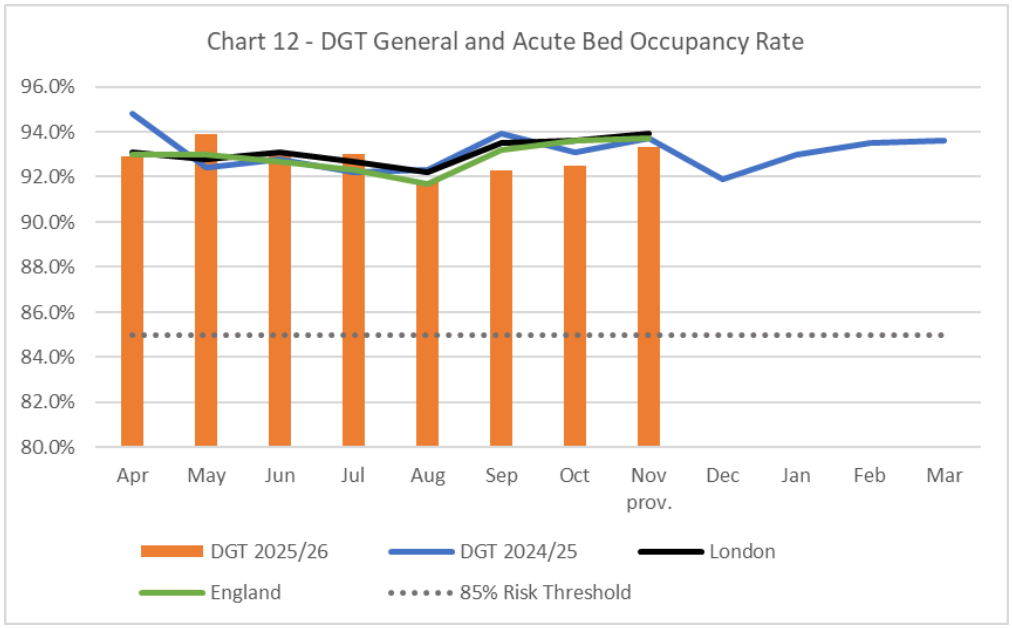
The proportion of patients staying 14+ days shows an improvement from 14.7% in September 2025 to 14.4% in October and 12.5% in November 2025. Similarly, 21+ day stays fell from 8.3% to 6.5% over the same period.

10. General and acute bed occupancy

High levels of hospital occupancy can have an impact on patient flow. Average bed occupancy above 85% is generally considered to be the point beyond which safety and efficiency are at risk. Local variation in supply and demand has seen some trusts exceed 95% occupancy. The focus on discharge pathways should help people who no longer meet the criteria to reside to return home or to the most appropriate care setting. Monthly bed occupancy data for Lewisham and Greenwich Trust and Dartford and Gravesham Trust is shown below for 2025/26.



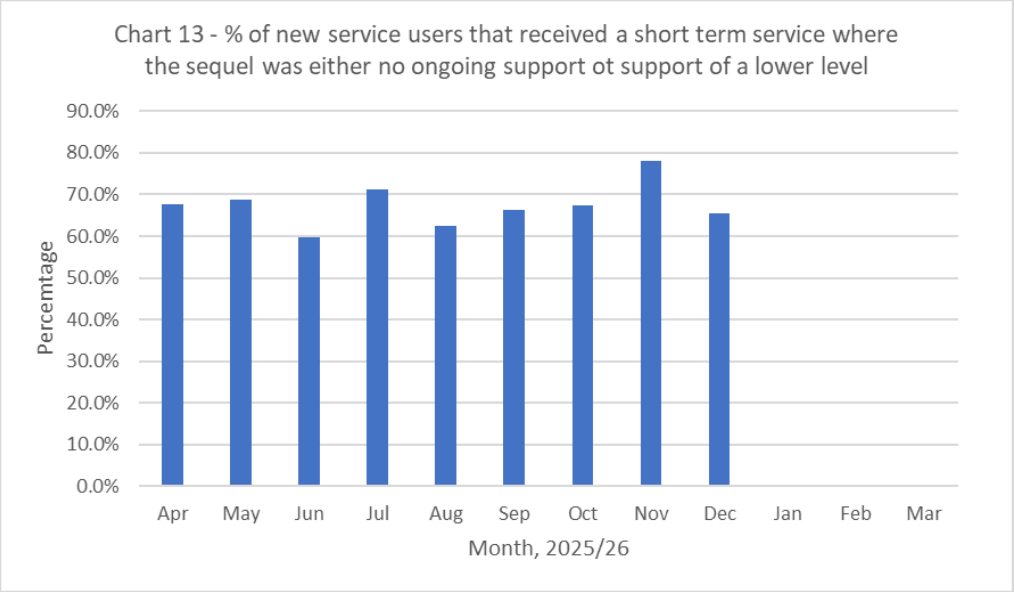
Source: Critical Care and General & Acute Beds – UEC Daily Situation Reports, NHS England



Source: Critical care and General & Acute Beds – UEC Daily Situation Reports, NHS England

11. Outcomes following short-term support to maximise independence

Through our short-term services, such as reablement, we aim to delay dependency, support recovery and promote independence. There is evidence of good outcomes being achieved as a result of this short-term support. Provisional data for the period April – December 2025 shows that 67.8% (579/854) of new service users required no further support or only lower-level support following short-term intervention.



Source: ASCH - Management Information Pack

In addition, during the same period, 82.3% (873/1061) of people who have ongoing support needs had an evidenced reduction in care on completion of reablement episodes.

Bexley Wellbeing Partnership Committee

Thursday 22nd January 2026

Item: 7

Enclosure: F

Title:	**2025/26 Finance Report: Month 8**
Author/Lead:	Asad Ahmad, Associate Director of Finance (Bexley), NHS South East London Integrated Care Board
Executive Sponsor:	Diana Braithwaite, Strategic Director, Integrated Health & Care/Place Executive Lead (Bexley), NHS South East London Integrated Care Board David Maloney, Director of Corporate Finance, NHS South East London Integrated Care Board

Purpose of paper:	**To provide an update on the financial position of Bexley (Place) as well as the overall financial position of NHS South East London Integrated Care Board and the Integrated Care System as at month 8 2025/26.**	**Update / Information**	***X***
		Discussion	***X***
		Decision	

Summary of main points:

Bexley place financial 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	3,483	3,429	54	5,225	5,144	81
Community Health Services	17,402	17,376	26	26,104	26,065	39
Mental Health Services	7,278	7,447	(168)	10,908	11,191	(283)
Continuing Care Services	17,806	17,359	447	26,709	26,030	680
Prescribing	26,174	26,608	(434)	39,134	39,807	(673)
Other Primary Care Services	1,000	1,024	(24)	1,501	1,537	(36)
Other Programme Services	817	817	0	1,225	1,225	0
Delegated Primary Care Services	33,109	33,109	0	49,664	49,663	0
Corporate Budgets	2,019	1,838	181	3,029	2,730	299
Total	**109,090**	**109,008**	**82**	**163,498**	**163,392**	**106**

As at Month 8 (November 2025) Bexley place is reporting an underspend of £82k year to date and £106k full year forecast.

South East London ICB Summary

- The ICB's financial allocation as at month 8 is £5,794,877k.
- As at month 8, the ICB is reporting a year to date (YTD) break-even position.
- Two places are reporting overspends YTD at month 8 – Bromley (£232k) and Lambeth (£8k), with a break-even position being forecast by all. Places have been tasked to identify additional mitigations to offset financial risks, to ensure delivery of their financial plans.
- As at month 8 the ICB is reporting an overall forecast break-even position against its financial plan.

	South East London ICS Summary • At month 8 (WD6), SEL ICS is reporting a YTD deficit of (£25.8m), £2.4m behind plan. • At month 8, the ICS system forecast remains at a break-even financial position.	
Potential Conflicts of Interest	There are no conflicts of interest as a consequence of this report.	
Other Engagement	Equality Impact	None, all Bexley residents have the same levels of access to healthcare.
	Financial Impact	There are no known risks to these numbers as they have now been published.
	Public Engagement	The finance reports are reported to public borough-based board meetings and also the position is reported by SE London ICB at the public Governing Body Meetings.
	Other Committee Discussion/ Engagement	The finance reports are discussed at SE London level at the Planning and Delivery Group, locally, it has been discussed at Bexley SMT and the LCP Executive.
Recommendation:	The Bexley Wellbeing Partnership Committee is recommended to: (i) Discuss and note the month 8 financial position for Bexley Place. (ii) Receive the NHS South East London ICB and NHS South East London ICS financial position as at month 8.	

South East London Integrated Care System

Bexley Wellbeing Partnership Committee

Finance Report

Month 8 (November) – 2025/26

Thursday 22nd January 2026

Agenda Item: 7
Enclosure: F(i)

Bexley Wellbeing Partnership

2025/26 Month 8 Bexley Place Financial Position

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	3,483	3,429	54	5,225	5,144	81
Community Health Services	17,402	17,376	26	26,104	26,065	39
Mental Health Services	7,278	7,447	(168)	10,908	11,191	(283)
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Delegated Primary Care Services	33,109	33,109	0	49,664	49,663	0
Corporate Budgets	2,019	1,838	181	3,029	2,730	299
Total	**109,090**	**109,008**	**82**	**163,498**	**163,392**	**106**

- As at Month 8 (November 2025) Bexley place is reporting an underspend of £82k year to date and £106k full year forecast.
- Prescribing is reporting an overspend of £434k year to date and £673k full year forecast. Prescribing data is provided two months in arrears; therefore, the financial position includes an estimate for this period. The main drivers for the current position are increased costs relating to endocrine (especially diabetes), flash glucose monitoring and appliances such as catheters. Work is ongoing by the medicines management team to deliver efficiencies to improve the financial position, including anticipated savings from the reduced cost of the drug Dapagliflozin coming off patent.
- Continuing Care is reporting an underspend of £447k year to date and £680k full year forecast. Continuing Care has seen a reduction in costs over several months and this is due to the number of care packages reducing as well as savings achieved following Continuing Care reviews conducted by the team. Continuing Care is a high-risk budget as any new high-cost placement can have a material impact on the financial position.
- Mental Health Services is reporting an overspend of £168k year to date and £283k full year forecast. The position includes a material overspend on the right to choose ADHD and ASD assessments conducted by private providers. This activity has been increasing significantly overtime and creating a cost pressure which is impacting all boroughs in South East London.
- Delegated Primary Care is reporting a breakeven position year to date and full year forecast. Delegated primary care is a ring-fenced allocation across South East London ICB, therefore any variances at individual places have been equalised to reflect a breakeven position. Without equalisation of budgets across the ICB, Bexley place is forecasted to underspend by £252k for the year based on the latest list size data.
- Corporate budgets are reporting an underspend of £181k year to date and £299k full year forecast. The underspends are a result of vacant posts which cannot be recruited to due to the recruitment freeze as per the current ongoing ICB change programme.
- Acute Services is reporting an underspend of £54k year to date and £81k full year forecast. The underspend is primarily on the patient transport services budget.
- Bexley place has an annual efficiency plan of £7,750k which is forecasted to deliver in full by year end.

South East London Integrated Care System

Appendix A

SEL ICB Finance Summary

Month 8 2025/26

Bexley Wellbeing Partnership

1. Key Financial Indicators

NHS South East London

- The below table sets out the ICB's performance against its main financial duties on both a year to date (YTD) and forecast basis.
- As at month 8, the ICB is reporting a year to date (YTD) and forecast out-turn (FOT) **break-even position** against its revenue resource limit (RRL) and financial plan. There have not been any major movements in the run rate to report this month. Within this reporting, the ICB has delivered **£40,202k** of savings YTD compared to the plan value of £39,035k.
- **All boroughs are reporting that they will deliver a minimum of financial balance at the year-end after the "equalisation" (implementation of the risk-share) of the delegated primary care budgets and for 2 boroughs non-recurrent support in respect of the new ICES contracts.**
- The ICB is showing a YTD underspend of **£1,527k** and forecast out-turn position of an underspend of **£2,004k** against the **running cost allowance.**
- All other financial duties have been delivered for the year to month 8 period.

Key Indicator Performance

	Year to Date		Forecast		
	Target	Actual	Target	Actual	
	£'000s	£'000s	£'000s	£'000s	
Expenditure not to exceed income	3,878,993	3,878,993	5,794,877	5,794,877	
Operating Under Resource Revenue Limit	3,878,993	3,878,993	5,794,877	5,794,877	
Not to exceed Running Cost Allowance	20,497	18,970	30,746	28,742	
Month End Cash Position (expected to be below target)	5,600	2,958			
Operating under Capital Resource Limit	n/a	n/a	n/a	n/a	
95% of NHS creditor payments within 30 days	95.0%	99.9%			
95% of non-NHS creditor payments within 30 days	95.0%	98.6%			
Mental Health Investment Standard (Annual)			537,494	549,166	

Bexley Wellbeing Partnership

2. Executive Summary

NHS South East London

- This slide summarizes the month 8 financial position of the ICB. The financial reporting is based upon the final plan submission. This included a **planned break-even position** for the ICB.
- The ICB's financial allocation as at month 8 is **£5,794,877k**. In month, the ICB has received an additional **£1,091k** of allocations. The additional allocations related to £500k for National Recovery Support, £499k for Wayfinder funding to support the PEP NHS App for Bromley and £92k for GIRFT for Community MSK. **As at month 8, the ICB is reporting a year to date (YTD) break-even position.**
- Due to the routine time lag, the ICB has received six months of 2526 prescribing data. After the usual accrual for two months of estimated prescribing expenditure, the ICB is reporting a **£2,195k overspend YTD across PPA and non PPA** budgets. The overspend continues to be variable across the Places.
- The continuing care financial position is **£267k underspent** at month 8, which is an improvement on last month. The boroughs which are most impacted with overspends are Lewisham, Bromley and Greenwich (to a much lesser degree) which is a continuation of the trend from last year. Lambeth, Southwark and Bexley are all reporting underspends this month.
- The YTD position for **Mental Health services** is an overall **overspend of £6,337k** which is a deterioration on last month. This is generated by pressures on cost per case services with all boroughs impacted. **ADHD and ASD assessments** are also a significant financial pressure, with both activity and costs increased significantly in this financial year. The new referral centre arrangements for these assessments is now live and started at the beginning of November.
- Places are also being impacted by the current contractual difficulties in the **community home equipment contract**, led by the London consortium. A full year cost pressure of **circa £1,500k** has been included in financial positions. Contractual changes were implemented from August.
- The ICB is continuing to incur pay costs for the remaining displaced staff following the original MCR process. All associated costs are charged to the balance sheet provision which was set up for this purpose. Some staff left the ICB in June, which leaves a small number of impacted staff who remain at the ICB.
- Two places are reporting overspends YTD at month 8 – **Bromley (£232k)** and **Lambeth (£8k),** with a break-even position being forecast by all. Places have been tasked to identify additional mitigations to offset financial risks, to ensure delivery of their financial plans.
- In reporting this month 8 position, the ICB has delivered the following financial duties:
    - Underspend of **£1,527k YTD** against its management costs allocation, with the monthly cost of displaced staff being charged against the provision.
    - Delivering all targets under the **Better Practice Payments code**;
    - Subject to the usual annual review, delivered its commitments under the **Mental Health Investment Standard**; and
    - Delivered the **month-end cash position**, well within the target cash balance.
- As at month 8 the ICB is reporting an overall **forecast break-even position** against its financial plan.

Bexley Wellbeing Partnership

South East London Integrated Care System

Appendix B

SEL ICS Finance Summary

Month 8 2025/26

Bexley Wellbeing Partnership

Executive Summary

Organisation	Year-to-date			Full Year		
	Plan Incl. DSF	Actual	Variance	Plan Incl. DSF	Forecast	Variance
	£m	£m	£m	£m	£m	£m
GSTT	(24.8)	(29.0)	(4.2)	0.0	0.0	0.0
KCH	0.4	2.0	1.6	0.0	0.0	0.0
LGT	0.0	0.1	0.1	0.0	0.0	0.0
Oxleas	0.0	0.1	0.1	0.0	0.0	0.0
SLaM	1.0	1.0	0.0	0.0	0.0	0.0
Provider total	**(23.4)**	**(25.8)**	**(2.4)**	**0.0**	**0.0**	**0.0**
SEL ICB	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
System total	**(23.4)**	**(25.8)**	**(2.4)**	**0.0**	**0.0**	**0.0**

- At month 8 (WD6), SEL ICS is reporting a **YTD deficit of (£25.8m), £2.4m behind plan.** This represents an overall **£0.3m deterioration** compared to month 7.
- GSTT are reporting a YTD deficit of **£29.0m, £4.2m** adverse to plan. This represents an adverse movement of **£1.5m** in-month. Drivers for this movement are set out in the following slide.
- KCH are reporting a **YTD surplus of £2.0m**, **£1.6m ahead of plan and an improvement of £1.1m** compared to month 7 driven by activity catchup and run rate improvement.
- All other organisations are reporting either a YTD break-even position or a slight surplus of £0.1m.
- **At month 8, the ICS system forecast remains at a break-even financial position.**

Bexley Wellbeing Partnership Committee

Thursday 22nd January 2026

Item: 8

Enclosure: G

Title:	**Place Risk Register**
Author/Lead:	Rianna Palanisamy, Partnership Business Manager, NHS South East London Integrated Care Board
Executive Sponsor:	Diana Braithwaite, Place Executive Lead (Bexley), NHS South East London Integrated Care System

Purpose of paper:	**To update the committee on the current risks on the Bexley place risk register and actions to mitigate those risks in the context of the boroughs risk appetite.**	**Update / Information**	***X***
		Discussion	
		Decision	

Summary of main points:	The Bexley Place risk register is currently reporting 14 open risks specifically relating to borough activities. The risks principally arise due to the following issues: Waiting lists for diagnosis of Autism and ADHD, vacancies within Safeguarding team, Primary care insecure lease arrangements, failure to deliver on the actions from the SEND inspection, the risk of overspend against aspects of the borough delegated budgets resulting in failure to deliver within the financial control total for 2025/26, the recommendations of the Better Care Fund support programme not being fulfilled, the inability to fully integrate system partners to meet the Joint Forward Plan goals and the targets not being met for flu vaccinations, SMI health checks and hypertension. The risks are reviewed monthly by the borough Senior Management Team. Where risks impact across several boroughs, they are also recorded on the NHS South East London Integrated Care Board (NHS SEL ICB) corporate risk register. The Senior Management Team also review the place comparative risks which assesses risks from each of the 6 SEL Boroughs. Further detail, mitigating actions, and gaps in control measures that require further work to address, are detailed in the attached report and appendix.	
Potential Conflicts of Interest	There are no conflicts of interest.	
Other Engagement	Equality Impact	None identified.
	Financial Impact	The finance risks reported concern financial risks which may impact the ICBs ability to meet its statutory duties.
	Public Engagement	These risks are highlighted in the regular report which is provided to the Bexley Wellbeing

		Partnership Committee at their meetings held in public.
	Other Committee Discussion/ Engagement	Risks as a whole are considered at the ICBs risk forum, which meets quarterly. The Board reviews the Board Assurance Framework at each meeting and is provided with an update on actions taken by other committees in relation their specialty associated risks.
Recommendation:	This report is for information and assurance to the Bexley Wellbeing Partnership Committee setting out the risks and associated mitigations.	

Bexley Place Risks – Report to the Bexley Wellbeing Partnership Committee

Thursday 22nd January 2026

1. Introduction

NHS South East London Integrated Care Board (NHS SEL ICB) manages its risk through a robust risk management framework, which is based on stratification of risk by reach and impact to identify:

- Risks to the achievement of corporate objectives which require Board intervention
- Risks which impact activity across multiple boroughs or directorates in south east London
- Place specific risks

The purpose of this report is to highlight to the Bexley Wellbeing Partnership Committee members the risks currently reported in the Bexley Place Risk Register.

2. Governance and risk management

Risk ownership is assigned to the most appropriate person within the relevant Bexley team at the time of raising the risk.

Risk review is a four-tier process comprising:

i. **Individual risk owner management** and review of the risk on a regular basis to ensure the risk register reflects the current status of the risk and any changes in circumstances are reflected in the score. This process includes a monthly scheduled review of all Bexley risks by the senior management team.

ii. The opportunity **to benchmark against risks held on risk registers for other boroughs** in south east London, and against risks held on the south east London risk register in a monthly risk forum, which comprises risk owners and risk process leads from across the ICB to discuss and challenge scoring of risks and the mitigations detailed.

iii. **Monthly review of the Bexley borough risk register** by members of the Bexley Wellbeing Partnership Committee, which holds a meeting held in public every other month, ensuring transparency of risks.

iv. **Regular review of the Board Assurance Framework** risks by the ICB Board at meetings held in public, together with **review of directorate risks** by Board committees.

Risk scores are calculated using a 5 x 5 scoring matrix which combines likelihood of occurrence by impact of occurrence. A summary of the potential grades for risks is shown in the table below:

Grade	Definition	Risk Score
Red	Extreme Risk	15-25
Amber	High Risk	8-12
Yellow	Moderate Risk	4-6
Green	Low Risk	1-3

Risks scoring 15 and above should therefore be given priority attention.

3. Bexley Place Risks

The Bexley Place risk register is reviewed on a monthly basis by the Senior Management Team, with a plan to further discuss on a one-to-one basis with the risk owner through a facilitated conversation led by the local governance and business support team.

The committee is asked to note the following:

- Of the 14 risks on the boroughs risk register, two are scored at 15 or above for their initial rating (i.e., the risk before any mitigation actions are put in place).
- Of the 14 risks on the Place based risk register:
  - **Nine** risks are rated as “high risk” (amber) after mitigations are put in place
  - **Four** risks are rated as “moderate risk” (yellow) after mitigations are put in place
  - **One** risk is rated as “low risk” (green) after mitigations are put in place

The underlying cause of these risks is:

- Concerns around achieving financial targets/ funding available.
- Capacity issues, either to meet demand within the borough or within the wider system.
- Insecure lease arrangements with a small number of practices within Bexley.
- Failure to deliver on one or more of the areas for priority action from the SEND inspection
- Targets not being met for SMI Health Check, Flu Vaccinations and Hypertension management
- Failure to fulfil the recommendations of the Better Care Fund Support Programme received in March 2025
- Inability to fully integrate and coordinate services across system partners, delaying in delivery of the Joint Forward Plan Goals
- Concerns around Children and Young people in Bexley not being able to access the support they need due to long waits for diagnosis of autism and ADHD

For further details on the risks, please see the below Bexley risk register in full.

4. Proposed actions for the committee

In relation to the above, the committee is recommended to consider the following actions:

- Review the risk register and assure itself as a committee that this accurately and comprehensively reflects the risks the borough currently holds.
- Review the controls in place and assure itself that these are underway.
- Consider the gaps in control and gaps in assurance and how the Committee can support the risk owners to ensure they are addressed.

Rianna Palanisamy
Partnership Business Manager, Bexley
NHS South East London Integrated Care Board

22nd January 2026

Risk ID	Risk Description	Initial Rating	Control Summary	Current Rating	Assurance in Place	Gaps in Assurance	Target Rating
503	A small number of practices within Bexley have insecure lease arrangements and/or unresolved issues with landlords that have the potential to lead to loss of premises within a relatively short time frame (< 6 months). There is the risk of a reactive and unplanned dispersal of those lists if appropriate premises cannot be secured and/or alternative arrangements (e.g. co-location or merger) cannot be agreed.	16	Regular liaison with the Lead Partner(s), ICB Estates Team and and LMC representative(s), Workshops and external consultancy input, facilitated through Practice Resilience funding.	9	Legal protections - Some legal protection afforded to the practices where the terms of the lease are being adhered to., Primary Care Delivery Group (Part2) Risk Register, clearly defines the risks for individual practices with plans in development to mitigate., Immediate risk associated with one practice has been resolved through purchase of the surgery premises by the Partner, enabling a new lease to be agreed.	Currently no identified/agreed estates solutions to mitigate current risks., Lack of clearly defined estates strategies at PCN/LCN level which makes it harder to assess the validity and implications of 'solutions' proposed by the affected practices, It is suspected that a number of Partnership Agreements including the property ownership and or lease agreements are not up-to-date and signed by all partners. These are reviewed at the point of renewal to provide this assurance., The agents and the DV are still negotiating to get an agreement. The Estates Team continue to liaise with the agent to request they expedite a resolution.	6
535	There is a risk that the prescribing budget may overspend due to: 1- Medicines supplies and costs increase No Cheaper Stock Obtainable/price concessions and Category M 2- Reduced capacity in the team to implement in year Quality, Innovation, Productivity & Prevention schemes by borough medicines optimisation teams due to a reduction in whole time equivalents following the management cost reduction programme. This is expected to have an additional impact on delivery given the latest ask for another restructure of the organisation 3- Entry of new drugs with increased cost pressure to prescribing budget. 4- Increased patient demand for self care items to be prescribed rather than purchased as cost of living increases 5- Prescribing budget although uplifted for 25/26 a gap remains with regards to forecast outturn and budget, especially factoring new NICE TA's being approved for medicines which will be initiated or end up being continued in primary care	12	Monthly monitoring of spend (ePACT and PrescQIPP), Review PPA budgets, Borough QIPP plans, and incentive schemes developed, SEL rebate schemes	12	Budget monitoring and continuous review of efficiency plans, Bexley Wellbeing Partnership ; Bexley Wellbeing Executive ; SEL ICB Board Assurance Framework. Actions regarding the prescribing budget are completed by Taher Esfandiari, Monthly practice prescribing dashboard, Monthly QIPP tracker, SEL ICB Primary Care Medicines Value Group for discussion and dissemination of supportive information to help with QIPP delivery/budgetary stewardship, SEL rebate scheme ensures savings are still realised, Prescribing support software harmonisation for SEL in place	Control over national guidance and price changes	6
546	Risk that expenditure for continuing health care services will exceed the 25/26 set budget. The growth funding received is lower than Funded Nursing Care & Any Qualified Provider rates and non AQP providers are requesting even higher rates. Also, increase in home care providers rates is likely for providers on Bexley Council's domiciliary care framework	12	Robust recovery plan and regular robust monitoring in place , including delivery on efficiency targets, Month 6 position is showing a healthy underspend. New risk rating at target level.	4	Budget monitoring and continuous review of efficiency plans. SEL process for approval of fee uplift requests. Robust 1:1 review process, Potential savings schemes amounting to £915k developed for internal CIP audit March 2025	Unable to control incoming high cost cases, Limited control of fee uplift requests from providers	6
550	There is a risk that system partners will fail to deliver on one or more of the areas for priority action from the SEND inspection and that required improvements are not made so that the local authority and ICB fail to meet their statutory duties and children and young people with Special Educational Needs and Disabilities do not receive the support they require.	9	The T&F has generated a project plan to address therapy gaps, Significant work has been done by teams across LBB, SELICB and SEND Partners. The latest Stocktake letter from DFE (October 2025) suggests positive areas of improvements made and some ongoing areas to further improve. New risk rating of 6., Significant work has been done by teams across LBB, SELICB and SEND Partners. The latest Stocktake letter from DFE (October 2025) suggests positive areas of improvements made and some ongoing areas to further improve. New risk rating of 6.	6	Progress report to Board, all Priority Action Plan actions Red Amber Green rated and updated monthly, SEND assurance now shared with Integrated Care Board Accountable Officer, Recent SEND PAP stocktake with NHS England and Dept for Education, Project manager in place and programme manager due to start in December, SEND transformation manager and project manager both started full time at beginning of December. Tracker to monitor delivery and impact of all PAP now populated and Board will review in December, Positive deep dive by DfE/NHSE with clear actions for continued improvement 22/01/25, SEND hub being rolled out- which will provide child level data and show where therapy gaps exist, SEND Board being assured that actions will be completed by the end of June 2025 and the evidence to support those actions is increasing weekly through the roll out of the SEND hub and collation of survey and audit results, SEND Hub is now producing real time information on gaps in therapy services in schools, New draft therapies commissioning model produced for agreement by partnership, A stocktake meeting with NHSE & DfE took place on Wednesday 16 April 2025. The chair stated that it was a 'very positive' meeting and no specific actions arose from it, A stock stake meeting with NHSE and DfE took place on Tuesday 15 July. A small number of actions are likely to arise., The IAB approved TOR for collaborative commissioning arrangements for therapies on Wednesday 3 July 2025, All PAP actions are now rated green or blue, Paper demonstrating impact of actions and changes/improvements since inspection developed and will be shared	Stocktake indicated concerns about pace, Potential cost pressures to implement new therapy model, current lack of child level data (until hub is fully rolled out) means still unable to pinpoint which children in which schools are not receiving therapy in line with Education Health & Care Plan, failure to recruit additional Occupational Therapy capacity at first attempt, Financial information to support development of therapies commissioning model is proving challenging to obtain, Early data from SEND hub shows therapy services gaps are bigger than previously thought and include SLT as well as OT, There is still work required to agree and operationalise new commissioning model, There is still work required to embed the new commissioning model which depends on the engagement of schools, There is a risk that changes will not sufficiently impact on families for survey outcomes to improve	4
582	There is a risk that inadequate immunisation coverage may increase the risk of outbreaks of vaccine-preventable diseases, especially measles and whooping cough.	12	The Borough Immunisation Coordinator works closely with practices to support improvement in uptake., Raising awareness on programme changes & signposting to associated supporting resources & toolkits	12	Communications - To ensure parents can make informed decisions about vaccinations, systems need to provide clear and up-to-date information about vaccines, including any potential side-effects as well as information on the diseases vaccines protect against., Doing the basics well - Robust call & recall processes, a range of clinics & appointments, easy registration processes for new families/patients, timely follow-up of DNA's by suitably trained staff alongside the offer of another appointment., Learning and review - Regular review by GP practices (individually and collectively) of their data and processes to understand their progress with vaccine uptake and identify training gaps and areas for development., Engagement and co-production - Seeking support from local stakeholders and community champions on how communities with lower uptake can be better served., Making Every Contact Count - Making immunisation everyone's business so a wide cohort of staff are equipped to have effective conversations with parents., In an effort to increase MMR (measles, mumps and rubella) vaccination rates, children and young people aged 5 to 19 can now catch up with missed vaccines at nine community pharmacies across south east London. This is part of a London wide push to make the vaccine more accessible to families. This includes Belvedere and Aspire Pharmacies., 24/25 Q4 data indicates some inprovements e.g. Coverage at 12 months DTaP/IPV/Hib/HepB. Bexley is	Some key vaccination indicators are below the 90% efficiency standard, e.g. MMR2 at 5 years is at 74.5%, and pre-school booster coverage is only 73%., Significant changes to the national routine vaccination schedule from July 2025 and also January 2026 are likely to require time to fully embed, potentially leading to further reduced coverage in the short term.	6

583	There is a risk that low rates of flu vaccination among under-65s at risk may increase acute demand during flu season, particularly for at-risk populations	12	Close working between the ICB and GP Practice/Community pharmacy to plan and promote vaccination campaigns., Use of a range of communication and media channels to promote vaccine eligibility and availability., Use of Making Every Contact Count (MECC) through scheduled outreach events promoting health and wellbeing.	12	Regular liaison with delivery partners through the bi-weekly Vaccination Oversight Group to identify and address trends and issues at an early stage., NHSE UEC winter plan references developing the "flu walk-in finder" so that, from October 2025, patients can easily look up when they can walk into a community pharmacy to get a vaccination, NHSE UEC winter plan references expanding the use of the National Booking Service for flu vaccination to make more appointments available, including keeping it open until the end of the flu campaign in March, Expanded comms campaign (including Better Access Bexley) form part of the plan to achieve projected increase., Community pharmacies are becoming increasingly ambitious on flu vaccinations so this will likely drive greater coverage. Good coverage in Bexley for 25/26 season., Community Pharmacy is providing flu vaccination for 2-3-year-olds - new for 2025/26.	Evidence of post pandemic vaccination 'fatigue' within the target population., There has been an issue with 24/25 flu data so we do not have a totally accurate picture for 24/25 but the projected plan is likely only a 1-2% increase on this year's performance in both cohorts (>65s and <65s clinically vulnerable)	6
584	There is a risk that the continued shortfall in SMI health checks, relative to the SEL Operating Plan target, may worsen health inequalities and reduce quality of care for a high-need group.	12	Joined up working and approach through the borough Mental Health Board., Practices are incentivised within the Bexley GP Premium for delivery over and above the ICB's Operating Plan target.	12	Social Media Messaging in place, user friendly physical health newsletter circulated November 25, Funds secured from Public Health for a smoking cessation worker - now recruited., Webinars scheduled between Sept and Dec - publicised via primary care channels and through Mind in Bexley.	In the last 12 months 52% of people with SMI have had physical health check vs an SEL operating plan target of 70% (24/25). November reporting shows Bexley slightly behind the expected trajectory of 55%., Significant practice level variation (34% lowest and 93% highest) representing a clear health inequality., SMI Health checks do not currently feature in plans for the new 2026 Bexley GP Premium (duplication of QOF) at a time when other boroughs are looking to include from April 26.	6
585	There is a risk that poor hypertension management within primary care may increase cardiovascular risk and contribute to poorer health outcomes for residents and future avoidable demand on secondary and acute health care services.	15	'Clinical Excellence South East London' (CESEL) work with practices and PCNs to ensure that CVD investment funding is focused on supporting the improvement of the hypertension target., Increasing awareness with the general public through community outreach events concerning the importance of having blood pressure checked and controlled., The 2024/25 priorities and operational planning guidance identifies increasing the percentage of patients with hypertension treated to NICE guidance to 80% by March 2025 as a national objective. For 2024/25, this will remain the primary aspirational goal for SEL. SEL will also pursue a 'minimum achievement' target (which will serve as the revised SEL ICB corporate objective) to achieve 85% over a 2 year time period (i.e. by end March 2026). This approach has been agreed by the PELs., Additional investment agreed by Primary Care Delivery Group in 25/26 targeted at rapid improvement to reach mid / upper 60% by May/June 2025 and achievement of the SEL 80% target by the end of March 2026.	12	Clear plans in place to recover position to target by 31 March 2026, including rapid improvement to reach mid / upper 60% by end of Q1 25/26 and 80% by end of March 2026., All practices to identify a dedicated team (champions) and Lead GP to take charge of hypertension management and set criteria/ priorities to recall relevant patients., A Care Coordinator will ensure appropriate patients are contacted, follow-ups arranged, missed appointments rescheduled, and continuous engagement through phone calls or digital platforms., Increasing awareness with the general public about the importance of having blood pressure checked and controlled - through community engagement events with blood pressure monitoring available., As at September 2025, the achievement figure for <80 years was 68.77% and for >80 years 80.83% which represents an improvement on 24/25 data.	The 2025/26 priorities and operational planning guidance identifies increasing the percentage of patients with hypertension treated to NICE guidance to 85% by March 2026 (for both <80 and >80) as a national objective which will be challenging to achieve for most practices based on current levels of achievement.	9
586	There is a risk that Bexley place may over spend against its delegated budget in 2025/26. There are significant financial risks against several budget areas including Prescribing and Continuing Care. If this materialises, it will impact the ICB's ability to maintain its financial position within the ICB's revenue resource limit which is a statutory requirement.	12	Budgets will be monitored closely to manage cost pressures, new investment will be delayed and spend freeze policy implemented inline with ICB policy to ensure a balanced budget is delivered.	6	The strategic objective of the Place to deliver a balanced budget is well understood across all teams and stakeholders. Expenditure is closely monitored and recovery actions are put in place where necessary to mitigate the risk of over spend against the overall place allocation. This is also addressed at senior management team and executive meetings, providing the necessary assurance.	None	3

587	There is a risk that Bexley place will not be able to deliver in full the 2025/26 efficiency plan identified. Failure to deliver the efficiency plan may result in Bexley place over spending against its delegated budget for 2025/26. If this materialises, it will impact the ICB's ability to maintain its financial position within the ICB's revenue resource limit which is a statutory requirement.	9	Monthly monitoring of existing schemes is in place. Continuous collaboration with all efficiency scheme owners to ensure the readiness to replace any failing scheme with viable ones.	6	There is a clear understanding of the strategic objective of Bexley place to deliver its efficiency plan. The risks on this is well discussed at the senior management team/executive meetings. Recovery/mitigation actions will be put in place as necessary.	None	3
588	There is a risk that Bexley does not fulfil the recommendations of the Better Care Fund Support Programme received in March 2025 so that required improvements to patient flow and discharge are not made in the local acute system	9	SRO's drawn from key partner organisations, SRO from LGT leading creating leadership capacity and alignment with UEC improvement plan, SRO from Oxleas leading on hub implementation, SRO from LBB leading on agreement of system wide metrics and and dashboard, SRO from RBG leading on OD programme and shared escalation system	9	SRO's taking ownership of progress and governance of each programme, MOU for integrated TOC Hub now signed off by SRO, JD for Toc Hub manager agreed by partners and ready for advert, TOC Hub Manager appointed and due to start in December 2025, TOCH SOP in development	Plans to deliver on recommendations are still forming, Integrated Toc Hub not yet fully implemented	6
595	There is a risk that there is an inability to fully integrate and coordinate services across system partners in a timely way which may delay delivery of the integrated Joint Forward Plan goals in relation to prevention, early intervention and personalised care, which if it occurs, will lead to lack of improved outcomes, widen health inequalities, increase demand on acute services, and reduce intended impact on system sustainability.	12	South East London ICS framework supports joined-up planning and delivery, Commitment and engagement from executives across partner organisations, Focus on personalised, preventative care embedded in the local models, Targeted development for frailty, long-term condition management and Children and Young people, Development and implementation of programme and project plans, Supports data-driven identification and targeting of need., Reduces reliance on health and care services	8	Regular ICS (NBC Board, ICB Board) and Bexley Wellbeing Partnership governance oversight (Community Based Care Delivery Board, BWP Executive Leadership Group), Programme-specific review groups, Stakeholder engagement feedback loops for service design and delivery assurance, Performance monitoring against outcomes and impact metrics, Co-design and co-development has been effectively implemented through successful public engagement forums, Robust process now in place across partner organisations to enable compliant data sharing, Work plan adjustments and back fill arrangements have been put in place to secure capacity to deliver integrated services	Limited real-time impact data especially in new models of care, Value based care contracting approach and framework to enable commissioning for outcomes	6
627	There is risk that with no designated safeguarding children doctor in post SEL ICB practitioners and providers will not be able to access the advice and support they may need to safeguard children This has been caused by the post becoming vacant This is a statutory post. If this post remains vacant there is a risk that the SEL ICB will non compliant with their statutory functions	3	As a statutory post agreement has been given by Chief Executive that post can be filled. Vacancy due to be advertised shortly. One designated safeguarding children doctor has made themselves available to provide advice and support. Several other designated doctors across the ICB SEL would also be available but on a limited basis	3	Designated Dr for Greenwich as agreed to cover. Named GP in Bexley providing support . If both are on leave at the same time support can be accessed by one of the other Designated Drs in SEL ICB or away at the same time support can be accessed by contacting one of the other Designated Drs in SEL ICB	None	3
642	There is a risk that children and young people in Bexley will not be able to access the support they need due to long waits for diagnosis of autism and ADHD	12	SEL Commissioning leads on the ASD and ADHD diagnostic pathways are developing an Assessment Hub to support priority screening and support for patients referred for a diagnosis. Locally, Bexley has expanded access to pre-and post-diagnostic support for ADHD and autism to support CYP and families while they wait for a diagnosis and post diagnosis. Oxleas our provider has sub-contracted an independent provider Healios to increase capacity and support with increased demand for autism assessments.	12	This has been raised as a concern across the local partnership and work is underway to consider how we can collectively support CYP based on presenting need rather requiring a formal diagnosis. Pre-and-post diagnostic workshops are available and have been scheduled. Other than ADHD prescribing, CYP can access health services without a diagnosis and waiting times for most health services are within national targets. The pilot assessment hub is due to start in Q3 for 2025/26 and will support with expediting access to assessments for ADHD and autism and alleviate some of the demand on the core commissioned pathway. Oxleas has increased output for autism assessments and is working to streamline their processes to meet increased demand.	Demand is still outstripping capacity and data indicates demand has significantly increased in recent months. This is likely to impact CYP who would require ADHD medication the most as other treatment pathways can be referred to without a diagnosis. Staff sickness in community paediatrics may further compound capacity concerns and negatively impact waiting times further.	6

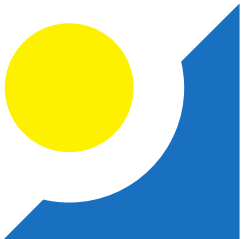
Agenda Item: 12
Enclosure: H

Bexley Wellbeing Partnership Committee

Glossary of NHS Terms

A&E	Accident & Emergency
AHC	Annual health Checks
AAU	Acute Assessment Service
ALO	Average Length of Stay
AO	Accountable Officer
APMS	Alternative Provider Medical Services
AQP	Any Qualified Provider
ARRS	Additional Roles Reimbursement Scheme
ASD	Autism Spectrum Disorder
BAME	Black, Asian & Minority Ethnic Group
BBB	Borough Based Board
BMI	Body Mass Index
CAMHS	Child and Adolescent Mental Health Services
CAN	Accountable Cancer Network
CAG	Clinical Advisory Group
CCG	Clinical Commissioning group
CEG	Clinical Executive Group
CEPN	Community Education Provider Networks
CHC	Continuing Healthcare
CHD	Coronary Heart Disease
CHYP	Children and Young People's Health Partnership
CIP	Cost Improvement Plan
CLDT	Community Learning Disability Team
CMC	Coordinate My Care
CoIN	Community of Interest Networks
CoM	Council of Members
COPD	Chronic Obstructive Pulmonary Disease
Covid-19	Coronavirus
CRG	Clinical Review Group
CRL	Capital Resource Limit
CQC	Care Quality Commission
CQIN	Commissioning for Quality and Innovation
CSC	Commissioning Strategy Committee
CSU	Commissioning Support Unit
CTR	Care Treatment Review
CSP	Commissioning Strategy Plan
CVD	Cardiovascular disease
CVS	Cardiovascular System
CWG	Clinical Working Group
CYP	Children and Young People
DBL	Diabetes Book & Learn
DES	Directed Enhanced Service
DH	Denmark Hill
DHSC	Department of Health and Social Care
DPA	Data Protection Act
DVH	Darent Valley Hospital

DSE	Diabetes Structured Education
EA	Equality Analysis
EAC	Engagement Assurance Committee
ECG	Electrocardiogram
ED	Emergency Department
EDS2	Equality Delivery System
EIP	Early Intervention in Psychosis
EoLC	End of Life Care
EPR	Electronic Patient Record
e-RS	e-Referral Service (formerly Choose & Book)
ESR	Electronic Staff Record
EWTD	European Working Time Directive
FFT	Friends and Family Test
FOI	Freedom of Information
FREDA	Fairness, Respect, Equality, Dignity and Autonomy
GB	Governing Body
GDPR	General Data Protection Regulation
GMS	General Medical Service
GP	General Practitioner
GPPS	GP Patient Survey
GPSIs	General Practitioner with Special Interest
GSF	Gold Standard Framework
GSTT	Guy's & St Thomas' NHS Trust
GUM	Genito-Urinary Medicine
HCA	Health Care Assistant
HCAI	Healthcare Acquired Infection
HEE	Health Education England
HEIA	Health and Equality Impact Assessment
HESL	Health Education England – South London region
HLP	Healthy London Partnership
HNA	Health Needs Assessment
HP	Health Promotion
HWBB	Health and Wellbeing Board
IAF	Improvement Assessment Framework
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICS	Integrated Care System
ICU	Intensive Care Unit
IFRS	International Reporting Standards
IG	Information Governance
IS	Independent Sector
JSNA	Joint Needs Assessment
KCH	King's College Hospital Trust
KHP	Kings Healthcare Partnership
KPI	Key Performance Indicator
LA	Local Authority
LAS	London Ambulance Service



LCP	Local Care Provider
LD	Learning Disabilities
LES	Local Enhanced Service
LGT	Lewisham & Greenwich Trust
LHCP	Lewisham Health and Care Partnership
LIS	Local Incentive Scheme
LOS	Length of Stay
LMC	Local Medical Committee
LQS	London Quality Standards
LTC	Long Term Condition
LTP	Long Term Plan
MDT	Multi-Disciplinary Team
NAQ	National Audit Office
NDA	National Diabetes Audit
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
MH	Mental Health
MIU	Minor Injuries Unit
NHSE	NHS England
NHSI	NHS Improvement
NICE	National Institute of Clinical Excellence
NICU	Neonatal Intensive Care Unit
OHSEL	Our Healthier South East London
OoH	Out of Hours
PALS	Patient Advice and Liaison Service
PBS	Positive Behaviour Support
PHB	Personal Health Budget
PPE	Personal Protective Equipment
PPI	Patient Participation Involvement
PPG	Patient Participation Group
PRU	Princess Royal university Hospital
PCNs	Primary Care Networks
PCSP	Personal Care & Social Planning
PHE	Public Health England
PMO	Programme Management Office
PTL	Patient Tracking list
QEH	Queen Elizabeth Hospital
QIPP	Quality, Innovation, Productivity and Prevention
QOF	Quality and Outcomes Framework
RTT	Referral to treatment
SEL	South East London
SELCA	South East London Cancer Alliance
SELCCG	South East London Clinical Commissioning Group
SELDOC	South East London doctors On Call
SLaM	South London and Maudsley Mental Health Foundation Trust
SLP	Speech Language Pathologist
SMI	Severe Mental Illness

SMT	Senior Management Team
SRO	Senior Responsible Officer
STPs	Sustainability and Transformation Plans
TCP	Transforming Care Partnerships
TCST	Transforming Cancer Services Team
THIN	The Health Improvement Network
TOR	Terms of Reference
UHL	University Hospital Lewisham
UCC/UTC	Urgent Care Centre of Urgent Treatment Centre
VCS	Voluntary and Community Sector/Organisations
WIC	Walk-in-Centre