Bexley Wellbeing Partnership Committee meeting held in public

Thursday 26th March 2026, 14:00 – 15:30

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 22nd January 2026 and matters arising	Encl. B	Chair	14:04
Decision				
4.	Bexley New GP Premium 2026/29	Encl. C	Jonathan Hudson	14:05
5.	South East London Integrated Care System: Children & Young Peoples Integrated Neighbourhood Teams Framework	Encl. D	Katie Farrar-Daniel	14:25
Assurance				
6.	Performance Assurance Report	Encl. E	Gita Prasad	14:45
7.	Finance Report: Month 10	Encl. F	Asad Ahmad	15:00
8.	Risk Register	Encl. G	Rianna Palanisamy	15:10
Public Forum				
9.	*Public Questions*			15:20
Closing Business				
10.	Any other business		Chair	15:25
For Information				
11.	Glossary	Encl. H		
12.	Date of the next meeting: Thursday 28th May 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:19.03.2026**

Name	Position Held	Declaration of Interest	State the change or 'No Change'	Sign
Diana Braithwaite*	Strategic Director, Integrated Health & Care/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 & Health, 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/Vice Chair, Bexley Wellbeing Partnership (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.		
Kate Heaps (n)	CEO, 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 Children's Services, London Borough of Bexley	Nothing to declare.		
Sarah Burchell	Director Neighbourhoods and Integration	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 London wide 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), London Borough of Bexley	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		
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 22nd January 2026, 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 (SD)	Chair, Bexley Wellbeing Partnership
2. Jennifer Bostock (JB)	Vice-Chair, Independent Member
3. Yolanda Dennehy (YD)	Director of Adult Social Care & Health, London Borough of Bexley
4. Diana Braithwaite (DB)	Strategic Director, Integrated Health & Care/Place Executive Lead (Bexley), NHS South East London Integrated Care Board (NHS SEL ICB)
5. Raj Matharu (RM) (via MS Teams)	Chief Executive Officer, Local Pharmaceutical Committee
6. Katie Clare (KC)	Public Health Consultant, London Borough of Bexley
7. Iain Dimond (ID)	Chief Operating Officer, Oxleas NHS Foundation Trust
8. Dr Folake Davies (FD)	Clocktower Primary Care Network
9. Dr Sonia Khanna (via MS Teams)	Frognal Primary Care Network
10. Dr Surjit Kailey (SK) (via MS Teams)	North Bexley Primary Care Network

In attendance

Keith Wood (KW) (via MS Teams)	Lay Member for Primary Care (Bexley), NHS SEL ICB
Abi Mogridge (AM) (via MS Teams)	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
Kate Heaps (KH)	Chief Executive Officer, Greenwich & Bexley Community Hospice
Jattinder Rai (JR)	Chief Executive Officer, Bexley Voluntary Service Council
Lisa Cooper (LC)	Deputy Director Community Physical Health (Bexley), Oxleas NHS FT
Douglas McLaren (DM)	Associate Director of Planning and Transformation, Dartford and Gravesham NHS Trust
Gita Prasad (GP)	Interim Director of Integrated Commissioning (Bexley), NHS SEL ICB
Asad Ahmad (AsA)	Associate Director of Finance (Bexley), NHS SEL ICB
Steven Burgess (StB)	Policy and Strategy Officer, London Borough of Bexley

Patrick Gray (PG)	Community Voice Manager (Bexley), NHS SEL ICB
Nicola Taylor (NT)	London Borough of Bexley Councillor
Rianna Palanisamy (RP) *(Presenter)*	Partnership Business Manager (Bexley), NHS SEL ICB
Samira Bouzkraoui (SB)	Business Support / PA, (Bexley) NHS SEL ICB
Nazima Bashir (NB) *(Minutes)*	Corporate Business Manager (Bexley), NHS SEL ICB

Apologies

Stephen Kitchman, Director of Children's Services, London Borough of Bexley

Dr Nicole Klynman, Director of Public Health, London Borough of Bexley

Sarah Burchell, Director of Community Physical Health, Oxleas NHS Foundation Trust

Tracey Jenkins, Director of Strategic Transformations and Partnerships, Dartford & Gravesham NHS Trust

Spencer Prosser, Chief Finance Officer, Lewisham and Greenwich NHS Trust

Kallie Heyburn, Programme Director (Bexley), NHS SEL ICB

Dr Miran Patel, APL Primary Care Network

Aysha Awan (AA), Head of Communications and Engagement (Bexley), NHS SEL ICB

		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 27th November 2025** Bexley Wellbeing Partnership agreed that the draft minutes of the public meeting held on 27th November 2025 were a true and accurate record of that meeting and approved them on that basis. **Matters Arising** Nil.	**SD**
4.	**Five Year Strategic Commissioning Plan: *Bexley Neighbourhood Delivery Plan*** **Diana Braithwaite (DB), Strategic Director, Integrated Health & Care/Place Executive Lead (Bexley), NHS South East London Integrated Care Board (NHS SEL ICB)** talked the group through the salient points. Apologised for Dr Nicole Klynman's absence; noted Katie Claire, Public Health Consultant was present for questions. • Highlighted that the *Bexley Neighbourhood Delivery Plan* was developed collaboratively with primary care, community and mental health services, social care, public health, the voluntary and community sector and residents. • Explained key benefits: improving resident outcomes, reducing duplication, better use of estates and community assets and clarity/accountability for shared neighbourhood goals. • Noted the plan is primarily a commissioning tool for system leads, with practical applications such as population health management and optimisation of estates. • Confirmed progress would be reported regularly. The Chair (SD) then invited questions and comments from the group. <u>Questions/Comments</u>: JR suggested the voluntary sector's role in neighbourhood delivery should be explicitly highlighted in the plan. The Vice-Chair (JB) acknowledged that the work was very interesting and asked two questions. First, she asked how the neighbourhood plan translates strategy into practical action - how someone in a frontline role might use it and requested an example of a GP, nurse, or voluntary sector partner applying the plan. Second, she asked about analogue to digital initiatives, specifically whether there were plans for a digital tool to predict	**DB**

the risk of falls in older adults given the ageing population. She also reflected that people might use the plan as an action plan with deadlines.

DB explained that the neighbourhood plan sets out the strategic intent of commissioners in Bexley and across South East London, guiding how time, effort, and resources are prioritised. She highlighted practical applications, including the use of population health management to anticipate resident needs and outcomes, and workshops to make best use of estates and community assets in support of integrated neighbourhood teams.

DB noted that the plan operates at a high level and feeds into wider South East London strategies, with detailed mobilisation plans developed locally to deliver its priorities. She confirmed that progress is monitored through regular reporting and acknowledged the importance of maintaining oversight and accountability as delivery progresses.

ID noted that neighbourhood working is part of national direction and the long-term plan. Highlighted Bexley is already well positioned with existing partnership work (e.g., frailty and long-term conditions). Supported JR's point on voluntary sector involvement.

YD emphasised the plan builds on the previous four year plan and existing partnership commitments e.g., Bexley Care Plus Memorandum (MOU). Highlighted that detailed neighbourhood plans will be required next year, considering changes in governance. Discussed the potential of predictive digital tools linking health and social care records to identify residents at risk of falls.

KH noted the plan continues existing work and reinforces progress. Emphasised shared responsibility across the partnership for delivery. Stressed importance of culture change, workforce development and communication with frontline staff and residents.

CA explained how frailty reviews and the GP premium support holistic assessments for patients at risk of falls. Highlighted referrals to voluntary sector organisations (e.g., Age UK, Dementia UK). Confirmed alignment between commissioning intentions and neighbourhood priorities.

The Vice-Chair (JB) acknowledged and praised the current analogue approach being used to assess falls risk, describing it as brilliant and important. She explained that in social care, a nationwide digital trial is underway to develop an app linking health and social care records to create a predictive risk tool. The tool, still in early development, aims to help professionals identify people at risk of falls who may not otherwise come to their attention.

LC highlighted existing digital tools (e.g., 'Get You Better' app, wound care apps) for residents and professionals. Explained the plan helps coordinate these tools across organisations and ensures support for those unable to use technology.

YD added context about trials elsewhere using linked records to identify top risk residents for falls prevention, noting cost considerations and successes.

The Chair (SD) thanked everyone for their contributions, invited any further feedback to be sent to DB.

The Bexley Wellbeing Partnership Committee

(i) **Approved** the 5-Year Neighbourhood Delivery Plan.

	(ii) **Provided** feedback on any key areas to support its successful implementation	
5.	**Joint Prevention & Early Intervention Grants Programme** **Gita Prasad (GP), Interim Director of Integrated Commissioning, NHS South East London Integrated Care Board (Bexley)** talked the group through the salient points. GP highlighted that the grants, jointly funded with the London Borough of Bexley, have been supporting voluntary sector partnerships for several years and are now up for renewal. The programme covers a diverse range of providers, including organisations serving people with sensory needs, advocacy services, Mencap, Age UK and others, reflecting a commitment to supporting diverse communities. In this next round, there will be a particular focus on widening access for autistic residents, with the Autism Partnership overseeing relevant grants for individuals, families and carers. GP emphasised that the grants are prevention focused, helping people access support in the community and delaying or avoiding the need for statutory services. Carers' support is a key priority to sustain community resilience. Looking ahead, the programme aims to extend its reach to children, young people and families, strengthen place-based approaches, map delivery across Bexley's three neighbourhoods and identify gaps in provision, ensuring the grants continue to meet evolving community needs. The Chair (SD) then invited questions and comments from the group. <u>Questions/Comments</u>: The Vice-Chair (JB) welcomed the proposals and asked about the large disparity in grant amounts between organisations, noting some receive as a small amount while others secure a larger amount and sought clarification on why. GP explained that differences reflect organisation size, historical arrangements and whether services were commissioned separately. Emphasised that the data shown is only part of the overall picture and that future adjustments could help level the playing field. JR added that some organisations receive core funding for overall operations, while others are funded for specific services, which explains the variation in grant amounts. KH explained that the hospice is not on the current grant list because, in the last funding round, they chose not to bid, recognising that partner organisations had greater need. She noted that when the hospice previously received a grant, it was for a specific project with defined outcomes and was costed accordingly, highlighting that some organisations receive targeted project funding rather than core operational support. YD clarified that the funding comes from the Better Care Fund (BCF), not as a separate grant for the voluntary sector and emphasised the borough and ICB's commitment to supporting voluntary organisations due to the value of prevention work in helping residents remain independent and reducing demand on statutory services. She explained that the original grants, let six years ago through a full bidding process, included both core costs and project-based funding and that subsequent extensions allowed time to review outcomes and needs. While the funding pot has not grown, a portion was carved out to address emerging needs. YD noted that the current	**GP**

	proposal seeks agreement to maintain the funding, with a three year arrangement that allows the working group, including BVSC, voluntary sector representatives and commissioners, to explore how best to allocate funds and potentially involve newer organisations. GP reassured that risks from reallocating funds have been mitigated through individual discussions with partners, using underspend to support the Autism Partnership without harming existing grant holder and maintaining smaller grants. Emphasised ongoing dialogue with voluntary sector partners. The Chair (SD) asked whether the inclusion of children, young people and families in future arrangements meant immediate changes or if work would start only after the current three-year grants. GP confirmed that during this renewal period, the current grants will continue as planned, but work on extending prevention efforts to children, young people and families will start later. The aim is to align existing grants and other prevention initiatives to create a more strategic, coordinated approach across the borough. YD clarified that investment in children and young people is managed separately from the current BCF adult prevention grants. She explained that while there is an opportunity to consider how children's prevention work could be integrated into future arrangements particularly in line with the national children's reform agenda and local transformation programmes any such incorporation would not draw from or reduce the existing adult focused BCF funding. No further questions were raised. The Chair (SD) thanked everyone for their contributions. **The Bexley Wellbeing Partnership Committee** **(i)** **Endorsed** 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)** **Supported** the future arrangements of the PEI grants to include prevention and early intervention for children and families **(iii)** **Noted** the intention to align the delivery of the PEI grants to Bexley's Neighbourhood delivery planning.	
6.	**Better Care Fund: Quarter 3 2025/26 NHS England Return** **Steven Burgess (StB), Policy and Strategy Officer, London Borough of Bexley** talked the group through the salient points. StB provided an update on Bexley's Quarter 3 2025/26 Better Care Fund return, confirming that all national conditions have been met. Performance is generally stable, with emergency admissions for those 65+ slightly above plan, same day discharge rates below target due to complex cases and new care home admissions remaining within the annual ceiling. Falls related admissions have decreased and reablement outcomes remain strong. He noted system pressures from higher emergency attendances, seasonal flu, and complex discharges, with mitigations including winter staffing, temporary beds, rapid response and community care navigators, multi-	**StB**

	agency discharge events and phased reopening of neuro-rehabilitation capacity. The Q3 return will be presented to the Health and Wellbeing Board for formal sign-off in March 2026. The Chair (SD) then invited questions and comments from the group. Questions/Comments: The Vice-Chair (JB) asked whether the reported drop in falls related hospital admissions meant that fewer people were falling, that falls were less severe, or that people were falling but not being admitted to hospital. She also asked for clarification on what a "discharge ready date" meant, noting that while statistics can look positive, the reasons behind them are not always clear to the public and outcomes depend on the follow-up support patients receive. StB clarified the discharge ready date, explaining it is the date set by professionals when a patient is medically fit to leave hospital and performance is monitored against whether patients are discharged on that date. YD explained that the data only captures hospital admissions due to falls and that Bexley has a significant number of such cases. She emphasised the ongoing focus on falls prevention and post-fall support, including services such as the new Ageing Well Hub in Sidcup, which supports frailty assessments and preventative care. The Vice-Chair (JB) responded, reiterating that the statistics can be misleading: lower admissions could be seen as positive or could be perceived as barriers to hospital access. She highlighted the importance of follow-up support like reablement in assessing whether discharges and reduced admissions truly benefit patients. DB confirmed that the discharge ready date reflects when a patient is medically fit for discharge. On falls, DB noted ongoing work to reduce incidents through frailty programmes and preventative support, acknowledging Bexley still has a high rate but good progress is being made. LC added that additional data on emergency department presentations shows some patients are treated without admission. She highlighted the range of interventions now available - falls clinics, care home follow-ups, rapid response teams and virtual wards that allow people to be supported at home rather than admitted. She also noted that Bexley's elderly population contributes to higher falls rates per 100,000 residents but emphasised continued efforts to reduce admissions safely. No further questions were raised. The Chair (SD) thanked everyone for their contributions. **The Bexley Wellbeing Partnership Committee:** **(I)** **Noted** the report is for information and assurance to the Bexley Wellbeing Partnership Committee.	
7.	**Finance Report: Month 8** **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. AsA provided an update on the Month 8 (November 2025) finance position for Bexley Place, noting a year-to-date underspend of £82k and a full year	**AsA**

	forecast underspend of £106k. He highlighted variances across Continuing Care, Mental Health, Prescribing and other service areas, with key drivers and mitigations outlined. All details and supporting data were shared in the papers circulated in advance of the meeting. The Chair (SD) then invited questions and comments from the group. <u>Questions/Comments</u>: The Vice-Chair (JB) asked about the high cost of attention deficit hyperactivity disorder (ADHD) pilot assessments and what mitigations are in place, seeking clarity on what can be done to manage demand and costs. ID explained there is a national mismatch between demand and capacity for neurodevelopmental assessments, driving use of the "right to choose" private assessments. ID outlined the local approach: a referral hub for adults hosted by Oxleas NHS FT to better manage capacity and reduce waiting times and a slightly different pilot for children and young people. Acknowledged that demand still outstrips NHS capacity, consequently private assessments remain unbudgeted. The Vice-Chair (JB) followed up asking whether "right to choose" is disproportionately used for ADHD/neurodiversity compared to other specialties. The Chair (SD) clarified that medically, right to choose referrals must come via a GP, but for ADHD, patients can access right to choose more directly, which may explain higher numbers. Asked for clarification about whether the referral hub restricts patients' national right to choose. ID responded that the hub directs patients and tracks referrals but does not prevent access to private assessments; tracking is challenging and costs continue to rise. DB added that the Oxleas NHS FT led approach helps audit and track referrals holistically, ensuring children remain connected to broader support systems, like schools. ID noted that most children waiting for assessments are already receiving some intervention via specialist paediatrics, unlike many adults and offered to discuss further outside the meeting. No further questions were raised. The Chair (SD) thanked everyone for their contributions. **The Bexley Wellbeing Partnership Committee:** **(i)** **Discussed** and **noted** the month 8 financial position for Bexley Place. **(ii)** **Received** the NHS South East London ICB and NHS South East London ICS financial position as at month 8.	
8.	**Risk Register** **Diana Braithwaite (DB), Strategic Director, Integrated Health & Care/Place Executive Lead (Bexley), NHS South East London Integrated Care Board (NHS SEL ICB)** talked the group through the salient points. <u>Key points:</u>	**DB**

	• The risk register is reviewed every two months and highlights challenges in achieving corporate objectives for the ICS/ICB. • It identifies risks, sets out mitigations and tracks changes in risk ratings. <u>Current risks include:</u> • Financial pressures (e.g., delivering a balanced position, BCF-related risks). • Corporate targets (e.g., immunisations, flu campaigns). • Operational issues like estates and leases. <u>There has been little movement this month due to:</u> • Mitigations are in place. • The financial year is ending. The team will reassess next year's challenges, particularly in commissioning and delivery planning. Some risks are common across all six boroughs, with similar RAG ratings and are reviewed at the ICB Committee chaired by Sir Richard Douglas. System-wide risks, like staff morale during ICB changes, are included even if individual places cannot directly influence them. The Chair (SD) then invited questions and comments from the group. No 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.	
9.	***Public Questions*** *Question 1 – Right to Choose Service* A query was raised seeking greater clarity on the differences between the "Right to Choose" pathway and a standard GP referral, beyond waiting times. It was noted that social media had exaggerated waiting times, which had influenced decision-making. Concern was expressed regarding limited information about continuity of care, crisis support and medication processes. Clearer communication was suggested to support informed patient choice. ID welcomed the feedback and agreed that improved communication particularly in relation to waiting times, ADHD medication processes and clinical governance would support more informed decisions. He confirmed that the matter will be taken forward to strengthen communication with general practices. ID clarified that his comments were not intended as criticism of the Right to Choose pathway. *Question 2 – Engaging Residents with GP Services Early* A question was raised regarding how, over the next three years, the partnership intends to strengthen early engagement with GP services to prevent conditions from deteriorating. It was noted that, although support is available, encouraging proactive access to GP care can be challenging. This can result in repeated urgent care attendance and worsening mental health outcomes. DB acknowledged this as a key challenge. DB highlighted work being done with data systems to identify patients with long-term conditions who have	**PQs**

	not been seen recently and proactively call them in. She also emphasised the importance of community outreach, including cancer screening awareness campaigns in North Bexley, which have already increased screening uptake. She stressed the role of public health messaging and ongoing outreach work. It was noted that community based preventative programmes can successfully engage individuals who may not otherwise access GP services. Council-funded initiatives were highlighted as examples of approaches that can act as indirect pathways into healthcare services. Positive feedback was shared regarding breast cancer and cancer first aid awareness campaigns. These initiatives were noted as successful in supporting individuals and families to increase awareness of health risks and early signs and symptoms. DB welcomed the feedback and emphasised the importance of co-production with residents and community champions in delivering the next commissioning plan. She stressed that working collaboratively with the community will be vital to improving engagement and early identification of health needs.	
10.	**New Year, New You** Patrick Gray (PG), Community Voice Manager (Bexley), NHS SEL ICB opened the session with a "New Year, New You" theme, highlighting how many people start fitness resolutions in January but often drop out due to crowded gyms, winter, or gym intimidation and emphasised the benefits of group activities for sustaining habits. He shared a variety of free and accessible programmes in Bexley supporting physical, mental and social wellbeing, including park runs, outdoor gyms, community volunteering, weight management programmes, walking groups and mental health initiatives through Mind in Bexley. The Vice-chair (JB) asked if GPs were aware of these services and PG confirmed strong coordination with social prescribers and primary care networks (PCNs). It was highlighted that sports based programmes, including activities such as badminton, football and netball, use physical activity to improve mental wellbeing, reduce social isolation and build confidence. The positive impact of volunteering and participation in these programmes on physical health, mental wellbeing and social connections was also noted. PG concluded by stressing that there is something for everyone to improve their health and wellbeing. The Chair (SD) commented that the session was very inspirational.	**PG**
11.	**Any other business** The Chair (SD) informed colleagues that he is stepping down as Chair, making this his final meeting in that role. He shared that he has had an amazing time and will continue in his other roles. He thanked everyone for their support and collaboration. DB thanked SD for his leadership, highlighting the continuity, stability and sense of purpose he has provided during a period of significant change, both within the partnership and previously at Bexley CCG. She acknowledged his strong commitment to collaboration and the legacy of his dedication and	**SD/DB**

	service. On behalf of the partnership and its partners, she expressed sincere thanks for his leadership. The Chair (SD) thanked DB and everyone for their kind words.	
12.	**Glossary** These glossary terms were noted.	**SD**
13.	**Date of the next meeting** Thursday 26th March 2026, Council Chambers, Bexley Civic Centre.	**SD**

Bexley Wellbeing Partnership Committee

Thursday 26th March 2026

Item: 4

Enclosure: C

Title:	**Bexley GP Premium 2026 – 2029**
Author/Lead:	Jonathan Hudson, Primary Care Contracts and Delivery Manager (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

Purpose of paper:	**The purpose of this paper in line with the Place Executive Lead's delegated authority for primary care services within NHS South East London Integrated Care Board – is to seek endorsement from the Bexley Wellbeing Partnership Committee for the Bexley GP Premium**.	**Update / Information**	
		Discussion	
		Decision	***X***
Summary of main points:	The rationale for a GP Premium is to commission activity in primary care that goes beyond core contractual requirements and directly supports system priorities, population health management, and improved outcomes for residents. A locally designed Premium enables targeted investment in preventative, proactive, and personalised care for priority populations, including people with multiple long-term conditions, frailty, and children and young people. By incentivising activity and outcomes that are not consistently delivered through national contracts, the Bexley GP Premium helps to address unmet need, reduce unwarranted variation between practices, reduce health inequalities, and strengthen the role of general practice in delivering neighbourhood-based care. The Bexley GP Premium is an activity-based outcomes-focused scheme that commissions primary care to provide proactive, preventative, and holistic services beyond core national GMS, PMS, and APMS contracts. The Bexley GP Premium focuses on priority populations set out in the Joint Local Health & Wellbeing Strategy and the Bexley Five Year Strategic Commissioning Plan (endorsed by the committee on 22 January 2026), including people with multiple long-term conditions, frail adults, and children and young people, delivering interventions such as holistic extended appointments, reduction in SABA monotherapy (asthma management), wound care, insulin initiation, GLP1 administration, shared care agreements, and advanced care planning through Universal Care Plans. The Bexley GP Premium aligns with national strategic priorities, supporting the **three shifts** from **treatment to prevention, hospital to community, and analogue to digital**, and is closely integrated with emerging **Integrated Neighbourhood Teams (INTs)** to provide coordinated, neighbourhood-level care that improves outcomes and patient experience. Payments are activity- and outcomes-based, with part of the scheme commissioned at the Primary		

	Care Network (PCN)-level to encourage collaboration and reduce variation across practices. The Bexley GP Premium has been **digitally integrated** within Ardens Manager (online GP data reporting dashboard) as part of an automated digital solution to support practices and NHS South East London Integrated Care Board with monitoring activity data and tracking associated payments. Use of Ardens Manager allows for the presentation of patient cohorts based a set of detailed pre-defined business rules (searches), supporting a population health-based approach to proactive and preventative care. By using Ardens Manager, practices can target efforts to the highest-risk patients, streamline delivery, and monitor outcomes in real time. The use of Ardens Manager also allows practices to have visibility of each other's achievement data so that variation can be addressed early at a PCN level. The Bexley GP Premium's co-designed indicators are structured to support preventative care, reduce avoidable hospital admissions, optimise medication, and improve long-term condition management, ultimately helping residents to **start well, live well, and age well**. The Bexley GP Premium was endorsed by the Primary Care Delivery Group (sub-committee) on 4th March 2026 and formally supported by the Local Medical Committee on 12th March 2026.	
Potential Conflicts of Interest	There is a *pecuniary* conflict of interest for GP representatives holding national General and Personal Medical Services contracts, who will be direct recipients and beneficiaries of the GP Premium In mitigation, voting members of the committee and GP representatives/Care Networks Clinical Leads will not be required to endorse the Bexley GP Premium.	
Other Engagement	Equality Impact	The Bexley GP Premium targets high-need and vulnerable populations to reduce variation in access and outcomes. Interventions focus on frail adults, people with multiple long-term conditions, cancer patients, children and young people, and underserved groups such as people with learning disabilities and those with serious mental illness. The Primary Care Network level collective endeavour encourages collaboration; spreads best practice and supports more equitable health outcomes across Bexley.
	Financial Impact	The Bexley GP Premium is funded by NHS South East London Care Board. For 2026/27, the Bexley GP Premium is valued at £2,216,896.55.
	Public Engagement	The Bexley GP Premium was shaped by patient and carer insights and includes co-designed indicators aligned to the engagement on the development of the Bexley Multiple long-term conditions and Ageing Well/Frailty Frameworks key engagement themes.

	Other Committee Discussion/ Engagement	• Bexley Primary Care Delivery Group (sub-committee): 07.05.2025, 03.09.2025, 03.12.2025, 07.01.2026 and 04.03.2026 • Local Medical Committee: 08.05.2025, 13.11.2025, 08.01.2026 and 12.03.2026.
Recommendation:	The Bexley Wellbeing Partnership Committee is recommended to: (i) **Endorse** commissioning of the redesigned Bexley GP Premium, including the associated key performance indicators. (ii) **Note** the alignment to the Joint Local Health & Wellbeing Strategy priorities, the Bexley Five Year Strategic Commissioning and NHS 10 Year Plans.	

Bexley GP Premium Redesign

1. Context

1.1 Since its introduction in 2023, the GP Premium has driven measurable improvements in patient experience, preventative care, and the proactive management of long-term conditions. Practices were commissioned to improve GP Patient Survey outcomes, and borough-wide patient satisfaction increased from 71% in 2024 to 74% in 2025, exceeding the NHS South East London Integrated Care Board (ICB) average and approaching the national average. Several practices achieved significant year-on-year improvements of between 10% and 17%, demonstrating the Premium's impact on access, responsiveness, and overall patient experience. The scheme has also strengthened cancer prevention activity, with all practices exceeding bowel cancer screening thresholds across both general and Learning Disability and Serious Mental Illness populations, and high engagement in borough-wide Cancer Roundtable meetings, supporting consistent clinical oversight and learning.

1.2 The GP Premium has successfully increased the delivery of care within primary care settings, supporting the shift from hospital to community. Uptake of insulin initiation and GLP-1 administration increased significantly in 2024/25 compared with 2023/24, reflecting growing confidence and capability within practices. Wound Care activity has also increased across the borough, bringing care closer to home, although variation between practices has highlighted opportunities for further standardisation. Referral management performance was strong prior to the retirement of this indicator, with the majority of practices exceeding expected thresholds. In addition, personalised care planning for frequent attenders has been widely implemented, with most practices achieving high-quality improvement scores, demonstrating improved proactive management of high-use patients.

1.3 The GP Premium has delivered particularly strong outcomes in proactive care planning and population health management. Since commissioning Universal Care Plans (UCPs), practices have created over 1,200 new UCPs and reviewed more than 1,300, with Bexley achieving the highest level of new UCP creation in south east London. Bexley practices have made significant improvements in outcomes for frail patients, delivering 4065 comprehensive reviews across 23-24 and 24-25, reflecting sustained progress across the years. The comprehensive reviews have delivered improved patient outcomes by preventing frailty deterioration, preventing falls, reducing crisis escalation, supporting personalised care and self-management. Furthermore, there has been a 4.4% increase in the dementia register between April 2024 and April 2025, indicating improved case-finding and diagnosis. Safeguarding activity has also increased significantly, with a 31% rise in the safeguarding at-risk register, reflecting improved identification and system awareness.

1.4 While variation between practices remains across some indicators, the previous GP Premium has demonstrably strengthened preventative care, personalised planning, and primary care capacity, providing a strong foundation for the redesigned scheme.

2. Strategic Commissioning

2.1 The Bexley GP Premium is a redesigned, outcomes-focused local scheme that commissions general practice to deliver proactive services beyond core national contractual requirements. It has been refreshed to better meet the needs of Bexley residents while maintaining alignment with borough, system, and national strategic priorities.

2.2 The redesign has been delivered within existing resources and is underpinned by a population health management approach. It aims to improve outcomes, reduce unwarranted variation, and tackle health inequalities by targeting investment towards priority population groups, ensuring services are delivered equitably and in proportion to need.

2.3 The Premium directly supports the three national strategic shifts: **treatment to prevention, hospital to community, and analogue to digital**. There is a stronger focus on prevention through proactive and anticipatory care, including holistic reviews, early lifestyle interventions, and

structured care planning. These approaches enable earlier intervention, promote self-management, and deliver more personalised care for people with complex needs, including those with multiple long-term conditions, frailty, cancer, and children and young people.

2.4 The Bexley GP Premium also advances the shift from hospital to community care by commissioning services within primary care that might otherwise sit in secondary care or not be delivered. This includes services such as frailty and multi-morbidity reviews, cancer care reviews, insulin initiation and GLP-1 administration, wound care, and shared care prescribing.

2.5 Digital enablement underpins delivery through tools such as EMIS (Egton Medical Information Systems) and Ardens Manager, which support population segmentation, risk stratification, automated monitoring, and outcomes-based payment. This reduces administrative burden while improving the targeting and effectiveness of interventions.

2.6 The Bexley GP Premium provides a contractual framework to support Integrated Neighbourhood Teams (INTs), aligning commissioned services to priority population cohorts and enabling coordinated, place-based care. Attention has been given to how Premium services interface with INT pathway, especially in frailty to minimise duplication and maximise system impact.

2.7 The indicators are closely aligned with the **Joint Local Health and Wellbeing Strategy** priority areas and national strategies, with a strong emphasis on prevention, personalised care, and delivering services closer to home. Across key areas such as long-term conditions, frailty, cancer, and asthma, the model promotes proactive, holistic, and multidisciplinary care to improve outcomes, reduce inequalities, and prevent deterioration.

2.8 Overall, the Bexley GP Premium supports a clear shift away from hospital-based care towards community-led models, enabled by stronger primary care and integrated neighbourhood working. Initiatives such as healthy weight management, targeted cancer screening, wound care, and end-of-life planning reinforce a preventative approach, helping residents to live healthier lives while reducing demand on hospital services.

3. Patient Carer & Insights

3.1 Patient and carer insight has helped shape the redesigned Bexley GP Premium and its wider alignment to emerging Integrated Neighbourhood Teams (INTs). The Bexley GP Premium includes co-designed indicators and reflects what people said they need from neighbourhood-based care: more proactive, person-centred support that is coordinated around the whole person rather than organised around single conditions.

3.2 Engagement undertaken as part of developing the multiple long-term conditions and frailty INTs highlighted consistent themes: people experience fragmented pathways with multiple appointments, limited continuity, and a need to repeat their story, and short problem-focused consultations that do not allow time to discuss how physical health, mood, pain, medicines, mobility and wider circumstances interact.

3.3 Patients and carers emphasised the importance of time and continuity, clear ownership of follow-up so agreed actions happen, and earlier, preventative support – particularly around falls and fear of falling, maintaining confidence and independence, tackling isolation, and identifying carers before crisis points.

4. Expected Benefits for Patients

4.1 The Bexley GP Premium is expected to deliver multiple benefits for residents in Bexley:

- **Improved patient health outcomes through proactive, preventative, and anticipatory care:** The Bexley GP Premium supports proactive and preventative care aimed at reducing the risk of avoidable deterioration and crisis, therefore helping patients to stay healthier for longer and live and age well.

- **Better management of long-term conditions:** Patients with multiple long-term conditions will benefit from **extended, holistic appointments** that bring physical health, mental wellbeing, medicines optimisation, and social support together, therefore improving long-term condition management, self-management, and quality of life.
- **Improved outcomes for frail and older residents: Comprehensive frailty assessments** focus on falls prevention, mobility, medication safety, mental wellbeing, and social support, helping older residents maintain independence, age well at home, and sustain their quality of life.
- **Care delivered closer to home:** By commissioning services such as wound care, insulin initiation, GLP1 administration, cancer care reviews, and shared care prescribing in general practice, the Bexley GP Premium **improves access, convenience, and continuity of care** for patients, while reducing the need for patients to attend secondary care settings.
- **Personalised care planning that follows patients:** Universal Care Plans **ensure patients' key information, care preferences**, and clinical needs are captured in a single shared plan, supporting continuity of care and **ensuring patients are treated in line with what matters most to them**.
- **Safer and more effective use of medicines:** Structured medication reviews in the long-term conditions, frailty, and cancer care reviews indicators seek to **improve medicines optimisation** and reduce the risks associated with polypharmacy, which is common in older patients and those with co-morbidities.
- **Better support for people living with and beyond cancer:** Holistic cancer care reviews in primary care provides patients with time to address physical symptoms, mental wellbeing, medication effects, and ongoing concerns after treatment, therefore improving their quality of life and access to support.

5. Population Health Approach

Multiple Long-term Conditions

5.1 Of Bexley's 257,217 residents, 26,049 (10.1%) are living with three or more long-term conditions. These individuals often need to navigate multiple services, leading to fragmented care, duplication, poorer outcomes, increased risk of crisis, and the need to repeatedly share their history despite frequent system contact.

5.2 The most common long-term conditions in Bexley include hypertension, depression, osteoarthritis, diabetes, obesity (BMI 40+), asthma, and chronic pain, reflecting a significant burden of both physical and mental health needs.

5.3 Patterns of service use vary widely, with some patients frequently attending primary and urgent care, while others remain disengaged from routine services – resulting in missed opportunities for early intervention and prevention.

5.4 National guidance emphasises the need for more proactive, personalised, and person-centred care. This approach supports better outcomes by delivering coordinated, preventative, and holistic care that considers patients' overall health, lifestyle, mental wellbeing, and social context, rather than treating conditions in isolation.

Frailty

5.5 Around 24,000 Bexley residents are living with frailty, including approximately 5,200 with moderate frailty who are at greatest risk of falls, hospital admission, and loss of independence. Frailty places significant demand on services, with people aged 65+ accounting for 28% of A&E attendances, and those with moderate frailty experiencing longer hospital stays.

5.6 While often linked to ageing, frailty also affects people aged 50–64, particularly those facing deprivation and long-term conditions. It is characterised by increased vulnerability to sudden health deterioration from relatively minor events. National and regional guidance emphasises the importance of proactive, personalised, and preventative care to identify frailty early, reduce avoidable crises, and support people to maintain independence for longer.

6. Priority Population Cohorts

6.1 The Bexley GP Premium will focus on three priority population groups:

- **People with three or more long-term conditions** – Extended, multi-disciplinary team-led holistic reviews that focus on personalised care planning, medication optimisation, lifestyle support, and social prescribing. These reviews aim to prevent deterioration, reduce crisis escalation, and improve patient control over long-term conditions.
- **Frail and rising-risk older adults** – Comprehensive holistic assessments, frailty case-finding, and anticipatory care planning, including Universal Care Plans (UCPs), to reduce avoidable hospital admissions, prevent falls, and support ageing well.
- **Children and Young People** – The initiative focuses on improving asthma management in children and young people by reducing reliance on SABA (short-acting beta agonist) inhalers as a standalone treatment. Instead, it promotes safer, preventative approaches in line with guidance, including transitioning most patients to combined preventer and reliever therapies (AIR or MART). This reflects evidence that excessive SABA use is linked to increased risk of asthma attacks and mortality, with South East London currently experiencing higher-than-average hospital admissions for asthma in this age group.

  GP practices will support patients aged 12–15 by educating them on the risks of SABA overuse and switching them to more effective treatment where appropriate. The overall aim is to improve long-term asthma control, reduce exacerbations and avoidable hospital visits, support better self-management, and align care with best practice while also reducing the environmental impact of inhalers.

7. Expanded Services

7.1 The redesigned Bexley GP Premium will explicitly commission a wider range of services to meet population needs and system priorities:

- **Cancer care reviews:** Practices will deliver extended, face-to-face reviews for cancer survivors 12–24 months post-diagnosis, focusing on holistic support, symptom management, and early identification of complications. This improves wellbeing, supports self-management, and shifts follow-up care from hospital to community settings.
- **Cancer screening (Learning Disabilities and Serious Mental Illness):** Targeted outreach will increase bowel and breast screening uptake among people with learning disabilities and serious mental illness, addressing barriers to access and aiming for earlier diagnosis, improved outcomes, and reduced inequalities.
- **Activity and lifestyle:** Practices will offer tailored lifestyle advice and follow-up for adults at risk (e.g. weight challenges with mental health conditions), promoting healthier behaviours, improving wellbeing, and reducing future demand on health services.
- **Wound care:** Simple and post-operative wound care will be delivered in primary care, improving access and continuity while reducing unnecessary hospital visits and supporting faster recovery.
- **Universal Care Plans (UCPs):** Practices will expand and update shared digital care plans to improve coordination, ensure patient preferences are respected, and support proactive, personalised care across services.

- **Insulin and GLP-1 services:** Primary care will take on insulin initiation and GLP-1 administration, improving access, supporting better diabetes control, and reducing pressure on specialist services.
- **Shared care agreements:** Practices will manage prescribing and monitoring of specialist medications in partnership with secondary care, improving access, continuity, and efficiency while reducing hospital workload.

7.2 These service expansions are underpinned by the use of digital tools (EMIS, Ardens Manager) for cohort identification, risk stratification, population health monitoring, and outcomes-based reporting.

8. Primary Care Network-Level Collective Endeavour

8.1 The redesigned Bexley GP Premium includes a *Primary Care Network-level collective endeavour* element. Aggregating practice-level activity to Primary Care Network (PCN) level encourages collaboration, shared learning, and equitable service delivery across neighbourhoods. High-performing practices support others, helping to reduce unwarranted variation and strengthen the emerging INT model.

9. Investment

9.1 The Bexley GP Premium is funded by NHS South East London Integrated Care Board from the delegated primary care budget.

9.2 The Bexley GP Premium has a total financial value of £2,216,896.55, which is equivalent to £9.15 per weighted patient. This value is based on the latest overall weighted population in Bexley, which, at 01.01.2026 is 242,283.78.

9.3 The table below shows each Bexley GP Premium indicator, the associated weighting percentage, the total monetary investment in the indicator (both overall and per weighted patient), and the total number of patients for all Bexley practices to see to achieve 100% across the entire Bexley GP Premium. It should be noted that, for indicators with achievement percentages/thresholds that practices need achieve the upper threshold to achieve full payment for the indicator.

Indicator	Percentage of premium (%)	Total financial allocation (£)	Total number of patients to be seen per indicator per year (100%)
Long-term conditions	36.39%	£806,804.97	7,915
Frailty	25.03%	£554,829.85	4,872
Activity and lifestyle	4.37%	£96,913.51	2,627
Cancer reviews	3.93%	£87,222.16	1,054
Cancer screening (Learning Disabilities + Serious Mental Illness)	1.09%	£24,228.38	1,017
Children and young people asthma management	1.09%	£24,228.38	535
Wound care	6.01%	£133,256.08	3,718
Universal Care Plan	8.74%	£193,827.02	2,778
Insulin initiation and GLP1 administration	2.20%	£48,456.76	231
Shared care agreements	11.15%	£247,129.45	N/A
Total	**100%**	**£2,216,896.55**	**24,747**

9.4 A key feature of the premium is that any potential underspend will be reinvested into Primary Care Networks/GP Practices delivering primary care services. This reinvestment will be targeted to address local population needs or additional interventions that improve outcomes and reduce

inequalities. Reinvestment ensures that funding continues to deliver tangible benefits for residents and strengthens neighbourhood delivery.

10. Monitoring and Assurance

10.1 Robust monitoring of the Bexley GP Premium will be ensured through a combination of digital reporting, regular performance review, and structured governance. Practices will use EMIS and Ardens Manager to capture activity, track patient cohorts, and report outcomes in real time, enabling accurate measurement of progress against indicators. Achievement data will be reviewed at both practice and PCN level to identify variations, support quality improvement, and enable targeted interventions where needed.

10.2 The Bexley GP Premium is digitally enabled through Ardens Manager (online GP data reporting dashboard), which automates cohort identification using pre-defined business rules, supports population health management and risk stratification, and provides real-time monitoring of activity and associated payments. This reduces administrative burden for practices and the ICB, helps target proactive support to higher-risk patients, and enables transparency of achievement across practices to identify and address variation early at PCN level.

10.3 The ICB and borough governance committees will oversee ongoing delivery, providing periodic assurance reports, reviewing indicators annually, and ensuring alignment with local strategic priorities, emerging INT pathways, and national guidance. This structured approach ensures transparency, accountability, and continuous improvement, enabling the Bexley GP Premium to deliver measurable benefits for residents.

11. Summary

11.1 The redesigned Bexley GP Premium is a **locally tailored, system-aligned commissioning mechanism** that enables primary care to deliver **preventative, neighbourhood-based, and digitally enabled care** for priority population groups. Key features include:

- Support for the **three national strategic shifts** – treatment to prevention, hospital to community, and analogue to digital.
- Alignment with **Integrated Neighbourhood Teams**, supporting neighbourhood-level proactive care for high-risk cohorts.
- Focus on **multi-morbidity, frailty, children and young people**, and targeted interventions to prevent deterioration and improve health outcomes.
- **Expanded service offerings** including wound care, Universal Care Plans, insulin administration, and shared care agreements.
- Use of **digital tools** for population segmentation, risk stratification, cohort identification, and outcomes monitoring.
- **PCN-level collective endeavour** to promote collaboration, share expertise, and reduce variation within neighbourhoods.
- **Ringfenced reinvestment** of any underspend to support primary care services and targeted local interventions.
- **Activity and outcomes-based payments** to demonstrate value for investment and improve patient outcomes.

11.2 By commissioning proactive, targeted, and outcomes-focused services, the Bexley GP Premium strengthens primary care's role in delivering improved outcomes, reducing inequalities, and supporting a sustainable health and care system. It ensures that funding is directed where it is most needed and aligns local delivery with system and national priorities.

Bexley Wellbeing Partnership Committee

Thursday 26th March 2026

Item: 5

Enclosure: D

Title:	**South East London Children & Young People Integrated Neighbourhood Team Framework**
Author/Lead:	Katie Farrar-Daniel, CYP Programme Manager, NHS South East London Integrated Care Board Gita Prasad, Interim Director of Integrated Commissioning (Bexley), NHS South East London Integrated Care Board/ London Borough of Bexley
Executive Sponsor:	Diana Braithwaite, Strategic Director, Integrated Health & Care/Place Executive Lead (Bexley), NHS South East London Integrated Care Board

Purpose of paper:	The purpose of this paper is to provide the Bexley Wellbeing Partnership Committee with an update on the development and adoption of the South East London Children and Young People Integrated Neighbourhood Team Framework.	**Update / Information**	
		Discussion	***X***
		Decision	***X***
Summary of main points:	The Children and Young People (CYP) Integrated Neighbourhood Team Framework was developed between October and December 2025 involving multiple stakeholders and staff from each of the six boroughs and across system partners, including residents. The framework forms part of the approach to implementing the Neighbourhood Health Service in South East London particularly the implementation of integrated neighbourhood teams for priority population groups. The CYP Framework describes a shift to earlier identification, prevention and holistic, community-based support leading to coordinated care for CYP with care delivered seamlessly across agencies and at the earliest opportunity. The scope is much wider than 'health' and includes engagement with partner agencies including education, social care, housing, and the voluntary sector. Bexley has taken steps towards establishing integrated neighbourhood working with the implementation of the Integrated Child Health team – a model that manages acute paediatric referrals through an integrated team of clinicians across primary, secondary, and community services. We are currently starting with a population health management approach and reviewing data and intelligence to inform the prioritisation of cohorts of CYP within the framework. Further engagement with local partners, CYP, and families will be undertaken to inform development and implementation of Bexley's CYP Integrated Neighbourhood Team model.		
Potential Conflicts of Interest	There are no conflicts of interest as a consequence of this report		

Other Engagement	Equality Impact	The framework promotes equality for example by recognising/respecting individual backgrounds, aspirations and needs.
	Financial Impact	The framework aims to reduce downstream demand via earlier identification, prevention and via a strengths-based approach that maximises potential.
	Public Engagement	To develop the framework, over 90 stakeholders were engaged across South East London, including children and young people, carers and representatives, frontline practitioners, clinicians, voluntary sector partners, and service leads. The feedback from children and young people has been used to inform the key components of the framework.
	Other Committee Discussion/ Engagement	• Bexley Wellbeing Partnership Executive • Children & Young People Programme Board
Recommendation:	The Bexley Wellbeing Partnership Committee is recommended to: (i) **Endorse** the SEL CYP Integrated Neighbourhood Team Framework. (ii) Note the alignment with Bexley's approach to developing an integrated model of care.	

South East London Integrated Care System

NHS South East London

SEL Children and Young People Integrated Neighbourhood Teams (INT) Framework

Summary

January 2026

Lets start with Zack's story

Meet Zack

Zack, 14-year-old male

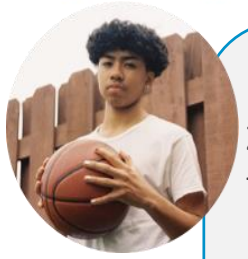
Academically struggling and is currently on the waiting list for ASD assessment (not picked up in primary school). History of severe bullying in school.

History of asthma, which is challenging to manage and is known to the community nursing team, Multiple sporadic exacerbations of asthma since age 6, requiring hospital admission.

- Father was absent, mother had significant mental health issues
- Substantial financial issues, resulting in risk of eviction
- Zack is known to social care, however, no current involvement as it was stepped down in the past
- Referrals to housing have been made but were not successful

Please note that this person's story is sourced from a combination of multiple real patient scenarios. Names and facts have been altered for patient confidentiality. The main purpose of the story is to highlight the opportunities for improving care in the current system.

Zack's story



Zack has been seen by the GP for asthma reviews; however, he has missed the follow-up appointments. He has previously demonstrated poor inhaler technique and inconsistent medication adherence, leading to multiple hospital admissions for exacerbations.

Zack has been on the waiting list for an ASD assessment for 6 months. During this time, he has experienced increasing difficulties at school, including reduced concentration in lessons and poor performance in assessments, leading to social withdrawal and disengagement from learning.

He has a limited support network and experiences difficulties forming friendships, leading to social isolation and a negative impact on his MH. His mother is unable to support him, due to her own MH challenges and faces additional barriers in accessing services due to language difficulties and limited awareness to available information.

Zack's asthma starts to flare up again in winter. His mother contacts the GP but was unable to get an appointment and did not feel his condition warranted a visit to A&E.

A week later his cough is much worse, and he has developed wheezing. Zack ends up in A&E with another exacerbation of asthma.
Unfortunately, he continues to wait for a formal ASD assessment and doesn't engage well at school.

Observations

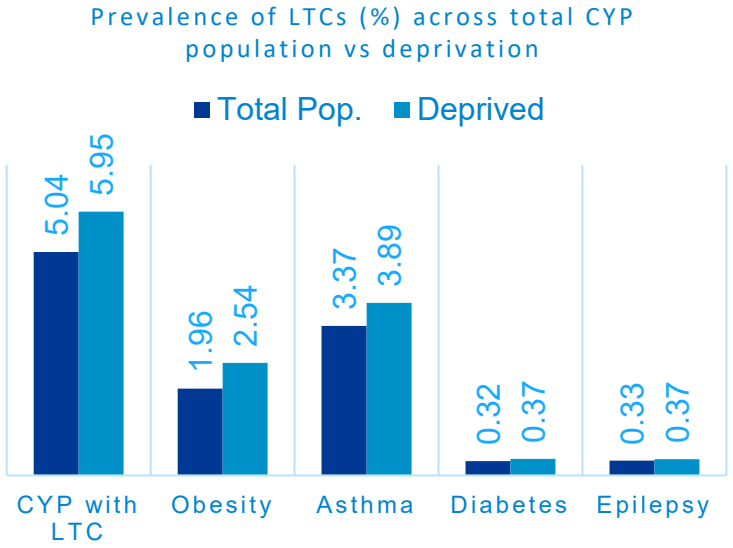
Did not preempt and act: Signs of recurring and increasing issues were an opportunity to act before it was too late.

Multiple siloed pathways: Looking at the child through a health lens, instead of the ability to consider the whole picture of physical and mental health, school and home problems. Lack of person-centred holistic assessment and multi-agency care planning that genuinely address the multifactorial issues faced by the child/family.

No mechanism for coordination between multiple agencies: Agencies not getting to the root of the problems and creating one understanding.

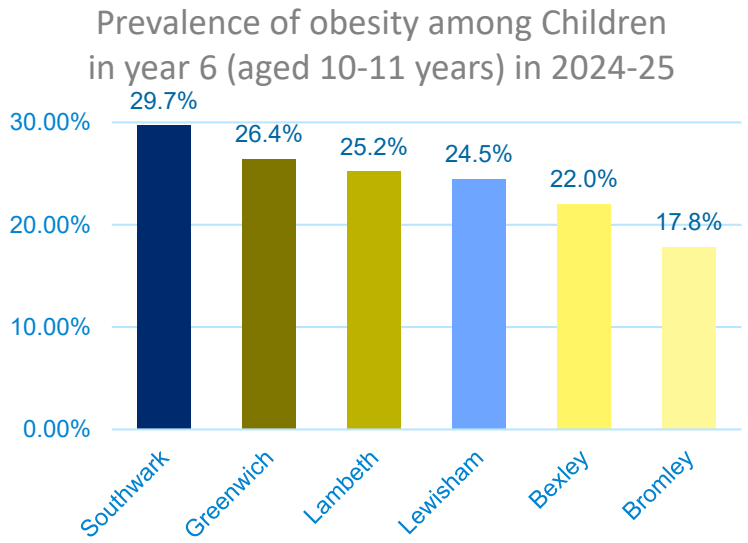
Missed opportunity:
To sum it all up, this child's case shows how we as a system could be far more efficient in providing coordinated and meaningful care.

We have many more stories that resemble Zack's across SEL – children living in pockets of deprivation do not have the best start of life, or those suffering from mental health concerns thrive less well



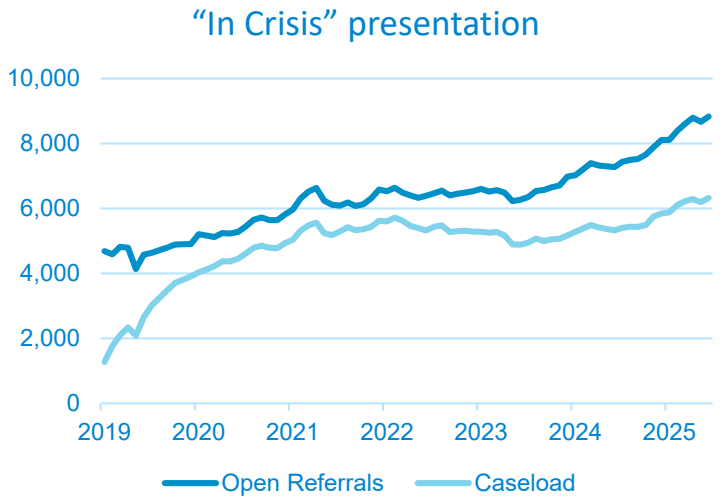
In deprived population, the prevalence of LTC and obesity is markedly higher (18% higher LTC and 30% higher for obesity)

Additionally, over 50% of all the CYP caseload in mental health services across SEL are of those from the 40% most deprived communities (in 2024-25)



Prevalence of obesity is higher than London (23.2%) and National (22.2%) average in 4 out of 6 boroughs in SEL

Childhood obesity clusters with other adverse bio-psycho-social experiences, including deprivation, social services involvement, homelessness risk, and mental health issues.



"In Crisis" presentation of caseload related to mental health issues are a 6 year peak, increasing nearly 3X since 2019.

The number of CYP waiting for their first contact for **over 52 weeks** for mental health services they are referred to, has increased **8X** for "in crisis" presentation, since 2019.

Engagement

What we heard from children, young people and their families resonated with Zach's story

Lack of coordination

Families experience care as disjointed, each agency expecting others to "fix it", highlighting siloed responsibilities. The call for peer navigators and care coordinators echoes the wider strategic gap around roles to ensure care continuity across multiple agencies.

"We have to dig to find the support for ourselves. We have to navigate. We used to have a care coordinator to address anything not working, which worked brilliantly"

Information, education and awareness

Front-line professionals lack up-to-date knowledge of local pathways, leading to inappropriate advice or signposting and avoidable escalation. Families also want practical education for employers, schools, siblings, children and parents, ideally delivered by people with lived experience.

"GPs are not aware of pathways but it's critical they give the right information. We were told by our GP to take our child to A&E because he wouldn't go to school on a particular day."

Waiting and managing expectations

Long waits for neurodevelopmental and mental health services are not just an access issue; the absence of interim support allows needs to escalate and family resilience to erode. Parents ask for honest information about who is doing what, realistic waiting times, clarity on offer/limits, and better communication.

"Provide support while we are waiting for 2 years for a service, to minimise the effects of the wait."

Environments and experience of care

Families see current emergency pathways as unsafe and traumatising for CYP, particularly neurodiverse children. They need choice of setting (home, community, groups) and psychologically safe environments with follow-up after diagnosis.

"Avoid A&E. It's overwhelming and overstimulating, especially for neurodiverse children. Children see things they shouldn't see. Do video conferencing instead, or have a children's A&E."

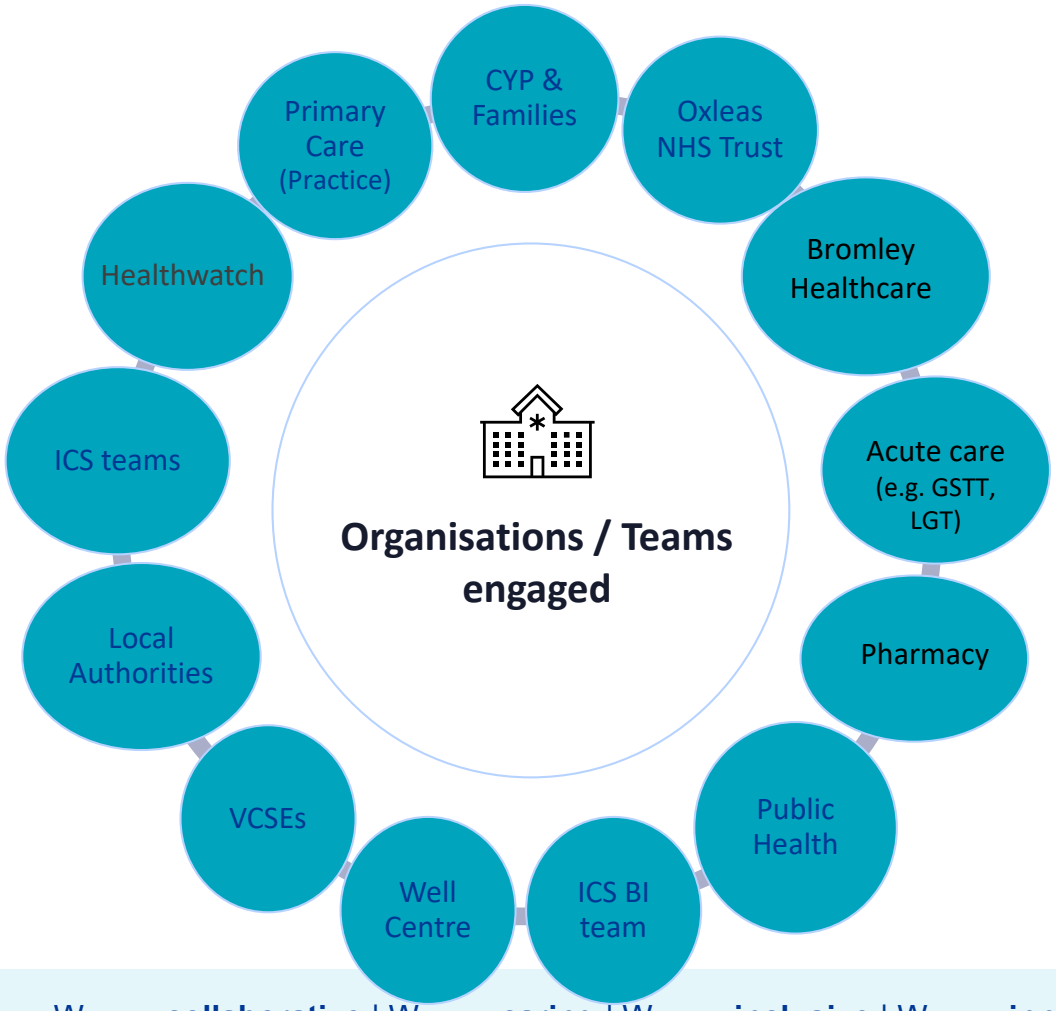
Transition of care to adult services

Transition is experienced as a cliff edge: responsibility abruptly shifts to young people with minimal preparation, reassurance or continuity. Families want transition to be actively managed, with detailed information transfer and practical "hints and tips",

"The attitude it's on you now that you are 18; we won't baby you anymore and so deal with it on your own."

Engagement

We engaged with more than 90 stakeholders from across the system, who corroborated the stories of service users and defined what and how we deliver INTs in neighbourhoods



- Frontline Practitioners
- Clinicians (CCPLs/GPs/ Paediatricians /Paediatric Nursing
- Operations and Management
- Service Users, Carers & Representatives
- Pharmacists
- Commissioners
- Service Leads
- Voluntary Sector partners

CYP Steering Group
(System Representatives)

CYP Core Group
(Clinical Lead + Commissioning Leads)

System-wide Workshop

Local Place Based CYP Forums

One To One Engagements

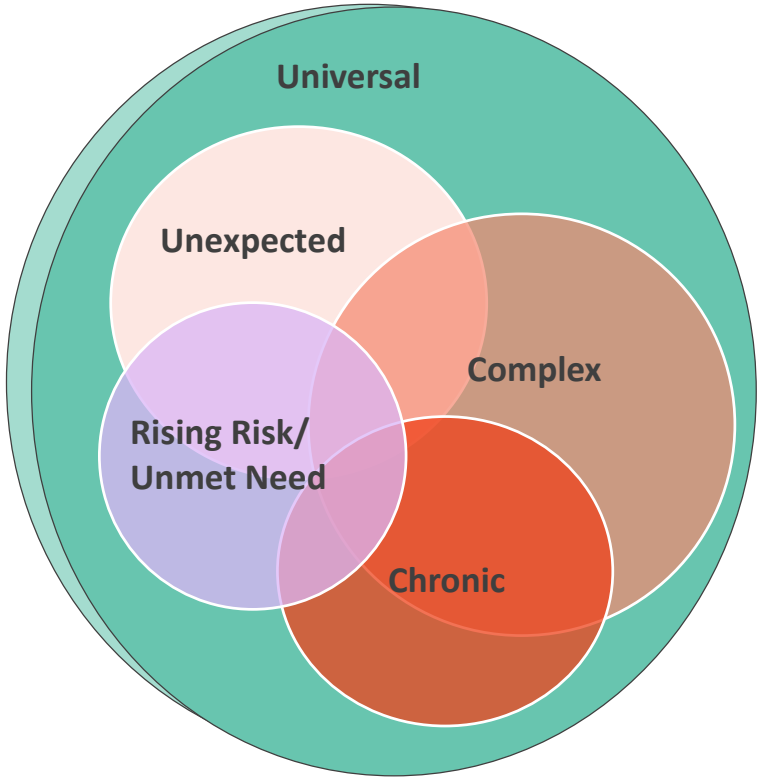
Family / CYP Engagement Forums
(In Progress)

Focus Groups
Local Authorities
Clinicians
Place Based Reps

Deep Dive Sessions
(e.g. SEND, Mental Health)

Ten key principles for the framework to achieve outcomes and reduce inequalities

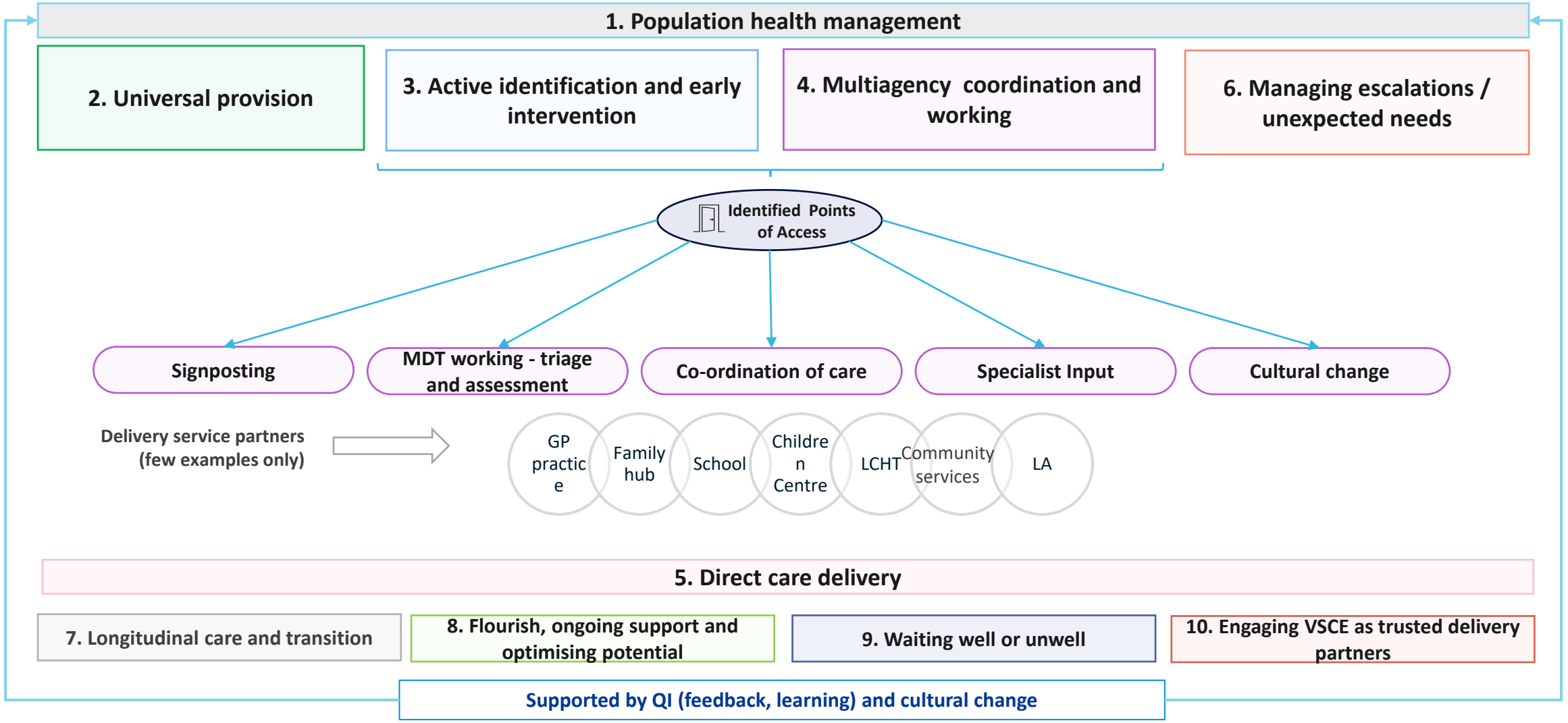
1. Know your population
2. Be needs-led, not diagnosis- led
3. Act early
4. Work holistically
5. Connect, don't silo



6. Empower and enable families and CYP
7. Build trusted relationships, good communication and knowledge sharing
8. Treat people with dignity and respect
9. Embed equity and access
10. Focus on maximising life chances

Neighbourhood working is all about creating a fundamental change in the way we work and connect

SEL CYP INT Framework – key functions / elements



SEL CYP INT Framework functions at a glance

Function	Description
1. Population Health Management	Systematically use data and intelligence, and moving beyond surveillance to actionable insight, informing how we shape delivery.
2. Universal health and care provision	Build Universal health and care provision as the foundation of the neighbourhood model, ensuring every child, young person and family has access to the core entitlements that keep them healthy, supported and connected to community life. Provision of information/knowledge is key.
3. Active identification and family-centred early intervention	Adopt a proactive approach to identifying emerging issues at the earliest possible opportunity, using early indicators and intelligence to inform timely intervention and ensuring access to appropriate services at the right time.
4. Multi-agency coordination and working	Build relational, value-based collaboration, based on a shared vision, accountability and language across agencies so that practitioners understand each other's roles, trust one another, and work as one 'communicative' system.
5. Direct Care	Deliver coordinated multi-agency care that brings together experts to provide holistic and integrated support to improve outcomes and provide better access by bringing services into the community.

Function	Description
6. Managing escalations	Create straightforward, aligned and timely approaches to trigger and manage escalation, agreed and understood between multiagency partners, to prevent issues from becoming critical events.
7. Longitudinal care and transition	Provide coordinated, non-fragmented care over time for individuals with chronic and complex needs, ensuring continuity of support, focusing on what matters to the CYP and their families.
8. 'Flourish;' ongoing support and optimising potential	Actively support CYP and their families to take a leading role in their own care, enabling informed decision making, with a strong focus on promoting holistic wellbeing.
9. Waiting well or unwell	Provide support to those waiting for assessment, diagnosis or intervention, helping them to prevent or address issues that may arise in the interim.
10. Engaging VCSE as trusted delivery partners	Embed VCSE partners as a core to INTs delivery. It's known (and plentiful evidence proves) that the VCSE offer is highly effective for CYP to address the growing prevalence of mental health and neurodiverse challenges that young people face.

Outcomes: how would we know it is working for our population

There are 8 outcome domains with KPIs under each of them

1. Active/early identification and prevention

Children and young people with emerging needs are identified early and supported through targeted preventative interventions, reducing escalation to crisis.

2. Improved access that is based on need

Children, young people and families can access timely, support based on need, reducing escalation to crisis or specialist intervention and improving equitable access for those least likely to self-present, including Core20 groups.

3. Voice of CYP and family

Making every contact count, avoiding repetition and having to tell their story several times. They feel heard in decisions, trust services and experience care as supportive and joined up.

4. Children and families are empowered (able to flourish)

Children, young people and families trust services, can easily access and navigate to the right support, and experience coordinated care as required.

5. Improved health and well-being outcomes

Children and young people are healthier overall, with improved physical and mental wellbeing, fewer crises/ escalations, higher uptake of preventative care and earlier identification and support for additional needs.

6. Improved multi-agency working & cultural change

A positive experience and supportive environment to improve staff wellbeing and job satisfaction overall. Improving multi-agency working by local knowledge of services available within SEL to support CYP.

7. System sustainability

Reducing demand from resource intensive areas such as secondary care, shifting focus into the community and neighbourhood.

8. Reduction in inequalities

Reducing health inequalities so children, young people and their families achieve equal outcomes across all population groups.

What would Zach's story look like once the SEL CYP INT framework is implemented

Case study: Zack's new story

What his journey could look like once the SEL CYP INT Framework is implemented

- ✓ Early support and timely intervention: The MH team in Zack's school identifies the rising risk at an early stage, informing the school link worker regarding the issues of bullying, non-attendance, isolation and poor performance.
- ✓ Aware that Zack suffers from asthma and is awaiting an assessment for ASD, the school link worker contacts the child's GP who triggers an MDT discussion.
- ✓ MDT review ensures ensures Zack is seen by the specialist asthma team, a medication review is undertaken by the pharmacy and a personalised asthma action plan is agreed with Zack.

Key functions

- ❖ **Active identification intervention**
- ❖ **Prevention of escalation**

- ✓ The neighbourhood MDT includes the school link worker, GP, paediatrician, practice nurse, CAMHS, housing, support worker and involvement of Zack and his mother. The focus is holistic care and understanding and addressing issues around asthma, poor school performance, isolation, housing and his mother's mental health problems.
- ✓ The discussion is centred on building trust and fostering open communication to identify root causes and achieve shared buy-in and co-production of a plan with the child and his mother.
- ✓ Zack is seen by the specialist asthma team, a medication review is undertaken by the pharmacy.
- ✓ A personalised asthma action plan is agreed with Zack supported by a community support worker appointed to coordinate and provide ongoing, hands-on support to the family. The support worker, able to socially prescribe, also liaises regularly with professionals to ensure progress is maintained and actions remained aligned.

Key functions

- ❖ **Multiagency coordination and working**
- ❖ **Direct care delivery**

Case study: Zack's new story

What his journey could look like once the SEL CYP INT Framework is implemented

Key functions

- ❖ **'Flourish', on- going support and optimising potential**
- ❖ **Waiting 'well' or 'unwell'**
- ❖ **Engaging VCSE as trusted delivery partners**
- ❖ **Universal health & care provision**

The holistic MDT co-produced plan includes:

- ✓ Initial mental health assessment and access to interim support whilst awaiting ASD assessment e.g. adjustments at school.
- ✓ Signposting to pre-diagnostic workshops e.g. peer support network for families awaiting an assessment.
- ✓ Prompt consultation with practice nurse and follow ups to assess inhaler technique and inhaler adherence.
- ✓ Navigation to local offers including youth/ community clubs to build confidence and reduce social isolation e.g. sports.
- ✓ Strategy agreed with school to address bullying and to support Zack with his performance at school.
- ✓ Investigation by housing into issues leading to eviction and provision of financial/ benefits advice for his mother.
- ✓ Visit by housing to the property to check for possible environmental causes triggering exacerbations of asthma e.g. damp and mould.
- ✓ Consultation with Zack's mother regarding her mental health assessment for talking therapy and agreeing a plan to prevent exacerbation for both herself and Zack. This includes providing information regarding access, navigation to local community support groups and ability to provide respite care if needed.

Delivery of CYP INT Framework is an ambition that will require a concerted effort across the system

Implementation roadmap

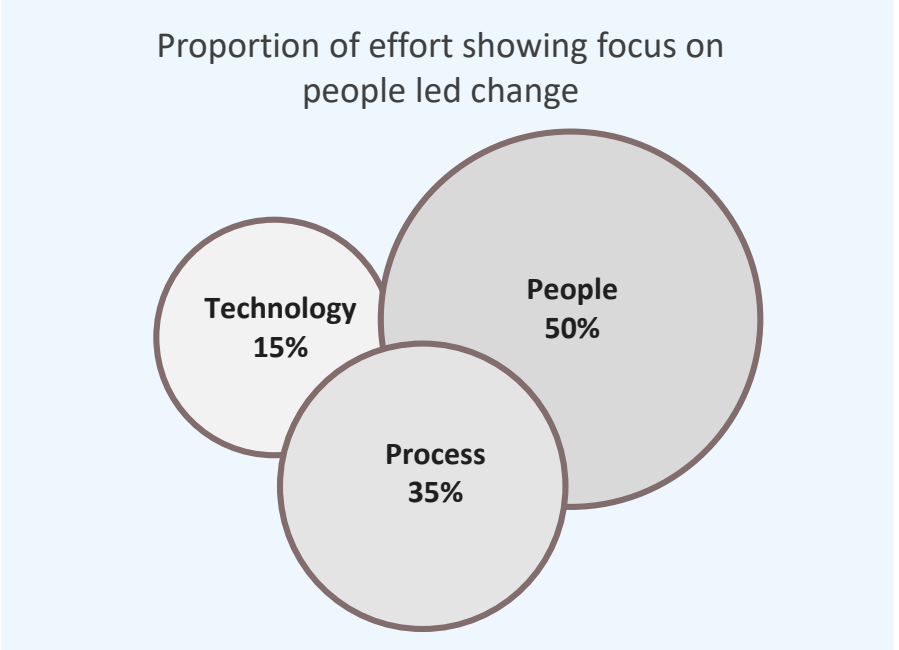
This roadmap sets out a phased, **test-and-learn approach** that enables neighbourhood teams to build confidence, embed new ways of working and establish a consistent culture of neighbourhood delivery across South East London

Phase 1: Test
2026/27
Launch test INTs (minimum 1 per Place) for a priority cohort.

Phase 2: Grow
2027/28
Share and learn from pilots and expand across priority cohorts

Phase 3: Embed
2028/29
Full delivery CYP INTs across SEL with clear operating model, governance and outcomes framework

Most healthcare transformations under invest in the human dimension



Change dominated by process and technology only achieves around a 10% level of adoption – hence the need to ensure we have an approach built around people and relationships

Roadmap for implementation: Neighbourhoods should follow a systematic approach based on system maturity

1. Socialising the framework at Place

- Bring together system stakeholders, including CYP, families and community representatives.
- Map current practice and local assets against the neighbourhood functions (e.g. active identification, MDT working).

2. Understanding your local population and agree priority for test phase

- Neighborhood's need to start with a bite-size focus. Year 1 is about testing the concept with one cohort or pathway
- Each neighbourhood to look at their local population data, connect with VCSE, communities, professionals and agree the local priority.
- Priority could be a population cohort (e.g. complex, SEND) or a pathway (mental health crisis, rising risks)

3. Defining the Operating Model

- Each Place and neighbourhood defines how the operating model works locally, building on existing assets (e.g. Family Hubs).
- Work systematically through each function to clarify roles, workflows and interfaces, centered on the agreed priority cohort.

4. Demand and capacity modelling

- For the priority cohort define the baseline for demand and capacity. As neighbourhoods do that, identify the biggest crunch points.
- Use the operating model to define total demand and capacity required to support priority cohort.
- Ramp up demand in stages.
- Define/decide: how do to reallocate existing capacity/resources.
- Final demand and capacity model aligned with the framework operating model.

5. Outcomes dashboard

- Agree a small set of clear outcomes and indicators that demonstrate impact.
- Define system-level dashboards and data points at both Place and SEL level.
- Use regular (e.g. monthly) reporting to support real-time learning and adjustment.

6. Phased implementation plan

- Develop a clear, phased implementation plan with defined stages, deliverables and timelines.
- Establish a robust delivery group representing neighbourhood, Place and SEL partners to support coordination and problem-solving.
- Set out clear expectations for SEL-level enablers and support to Places (e.g. data, learning, facilitation).
- Agree a shared communication approach for transparency and engagement across partners.

7. QI - Test and learn

- Embed a Quality Improvement (QI) approach, including named quality champions, regular QI cycles and monthly learning sessions using a PDSA methodology.
- Put in place proportionate governance and oversight, including meaningful involvement of CYP and family voice.
- Create system-wide learn and share events at SEL and most importantly, acknowledge efforts and celebrate success

Cohorts

Potential cohorts – for initial case finding and management / risk stratification

1. Core 20 population
2. CYP living in deprivation
3. CYP with identified mental health issues or emotional and wellbeing concerns and /or are in crisis
4. CYP with persistent school absence including emotionally based school avoidance (EBSA)

Bexley Wellbeing Partnership Committee

Thursday 26th March 2025

Item: 6

Enclosure: E

Title:	**Local Care Partnership Supplementary Performance Data Report**
Author:	Gita Prasad, Interim Director of Integrated Commissioning (Bexley), NHS South East London Integrated Care Board
Executive Lead:	Diana Braithwaite, Strategic Director, Integrated Health & Care/Place Executive Lead (Bexley), NHS South East London Integrated Care Board

Purpose of paper:	This report is produced by the NHS SEL ICB assurance team and is intended to be used by Local Care Partnerships as part of their local assurance processes. The latest position against key areas of local performance is presented, highlighting achievement against national targets, agreed trajectories and other comparators. An overview of performance and wider SEL context is provided to support interpretation of the data. This report is intended to be used by the Bexley Wellbeing Partnership to identify areas where performance is not in line with expectations and where members/teams may be required to provide additional explanation and assurances that issues are being addressed either locally or as part of a wider system approach.	Update / Information	***X***
		Discussion	
		Decision	
Summary of main points:	The report covers a range of metrics where LCPs either have a direct delegated responsibility for delivery or play a key role in wider SEL systems. It covers the following areas: • Areas of performance delegated by the ICB board to LCPs • Metrics aligned to the six ICB corporate objectives that fall within delegated responsibilities for LCPs. • Metrics requested for inclusion by LCP teams The latest available report (January 2026) presents a mixed position for Bexley but with some areas of strong consistent performance and other areas that have been consistently underperforming. Some indicators have improved in this period and a couple have worsened. • Based on the latest available data Bexley is performing **at or above the required trajectory** on dementia diagnosis, Talking Therapies (with the exception of discharge metrics), Continuing Health Care (CHC), LD and Autism Annual Health Checks, Breast Cancer coverage and Bowel Cancer screening. Children receiving DTaP/IPV/Hib % at 24 months has also improved.		

	Performance is **below the required trajectory** for: **Mental Health (Adult)** • Access to talking therapies (discharge) for Nov 2025 data has seen a drop in performance from 180 reported in the last period, to 140, which is also below the benchmark of 176 • SMI Healthchecks for Q3 25/26 has slightly dipped a few percentage points from Q1's performance which was 55% and now reporting 52% which is below the benchmark of 62% **Childhood Immunisations (Q2 25/26 data)** • Children Receiving MMR1 at 24 months had improved since the last period but is still under target *(PH efficiency standard **90%** / Current Performance **84%**)* • Children Receiving MMR1 at 5 years *(PH efficiency standard **90%** / Current Performance **88%**)* • *(*Children Receiving MMR2 at 5 years *(PH efficiency standard **90%** / Current Performance **71%**)* • Children receiving DTaP/IPV/Hib % at 12 months *(PH efficiency standard **90%** / Current Performance **86%**)* • Children receiving pre-school booster (DTaP/IPV%) % at 5 years *(PH efficiency standard **90%** / Current Performance **66%**)* • Children receiving DTaP/IPV% at 5 years *(PH efficiency standard **90%** / Current Performance 88**%**)* **Cancer (*Jun 24 data)** • Cervical Cancer Coverage (25-64 combined) *(Corporate objective **72.1%** / Current Performance **71.5%**)* **Hypertension (Q2 25/26 data) *** • Patients with hypertension recorded as being treated in line with NICE Guidance *(Corporate trajectory **75%** / Current Performance **73%**)* **** Sep-25 (Local Reporting Data shows Bexley at 71% against a Corporate Trajectory of 75.4%. This is the best performance of the 6 SEL boroughs and reflective of additional investment and focus within Primary Care in recent months.*** **Flu vaccination (Dec 25 data)** • Flu vaccination rate over 65s *(Corporate objective **75%** / End of Season Performance **70%**)* • Flu vaccination rate under 65s at risk *(Corporate objective **42%** / End of Season Performance **36.9%**)* **** 2025/26 vaccinations for flu commenced on 1st October 2025 and therefore reliable data on this year's performance trajectory is not yet available.*** **Appendix 1** provides a short narrative on each of the metrics, including any mitigating factors and/or plans to address shortfalls or deficits within the next reporting period.
Potential Conflicts of Interest	This report is for information only. There are no conflicts of interest.

Other Engagement	Equality Impact	The stated mission of the South East London Integrated Care System is to help people in South East London to live the healthiest possible lives. The Bexley Wellbeing Partnership (BWP) supports this through helping people to stay healthy and well, providing effective treatment when people become ill, caring for people throughout their lives, taking targeted action to reduce health inequalities, and supporting resilient, happy communities as well as the workforce that serves them.
	Financial Impact	This report if for information only. There are no financial impacts.
	Public Engagement	The majority of the information provided in this report is publicly available via NHS Digital.
	Other Committee Discussion/ Engagement	This report and any required mitigations are discussed at the NHS SEL ICB Board and the Bexley Wellbeing Partnership Executive. It is being reported to the Bexley Wellbeing Partnership Committee for information.
Recommendation:	The Bexley Wellbeing Partnership is recommended to: (i) Review 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.	

Appendix 1 – Bexley Local Care Partnership - LCP performance exception report

Performance Metric	Reporting Period	Expected Standard / Trajectory	Latest Performance Position	Trend Since Last Report	SEL context and description of performance	Mitigations and Improvement Actions
Mental Health (Adult) IAPT Discharge (Talking Therapies) SMI Healthchecks	Dec 25 Q3 25/26	176 62%	140 52%	ê ê	The NHS Talking Therapies metrics introduced in 2024/25 have continued into 2025/26. The targets are as follows: • Number of patients discharged having received at least 2 treatment appointments in the reporting period. • Reliable improvement rate for those completing a course of treatment. • Reliable recovery rate for those completing a course of treatment SEL did not achieve the targets and trajectories for these metrics in December 2025. 52% for SMI Healthchecks suggest performance is holding up well, against trajectory. The performance of this metric has shown a similar pattern in previous years. The way this metric is measured in 25/26 has changed, compared with previous years. The risk of being unable to meet the metric consistently throughout the year has been added to the risk register for the Mental Health Programme.	There was significant overperformance against this metric in Q1. The provider has advised that the holiday season has suppressed activity in the third quarter, especially November and December 2025. The provide has commenced an analysis of the 603 clients discharged prior to treatment in Q3. Activity might have been impacted by a downturn in the numbers of people entering treatment. The CCPL has led Bexley Primary Care practitioners' delivery in this area, via webinars, roundtable sessions with GPs. Mind in Bexley has also offered premises as a venue for physical health checks to take place, to support engagement between service users and GPs.
Childhood Immunisations, including:	Q2 – 25/26				The 25/26 operational guidance states that it remains critical that ICSs explicitly agree local ambitions and delivery plans for vaccination and services aimed at	Public Health has led work to better understand the barriers to childhood immunisation uptake in Bexley. The findings have been

Performance Metric	Reporting Period	Expected Standard / Trajectory	Latest Performance Position	Trend Since Last Report	SEL context and description of performance	Mitigations and Improvement Actions
Children Receiving MMR1 at 24 months Children Receiving MMR1 at 5 years Children Receiving MMR2 at 5 years Children receiving DTaP/IPV/Hib % at 12 months Children receiving pre-school booster (DTaPIPV) % at 5 years Children receiving (DTaPIPV) % at 5 years		90% 90% 90% 90% 90% 90%	84% 88% 71% 86% 66% 88%	é ê ê ê ê ê	addressing the leading causes of morbidity in all age groups, including CYP. The performance indicators have an efficiency standard of 90% and an optimal performance standard of 95% for childhood immunisations. Based on current performance for south east London (and London more widely), the 90% efficiency standard was used as the comparator for RAG rating. As a note of caution quarterly cover data can include some spurious or incomplete data and the 24/25 Q1-3 data has since been republished .	collated and used to inform the development of a targeted programme to improve MMR uptake and strengthen staff confidence in discussing the benefits of all vaccinations with patients. The main phase of the project is planned to roll out in April 2026; however, three vaccine confidence training sessions were delivered across South East London in late February and early March, with the Bexley session held on 3 March. Following the implementation of the new MMRV vaccine from 1st Jan 2026, SELWDH hosted a webinar to support practices with the rollout of the programme in accordance with the accelerated 2nd dose schedule adopted by SEL Updated local & national literature to support the MMRV programme rollout has been developed and is available to practices A bespoke Immunisation & Vaccination page has been developed for BexleyNet. Making Every Contact Count (MECC) continues to be the approach for all community & outreach events. Practices and local authority early years & education colleagues have

Performance Metric	Reporting Period	Expected Standard / Trajectory	Latest Performance Position	Trend Since Last Report	SEL context and description of performance	Mitigations and Improvement Actions
						been given the opportunity to order vaccine leaflets and timeline cards in multiple community languages to share with patients and support conversations.
Cervical Cancer Coverage (25-64 combined)	Jun 24	72.%	71.5%	ê	Cervical cancer screening is currently below the nationally defined optimal level of screening of 80%. Bexley is the second highest performing borough in SEL and is just marginally below the expected standard trajectory. Screening is directly commissioned by NHS England, and delivery is through regional teams. Changes to programme, workforce, capacity etc. require NHS England to action. Given this, we rely on a joint approach with other London ICBs on common issues within these areas and advocate for regional solutions such as addressing workforce and capacity challenges within programmes, improving processes and operational pressures, and coordinating potential mutual between screening providers. Local actions for SEL require focus on improvements within the current programme structure/resource.	Raising awareness with the general public regarding the importance of cervical screening, through community engagement events. Practices encouraged to pro-actively engage with patients, contacting them several times if they do not respond to their cervical screening invitation. A number of Bexley Practices have recently signed up to the NHSE HPV self sampling pilot, where patients can take a swob themselves – therefore this will hopefully increase uptake. North Bexley is raising awareness through outreach work with local community groups. Cancer data packs sent quarterly to Practices so they can track their performance against their peers and the borough target.
Management of hypertension treated to NICE Guidance	Q2 – 25/26	75%	73%	é	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 as a national objective.	Local data reporting shows Bexley as the best performing borough in SEL with 73% treated to NICE Guidance (under 80s).

Performance Metric	Reporting Period	Expected Standard / Trajectory	Latest Performance Position	Trend Since Last Report	SEL context and description of performance	Mitigations and Improvement Actions
					Bexley has made a significant improvement, as can be seen in the data. 2025/26 performance will be reported against straight line trajectories for each LCP to achieve the 85% target by March 2026. There is a significant time lag (of approximately 4 months) in the publishing of national reporting (CVD PREVENT) of this metric. To support local monitoring of performance, the SEL LTC team have used the local data as the basis for trajectories up to March 2026. Hypertension is predominantly managed in general practice and there is wide variation in achievement across practices, not always explained by demography.	The ICB has made an incentive investment to the Practices in 25/26 (in addition to the GP Premium) to ensure that as many practices as possible meet or exceed 85% of eligible patients treated to NICE guidance standards. As well as making a significant increase in the management of hypertension, Practices have also increased their detection of prevalence by 15%. Working together with 'Clinical Excellence South East London' (CESEL) to ensure that the CVD investment funding is focused on supporting the improvement of the hypertension target. 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 – such as at the Gurdwara in Belvedere and blood pressure testing in the Civic Offices for staff and the public. Community Pharmacy are carrying out blood pressure checks and are able to deliver Ambulatory Blood Pressure Monitoring. Quarterly data packs sent to Practices with their achievement, benchmarked against other Bexley Practices and SEL.

Performance Metric	Reporting Period	Expected Standard / Trajectory	Latest Performance Position	Trend Since Last Report	SEL context and description of performance	Mitigations and Improvement Actions
Adult Flu Vaccination (over 65s)	Dec 25	75%	70%	é	The south east London ICB board set improving adult flu vaccination rates as a corporate objective. The ambition for 2023/24 was to improve the vaccination rate of people aged over 65 to 73.7%. Performance in 2023/24 (year 1) was significantly below ambition for both metrics and represented a decrease in performance from the previous year. In order to ensure that 24/25 ambitions were informed by place, their knowledge of and insights into their local population, their role in commissioning services and their strategic plans for delivery, each borough team set their own ambitions to improve uptake for the two main adult flu cohorts for the upcoming flu season. This approach to setting ambitions has also taken place ahead of the 2025/26 flu season. The 2024/25 flu season saw high levels of flu with associated hospital admission rates higher than the two previous years.	The 25/26 flu vaccination programme commenced on 1st October 2025 and therefore reliable uptake data and forecast trajectories are not available for this report. Key 25/26 actions will include: • Operational Vaccination Oversight Group • Borough tailored comms & engagement to support national campaigns such as 'why we get vaccinated' • Focused engagement with community groups representing underserved communities • Work with Community Champions to share key messaging • Bexley Winter Wellbeing messaging in the Bexley magazine - pull out and keep booklet • Encourage practices to maximise the potential for flu & COIVD-19 co-administration, where feasible and inline with patient choice • Support focused thinking on how to encourage uptake amongst cohorts with historically low uptake (such as
Adult Flu Vaccination (under 65s at risk)	Dec 25	42%	36.9%	↑		

Performance Metric	Reporting Period	Expected Standard / Trajectory	Latest Performance Position	Trend Since Last Report	SEL context and description of performance	Mitigations and Improvement Actions
						Immuno Suppressed, asthma & diabetes where their disease is well-managed)

South East London Integrated Care System

NHS South East London

Bexley Local Care Partnership
LCP performance data report

February 2026

Contents

Overview of report

Summary:

- This report is produced by the SEL ICB assurance team and is intended to be used by LCPs as part of their local assurance processes.
- The latest position against key areas of local performance is presented, highlighting achievement against national targets, agreed trajectories and other comparators. An overview of performance and wider SEL context is provide to support interpretation of the data.
- This report is intended to be used by the responsible LCP committee/sub-committee to identify areas where performance is not in line with expectations and where members/teams may be required to provide additional explanation and assurances that issues are being addressed either locally or as part of a wider system approach.

Contents and structure of report:

- The report covers a range of metrics where LCPs either have a direct delegated responsibility for delivery or play a key role in wider SEL systems. It covers the following areas:
    - Areas of performance delegated by the ICB board to LCPs.
    - Metrics aligned to the six ICB corporate objectives that fall within delegated responsibilities LCPs.
    - Metrics requested for inclusion by LCP teams.

Structure

- A dashboard summarising the latest position for the LCP across all metrics is included on page 4.
- This is followed by a series of more detailed tables showing performance across south east London with explanatory narrative.
- Metrics are RAG rated based on performance against national targets, agreed trajectories or national comparators (where included in the tables). Arrows showing whether performance has improved from the previous reporting period is also included.

Definitions:

- Definitions and further information about how the metrics in this report are calculated can be found here.

Bexley performance overview

Standard	Trend since last period	Period covered in report	Comparator	Benchmark	Current performance
Dementia diagnosis rate	↑	Jan-26	National standard	67%	71%
IAPT discharge	↔	Dec-25	Operating plan	176	140
IAPT reliable improvement	↑	Dec-25	Operating plan	67%	73%
IAPT reliable recovery	↑	Dec-25	National standard	48%	58%
SMI Healthchecks	↑	Q3 - 25/26	Local trajectory	62%	52%
PHBs	↑	Q3 - 25/26	LTP indicative trajectory	535	539
NHS CHC assessments in acute	↔	Q3 - 25/26	National standard	0%	0
CHC - Percentage assessments completed in 28 days	↑	Q3 - 25/26	National standard	80%	85%
CHC - Incomplete referrals over 12 weeks	↔	Q3 - 25/26	National standard	0	0
Children receiving MMR1 at 24 months	↑	Q2 - 25/26	PH efficiency standard	90%	84%
Children receiving MMR1 at 5 years	↓	Q2 - 25/26	PH efficiency standard	90%	88%
Children receiving MMR2 at 5 years	↓	Q2 - 25/26	PH efficiency standard	90%	71%
Children receiving DTaP/IPV/Hib % at 12 months	↓	Q2 - 25/26	PH efficiency standard	90%	86%
Children receiving DTaP/IPV/Hib % at 24 months	↑	Q2 - 25/26	PH efficiency standard	90%	92%
Children receiving pre-school booster (DTaPIPV%) % at 5 years	↓	Q2 - 25/26	PH efficiency standard	90%	66%
Children receiving DTaP/IPV/Hib % at 5 years	↓	Q2 - 25/26	PH efficiency standard	90%	88%
LD and Autism - Annual health checks	↑	Dec-25	Local trajectory	605	717
Bowel Cancer Coverage (60-74)	↑	Apr-25	Corporate Objective	75%	75%
Cervical Cancer Coverage (25-64 combined)	↓	Jun-24	Corporate Objective	72%	72%
Breast Cancer Coverage (50-70)	↑	Apr-25	Corporate Objective	71%	72%
Percentage of patients with hypertension treated to NICE guidance	↑	Q2 - 25/26	Corporate Objective	75%	71%
Flu vaccination rate over 65s	↑	Jan-26	Corporate Objective	75%	69%
Flu vaccination rate under 65s at risk	↑	Jan-26	Corporate Objective	42%	37%
Flu vaccination rate – children aged 2 and 3	↑	Jan-26	-	-	37%
Appointments seen within two weeks	↓	Dec-25	-	-	91%
Appointments in general practice and primary care networks	↑	Dec-25	Operating plan	-	106615
Appointments per 1,000 population	↑	Dec-25	-	-	406

Performance data

Dementia Diagnosis Rate

SEL context and description of performance

- The national dementia diagnosis rate target is 66.7%. Dementia diagnosis rate is defined as the diagnosis rate for people with dementia, expressed as a percentage of the estimated prevalence.
- South east London is achieving this target. January 2026 performance was 71.0%.
- There is, though, variation between boroughs. Greenwich has not achieved the target during the previous 24 months.

		Jan-26						
Metric	Target	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Dementia diagnosis rate*	66.7%	71.4%	72.9%	62.9%	73.2%	71.6%	71.1%	71.0%
Trend since last report	-	↑	↔	↓	↓	↑	↑	↔

Talking Therapies

SEL context and description of performance

- The NHS Talking Therapies metrics introduced in 2024/25 have continued into 2025/26. The targets are as follows:
  - Number of patients discharged having received at least 2 treatment appointments in the reporting period.
  - Reliable improvement rate for those completing a course of treatment.
  - Reliable recovery rate for those completing a course of treatment and meeting caseness.
- SEL did not achieve the targets and trajectories for these metrics in December 2025.

	Dec-25						
Metric	Bexley - MIND	BHC	Greenwich (Oxleas)	Lambeth (SLaM)	Lewisham (SLaM)	Southwark (SLaM)	SEL
Talking Therapies discharge metric	140	215	290	515	430	325	1885
Trajectory	176	248	295	533	377	360	2035
Trend since last reporting period	↔	↑	↑	↓	↑	↑	↑

		Dec-25						
Metric	Target	Bexley - MIND	BHC	Greenwich (Oxleas)	Lambeth (SLaM)	Lewisham (SLaM)	Southwark (SLaM)	SEL
TT reliable recovery	48%	58.0%	43.0%	46.0%	49.0%	45.0%	42.0%	47.0%
Trend since last report	-	↑	↓	↓	↑	↑	↓	↑

		Dec-25						
Metric	Target	Bexley - MIND	BHC	Greenwich (Oxleas)	Lambeth (SLaM)	Lewisham (SLaM)	Southwark (SLaM)	SEL
TT reliable improvement	67%	73.0%	64.0%	64.0%	66.0%	66.0%	63.0%	66.0%
Trend since last report	-	↑	↓	↓	↑	↑	↓	↔

SMI Physical Health Checks

SEL context and description of performance

- The south east London ICB board has set Improving the uptake of physical health checks for people with SMI as a corporate objective.
- There was a significant increase in the number of AHCs undertaken for people with an SMI during 2023/24 and the SEL operating planning trajectory was achieved at the end of 2023/24. However, the proportion of people receiving an AHC during 2024/25 did not increase in line with the planned trajectory and the end of year target was not achieved.
- The proposed 2025/26 SEL corporate objectives ambition for SMI health checks is 75%. This aligns with NHSE expectations and the final year target of the Long Term Plan. Performance is reported below against an indicative trajectory to support in year tracking towards the target by Q4.
- Where annual health checks are being completed, quality can vary as can onward referral to other physical health services.

	Q2 - 2025/26						
Metric	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
SMI Healthchecks	52.2%	54.3%	52.4%	58.7%	54.6%	59.6%	56.0%
Indicative trajectory	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%
Trend since last report	↑	↑	↑	↑	↑	↑	↑

***NOTE:** The above figures have been calculated based on published LCP performance for Q2: Physical Health Checks for People with Severe Mental Illness - NHS England Digital.

Personal Health Budgets

SEL context and description of performance

- ICBs are required to submit the quarterly mandatory personal health budgets data submission which provides details of the number of children and adults with a personal health budget in place during the year.
- The NHS 10 year plan includes a commitment to at least double the number of people offered a Personal Health Budget by 2028 - 2029.
- Regional targets and trajectories for the number of people receiving a personal health budget for 2025/26 are not in place.
- Annual SEL and borough level targets were agreed as part of the Long Term Plan up to 2023/24. The south east London target was not achieved. Trajectories for the final year of this plan have been included in the table below to provide a comparison for current delivery but is not used as the basis for RAG rating performance.

	Q3 - 2025/26						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Cumulative number of people with a personal health budget year to date	539	1043	525	386	265	345	3107
Indicative LTP trajectory	535	764	662	739	611	586	3898

NHS Continuing Health Care

SEL context and description of performance

- There are a number of national standards which systems are required to achieve consistently. Where deviating from the standard, there is an expectation that performance will be addressed as a priority. Performance standards are as follows:
  - A national target was previously set to reduce the number of CHC assessments in an acute hospital setting to less than 15%. The aim, however, is that zero assessments should be completed in an acute setting and this is the benchmark that LCP and ICB teams are measured against.
  - Complete assessments of eligibility within 28 days from the date of referral in >80% cases.
  - Reduce the number of outstanding referrals exceeding 12 weeks to Zero
- All targets were achieved at the end of 2024/25.
- At the end of quarter 3 2025/26, SEL was achieving the 28 day target. There is, however, variation across boroughs. There were also 4 incomplete referrals over 12 weeks. These were all in a single borough.

		Q3 - 25/26						
Metric	Target	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
NHS CHC assessments in acute	0	0	0	0	0	0	0	0
Trend since last reporting period	-	↔	↔	↔	↔	↔	↔	↔

	Q3 - 25/26						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
CHC - Percentage assessments completed in 28 days	85%	91%	68%	89%	60%	88%	82%
Trajectory	80%	80%	80%	80%	80%	80%	80%
Trend since last reporting period	↑	↑	↓	↑	↓	↑	↓

	Q3 - 25/26						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
CHC - Incomplete referrals over 12 weeks	0	0	0	0	4	0	4
Trajectory	0	0	0	0	0	0	0
Trend since last reporting period	↔	↔	↔	↔	↑	↔	↑

Childhood immunisations (1 of 2)

Description of metric and SEL context

- Vaccination saves lives and protects people's health. It ranks second only to clean water as the most effective public health intervention to prevent disease. Through vaccination, diseases that were previously common are now rare, and millions of people each year are protected from severe illness and death. South East London and our 6 local care partnerships recognise this in the ICS Strategic Priorities and our Joint Forward Plan.
- South East London ICB has a Vaccination and Immunisation Strategy and has embedded within the six boroughs an approach to increase uptake by developing trust and confidence in the childhood immunisation programme with local communities.
- Since December 2023 there have been a number of reported cases of measles across the country resulting in a national and regional response. SEL boroughs and programme team are co-ordinating and aligning plans across the system in response to the concerns. A full report detailing the position and proposed actions was agreed at the ICB Executive Committee in February 2024. Actions included: SRO/director level attendance at London IMT meetings; production of regular sitrep feeding up to London IMT; A sub-group of the SEL board meets on a regular basis with borough leads, public health, communications and primary care leads to co-ordinate the local response and to support local plans. Each borough has produced a local action plan and are using their local place level vaccination groups to support delivery.
- Borough plans are also in place in response to the rise in numbers of whooping cough numbers and the imperative to focus on the full range of childhood immunisations including pertussis and flu.
- The 24/25 operational planning guidance identified the following as a key action for systems: maximise uptake of childhood vaccinations and flu vaccinations for CYP, achieving the national KPIs in the Section 7a public health functions agreement, including reducing inequalities. The 25/26 operational planning guidance states that it remains critical that ICSs explicitly agree local ambitions and delivery plans for vaccination and services aimed at addressing the leading causes of morbidity in all age groups, including CYP.
- The performance indicators have an efficiency standard of 90% and an optimal performance standard of 95% for childhood immunisations. Based on current performance for south east London (and London more widely), the 90% efficiency standard is used as the comparator for RAG ratings.

		Q2 - 25/26								
Metric	**Efficiency standard**	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**	**London**	**England**
Children receiving MMR1 at 24 months	90%	83.5%	87.4%	82.7%	77.6%	83.6%	81.3%	81.0%	79.5%	88.1%
Trend since last reporting period	-	↑	↑	↓	↔	↑	↔	↓	↓	↓

		Q2 - 25/26								
Metric	**Efficiency standard**	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**	**London**	**England**
Children receiving MMR1 at 5 years	90%	88.1%	90.6%	85.4%	85.0%	89.1%	83.5%	84.7%	84.5%	92.0%
Trend since last reporting period	-	↓	↑	↓	↑	↑	↓	↓	↑	↔

		Q2 - 25/26								
Metric	**Efficiency standard**	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**	**London**	**England**
Children receiving MMR2 at 5 years	90%	70.9%	80.8%	69.9%	73.5%	74.0%	72.0%	71.2%	69.0%	83.5%
Trend since last reporting period	-	↓	↑	↑	↑	↓	↓	↓	↑	↑

Important Note: SEL Borough level data for quarters 1 to 4 2024/25 included only children registered with a GP and did not include children not registered with a GP practice. See Quarterly vaccination coverage statistics for children aged up to 5 years in the UK (COVER programme): January to March 2025 - GOV.UK **for more details**

Childhood immunisations (2 of 2)

		Q2 - 25/26								
Metric	Efficiency standard	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving DTaP/IPV/Hib % at 12 months	90%	85.8%	87.2%	85.9%	86.2%	87.6%	85.8%	85.8%	84.7%	90.4%
Trend since last report	-	↓	↓	↓	↓	↓	↓	↓	↓	↓

		Q2 - 25/26								
Metric	Efficiency standard	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving DTaP/IPV/Hib % at 24 months	90%	92.0%	91.5%	89.1%	86.1%	88.9%	89.5%	88.2%	86.9%	92.3%
Trend since last report	-	↑	↔	↓	↑	↑	↑	↓	↔	↔

		Q2 - 25/26								
Metric	Efficiency standard	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving pre-school booster (DTaPIPV%) % at 5 years	90%	66.0%	74.6%	66.2%	67.2%	70.0%	61.0%	64.9%	66.3%	81.8%
Trend since last report	-	↓	↑	↓	↑	↑	↓	↑	↑	↑

		Q2 - 25/26								
Metric	Efficiency standard	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving DTaP/IPV/Hib % at 5 years	90%	88.3%	91.4%	87.6%	87.4%	89.4%	84.4%	86.5%	86.6%	92.7%
Trend since last report	-	↓	↑	↓	↑	↑	↓	↓	↑	↓

Important Note: SEL Borough level data for quarters 1 to 4 2024/25 included only children registered with a GP and did not include children not registered with a GP practice. See [Quarterly vaccination coverage statistics for children aged up to 5 years in the UK (COVER programme): January to March 2025 - GOV.UK](#) **for more details**

Learning disabilities and autism – annual health checks

SEL context and description of performance

- The south east London ICB board has set improving the uptake of physical healthchecks for people with LDA as a corporate objective and a south east London trajectory for 2025/26 was submitted as part of the operational planning process.
- SEL achieved the 2024/25 plan with 7,471 health checks delivered against a plan of 6,600. All LCPs achieved their individual targets.
- All LCPs are achieving their December 2025 trajectory.
- Where annual health checks are being completed, quality can vary as can onward referral to other physical health services.

	Dec-25						
Metric	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
LD and Autism - Annual health checks	717	759	1001	969	1143	884	5473
Trajectory	605	625	831	852	981	649	4545

Cancer screening

SEL context and description of performance

- The south east London ICB board has set improving breast, bowel and cervical screening a corporate objective. At an SEL level, bowel cancer screening coverage is currently below the revised nationally defined optimal level of screening of 76%. Cervical cancer screening is currently below the nationally defined optimal level of screening of 80%. Breast cancer screening is currently below the nationally defined optimal level of screening of 70-80%.
- SEL set overall ambitions for improving breast, bowel and cervical screening a corporate objective. Indicative LCP level annual targets have also been shared via the six Place Executive Leads (PELs). These are based on a standard proportional reduction in the unscreened population at an LCP level for each cancer cohort. This means that there is an expectation that all LCPs will improve uptake but those with a lower baseline uptake would have a slightly larger stretch for the year. Thus, supporting a reduction in inequality between boroughs.
- Screening is directly commissioned by NHS England, and delivery is through regional teams. Changes to programme, workforce, capacity etc. require NHS England to action. Given this, we rely on a joint approach with other London ICBs on common issues within these areas and advocate for regional solutions such as addressing workforce and capacity challenges within programmes, improving processes and operational pressures, and coordinating potential mutual between screening providers. Local actions for SEL require focus on improvements within the current programme structure/resource.

	Apr-25						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Bowel Cancer Coverage (60-74)	74.5%	76.4%	65.5%	61.8%	64.1%	63.3%	67.9%
Trajectory	74.6%	76.6%	66.4%	62.9%	65.1%	63.7%	68.6%
Trend since last reporting period	↑	↑	↓	↓	↓	↑	↔

	Jun-24						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Cervical Cancer Coverage (25-64 combined)	71.5%	73.7%	66.0%	62.7%	67.4%	63.6%	66.9%
Trajectory	72.1%	74.4%	66.2%	63.3%	68.0%	64.4%	67.4%
Trend since last reporting period	↓	↓	↓	↓	↓	↓	↓

	Apr-25						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Breast Cancer Coverage (50-70)	72.2%	72.6%	60.0%	59.1%	60.2%	60.7%	64.2%
Trajectory	71.2%	72.2%	59.8%	57.8%	59.6%	60.7%	63.6%
Trend since last reporting period	↑	↑	↑	↑	↑	↑	↑

NOTE: Due to lag in national reporting, local data is shown. This uses the same data source.

Management of hypertension to NICE guidance

SEL context and description of performance

- The south east London ICB board has set improving the percentage of patients with hypertension treated to NICE guidance as a corporate objective.
- The 2024/25 priorities and operational planning guidance identified increasing the percentage of patients with hypertension treated to NICE guidance to 80% by March 2025 as a national objective. For 2024/25, this remained the primary aspirational goal for SEL. SEL are also pursuing a 'minimum achievement' target (which serves as the revised SEL ICB corporate objective) to achieve 80% over a 2 year time period (i.e. by end March 2026). This approach has been agreed by the Place Executive Leads (PELs)
- Performance is reported against straight line trajectories for each LCP to achieve the 80% target by March 2026.
- There is a significant time lag (of approximately 4 months) in the publishing of national reporting (CVD PREVENT) of this metric. To support local monitoring of performance, the SEL LTC team have used the local data as the basis for trajectories up to March 2026. However, please see caveat below regarding recent changes in local data.
- Hypertension is predominantly managed in general practice and there is wide variation in achievement across practices, not always explained by demography. People at risk may not have sufficient support to understand the importance of detecting and managing raised blood pressure.

	Dec-25 (Local data reporting)*						
Metric	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
Percentage of patients with hypertension treated to NICE guidance	74%	72%	69%	69%	67%	70%	70%
Trajectory	78.5%	78.7%	78.7%	78.7%	78.2%	78.6%	78.6%
Trend since last report	↔	↑	↑	↑	↑	↑	↑

Note: Recent data migration has resulted in correction to historic data.

	Q2-25/26 (using published CVD prevent reporting)**						
Metric	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
Percentage of patients with hypertension treated to NICE guidance	70.6%	68.3%	66.3%	66.0%	62.4%	66.3%	66.7%
Trajectory	75.4%	76.2%	76.0%	76.0%	74.5%	75.8%	75.7%

*Local data has been updated to include coding for self reporting of home monitoring. This affects current and historic data and has led to an increase in reported performance. Further work is taking place to confirm that local reporting is inline with the national data definitions.
**CVD prevent data published at PCN level is used to calculate overall borough level performance

Adult flu immunisation (1 of 2)

SEL context and description of performance

- The south east London ICB board has set improving adult flu vaccination rates as a corporate objective.
- Performance in 2023/24 and 2024/25 was below the ambitions agreed at the start of each year for both cohorts.
- In order to ensure that 25/26 ambitions were informed by place, their knowledge of and insights into their local population, their role in commissioning services and their strategic plans for delivery, each borough team set their own ambitions to improve uptake for the two main adult flu cohorts for the upcoming flu season.
- Borough teams have planned their targets based on improving last year's performance as published at Seasonal influenza vaccine uptake in GP patients: winter season 2024 to 2025 - GOV.UK. They may require revision should historic data be revised.
- The below table provides targets set at borough level for 2025/26.
- The following slide shows uptake vs an indicative trajectory (based on delivery in previous years). Data is published at Seasonal influenza vaccine uptake in GP patients: monthly data, 2025 to 2026 - GOV.UK

Year end targets for 2025/26 proposed by borough teams:

	65+ cohort vaccination target for 2025/26 season	<65 at risk cohort vaccination target for 2025/26 season
Bexley	75.0%	42.0%
Bromley	75.0%	41.0%
Greenwich	64.5%	36.9%
Lambeth	60.0%	32.5%
Lewisham	61.0%	34.3%
Southwark	62.6%	34.2%
SEL	67.5%	36.3%

Adult flu immunisation (2 of 2)

Published January 2026 Performance

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Over 65s vaccinated	69.1%	72.8%	61.8%	53.5%	53.3%	54.8%	62.4%
Local October trajectory	74.7%	74.7%	64.0%	59.6%	60.5%	62.2%	67.1%

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Under 65s at risk vaccinated	36.9%	40.3%	36.2%	31.4%	30.9%	33.8%	34.6%
Local October trajectory	41.7%	40.7%	36.6%	32.2%	33.9%	33.6%	35.9%

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Children aged 2 and 3 vaccinated	37.3%	48.2%	37.8%	38.4%	42.0%	39.7%	40.8%

Primary care access

SEL context and description of performance

- The 2025/26 Priorities and Operational Planning guidance states that ICBs are expected to continue to support general practice to enable patients to access appointments in a more timely way and improve patient experience.
- The following trajectories have been agreed at an SEL level as part of the annual planning process:
    - Planned number of general practice appointments.
- Appointments totalled 763,859 in December against the operating plan of 733,777.

		Dec-25						
Metric	Planning trajectory	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Appointments seen within 2 weeks	-	90.8%	88.4%	92.8%	91.0%	86.7%	87.4%	89.7%

		Dec-25						
Metric	Planning trajectory	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Appointments in general practice and primary care networks	733,777	106,615	141,979	121,775	167,716	110,320	115,454	763,859
Appointments per 1,000 population	-	406	396	368	381	323	319	364

Bexley Wellbeing Partnership Committee

Thursday 26th March 2026

Item: 7

Enclosure: F

Title:	**2025/26 Finance Report - Month 10**
Author/Lead:	Asad Ahmad, Associate Director of Finance (Bexley), NHS South East London Integrated Care Board
Executive Sponsor:	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 the ICB and the ICS as at month 10 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	4,413	4,344	69	5,295	5,212	83
Community Health Services	21,753	21,527	226	26,104	25,861	243
Mental Health Services	9,221	9,975	(754)	11,065	12,009	(944)
Continuing Care Services	22,258	21,663	595	26,709	25,985	724
Prescribing	32,718	33,550	(832)	39,134	40,006	(872)
Other Primary Care Services	1,278	1,308	(30)	1,534	1,570	(36)
Other Programme Services	1,021	500	521	1,225	600	625
Delegated Primary Care Services	41,386	41,386	0	49,664	49,663	0
Corporate Budgets	2,524	2,303	221	3,029	2,775	254
Total	**136,572**	**136,557**	**15**	**163,759**	**163,682**	**77**

As at Month 10 (January 2026) Bexley place is reporting an underspend of £15k year to date and £77k full year forecast.

South East London ICB Summary

- The ICB's financial allocation as at month 10 is £5,887,195k.
- As at month 10, the ICB is reporting a year to date (YTD) break-even position.
- One place is reporting a material overspend YTD at month 10 – Bromley (£369k – driven by MH and CHC overspends), with a break-even or better position being forecast by all. All places have been tasked to identify additional mitigations to offset financial risks, to ensure delivery of their financial plans.
- As at month 10 the ICB is reporting an overall forecast break-even position against its financial plan.

South East London ICS Summary

	• As at month 10 SEL ICS is reporting a YTD deficit of (£16.2m), £5.8m ahead of plan. • At month 10, 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	Not applicable
	Financial Impact	The paper sets out the financial position as at M10 2025/26.
	Public Engagement	Not applicable
	Other Committee Discussion/ Engagement	The finance reports are discussed at the ICB Executive meeting, locally it has been discussed at Bexley SMT and the LCP Executive.
Recommendation:	The Bexley Wellbeing Partnership Committee is recommended to: (i) Discuss the month 10 financial position for Bexley Place. (ii) Note the NHS South East London ICB and NHS South East London ICS financial position as at month 10.	

South East London Integrated Care System

Bexley Wellbeing Partnership Committee

Finance Report

Month 10 (January 2026) – FY 2025/26

Thursday 26th March 2026

Bexley Wellbeing Partnership

2025/26 Month 10 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	4,413	4,344	69	5,295	5,212	83
Community Health Services	21,753	21,527	226	26,104	25,861	243
Mental Health Services	9,221	9,975	(754)	11,065	12,009	(944)
Continuing Care Services	22,258	21,663	595	26,709	25,985	724
Prescribing	32,718	33,550	(832)	39,134	40,006	(872)
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Other Programme Services	1,021	500	521	1,225	600	625
Delegated Primary Care Services	41,386	41,386	0	49,664	49,663	0
Corporate Budgets	2,524	2,303	221	3,029	2,775	254
Total	**136,572**	**136,557**	**15**	**163,759**	**163,682**	**77**

- As at Month 10 (January 2026) Bexley place is reporting an underspend of £15k year to date and £77k full year forecast.
- Mental Health Services is reporting an overspend of £754k year to date and £944k full year forecast. The overspend is driven by an increase in spend relating to section 117 mental health and learning disabilities cost per case placements. The position also 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. Work is being undertaken across all boroughs to identify options to mitigate the cost pressure going into the next financial year.
- Continuing Care is reporting an underspend of £595k year to date and £724k full year forecast. Continuing Care has seen a reduction in costs this financial year and this is due to the number of care packages reducing as well as savings achieved following Continuing Care reviews conducted by the team.
- Prescribing is reporting an overspend of £832k year to date and £872k 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 and GLP-1s such as tirzepatide), flash glucose monitoring and appliances such as catheters. Work is ongoing by the medicines management team to deliver efficiencies to improve the financial position. The forecast spend includes a run-rate improvement due to the favourable financial impact of the drug Dapagliflozin coming off patent during the year.
- 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 £249k for the year based on the latest list size data.
- Other Programme services budget is reporting a forecast full year underspend of £625k. This is following the release of uncommitted growth funding to mitigate the cost pressures being seen in the overall Bexley place budgets.
- Corporate budgets are reporting an underspend of £221k year to date and £254k full year forecast. The underspend is a result of vacant posts which cannot be recruited to due to the recruitment freeze as per the current ongoing ICB change programme.
- Acute and Community Services is reporting small underspends against several services.
- Bexley place has an annual efficiency plan of £7,750k which is forecasted to deliver in full by year end.

Appendix A

SEL ICB Finance Summary

Month 10 2025/26

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 10, 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. Within this reporting, the ICB has delivered **£50,700k** of savings YTD compared to the plan value of £49,600k.
- **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 **£6,999k** and forecast out-turn position of underspend of **£7,164k** against the **running cost allowance (RCA)** due to the full allocation received from NHSE in respect of redundancy costs **(£12,486k)** being badged as RCA whereas some costs will be programme costs. The full anticipated impact of the ICB change programme on redundancy costs has been included in the month 10 accounts as either a provision or an accrual as per accounting rules.
- All financial duties have been delivered for the year to month 10 period.

Key Indicator Performance	Year to Date		Forecast		
	Target	Actual	Target	Actual	
	£'000s	£'000s	£'000s	£'000s	
Expenditure not to exceed income	4,905,320	4,905,320	5,887,195	5,887,195	
Operating Under Resource Revenue Limit	4,905,320	4,905,320	5,887,195	5,887,195	
Not to exceed Running Cost Allowance	40,210	33,211	47,184	40,020	
Month End Cash Position (expected to be below target)	5,663	341			
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%	98.7%			
Mental Health Investment Standard (Annual)			537,494	549,722	

Executive Summary

NHS South East London

- This report sets out the month 10 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 10 is **£5,887,195k**. In month, the ICB has received an additional **£66,001k** of allocations. These are as detailed on the following slide. **As at month 10, the ICB is reporting a year to date (YTD) break-even position.**
- Due to the routine time lag, the ICB has received eight months of 2526 prescribing data. After the usual accrual for two months of estimated prescribing expenditure, the ICB is reporting a **£3,734k overspend YTD across PPA and non PPA** budgets. The overspend continues to be variable across the Places.
- The continuing care financial position is **£259k overspent** at month 10, which is a deterioration on last month. The boroughs which are most impacted with overspends are Lewisham, Bromley and Greenwich which is a continuation of the trend from last year. The YTD position for **Mental Health services** is an overall **overspend of £8,698k** 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 went live at the beginning of November but the impact is not yet known.
- 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.
- One place is reporting a material overspend YTD at month 10 – **Bromley (£369k – driven by MH and CHC overspends), with a break-even or better position being forecast by all.** All places have been tasked to identify additional mitigations to offset financial risks, to ensure delivery of their financial plans. More detail regarding the individual place financial positions is provided later in this report.
- In reporting this month 10 position, the ICB has delivered the following financial duties:
    - Underspend of **£6,999k YTD** against its management costs allocation, due to the allocation in respect of redundancy all being badged as running costs (RCA) whereas some costs will be programme costs. The full anticipated impact of the redundancy programme has been included as provisions and accruals this month, as the allocation has now been received.
    - 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 10 the ICB is reporting an overall **forecast break-even position** against its financial plan.

Budget Overview

NHS South East London

	M10 YTD								
	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	PCD Team	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Budget									
Acute Services	4,413	6,953	5,909	539	735	201	2,790,598	-	**2,809,348**
Community Health Services	21,753	79,971	34,286	25,576	29,533	32,063	232,395	-	**455,577**
Mental Health Services	9,221	12,739	7,399	20,597	6,641	9,084	535,308	5,633	**606,622**
Continuing Care Services	22,258	23,447	25,256	29,925	21,182	17,098	-	-	**139,166**
Prescribing	32,718	44,011	32,149	36,785	36,718	30,272	-	1,940	**214,594**
Other Primary Care Services	1,278	1,691	1,608	3,324	1,784	789	-	14,771	**25,244**
Other Programme Services	1,021	-	1,496	-	-	727	16,460	3,738	**23,441**
Programme Wide Projects	(0)	-	-	-	21	216	-	8,911	**9,149**
Delegated Primary Care Services	41,386	59,277	52,962	80,379	60,530	64,641	-	(1,085)	**358,090**
Delegated Primary Care Services DPO	-	-	-	-	-	-	52,561	142,674	**195,235**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	-	-	**-**
Corporate Budgets	2,524	3,104	2,935	3,889	2,771	3,450	-	50,183	**68,855**
Total Year to Date Budget	**136,572**	**231,193**	**164,000**	**201,014**	**159,914**	**158,539**	**3,627,322**	**226,765**	**4,905,320**

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	PCD Team	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Actual									
Acute Services	4,344	6,540	5,923	539	761	236	2,793,391	-	**2,811,733**
Community Health Services	21,527	79,075	34,194	25,638	25,787	29,608	229,543	-	**445,371**
Mental Health Services	9,975	13,894	9,389	21,907	7,561	11,237	535,296	6,059	**615,320**
Continuing Care Services	21,663	24,604	25,322	28,464	22,860	16,512	-	-	**139,425**
Prescribing	33,550	43,759	33,359	37,272	38,115	31,972	-	300	**218,328**
Other Primary Care Services	1,308	1,524	1,470	2,726	1,577	764	-	14,682	**24,052**
Other Programme Services	500	-	-	-	-	-	16,460	14,232	**31,192**
Programme Wide Projects	-	-	(1,333)	-	22	216	-	8,676	**7,580**
Delegated Primary Care Services	41,179	58,426	53,379	80,573	60,283	64,596	-	(546)	**357,889**
Delegated Primary Care Services DPO	-	-	-	-	-	-	52,562	140,637	**193,198**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	-	(675)	**(675)**
Corporate Budgets	2,303	2,888	2,753	3,865	2,702	3,234	70	44,092	**61,907**
Total Year to Date Actual	**136,349**	**230,711**	**164,456**	**200,983**	**159,668**	**158,374**	**3,627,322**	**227,457**	**4,905,320**

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	PCD Team	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Variance									
Acute Services	69	413	(14)	0	(26)	(35)	(2,793)	-	**(2,385)**
Community Health Services	226	896	92	(61)	3,746	2,455	2,851	-	**10,205**
Mental Health Services	(754)	(1,155)	(1,990)	(1,310)	(921)	(2,154)	12	(426)	**(8,698)**
Continuing Care Services	595	(1,157)	(66)	1,461	(1,678)	585	-	-	**(259)**
Prescribing	(832)	252	(1,210)	(487)	(1,397)	(1,700)	-	1,640	**(3,734)**
Other Primary Care Services	(30)	167	137	598	207	25	-	89	**1,193**
Other Programme Services	521	-	1,496	-	-	727	0	(10,494)	**(7,751)**
Programme Wide Projects	(0)	-	1,333	-	(0)	-	-	235	**1,568**
Delegated Primary Care Services	208	851	(416)	(194)	246	45	-	(539)	**201**
Delegated Primary Care Services DPO	-	-	-	-	-	-	(0)	2,037	**2,037**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	-	675	**675**
Corporate Budgets	221	215	182	24	69	216	(70)	6,091	**6,948**
Total Year to Date Variance	**223**	**482**	**(456)**	**31**	**246**	**165**	**(0)**	**(691)**	**0**
Delegated P/Care Equalisation	**(208)**	**(851)**	**416**	**194**	**(246)**	**(45)**		**740**	**-**
Revised YTD Variance	**15**	**(369)**	**(40)**	**225**	**0**	**120**	**(0)**	**49**	**0**

- As at month 10, the ICB is reporting a YTD **break-even position**, albeit with **pressures in specific budgets.** Key areas of financial pressure are in **mental health services, CHC for some Places and prescribing.**
- Due to the routine time lag, the ICB has received eight months of 2526 prescribing data. After the usual accrual for two months of estimated prescribing expenditure, the ICB is reporting a **£3,734k overspend YTD** across PPA and non PPA budgets. The overspend continues to be variable across the Places.
- The CHC financial position is **£259k overspent** at month 10, which is a deterioration on last month's reported numbers. The boroughs which are most impacted are Lewisham, Bromley and Greenwich which is a continuation of the trend from last year.
- The YTD position for Mental Health services is an overall **overspend of £8,698k** 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 went live at the beginning of November but the impact of this is not yet known.
- 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 still leaves a small number of impacted staff who remain at the ICB.
- One place is reporting a material overspend YTD at month 10 – Bromley (£369k), **with a break-even or better position being forecast by all.** Places have been tasked to identify additional mitigations to offset financial risks, to ensure delivery of their financial plans. More detail regarding the individual place financial positions is provided later in this report.

South East London Integrated Care System

Appendix B

SEL ICS Finance Summary

Month 10 2025/26

Bexley Wellbeing Partnership

ICS Financial Position – I & E Summary

- **As at month 10 SEL ICS is reporting a YTD deficit of (£16.2m), £5.8m ahead of plan. This reflects a £2.9m improvement compared to month 9.**
- **The main in-month improvement is within KCH (£2.5m), largely driven by the net impact of NHSE industrial action (IA) funding (£0.7m) and improved contractual performance (£1.8m).**
- **KCH is now £5.1m ahead of plan.**
- **All other organisations are reporting either a year-to-date break-even position or a slight surplus of between £0.4m and £0.1m.**

Organisation	YTD					Forecast				
	Plan (pre Deficit Support Funding)	Plan Deficit Support Funding	Plan (incl. Deficit Support Funding)	Actual	Variance	Plan (pre Deficit Support Funding)	Plan Deficit Support Funding	Plan (incl. Deficit Support Funding)	Actual	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
GSTT	(23.4)	0.0	(23.4)	(23.0)	0.4	0.0	0.0	0.0	0.0	0.0
Kings	(62.1)	62.5	0.4	5.5	5.1	(75.0)	75.0	0.0	0.0	0.0
LGT	0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0
Oxleas	0.0	0.0	0.0	0.2	0.2	0.0	0.0	0.0	0.0	0.0
SLAM	1.0	0.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0
Provider Total	**(84.6)**	**62.5**	**(22.1)**	**(16.2)**	**5.8**	**(75.0)**	**75.0**	**0.0**	**0.0**	**0.0**
ICB	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
System Total	**(84.6)**	**62.5**	**(22.1)**	**(16.2)**	**5.8**	**(75.0)**	**75.0**	**0.0**	**0.0**	**0.0**

To achieve the reported position, a total of **£193.3m** of **non recurrent mitigations** has been applied year to date. Of this, **£87.4m** was included in financial plans, with **£105.9m** deployed **above planned levels.**

Non Recurrent Mitigations - YTD at Month 10 - £'M			
Organisation	**Planned**	**Actual**	**Variance/ Unplanned**
GSTT	19.2	86.8	67.6
KCH	-	9.4	9.4
LGT	29.8	57.2	27.4
Oxleas	20.4	23.3	2.9
SLaM	18.0	16.6	(1.4)
SEL Providers	**87.4**	**193.3**	**105.9**

- These mitigations have been used to offset:
  - £88.2m YTD in-year pressures, including increased non- pay cost driven by inflation, pathology and winter pressures, the impact of the pay awards, and higher than planned sickness cover costs.
  - £70.8m of efficiency slippages.
  - £22.7m unplanned shortfall on income; specialised commissioning, non-clinical income and other patient income.
  - £11.6m on independent sector and prior year cyber attack legal costs.
- **At month 10, the ICS system forecast remains at a break-even financial position.**

Bexley Wellbeing Partnership Committee

Thursday 26th March 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, Strategic Director, Integrated Health & Care/Place Executive Lead (Bexley), NHS South East London Integrated Care Board

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 26th March 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:
  - **One** risk is rated as “extreme risk” (red) after mitigations are put in place
  - **Six** risks are rated as “high risk” (amber) after mitigations are put in place
  - **Seven** risks are rated as “moderate risk” (yellow) 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

3rd March 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 £9 15k developed for internal CIP audit March 2025, Month 9 finances reported a healthy underspend and forecasts that the service is on track to achieve an overall underspend. Risk reduced due to the financial position.	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, SEL ICB 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, SEL ICB 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	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 22/0 1/25, 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	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	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.,	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	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 Q125/26 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	6	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, TOCH Highlight Report in January 2026 has demonstrated progress, Partners continue to support flow and discharge, funding of initiatives and working with care providers to achieve flow and hospital discharge.	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	6	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, A good account of integrated working has been cited in Q3 of the BCF return, providing sufficient evidence system partners are targeting support appropriately.	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	4	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, Designated Dr for Greenwich continues to support but forward she may not have the capacity to continue supporting but will advise if this does occur. Named GP continues to support	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.	16	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., Quarter Three performance report on the ASD diagnostic pathways shows adverse performance with the number of ASD assessments completed decreasing from 172 in Q2 to 146 in Q3 and the average waited time of those seen increasing. Therefore overall risk is raised to 16.	6

Agenda Item: 11
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