South East London Integrated Care System

Bexley Wellbeing Partnership

Bexley Wellbeing Partnership Committee meeting held in public

Thursday 22nd May 2025, 14:00 – 16:00

Venue: Welling United Football Club, Park View Road, Welling DA16 1SY

Agenda

No.	Item	Encl.	Presenter	Time
Opening Business and Introductions				
1.	Introductions and apologies		Chair	14:00
2.	Declarations of Interest	Encl. A	Chair	14:03
3.	Notes from 27th March 2025 and matters arising	Encl. B	Chair	14:04
Decision				
4.	Community Champions Vision & Strategy	Encl. C	Aysha Awan	14:05
5.	SEL Ageing Well Frailty Framework	Encl. D	Kallie Heyburn	14:20
6.	Lyndhurst Medical Centre – Contract Variation	Encl. E	Graham Tanner	14:35
Assurance				
7.	Primary Care Quarterly Business Report Q4 2024/25	Encl. F	Graham Tanner	14:55
8.	Risk Register 2025/26	Encl. G	Rianna Palanisamy	15:05
9.	Finance Report – Month 12	Encl. H	Asad Ahmad	15:15
Public Forum				
10.	*Public Questions*			15:25
Let's Talk				
11.	The Power of Sport		Chair	15:27
Closing Business				
12.	Any other business		Chair	15:57
For Information				
13.	Glossary	Encl. I		
14.	Date of the next meeting: Thursday 24th July 2025, Council Chambers, Civic Centre.			

ITEM: 2

ENCLOSURE: A

Declaration of Interests: Update and signature list

Name of the meeting: Bexley Wellbeing Partnership Committee **Date:16.05.2025**

Name	Position Held	Declaration of Interest	State the change or 'No Change'	Sign
Dr Sid Deshmukh*	Chair- Bexley Wellbeing Partnership	1. Senior Partner Sidcup Medical Centre PMS Contract - Financial Interest Materiality 50% 2. Shareholder of GP Federation 3. Shareholder Frogmed Limited (Dormant company) 4. Chair - Frognal Primary Care Network GP Lead 5. Wife (Dr Sonia Khanna-Deshmukh) is Frognal PCN Clinical Director 6. Non-financial personal interest in Inspire, Father-in-law Mr Vinod Khanna is Chief Executive. Community Trust; a) Wheelchair service; b) Joint Equipment Store; c) Personal Health Budgets; d) Information and service support for people with physical and sensory impairment. 7. Chairman, Bexley Health Neighbourhood Care CIC 8. Clinical Lead, Frognal Local Care Network 9. Clinical Lead, Primary/Secondary Care Interface 10. GP Partner, Station Road Surgery, Sidcup		
Diana Braithwaite*	Place Executive Lead (Bexley), NHS South East London Integrated Care Board	Nothing to declare.		
Dr Nicole Klynman*	Director of Public Health London Borough of Bexley Council	1. Salaried GP at Leyton Healthcare		
Yolanda Dennehy*	Director of Adult Social Care, London Borough of Bexley Council	Nothing to declare.		

Raj Matharu*	LPC Representative	1. Chief Officer of Bexley, Bromley & Greenwich Local Pharmaceutical Committee 2. Chief Officer of Lambeth, Southwark & Lewisham Local Pharmaceutical Committee 3. Chair of Community Pharmacy London 4. Board Member of Pharma BBG LLP 5. Superintendent Pharmacist of MAPEX Pharmacy Consultancy Limited. 6. Wife is lead pharmacy technician for the Oxleas Bromley medicines optimisation service (indirect interest)		
Keith Wood	Lay Member, Primary Care (Bexley)	Nothing to declare.		
Jennifer Bostock*	Independent Member (Bexley)	1. Independent Advisor and Tutor, Kings Health Partners (financial interest) 2. Patient Public involvement Co-Lead, DHSC/NIHR 3. Independent advisor and Lay Reviewer, UNIS 4. Lay co-applicant/collaborator on an NIHR funded project 5. Independent Reviewer, RCS Invited Review Mechanism 6. Lay co-applicant, HS2		
Dr Pandu Balaji*	Clinical Lead – Frognal Primary Care Network	GP partner, Woodlands Surgery (financial interest)		
Dr Miran Patel*	Clinical Lead – APL Primary Care Network	1. GP Partner, The Albion Surgery (financial interest) 2. Clinical director, APL PCN (financial interest)		
Dr Nisha Nair*	Clinical Lead – Clocktower Primary Care Network	1. GP Partner, Bexley Group Practice (financial interest) 2. Clinical director, Clocktower PCN (financial interest)		
Dr Surjit Kailey*	Clinical Lead – North Bexley Primary Care Network	1. GP Partner, Northumberland Health Medical Centre (financial interest) 2. Co-director of BHNC (financial interest) 3. Co-clinical director, North Bexley PCN (financial interest) 4. Co-medical Director Grabadoc (financial interest)		
Abi Mogridge (n)	Chief Operating Officer, Bexley Health Neighbourhood Care CIC	Nothing to declare.		

Jattinder Rai (n)	CEO, Bexley Voluntary Service Council (BVSC)	Nothing to declare.		
Rikki Garcia (n)	Chair, Healthwatch Bexley	Nothing to declare.		
Kate Heaps (n)	CEO Greenwich and Bexley Community Hospice	1. CEO of Greenwich & Bexley Community Hospice – financial interest 2. Chair of Share Community - a voluntary sector provider operating in SE/SW London with spot purchasing arrangements with LB Lambeth – non-financial professional interest		
Andrew Hardman	Chief Commercial Officer, Bromley Healthcare	Nothing to declare.		
Stephen Kitchman	Director of Services for Children and Young People, London Borough of Bexley Council	Nothing to declare.		
Sarah Burchell	Director Adult Health Services, Bexley Care	Nothing to declare.		
Iain Dimond*	Chief Operating Officer, Oxleas NHS Foundation Trust	Nothing to declare.		
Dr Sushantra Bhadra	Clinical Director, North Bexley Primary Care Network (deputising for Dr Kailey)	1. GP Partner, Riverside Surgery – financial interest 2. Member of the Londonwide LMC – financial interest 3. Clinical Director, North Bexley PCN – financial interest		
Deborah Travers	Associate Director of Adult Social Care (deputising for Deputy Director of Adult Social Care)	Nothing to declare.		
Dr Sonia Khanna	Clinical Director, Frognal PCN (deputising for Dr Pandu Balaji)	1. GP Partner, Sidcup Medical Centre – financial interest 2. Practice is member of Bexley Health Neighbourhood Care – financial interest 3. Joint Clinical Director, Frognal PCN – financial interest 4. Husband, Dr Sid Deshmukh, is Frognal PCN chair, BHNC Director, Clinical lead – Urgent Care, Senior Partner at Sidcup Medical Centre, shareholder of Frogmed Ltd (dormant company) and Chair of Bexley Wellbeing Partnership – indirect interest 5. CYP and Families Clinical Lead – Bexley – non-financial professional interest		

		6. Father, Mr Vinod Khanna, is Chief Executive Officer of Inspire Community Trust – non-financial personal interest. 7. Member of Bexley LMC – non-financial professional interest. 8. GP Appraiser for south east London – non-financial personal interest.		
Dr Adefolake Davies	Clinical Director – Clocktower Primary Care Network	1. Clinical Director, Clocktower PCN – Financial Interest 2. Shareholder, Bexley Health Neighbourhood Care – Financial Interest 3. Shareholder, Bexley Health LTD – Financial Interest 4. GP Principal, Dr Davies and Partner – Financial Interest		
Ellie Thomas	Associate Director, Planning and Partnerships, Dartford & Gravesham NHS Trust	Nothing to declare.		
Spencer Prosser	Chief Finance Officer, Lewisham and Greenwich NHS Trust	###		

***voting member.**

members who have not made the annual declaration for 2024/25 will be requested to make a verbal declaration within the meeting.

Agenda Item: 3
Enclosure: B

Bexley Wellbeing Partnership, Meeting in public

Minutes of the meeting held on Thursday, 27th March 2025, 14:00 hrs to 16:00 hrs

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

(and via Microsoft Teams)

Voting Members

Name	Title and organisation
1. Jennifer Bostock (JB)	Vice Chair & Independent Member
2. Dr Nicole Klynman (NK)	Director of Public Health, London Borough of Bexley
3. Iain Dimond (ID)	Chief Operating Officer, Oxleas NHS Foundation Trust
4. Jim Beale (JB)	Deputy Director of Adult Social Care & Health, London Borough of Bexley (LBB)
5. Diana Braithwaite (DB)	Place Executive Lead (Bexley), NHS South East London Integrated Care Board (NHS SEL ICB)
6. Raj Matharu (RM)	Chief Officer, Local Pharmaceutical Committee

In attendance

Keith Wood (KW)	Lay Member for Primary Care (Bexley), NHS SEL ICB
Jattinder Rai (JR)	Chief Executive Officer (CEO), Bexley Voluntary Service Council
Abi Mogridge (AM)	Chief Executive Officer (CEO), Bexley Health Neighbourhood Care CIC (GP Federation)
Steven Burgess (StB)	Policy and Strategy Officer, London Borough of Bexley
Miran Patel (MP)	APL Primary Care Network
Spencer Prosser (SB)	Chief Financial Officer, Lewisham & Greenwich NHS Trust
Andrew Hardman (AH)	Chief Commercial Officer, Bromley Healthcare
Graham Tanner	Associate Director, Primary & Community Care (Bexley), NHS SEL ICB)
Kallie Heyburn (KH)	Bexley Wellbeing Partnership Programme Director, NHS SEL ICB)
Sarah Birch (SaB)	Head of Community Based Care, (Bexley) NHS SEL ICB
Aysha Awan (AA)	Head of Communications and Engagement, (Bexley) NHS SEL ICB
Rianna Palanisamy (RP) *(Presenter)*	Partnership Business Manager (Bexley) NHS SEL ICB
Carol Yates (CY)	Children and Young People's Programme Manager
Charlotte Flewers (CF)	Bexley Maternity Voices Partnership
Emma Seaton (ES)	Mind in Bexley
Kavita Trevena (KT)	The Unlikely Mummy
Nazima Bashir (NB) (via MS Teams) (Minutes)	Corporate Business Manager, (Bexley) NHS SEL ICB

Apologies

- Dr Sid Deshmukh, Chair, Bexley Wellbeing Partnership Committee, NHS SEL ICB (Bexley)
- Yolanda Dennehy, Director of Adult Social Care, London Borough of Bexley (LBB)
- Dr Clive Anggiansah, Clinical and Care Professional Lead – Community Based Care
- Alison Rogers (AR), Director of Integrated Commissioning (Bexley), NHS SEL ICB/LBB
- Stephen Kitchman, Director of Children's Services
- Dr Surjit Kailey, North Bexley Primary Care Network
- Dr Mehal Patel, APL Primary Care Network
- Sarah Burchell, Service Director Adult Community Physical Health Services, Oxleas NHS Foundation Trust
- Dr Adefolake Davies, Clocktower Primary Care Network

- Kate Heaps, Chief Executive Officer, Greenwich & Bexley Community Hospice

		Actioned by
1-2	**Welcome, apologies and declarations of interest** The Vice Chair, Jennifer Bostock (JB) opened the meeting and welcomed all present. Apologies noted above and the meeting was declared as being quorate. There were no new declarations of interest other than those recorded on the register of interests.	**JB**
3.	**Draft minutes of the public meeting held on 23rd January 2025** Bexley Wellbeing Partnership agreed that the draft minutes of the public meeting held on 23rd January 2025 were a true and accurate record of that meeting and approved them on that basis **Matters Arising** No additional matters were raised.	**JB**
4.	**Refreshed Integrated Forward Integrated Plan 2025/26** **Kallie Heyburn, Bexley Wellbeing Partnership Programme Director, NHS South East London Integrated Care Board** talked the group through the overview of the refreshed 2025/26 Integrated Joint Forward Plan. **The Bexley Wellbeing Partnership Committee:** (i) **Agreed** the refreshed 2025/26 Integrated Joint Forward Plan.	**KH**
5.	**South East London Integrated Care System: Neighbourhoods & Integrated Neighbourhood Teams Framework** **Diana Braithwaite, Place Executive Lead (Bexley), NHS South East London Integrated Care Board** presented the SEL Neighbourhoods & Integrated Neighbourhood Teams Framework, highlighting its relevance to long-term conditions (LTC), frailty, and the involvement of community pharmacies. She noted that the framework had already been presented to and endorsed by the NHS SEL ICB Board, and that each SEL borough will adopt and take forward the implementation locally. DB emphasised that community pharmacies play a vital role in the model and committed to taking the discussion around their involvement back to the boroughs. DB reinforced that the framework is not just about structural change but about how systems collaborate to deliver truly integrated care, including links with Adult Social Care and work being led by Oxleas NHS Foundation Trust through Bexley Care. The Chair, JB raised a question about co-production, specifically what it entails and how decisions can avoid being made without genuine resident input. In response, DB explained co-production as a process of involving residents in service design and delivery and provided example:: • A recent Bexley workshop on the LTC model with residents who have lived experience.	**DB**

	• The use of 500+ community champions across the boroughs, some focusing on areas like cancer awareness and screening education. • The development of a vision and strategy to guide how these champions are supported and included. JB welcomed the response, praising the approach. Following this, the Chair invited for the group to share any further comments or questions. With no objections raised, the decision to endorse the framework was confirmed, and the next step is its formal approval and implementation at the borough level. Raj Matharu (RM) requested further clarity on the role of community pharmacies in the framework. DB assured RM that the role of community pharmacies is a key consideration and reiterated the importance of including conversations around medication optimisation and prescribing, supported by the Head of Optimisation and local clinical teams. **The Bexley Wellbeing Partnership Committee:** (i) **Endorsed** the local health and care system's approach to neighbourhoods. (ii) **Approved** the South East London Integrated Care System Neighbourhoods & Integrated Neighbourhood Teams Framework Noted with one objection from Raj Matharu.	
6.	**SEL Integrated Care System: Voluntary, Community & Social Enterprise Charter** **Diana Braithwaite, Place Executive Lead (Bexley), NHS South East London Integrated Care Board** opened the item by talking the group through the SEL Integrated Care System (ICS) Voluntary, Community & Social Enterprise (VCSE) Charter, with support from Jim Beale (JB) and Jattinder Rai (JR). She explained that the Charter sets out how the system works with and supports the VCSE sector, and that while it has taken some time to reach Bexley, it has already been adopted at the SEL ICS level. DB emphasised the importance of endorsing the Charter to show full support for the voluntary sector in Bexley. However, she also acknowledged the current financial pressures across the system and made clear that this Charter does not imply any new or additional financial commitments. JB echoed DB's comments, reinforcing how Bexley's collaborative way of working with the voluntary sector helps deliver strong outcomes for residents. JR raised a concern about the messaging, pointing out that financial constraints were being mentioned alongside the voluntary sector and asked how the two are connected. JB responded by clarifying that the Council works with the voluntary sector through both commissioned services and voluntary contributions. JR added that while the sector is called "voluntary," it includes social enterprises and commissioned organisations with staff and responsibilities, particularly in Bexley, where 8 organisations are commissioned for adult social care delivery. JB then commented on the importance of using clear, accessible language when referring to the voluntary sector in public communications, as terms	**DB**

	may not be easily understood especially where there are colloquial understandings – e.g. the word 'voluntary' implies that no money is involved. JR agreed this was a fair point. Iain Dimond (ID) supported the Charter but asked whether Bexley was adopting something new or if it reflected existing work. JR explained that the Charter aligns closely with the Bexley Compact, which has recently been refreshed but has largely remained consistent since 2016. Therefore, adopting the Charter would not represent a significant change for Bexley. Raj Matharu raised a concern about procurement processes, especially regarding competitive tendering and the impact on smaller organisations. He asked whether there were governance mechanisms to ensure fairness. JB acknowledged the point and said he would look into the details. DB added that there are established mechanisms under the Provider Selection Regime, depending on the services being commissioned or decommissioned. JB asked if the committee could now approve the Charter. No objections were raised, and the Charter was endorsed. **The Bexley Wellbeing Partnership Committee:** (i) **Approved** the adoption of the SEL VSCE Charter in Bexley. (ii) **Noted** the London Borough of Bexley response to the Charter.	
7.	**Better Care Fund 2025/26 Plan** **Stephen Burgess (StB), Policy and Strategy Officer for London Borough of Bexley,** presented the Draft Bexley Better Care Fund (BCF) Plan for 2025/26. Alongside his presentation, he outlined the next steps for final approval and sign-off. JB asked for clarification on what was meant by "metrics", especially for the benefit of the public. StB explained these are measurable system-wide targets (e.g. emergency hospital admissions) that are tracked and monitored throughout the year. JB challenged the use of the term "recognise" when StB discussed data discrepancies, suggesting it was not accurate to describe it as 'not recognised' but rather 'disagreed with'. The importance of using meaningful language was reiterated for both the committee, staff and the public. StB accepted the point and clarified that they disagree with some of the pre-populated metrics in the BCF template, as they do not match local performance dashboards. He emphasised that their local plan is based on data validated by ICB and council performance colleagues. JB asked whether the term "uplift" referred to an increase in funding, and where that funding would come from given the financial constraints that are currently being faced. StB confirmed that it refers to a modest increase in NHS funding as part of mandatory Better Care Fund requirements, acknowledging that it aims to maintain adult social care capacity. However, he noted that: • The uplift does not keep pace with inflation or rising system costs.	**StB**

	• The BCF narrative includes a case for the insufficiency of current funding, especially in relation to discharge support. JB followed up to ask if it's more likely there will be cuts. StB agreed this is a valid interpretation, noting that while nominal funding may rise, it does not offset the increasing demand and inflationary pressures. He reaffirmed their commitment to transparency in highlighting these challenges within the plan. JB appreciated the detailed responses and acknowledged the public's awareness of national challenges. She stressed that this plan reflects the local team's commitment and ambition, even if external circumstances may limit what can be achieved. **The Bexley Wellbeing Partnership Committee:** (i) **Commented** on the Draft Bexley BCF Plan for 2025-26 (Appendices A-C) (ii) **Authorised** the Place Executive Lead (Bexley) on behalf of NHS South East London ICB to review and agree the BCF Plan for 2025-26 with the Director of Adult Social Care and Health (London Borough of Bexley) so that these documents can be recommended for further approval and sign-off.	
8.	**Tackling Health Inequalities: Progress Report** **Sarah Birch (SaB), Head of Community Based Care, (Bexley) NHS SEL ICB**, delivered an update on the progress of place-based health inequality projects entering their second year of delivery. Originally funded by £536K delegated to the 3 Local Care Networks and £100K to Public Health for borough wide initiatives, projects were informed by Public Health data and extensive community engagement to ensure alignment with lived experiences. **Key Project Updates:** **North Bexley** • Cancer Awareness Project: Focused on low breast cancer screening uptake and limited awareness of prostate cancer. Major emphasis on training community champions to deliver culturally sensitive awareness and to scale impact through "super champions" with lived experience. • Slade Green Community Support: Supporting Howbury Friends to resource a bottom-up, resident led approach, particularly around mental health and cost-of-living support. Collaborative efforts include partners like Mind and Oxleas NHS FT. **Clocktower** • Priorities around children and young people's mental health, with two projects: ○ Counselling Matters: 12-week one-to-one counselling forming part of the social prescribing offer.	**SaB**

	○ Blackfen Community Library: Youth-focused social projects to build resilience and confidence, showing early positive outcomes in reducing social anxiety. **Frognal** • Continued success of Functional Fitness MOTs, helping older, often isolated adults maintain independence and reduce fall risk. Focus on deprived areas like North Cray and links with sheltered housing. **Public Health (Borough-wide)** • Pilots addressing the mental-physical health connection are underway and being evaluated. • Ongoing focus on activating community spaces for wellbeing. **Digital Inclusion and AI Concerns** • Digital exclusion was addressed through a Digital Champions project, embedding support across 14 voluntary organisations and GP practices. Over 100 patients supported in the last year. JB raised concerns about AI in healthcare potentially introducing new inequalities (e.g., gender bias in hospital discharge tools). SaB and DB acknowledged the issue and committed to keeping it on the radar. ID raised concerns around clearly defining the inequalities being addressed and ensuring projects align with funding purposes. SaB and DB clarified that while some outcomes (like reduced hospital admissions) are long-term, the focus remains on addressing both overt and less visible inequalities. Dr Nicole Klynman (NK) reinforced the importance of prevention, even in tight financial climates, and the need to consider inequality beyond deprivation (e.g., geographic, age-based, or digital). The Chair invited for the group to share any further comments or questions. **The Bexley Wellbeing Partnership Committee:** (i) **Noted** the update report on the progress being made with the delivery of the health inequalities projects.	
9.	**Local Care Partnership Supplementary Performance Report** **The Bexley Wellbeing Partnership:** (i) **Reviewed** the report and the mitigations/actions highlighted in Appendix 1 for each of the metrics RAG rated as red based on the latest reporting period.	**GT**
10.	***Public Questions*** No public questions were received online.	
11.	**Let's Talk - Parenthood** Charlotte, Emma, and Kavita each play pivotal roles in supporting perinatal and postnatal mental health in Bexley. Carol emphasised the importance of focusing on the first 1,000 days of a child's life and highlighted the efforts in	

	Bexley to broaden perinatal and mental health services, with the Bexley Maternity Voices Partnership (MVP) helping improve maternity care through local engagement. Charlotte, as co-chair of the MVP, shared her work in gathering feedback from families to enhance maternity services, despite challenges like the lack of a local maternity unit, and her efforts to connect families with essential support networks. Emma spoke about the *Mindful Mums* programme, offering peer support and resilience building tools for new mums, with a focus on preventing mental health issues during the perinatal period. Lastly, Kavita, founder of The Unlikely Mummy, shared her personal journey of overcoming mental health struggles and creating a non-profit to offer holistic support to mums, including counselling and wellness services. She emphasised the need for better awareness and resources for mums, particularly in underserved communities, and works closely with healthcare providers to advocate for improved care. The Vice Chair, JB, expressed her appreciation for the powerful and inspiring stories shared, saying it was a wonderful way to end the meetings. She thanked everyone for attending and acknowledged the organisation of the speakers.	
12.	**Any other business** There was no further business and the Chair closed the meeting.	**JB**
13.	**Better Care Funding 2024/25 Q3 Return** **The Bexley Wellbeing Partnership Committee:** **Noted** the Better Care Funding 2024/25 Q3 Return.	
14.	**Month 11 Finance Report** **The Bexley Wellbeing Partnership Committee:** **Noted** the Month 11 Finance Report.	
15.	**Risk Register** **The Bexley Wellbeing Partnership Committee:** **Noted** the Risk Register.	
16.	**Glossary** These glossary terms were noted.	
17.	**Date of the next meeting** Thursday 22nd May 2025, Welling United Football Club Park View Road, Welling DA16 1SY	**JB**

Bexley Wellbeing Partnership Committee

Thursday 22nd May 2025

Item: 4

Enclosure: C

Title:	**Bexley Community Champions Vision and Strategy**
Author/Lead:	Aysha Awan, Head of Communications, NHS South East London Integrated Care Board, supported by PPL
Executive Sponsor:	Diana Braithwaite, Place Executive Lead (Bexley), NHS South East London Integrated Care Board Yolanda Dennehy, Director of Adult Social Care & Health, London Borough of Bexley

Purpose of paper:	The purpose of this report is to inform the Bexley Wellbeing Partnership committee of the Community Champions Vision and Strategy, following the initial launch of the Community Champions programme in 2020 by the London Borough Bexley. The report details the growth and development of the programme since 2020, when it was established to help residents access health and wellbeing as well as practical support during the pandemic. Recommendations have been made to develop the programme further for the benefit of residents.	**Update / Information**	
		Discussion	
		Decision	***X***
Summary of main points:	Since 2020, the Community Champions programme in Bexley has been **instrumental in reaching diverse groups, especially those who are seldom heard.** By filling gaps in **communication, promoting community cohesion, and strengthening public health responses**, the champions have helped to enhance the effectiveness of local health initiatives. To ensure long term sustainability and impact, we have have worked with partners across the system, Champions and local residents to develop a vision and strategy for Champions, which formalises their structure and support and, for organisations, clarifies the Champions offer and any key expectations around working with them. The Vision and Strategy aims to: • Create a roadmap to **ensure that Community Champions remain a sustainable and impactful part** of the local health and care landscape. • **Reconcile** different perspectives to achieve a **shared buy-in** for the Champions model in Bexley, by taking on board the views of Community Champions and the organisations that benefit from their support. • Determine resident priorities and empower communities to thrive, using data and insights to further shape the Community Champion programme for the benefit of residents.		

	The vision and strategy for the Bexley Community Champion programme has been shaped through three key approaches: **direct engagement with community champions, collaboration with organisations and teams across Bexley, and a review of best practices.**	
Potential Conflicts of Interest	There are no conflicts of interest as a consequence of this report.	
Other Engagement	Equality Impact	Overall, the initiative is anticipated to have a positive impact on equality. The programme is designed to bridge the gap between communities and organisations by ensuring that local voices, particularly those of seldom-heard groups, actively influence decision-making. The approach promotes inclusivity and aims to improve the quality of life for all residents, by fostering responsive, community-led services. The Community Champion programme is open to all Bexley residents aged 18 and over, regardless of other protected characteristics. While this means **individuals under 18 are not included**, the impact is considered neutral for this group. The strategy further recommends exploring the development of Young Peoples' Community Champion programme, which would extend benefits to younger residents in the future. The development of the vision and strategy involved proactive and inclusive stakeholder engagement, using multiple channels and scheduling sessions at varied times to remove participation barriers. This inclusive engagement approach is recommended to continue throughout the programme to ensure ongoing representation and equitable input. Monitoring equality impact is essential for the ongoing success of the programme and will be evaluated as part of the quarterly programme boards.
	Financial Impact	Funding has been provided by the Bexley Wellbeing Partnership on a non-recurrent basis.
	Public Engagement	Community Champions have played a central role in shaping the strategy through various engagement methods, including: • Participation in Champion Events: These gatherings provided insight into what matters most to champions and their areas of interest. • Champion Survey Analysis: Reviewing survey results offered a deeper understanding of champion demographics, their motivations, future ambitions, and suggestions for programme enhancements. There was the opportunity for

		support to complete the survey should this be required. • Five one-on-one Interviews with champions: These sessions helped develop case studies showcasing successful initiatives and identify any challenges faced by champions. Interviews were offered at different times of the day and in-person or virtual. • Five Focus Groups: Conducted both online and in person, at different times of the day, these discussions tested the emerging vision and strategy, ensuring alignment with the champions' perspectives and aspirations.
	Other Committee Discussion/ Engagement	Bexley local health and care system have been actively involved throughout the process, both in shaping the vision and strategy and in refining the draft document following extensive engagement. Engagement forums have included: • London Borough of Bexley Extended Leadership Team • London Borough of Bexley Leader Briefings • NHS SEL ICB Bexley Senior Management Team Meetings • Bexley Wellbeing Partnership Executive Leadership Team • NHS SEL ICB Bexley Primary Care Transformation Group
Recommendation:	The Bexley Wellbeing Partnership Committee is asked to endorse the Community Champions Vision & Strategy.	

Bexley Community Champions

Vision & Strategy

May 2025

South East London Integrated Care System

LONDON BOROUGH OF BEXLEY

Oxleas NHS

Bexley Wellbeing Partnership

Bexley Community Champions

Introduction

Since 2020, the Community Champions programme in Bexley has been **instrumental in reaching diverse groups, especially those who are seldom heard.** By filling gaps in **communication, promoting community cohesion, and strengthening public health responses**, the champions have helped to enhance the effectiveness of local health initiatives.

Community Champions serve as trusted intermediaries, helping to connect health and care services with local residents who may otherwise be difficult to reach. **To ensure long term sustainability and impact, we have worked with partners across the system, Champions and local residents to develop a vision and strategy for Champions**, which formalises their structure and support and, for organisations, clarifies the Champions offer and any key expectations around working with them.

Building Bridges Between Services and Communities

The unique value of Community Champions lies in the **trust and connections** they have within their communities.

They act as a **vital link between health and care services** and the people they serve.

By acting as **trusted voices**, they helped to disseminate critical information, provide support, and strengthen community resilience during times of crisis.

Bexley's Long-Term Vision and Strategy

A roadmap to **ensure that Community Champions remain a sustainable and impactful part** of the local health and care landscape.

Rooted in the views of Community Champions and the organisations which work with them, the vision and strategy **reconcile** different perspectives to achieve **shared buy-in** for the Champions model in Bexley.

Through aligning our **community power** with resident priorities and population health data insights, the vision and strategy maximise positive impact for Bexley.

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Methodology

The vision and strategy for the Bexley Community Champion programme has been shaped through three key approaches: **direct engagement with community champions, collaboration with organisations and teams across Bexley, and a review of best practices,** including national guidelines and innovative efforts from across the country.

Community Champion Engagement

Community champions have played a central role in shaping the strategy through various engagement methods, including:

- **Participation in champion events** to gather insight into what matters most to champions and their interests
- **Survey analysis** to understand champion demographics, motivations, future ambitions, and suggestions
- **One-on-One interviews** to develop case studies and identify any challenges to the role
- **Focus groups** online and in person to gather feedback on early iterations of the vision and strategy

Desk Based Review

The best practice review incorporated **insights from 22 papers, including government reports and academic papers** and an **analysis of similar initiatives across the country**.

Engagement with Organisations

As part of the strategy development, we **engaged with various individuals, teams, and committee**s to explore and refine key aspects of the program, including:

- **Identifying future opportunities** where champions can make the greatest impact
- **Defining champion roles and** clarifying the responsibilities of champions
- **Celebrating and promoting champion activities to highlight** champion contributions and raise awareness.
- **Enhancing recruitment and onboarding processes**
- **Strengthening success metrics with a** more robust framework to evaluate the program's impact.
- **Testing the Vision and Strategy – to** ensure the emerging framework aligns with the needs and expectations of all stakeholders.

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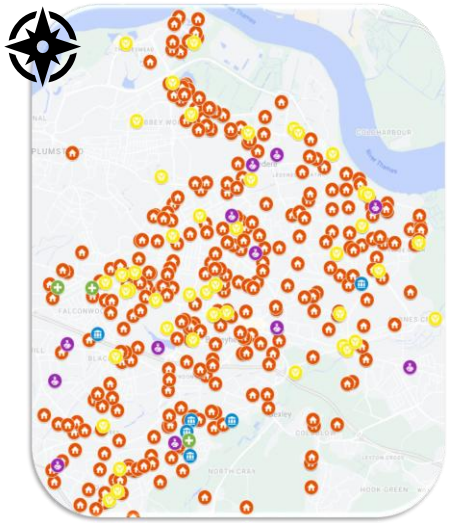
Community Champions in Bexley now

Bexley already has an established Champions programme, managed through the Bexley Volunteer Service Council, with around 500 Champions currently registered across the borough.

Registered Champions



34% based in the North of Bexley

32% based in Clocktower

27% based in Frognal

- There are **around 500** Champions registered with the BVSC.
- 7% of Bexley's Community Champions are based outside of the borough
- While there are community champions across the borough, a large proportion of champions are based in the **Clocktower area**.

Past and ongoing projects

- **Shaping outreach services:** Champions helped with designing a bus for COVID information, suggested sites, and delivered flyers to build awareness. Subsequently, Champion feedback prompted a change of towards more general **health and wellbeing info.**
- **Shaping health services:** Champions have been involved in co-production and engagement around the recent **urgent care service recommissioning** and the ongoing **Erith Hospital service redesign.**
- **Supporting with Partnership branding and events:** Champions gave advice on the redesign of the BWP logo and online presence, and submitted videos for the Bexley 2050 launch.
- **General Engagement:** Champions have helped us engage with the public on numerous occasions, such as the Thamesmead Festival, Lark in The Park, South Asian Heritage Month, and Black History Month**.**

Existing support/ infrastructure

BVSC Bexley Voluntary Service Council

- There is **Volunteer Coordinator for Community Champions role**, funded by the Partnership
- Champions sign-up through an online form on the Bexley Council website
- Champions receive a **weekly email newsletter** advertising in-person and online opportunities available to them
- There are **Champions Facebook pages/ Whatsapp groups**

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Case Studies: An Overview

Champions were invited to share stories about their experiences in a format of their choice. The below summarises the key themes which emerged, and some of the stand-out details shared.

When residents have **'spare time and energy'** Community Champions is a perfect opportunity

30 volunteering opportunities were shared across the case studies received

These were across **17** organisations **in** Bexley

*I found myself in discussions with medical professionals and treated as an equal – **I know my views were appreciated***

The role can evolve over time as new opportunities emerge

The time needed can be anything from **weekly to one-off**

Being a Champion gives people both **direct and indirect** opportunities to help others

Champions often sign-up or hear about the role online via **Facebook or Whatsapp groups**

Challenges of the role can include...

Managing volunteering **time commitments**, especially if you are employed

Having the right **information to hand**, to sign-post people

Understanding how best to **reach all of Bexley**, to help everyone be heard

Champions often start in the role **spreading key health and wellbeing information**

Champions bring a wide range of unique **perspectives, backgrounds and experiences** to the role

*The **first step to volunteering** is always the hardest to take*

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Vision Statement

Pulling together the best practice review and engagement activities, a vision statement has been developed that should be recognised and reflected at an individual, community, organisation and system level.

To create **a dynamic, interconnected community** in Bexley where local champions amplify voices and bridge the gap between organisations and residents.

Through fostering two-way communication, we aim for data-driven, **community-informed priorities** that empower residents and guide organisations to adapt in response to the true needs of the community.

By harnessing the power of community voices and **addressing the broader factors of health and wellbeing**, we strive to build a more inclusive, responsive environment that supports overall well-being and equitable opportunities for all.

- Implement **clear metrics** to track impact and progress.
- Regularly **review feedback** from champions, organizations, and residents.
- **Share evaluation results** transparently with all stakeholders to celebrate achievements and identify improvement areas.

- **Two-Way Communication:** Facilitate open conversations between the community and organisations, ensuring that local voices are heard and considered in decision-making.
- **Feed into Organisational Priorities:** Provide valuable insights from the community to help shape and align organisational priorities with the needs and interests of local residents.
- **Support Quality of Lide :** Actively contribute to addressing the broader determinants of quality of life by supporting initiatives that promote positive community health outcomes.

- **Celebrate champions**' contributions through events, awards, and public recognition.
- **Share success stories** with the community to build trust and inspire participation.

- **Criteria:** Recruit champions who are passionate, community-focused, and represent diverse groups. At a minimum, they should take on an information sharing role.
- **Onboarding:** Provide clear role descriptions, training, and expectations for champions and organisations.
- **Inclusivity:** Ensure representation from underrepresented and those who are seldom heard through reaching out to local neighbourhoods or existing community groups.

- **Establish networks** for champions to share ideas, challenges and solutions
- Organisations should **provide regular check-ins and ongoing support** for community champions, ensuring they have the necessary resources, guidance, and tools to carry out their work effectively.
- **Champion coordinators and community voice managers need adequate support**, such as financial resources, event space, and training opportunities, to effectively manage and empower the champions.

- Offer **opportunities to gain new skills**, such as leadership, communication, and safeguarding.
- **Use existing training programmes** within Bexley and tailor them to champions as required
- Conduct regular workshops and events tailored to champion needs.
- **Provide certifications or incentives** to acknowledge skill development and participation.

- **Champions act as connectors between their community and local organisations to provide two way conversations**
- Responsibilities may include promoting health initiatives, sharing information, supporting residents in accessing services or involvement in specific projects
- Clearly **outline what champions can and cannot do** to manage expectations.

Roles & Responsibilities: Fields of Contribution

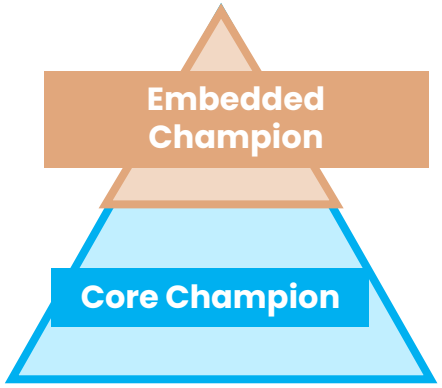
Since the pandemic, the fields of contribution a community champion participates in have expanded to cover the broader factors of that shape quality of life.

Fields of contribution:

Health & Social Care	Promoting access to healthcare services, supporting social care initiatives, and improving overall community wellbeing.
Parks, Leisure & Libraries	Encouraging community use of parks, recreational facilities, and libraries to foster engagement, relaxation, and learning.
Community Safety & Environment	Creating a safe, clean, and sustainable environment through initiatives that reduce crime and improve public spaces.
Parking & Transport	Supporting projects that improve transportation options, parking solutions, and access to local areas..
Housing	Advocating for better housing opportunities, maintenance, and support for residents in need of accommodation.
Education	Promoting lifelong learning, school engagement, and access to resources that enhance personal development.
Business & Employment	Assisting local businesses, encouraging entrepreneurship, and supporting employment and skill-building opportunities.
Rubbish & Recycling	Promoting responsible waste management, recycling initiatives, and community clean-up efforts.

Roles & Responsibilities: Types of roles

At the two tiers of community champion involvement, there are different types of roles they may take on. There are also roles that are clearly not expected or appropriate for community champion to do.



Example of roles:
- Attending focus groups
- Distributing community aid, and leaflets
- Support hosting community events
- Mentoring new champions

Example of roles:
- Sharing information via whatsapp, leaflets or word of mouth
- Gathering feedback on initiatives
- Promoting the community champion programme
- Attending community champion feedback events

What a champion is NOT

- **Top-Down Decision-Makers**: They are not simply individuals with authority who impose decisions from above; instead, they represent and amplify the voices and needs of the community.
- **Solo Leaders**: They do not work in isolation but instead collaborate with other community members, stakeholders, and organisations
- **Overnight Experts**: They are not expected to have all the answers or be experts in every issue but are passionate advocates
- **Exclusive Representatives**: They are not meant to represent only one group or interest but should be inclusive and representative of diverse perspectives within the community
- **Delivering Projects**: Community champions are not responsible for directly delivering projects, but instead focus on gathering insights, feedback, and community input to support the development and success of those projects.

Safeguarding Considerations

Expectations of Community Champions:
- **Safeguarding Awareness**: Community champions are expected to remain vigilant and aware of safeguarding concerns within the community. Any signs of harm, abuse, or neglect should be reported immediately.
- **Confidentiality**: While maintaining confidentiality is important, safeguarding concerns take priority. If a situation arises that involves potential harm, community champions must act to ensure the safety of individuals, even if it means breaching confidentiality.
- **Appropriate Boundaries**: Community champions should maintain professional and appropriate boundaries, particularly when engaging with vulnerable individuals or groups.

Expectations of the Partnership:
- **Training and Support**: The partnership will provide basic safeguarding training and ongoing support to ensure community champions understand how to identify and respond to safeguarding concerns.
- **Clear Reporting Procedures**: Community champions will be provided with clear guidelines on how to report safeguarding issues and will have access to necessary resources for support.
- **Protection and Guidance**: In the event of a safeguarding issue, the partnership will ensure community champions receive support and guidance, taking appropriate actions to protect those at risk.

Commissioning organisation

Previously, there have been no firm commissioning arrangements for Community Champions in Bexley. However, for a longer-term strategy and vision for Community Champions, there are multiple organisations which could lead on their commissioning, or there could be a joint commissioning function in place.

Organisation	Benefits	Drawbacks
Bexley Wellbeing Partnership	• Brings together all partners across the Bexley system, promoting integration and collaboration across health, social care, and other sectors. • Provides a platform for joint decision-making and resource-sharing to address local priorities.	• Risk of being perceived as overly focused on health-related initiatives, potentially sidelining other sectors such as housing or education. • May require additional effort to highlight cross-sectoral goals.
South East London ICB	• Ensures a standardised approach across all SEL boroughs, creating consistency in service delivery and reducing duplication of efforts. • Can leverage its health system expertise to improve public health outcomes.	• Standardisation might overlook place-specific or neighbourhood-level needs, leading to less effective local interventions. • Predominantly focused on health, which may limit broader community impact or multi-sectoral collaboration.
Bexley Council	• Covers a wide range of services and sectors, including health, safety, education, and housing, enabling a holistic approach to community needs. • Strong understanding of local governance and community-specific challenges.	• May not act as effectively as an integrator compared to the Bexley Wellbeing Partnership. • Risk of fragmented delivery if collaboration with health and other sectors is not prioritised.
Joint commissioning	• Ensures that all priorities from across different organisations are considered, enabling a balanced approach to champion activities. • Encourages alignment and shared objectives among stakeholders.	• The large number of stakeholders may create coordination challenges, especially if the community champion coordinator reports to multiple organisations. • Could slow decision-making due to differing organisational priorities.

Commissioning Recommendations

Joint commissioning is recommended by the Bexley Wellbeing Partnership and the Council due to strong foundations in collaboration, multi-sectoral integration, and potential for addressing local needs comprehensively. This approach offers the most robust framework for aligning efforts across health, social care, and other key services whilst balancing the priorities of both parties.

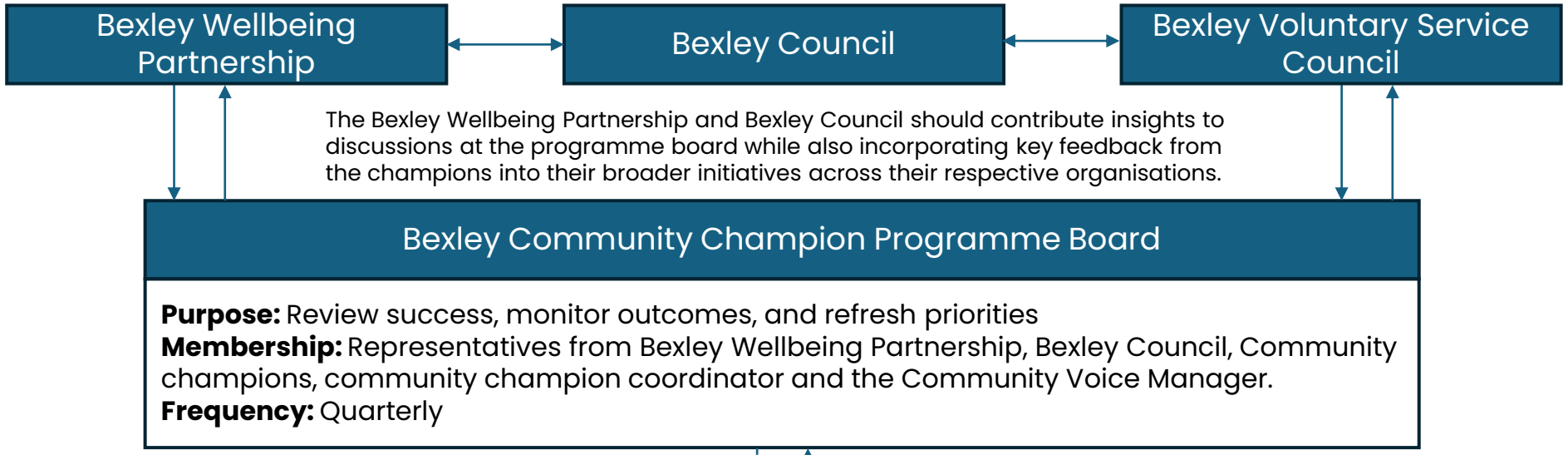
Financial Costs Breakdown:

Area	Description	Current One-off Costs (per year)	Current Recurrent Costs (per year)	Recommended Recurrent Budget (per year)
Staff costs	Community Champion Coordinator Salary	N/A	£39,000	£39,000
	Expenses	£1,000	£1,000	£2,000
Events	Recognition events and champion networking events	No agreed budget		£5,000
Floating budget	Flexible financial support to address emerging needs, fund activities and ad hoc training opportunities, and enhance the impact	No agreed budget		£8,000
	TOTAL	£1,000	£40,000	**£54,000**

There are no recommended one-off costs for the future.

Governance for Community Champions

Programme governance for the Community Champions is a critical component of ensuring accountability and trust for both the organisations and individuals involved. It should also serve to empower the Champions by including their representation on the programme board and actively incorporating broader feedback from the group at every stage of the process.



Local residents should be feeding in their priorities and hearing back about what actions are being taken.

Regular events and conversations should be happening between these different groups to ensure champions are given appropriate opportunities that benefit Bexley services and ultimately residents.

Bexley Wellbeing Partnership

Bexley Community Champions

What does the year look like?

A typical year for the community champion coordinator with support from the community voice manager, may look like this..

Ensuring there are a **sustainable number of champions** through promoting the programme and holding onboarding sessions.

Prioritising programme of work based on champion interests, and priorities of the council and wellbeing Partnership.

Planning and holding a **recognition event** alongside other Bexley organisations

Writing an **impact report**

Identifying programmes of work for community champions and **reviewing request forms from organisations** for champion support.

Encouraging champions to sign-up to various opportunities at events, through social media and other mechanisms.

Monitoring success of the programme through collating qualitative and quantitative feedback from different projects

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Recommendations Summary (1/2)

Through engagement with diverse stakeholders and a review of national best practices, a series of recommendations has been crafted to shape the future of the Bexley Community Champion Programme.

BEXLEY COMMUNITY CHAMPION FRAMEWORK RECOMMENDATIONS

Roles & Responsibilities:

- All champions should adopt the role of "core champion," which includes sharing information as a minimum.
- Champions can take on additional roles as "embedded champions" by participating in specific projects or focus groups, depending on their interests and availability.
- The Community Voice Manager and Champion Coordinator should play a vital role in recruiting new champions, retaining their engagement, and managing their transition when they exit the programme.

Recruitment & Onboarding:

- Champions should complete a detailed application form for monitoring and evaluation, capturing geographical location, demographics, and areas of interest.
- Introduce basic screening, such as agreeing to a Champion Charter, with optional DBS checks as a maximum requirement (noting costs and potential deterrence).
- Level 1 Safeguarding training should be mandatory, with free courses available.
- Champions must attend an onboarding session to clarify roles and manage expectations before receiving the "community champion" title.

Training & Development

- Free training opportunities should be promoted to champions to support their skills and development.
- The community champion coordinator should identify and address skills gaps through ad hoc training events that benefits wide groups of champions.

Collaboration & Support:

- Organisations seeking champion support should complete a request form, outlining the purpose, expected benefits, and planned support for champions. This allows the coordinator to assign appropriate champions and prioritise efforts.

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Recommendations Summary (2/2)

BEXLEY COMMUNITY CHAMPION FRAMEWORK RECOMMENDATIONS *(cont.)*

Recognition & Celebration:
- Hold an annual celebration event, ideally linked with broader efforts like the BVSE awards, to enhance visibility and recognition.
- Host regular events to foster connection, share success stories, and promote the program.
- Use social media, websites, and the Bexley Council magazine to keep champions, residents, and organizations informed and engaged with program updates.
- Publish an annual impact report featuring both qualitative and quantitative metrics to showcase the program's outcomes.

Monitoring & Evaluation:
- There should be a robust method for monitoring and evaluation including both qualitative and quantitative metrics.

OTHER RECOMMENDATIONS

Programme Scope:
- Expand the champion program beyond health and wellbeing to address broader factors and determinants of health.
- Implement a Community Champions Program for young people (over 18 years) provide benefits to individuals, organizations, and the community.These would have a similar role to current Champions with a focus on those areas which are most important to Young People, supported by additional staff and with recognition which is appropriate to areas which are important to young people (e.g. evidence of skills developed / work experience).

Commissioning:
- The program should be jointly commissioned by the Bexley Wellbeing Partnership and the Council to align resources and efforts.

Governance and Feedback:
- Establish a Bexley Community Champion Board meeting quarterly to share insights from neighbourhood-level conversations and organizational priorities.
- Regularly review and co-design program priorities with champions to ensure alignment with community needs.

South East London Integrated Care System · London Borough of Bexley · Oxleas NHS · Bexley Wellbeing Partnership · Bexley Community Champions

Bexley Wellbeing Partnership Committee

Thursday 22nd May 2025

Item: 5

Enclosure: D

Title:	**SEL Ageing Well Framework**
Author/Lead:	Kallie Heyburn, Bexley Wellbeing Partnership Programme Director, NHS South East London Integrated Care Board Alison Rogers, Director of Integrated Commissioning (Bexley), NHS South East London Integrated Care Board / London Borough of Bexley
Executive Sponsor:	Diana Braithwaite, 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 SEL Ageing Well Framework.	**Update / Information**	
		Discussion	
		Decision	***X***
Summary of main points:	The Ageing Well Framework was developed between January and March 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 Ageing Well Framework describes a shift to earlier identification, prevention and holistic, age-friendly community-based support leading to increased self-help, prolonged independence and quality of life. The scope is wider than 'health' and includes societal factors such as housing, transport and the need to destigmatise ageing, so people feel heard, respected and valued. The document enables boroughs to assess themselves against the framework to develop and or enhance local plans, leading to a more consistent approach to Neighbourhood Health Services across SEL that reflects best practices, whilst recognising local difference. Bexley has already commenced work in relation to designing a borough wide end-to-end integrated model of care for frailty based on the needs of the local population. The actions taken to date align with the proposed next steps outlined in the framework, and current planned actions will ensure a systematic approach is adopted to support successful implementation.		
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. An equality impact assessment will be completed as part of the Bexley end to end integrated model for frailty.
	Financial Impact	The framework aims to reduce downstream demand via earlier identification, prevention and via a strengths-based approach that increases self-help.
	Public Engagement	Around 100 residents took part in four face to face workshops across South East London and further residents participated in a wide range of meetings and face to face sessions.
	Other Committee Discussion/ Engagement	Two progress updates and the emerging draft framework were presented to the NHS SEL ICB Neighbourhood Based Care Board and more recently the Bexley Community Based Care Board endorsed the framework on 30th April 2025.
Recommendation:	The Bexley Wellbeing Partnership Committee is recommended to endorse the SEL Ageing Well Framework and to note the alignment with Bexley's approach to developing an integrated model of care for frailty.	

South East London Integrated Care System

NHS South East London

SEL Ageing Well Framework

'Age without limits: you say, your way'

Final Draft Report
April 2025

Programme supported by:

HEALTH INTEGRATION PARTNERS

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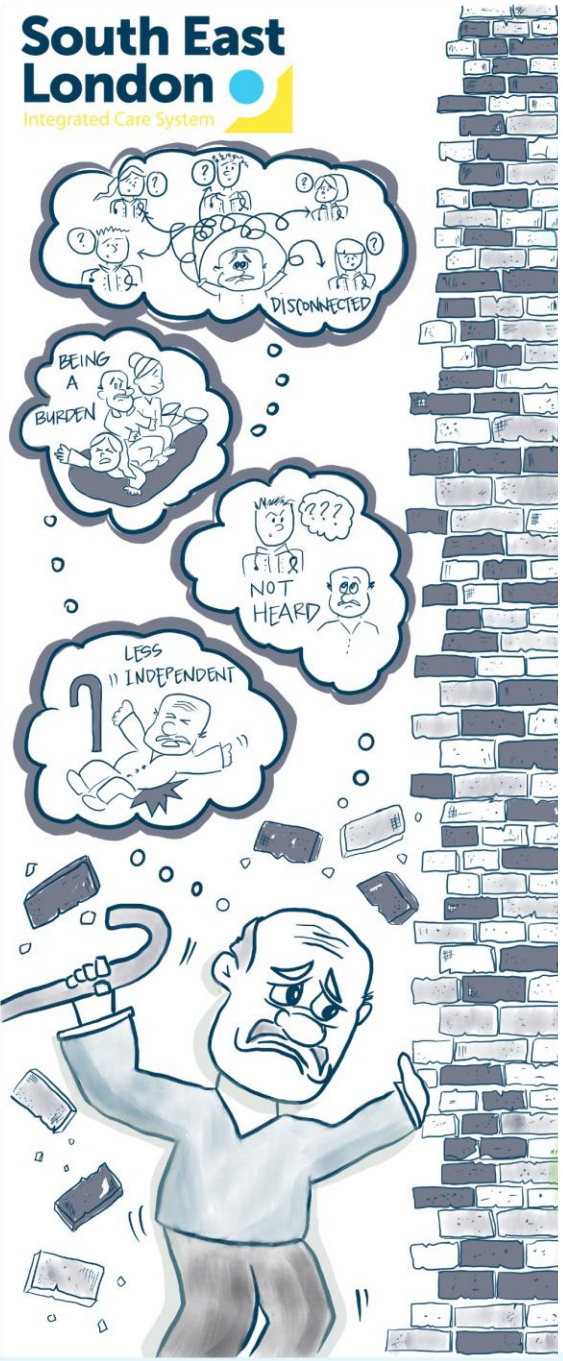


Executive summary

Introduction

- The SEL Ageing Well framework was developed between January and March 2025 driven by multiple stakeholders at Place and involving colleagues from across the whole SEL system. The framework builds on the good work already underway at Place, enabling Places to incorporate it as part of their local development. The framework will help us to share success between Places, develop parity and a consistent offer for SEL, recognising the need for local variation.
- Over 170 SEL colleagues and stakeholders have been involved in multiple working sessions to develop a shared vision and ambition for the framework with over 70 colleagues taking part in 3 face to face workshops to define the detail.
- The focus of the framework is initially on those aged 65+ including those at all stages of the frailty continuum (mild, moderate and severe). However, it is recognised that many of the elements included apply to younger cohorts showing earlier signs of ageing or frailty. The framework is not just health focused. It encompasses the wider factors and determinants pertinent to ageing well such as destigmatising ageing, building age friendly communities, the role of the carer and tackling social isolation. Definitions of ageing well and frailty were shaped as part of the work to achieve a focus on what would be important.
- The Ageing Well framework is aligned with and enabled by other emerging SEL strategies for example, Integrated neighbourhood Teams, Long Term Conditions and Urgent Community Response; recognising the interplay between these. The framework also aligns with key national directives such as the 2025/26 NHS Operating Guidance, 2025/26 Neighbourhood Health Guidelines and Lord Darzi's investigation in 2024.

Executive summary .. *continued*

Why we want to promote ageing well

- There are compelling reasons for promoting ageing well in SEL. More than 61% of non-elective beds are utilised by those age 65+ (equivalent to 1594 beds at a cost of over £250m in 2023/4).
- At least 12% of these admissions (154 per day) are due to ambulatory care sensitive conditions and therefore could be avoided with more effective management in the community.
- 50% of frail patients also stay in hospital for over 21 days, adding to the severity (and consequences) of hospital acquired disability.
- For those aged 65 and above admission costs and associated A&E attendance rates are higher in SEL compared to national benchmarks
- By 2028 the SEL over 65 population is expected to grow by 18%, adding to the above pressures. There is therefore a need to shift the focus to earlier identification and prevention – whilst equally supporting those at the other end of the frailty scale.
- The voices of residents also strongly point to the need for change. Over 100 residents were spoken to as part of the work. Their views, along with those captured from existing engagement work have helped inform priorities within the framework. For example, residents highlighted the need to feel more respected, trusted, listened to and believed.
- Residents need more help with the practicalities of life but want to remain independent and resilient despite vulnerabilities. They want purpose and connection and to be seen as 'whole' beings, equal to younger people. They also want to see more joined-up services that intervene with each other on their behalf.
- Unpaid carers want more flexible support and respite opportunities to help them to continue in their roles.
- A graphic has been produced that distills the views and aspirations of residents and is included in this report.

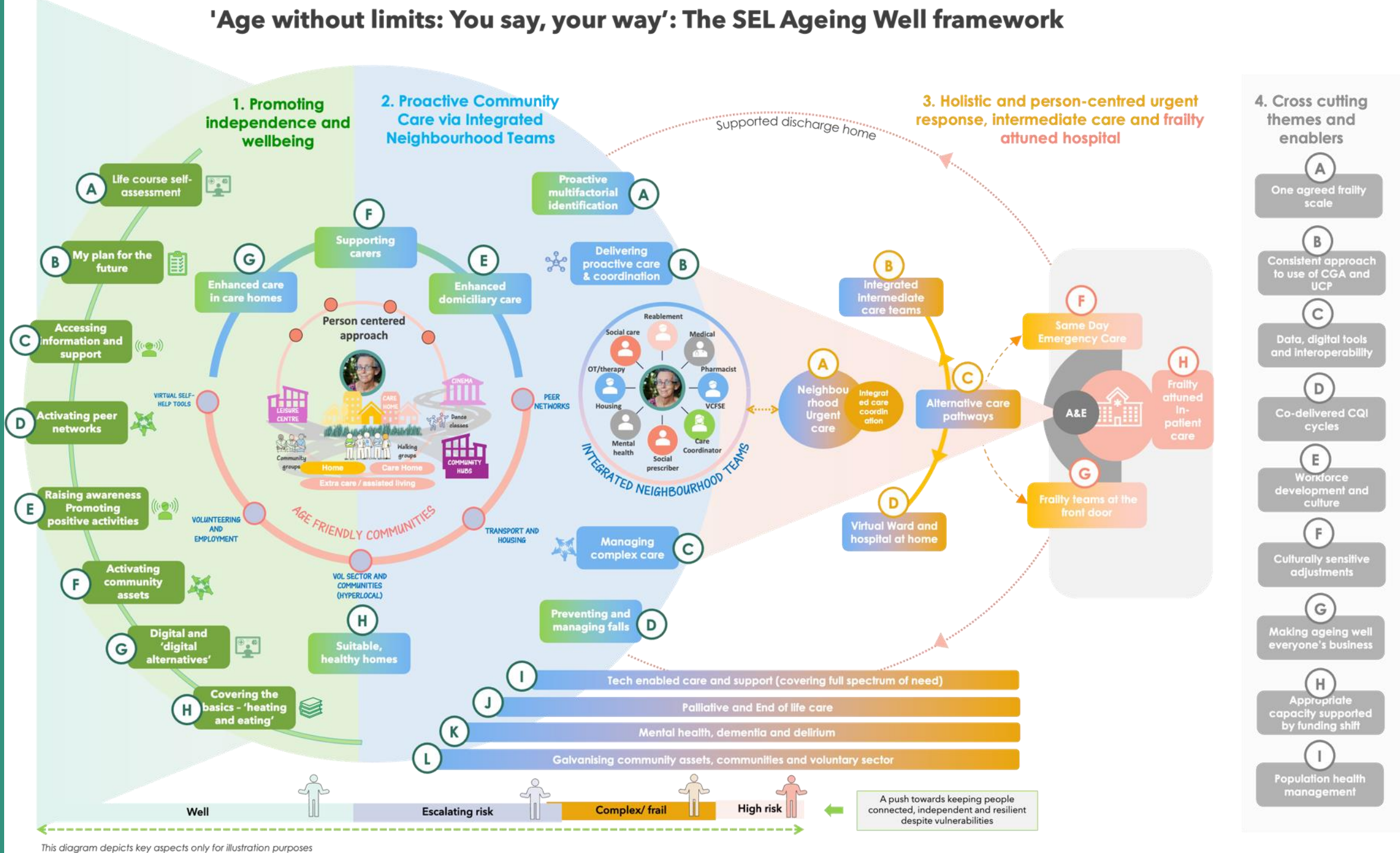
Executive summary .. *continued*

'Age without limits: You say, your way': The Ageing Well framework

- The framework comprises three interconnected zones, enabling people to move easily between zones based on where they are in their journey. The underlying principles and values relevant to all zones are also captured, such as the need for seamless navigation, a focus on active and engaged living and effective self-help.
- Zones are:
  - **Zone 1: Promoting independence and Wellbeing** – Supporting people to age well, maintain independence and social participation
  - **Zone 2: Proactive Community Care via Integrated Neighbourhood Teams** – Early identification of frailty and well-coordinated community-based care/response to exacerbation
  - **Zone 3: Holistic and person-centred Urgent Response, Intermediate Care and Frailty Attuned Hospital** – Neighbourhood based urgent response, step up/step down intermediate care, hospital front door and inpatient care
- Key principles and requirements for the care and support of people living with mental health problems, dementia and/or delirium are also captured for each zone. Palliative and end of life care and support needs are also summarised.
- A single overarching diagram that captures all the key elements of the framework per zone is provided. Each of these elements is then described in a zone summary, followed by more detailed description of each of the elements. These descriptions of each element include the factors and principles considered most important to SEL colleagues and reference some example initiatives already underway in SEL where good outcomes are being achieved.
- A range of enablers have been identified as critical to the development of the framework and a brief description of each is included. Key enablers include moving towards one agreed frailty score, a consistent approach to the use of tools such as Comprehensive Geriatric Assessment (CGA) and the Universal Care Plan (UCP), Workforce Development and Culture and Population Health Management (PHM).

The SEL Ageing Well Framework

'Age without limits: You say, your way': The SEL Ageing Well framework



This diagram depicts key aspects only for illustration purposes

Executive summary .. *continued*

How will we know we are making a difference?

- Outcomes that can be used to monitor and evaluate the success of the framework have been defined in areas such as quality of life, the effectiveness of support provided and whether we are reducing health inequalities for this population. Following review these outcomes have been further refined and prioritised. Potential key performance indicators for each outcome are suggested and an example system-level dashboard is outlined.

How will we implement the framework?

- Key success principles for implementing the framework are described, based on learning from elsewhere. The key to success during delivery is to emphasise a focus on people – for example, creating meaning, engaging and taking people on the journey, developing the right skills and motivations and providing strong leadership that inspires and establishes clear accountability.
- An overview implementation road map is provided summarising the key next steps at Place and SEL levels to deliver and embed the framework. As part of this it is proposed that Places assess themselves against the framework to help identify opportunities and priorities for delivery. These can then feed into (existing) local roadmaps for delivery.
- It is recommended that these roadmaps include definition of the ideal local care model and plans for local leadership, resources and project and change management methods. In parallel, demand and capacity modelling can take place to understand the impacts and shape the ‘left shift’ in resources required to invest in delivery. Implementation is likely to be phased and will need to be supported by a robust project delivery team and clarity on what support will be provided to Places.
- A QI methodology will be required that enables real-time learning and improvement and sharing of success between Places.

Executive summary .. *continued*

Next steps

Continued work is now required to support Places to adopt it as part of local design, planning and delivery. This includes:

- Broadening the engagement and socialisation of the model with stakeholders
- Individual Place led self-assessment against the framework, assess gap / opportunity for development
- Creation of Place roadmaps for implementation.

Appendices

- A set of appendices are provided which include a record of key outputs from workshops that have helped in shaping the framework and a summary of external cases studies and recognised best practices from elsewhere.

The picture on the right depicts the vision as defined during the resident and carer engagement sessions. Illustration done by an artist.

South East London Integrated Care System

NHS South East London

2. Introduction

HEALTH INTEGRATION PARTNERS

The work to deliver the SEL Ageing Well framework will require continued stakeholder engagement and understanding, enabling Places to utilise it as part of local design, planning and delivery

This report reflects the work that took place between January and March 2025, involving a wide range of stakeholders across SEL in developing the SEL Ageing Well framework. Continued work is required to refine the framework and support Places to adopt it as part of local design, planning and delivery. A great deal of work is already underway at Place to support residents with ageing well. This framework builds upon that work. It is not a mandated framework, but rather a capture of the most important elements and principles expressed by SEL colleagues alongside recognised best practices. It will hopefully enable achievement of local aims at an accelerated pace, sharing of 'what good looks like' between Places and greater parity of provision as part of a unified approach – recognising the need for local variation.

The framework will:

- Help **ensure parity** in the offer we provide to people
- Enable us to **maximise** our collective resources
- Enable us to **share best practice** and the good work already underway at a local level
- Provide a more s**treamlined experience** for people and staff.

Benefits of a shared SEL frailty framework:

- **Consistent approach**: e.g., assessment and care planning tools acknowledged by all partners
- **Collaboration and workforce:** real integration in place-based systems, with an upskilled, flexible workforce
- **People and processes:** Improved consistency of care, and increased focus on prevention and early identification of frailty
- **Measuring impact:** measuring consistent outcomes across the board and knowing what good looks like.

The development of the Ageing Well framework has been led and overseen by colleagues from across SEL

Colleagues from across the SEL system have participated in the development of the framework, including from the ICB, Local Authorities, Public Health, Primary Care, community-based care, VCFSE, acute care and mental health. Colleagues have taken part in **121's, extensive discussions, ongoing working sessions/forums and 3 key workshops each with around 50-70+ attendees** to help shape the recommendations. Four resident workshops were also held and several residents also joined in other forums and workshops:

121 sessions	**Place based meetings**	**3 Workshops**	**Meetings to align with INT/LTC developments**	**Resident and carer voice sessions**
Reference group meetings	**VCSE meetings**	**Housing and Social care meeting**	**4 deep dive meetings for core elements***	**Regular core Group meetings**

* care homes, domiciliary care, palliative and end of life care and mental health, dementia and delirium.

Engagement with multiple stakeholder groups from across the system to build the picture

A list of the names of key stakeholders who participated in this work can be found in the appendices.

The 3 face to face workshops were very well attended and represented all Places

The overall objective of the framework is to pull together our collective ambition for ageing well, building on the work already underway

A great deal of positive work on ageing well and frailty is under way at Place. The development of the framework is an opportunity to pull this together and build on it to define shared principles, key elements and best practices - towards providing consistent care that is equitable, safe and efficient. Objectives include:

- **Forming a co-developed vision with Place to generate local ownership**
- **Understanding current services, success stories and linking into other work at Place e.g. INTs, LTC, enhanced care in care homes**
- **Maximising the value of our collective learning and resources**
- **Encompassing wider factors and determinants e.g. housing, social isolation and building ageing attuned communities**
- **Inclusion of patient stories and involving residents in helping to shaping the framework**
- **Defining ageing well and frailty and addressing the needs of people across the frailty continuum**
- **Inclusion of the role of unpaid carers and family, acknowledging their important role**
- **Bringing together all partners across the system to improve service quality, optimise skills and manage pathways**

The work has taken place over three months, following a structured methodology

December	January	February	March	April
Mobilisation	**Establishing the baseline position and ambition**	**Developing the SEL Ageing Well framework**	**Testing and refinement of the framework**	**Finalising the framework**
• Confirm objectives, scope and outputs • Stakeholder mapping • Request for data and documents • Establishment of core design group • Initial comms, diarising and set up • Workshop dates to be confirmed • Project governance	Defining the 'as is' position and ambition at Place level via questionnaire template Data story board & patient stories Connecting with key stakeholders e.g., executives to create buy-in **Workshop 1** • Definitions of ageing well and frailty • Agree cohesive vision and ambition • Place level 'as is' positions	Place based focus group meetings –10 things Place's want from the framework Connect with resident groups to capture voice National & international best practice learnings **Workshop 2** • Defining the framework and key components • Presentation of the residents' voice	Sub-group meetings to define opportunities to generate ageing well services & communities 1:1's with wider system to fill in the gaps, refine & ratify outputs Governance forums e.g., Ageing Well groups/ UEC to broaden buy-in **Workshop 3** • Finalising the framework • Outcome measures • Developing a mantra • Defining next steps for implementation	• Development Roadmap including overall phasing and timeframes and at Place • Final 1:1 meetings as required • presentation at board meeting(s) • Final sign-off • Final
OUTPUTS 1. **Stakeholder map** 2. **Comms and diarised meetings** 3. **Agreed governance**	1. **Key opportunities around ageing well and frailty** 2. **Cohesive vision and ambition** 3. **Current work at Place** 4. **Definitions**	1. **Framework with unified language** 2. **Clear way forward for social construct elements** 3. **Residents' voice reflected in the framework**	1. **Final report including vision, SEL framework, outcomes, etc.** 2. **Roadmap leading into delivery**	1. **Finalised roadmap** 2. **Finalised report document complete and endorsed**

Definitions of ageing well and frailty were shaped early on to achieve consensus on the core drivers for the work and population in scope

- Around 70 colleagues and 100 residents were asked what 'ageing well' means to them and their views are reflected throughout
- It was agreed that mild, moderate and severe frailty are in scope and the priority focus in on people aged 65+
- However, it's recognised that frailty can occur much earlier (particularly in those prone to health inequalities e.g. lower socio-economic groups, significant mental health disorders) and therefore elements of the framework (such as early identification, prevention and positive ageing) increasingly apply to younger cohorts.

The appendices include a capture of what ageing well means to SEL colleagues and overall definitions for ageing well and frailty - drawn from these views and from recognised national bodies. Excerpts are as follows:

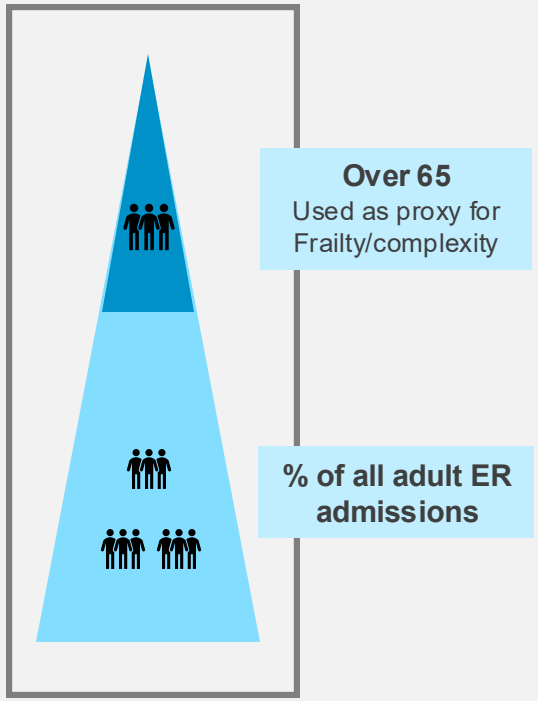
Ageing well *- The ability to maintain low risk of disease-related disability, high mental and physical function, and active engagement with life - including a positive attitude, sense of engagement, purpose and a desire to stay active and healthy in later life, including seeking help when needed and practicing self-care.*

Frailty *- a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves... a state of increased vulnerability resulting from aging-associated decline in reserve and function.*

Ageing well and frailty definitions

3.
Why we want to promote ageing well

Let us understand the scale posed by frailty across SEL: More than 61% of non elective beds are utilised by over 65 (over 65 used as a proxy in absence of frailty data)



Over 65
Used as proxy for Frailty/complexity

% of all adult ER admissions

	Number of admissions per day (2023/24) (Non elective only)	Number of beds utilised [1] (2023/24)	Total cost of admissions [2] (2023/24)
Over 65	154	1594	Over £250m
% of all adult ER admissions	39%	61%	54%

Length of stay of patients over 65 is longer largely due to higher complexity, social circumstances or process bottlenecks. Hence, the total bed days is disproportionately higher than total admissions

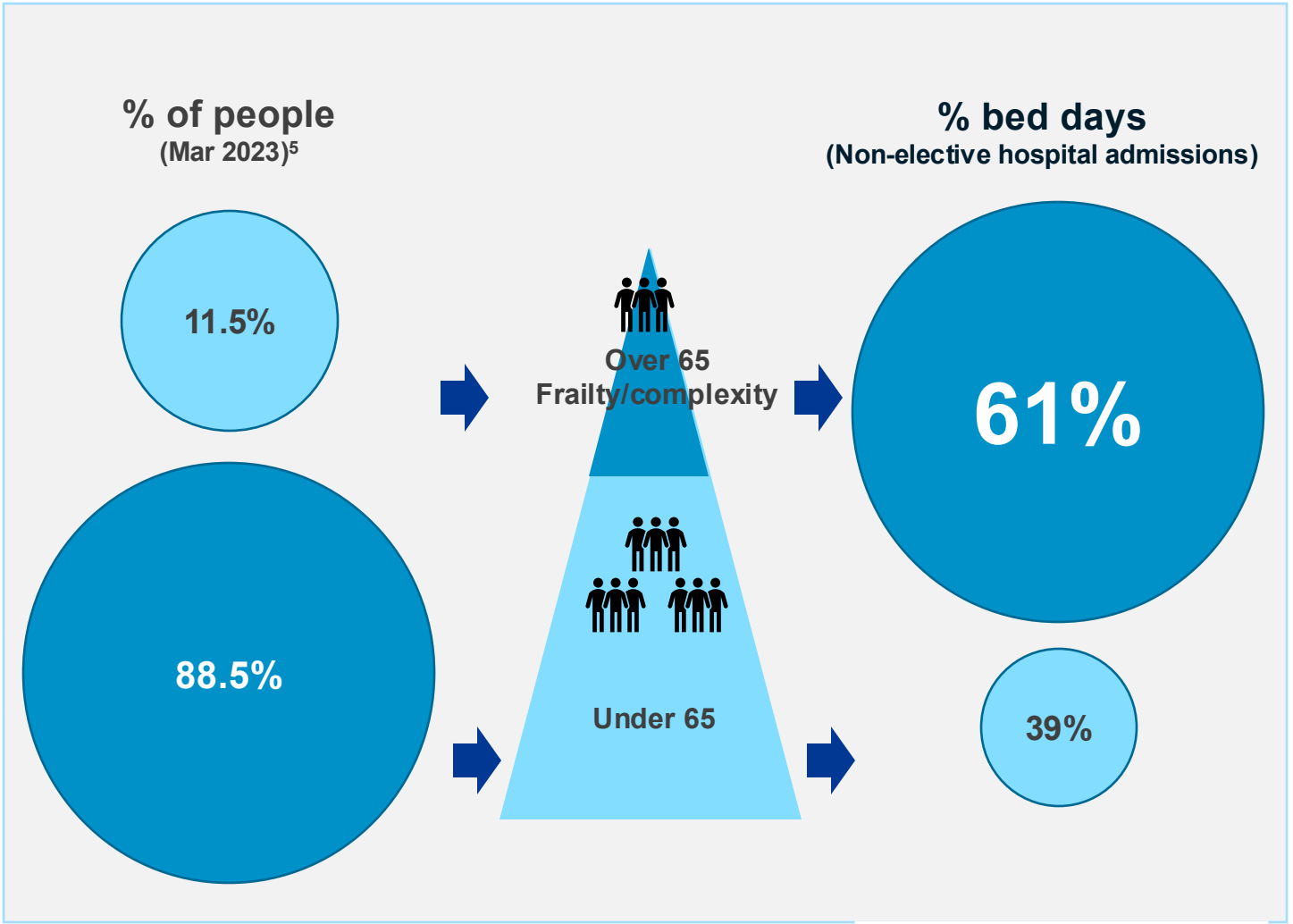
*Please note, data to be validated further
Data source: SUS aggregate download FY 2023/24
[1] Beds utilized calculation (bed-days / 365 and then adjusted for 95% occupancy – BOR)
[2] PBR cost used a proxy for total cost

With increased population growth and composition, the pressure and need for hospital beds will rise

Population growth

By 2028, the population aged 65 and over in SEL is projected to grow by 18%[3]

- **Bexley:** Population 244,247. Up to half of Bexley's population of over 65's are affected by frailty, rising to 65% in those over 90 years of age. There are estimated 23,500 people aged above 50 with frailty[4].
- **Bromley:** Population: second eldest population in London (17.7%), expected to grow to 67,000 over 65's by 2030[4].
- **Greenwich:** 289,100 residents within Greenwich. Number of residents aged over 65 has risen by 15.6% since 2011[4].
- **Lambeth:** 322,000 residents, 50% growth expected in the over 50s in the next 10 years[4].
- **Lewisham:** 200,600 population, 9.5% are aged 65 or over. Younger population, however, it is thought population growth won't be evenly spread across the ages, and there will be an increase in the older population[4].
- **Southwark:** 307,000 residents, comparatively younger population, population will continue to grow with over 17,000 additional people living in the borough by 2030[4].



*Please note, data to be validated further
[3] SEL ICS People strategy 2023/24- 2027/28
[4] South East London 2024/25 Joint Forward Plan
[5] Population and Person Insight data (PaPI)

There are a number of admissions that can be avoided through better proactive care in the community

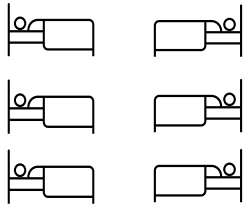
Number of admissions per day (Emergency only)

154

Ambulatory Care Sensitive Conditions (ACSC)

12%

1 ward in each Place



Falls	Sepsis	Pneumonia	UTI	COPD exacerbation
Congestive Heart Failure	Acute Renal failure	Cellulitis	Pneumonitis due to food and vomit	Fracture of neck of femur

Avoidable admissions

ACSC are conditions for which effective management and treatment within the community, should limit emergency admission to hospital.

A few examples include heart failure, COPD, influenza, pneumonia.

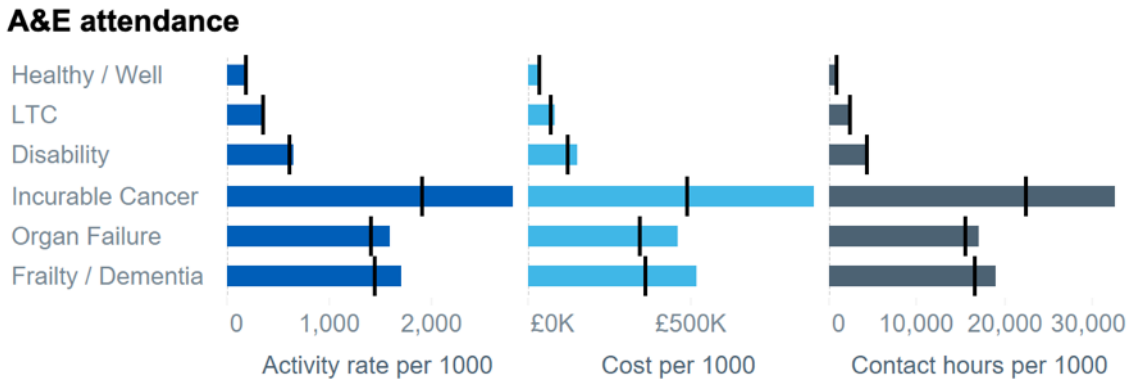
"In 2022/23, within 10 months, there were 1598 avoidable admissions to hospital relating to Ambulatory Care Sensitive Conditions, compared to 2205 in 2021/22. This suggested a 5% reduction target was on course to be met and exceeded.[5]"

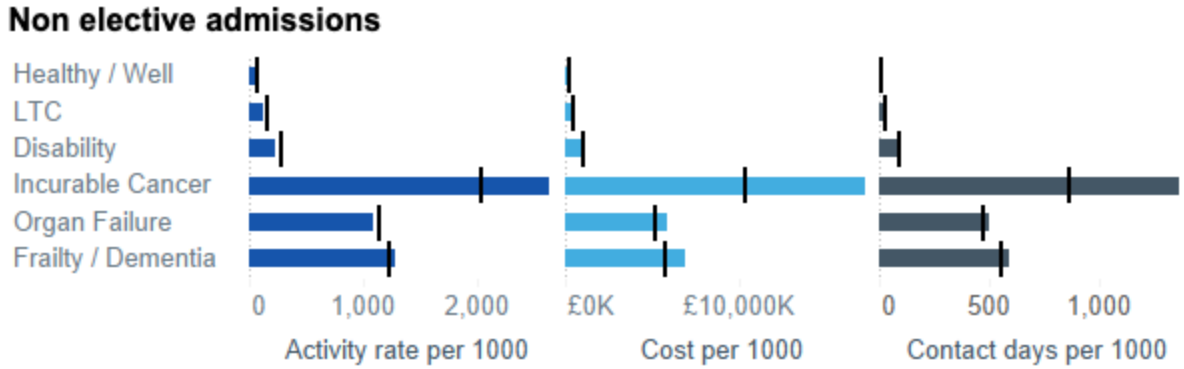
Utilisation of services for those that are frail/ dementia is substantial

For those aged 65 years and above, non-elective admission activity rates per 1000 are higher for SEL when benchmarked against national data[5]:

- SEL 245 per 1000
- England 238 per 1000

Non-elective admissions[5]: Cost per 1000 people in SEL is £1,223,000 which is £250,997 higher than the national benchmark





- For those with frailty/ dementia, in relation to A&E attendance, the activity rate, cost and contact hours are all above national benchmarks.
- The progression from LTC to frailty results in a substantial increase in activity and cost, hence prevention is critical.

We want to draw attention to hospital acquired disability (HAD)

50% of frailty patients stay in hospital for over 21 days[6]

The cumulative impact of extended or complicated hospitalisation among older patients typically results in patients experiencing a decrease in muscle mass and significant functional decline due to a complex process of physiological changes that can affect multiple systems

(Brown, Friedkin, & Inouye, 2004; Brown, Redden, Flood, & Allman, 2009; Chastin et al., 2019).

In a study of hospitalised community-dwelling older people at 6 months after discharge, 43% needed continuing help with medications, 24% were still unable to walk a quarter of a mile, and 45% were still unable to drive. The overall prevalence of HAD across studies has been estimated to be around 30%

National Institutes of Health (NIH)

Studies have observed that at least 30% of older patients hospitalised with an acute medical illness show a persistent decline in their ability to maintain Activities of Daily Living (ADLs)

(BMC Geriatrics)

So significant can the muscle loss be in bedridden seniors that while complete bed rest causes young adults to lose about 1% of muscle mass per day, the elderly may lose up to 5% per day

(Sarcopenia: Loss of Muscle Mass in Older Adults. Mary Ann E. Zagaria, 2010)

It has been estimated that 68 % of patients are discharged from post-acute medical settings below their pre-admission level of function.

(Gill, Gahbauer, Han, & Allore, 2009)

This means that post-hospitalisation, patients are not only recovering from their acute illness but also facing physiological stress and susceptibility to complications not directly related to the cause of their admission.

(English & Paddon-Jones, 2010; Hartley et al., 2019; Kortebein, 2009; Kosse, Dutmer, Dasenmbrock, Bauer, & Lamoth, 2013)

National Audit Office (NAO)

Today's analysis by the National Audit Office reveals that after spending ten days in hospital unnecessarily, a patient's health has deteriorated to such extent their life expectancy has been shortened by ten years - 18th March 2024

'It is often said that for every 10 days of bed rest in hospital, the equivalent of 10 years of muscle ageing occurs, in people over 80 years old- this may or may not be true to the word but certainly puts things in perspective'.
Dr Amit Arora, consultant geriatrician

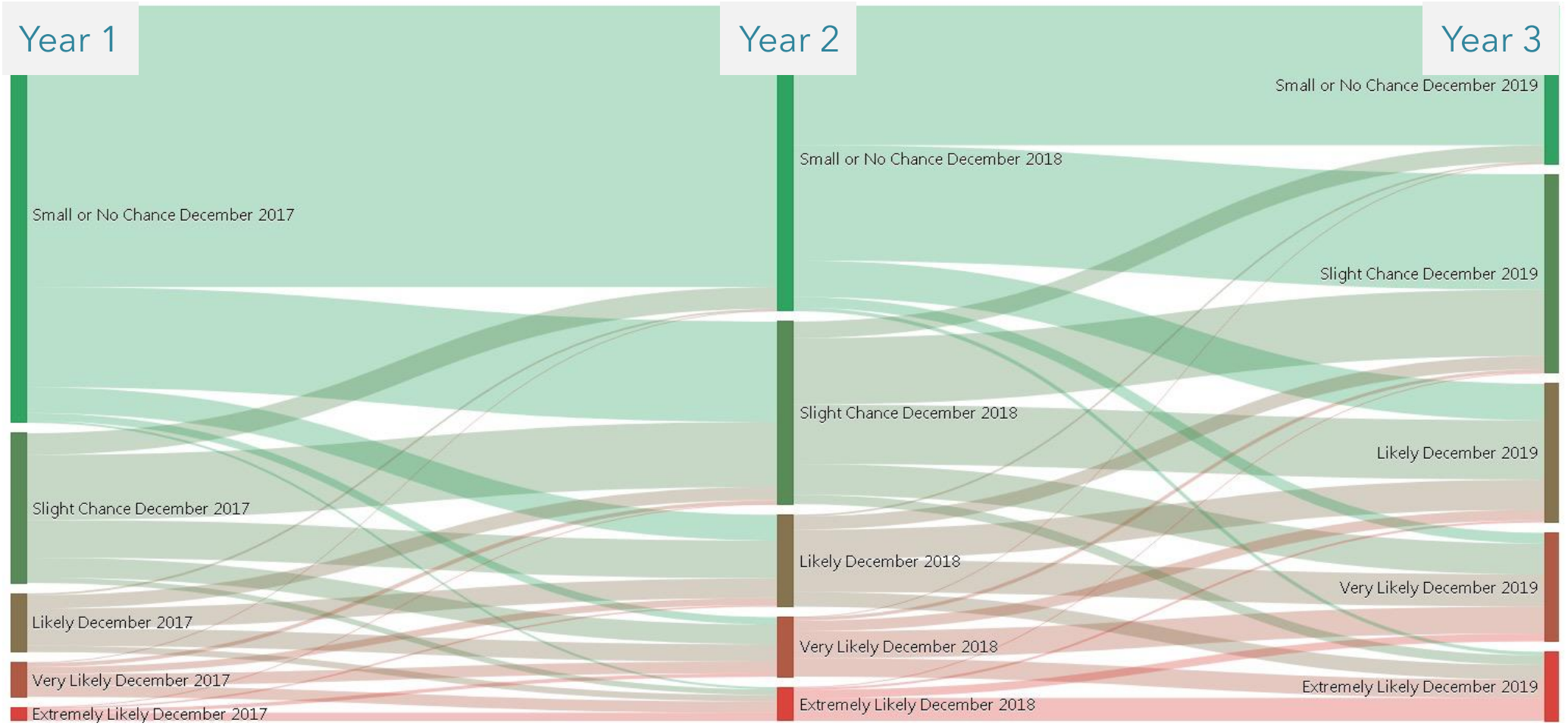
**Please note, data to be validated further. Data source: Frailty and multiple LTC SEL ICB presentation*

How risk/complexity changed over 3 years and why it is critical that we capture people at/before the point of rising risk (example taken from another ICS with pseudonymised data)

The chart shows how risks rose in people across a period of 3 years. Data is only for over 65 across one Place (2 boroughs).

It shows how those who had low risk (green) in Year 1, moved into higher risk segments (red) just within a period of 1 or 2 years.

Risk was measured using ACG algorithm from John Hopkins customised further to improve identification. Includes aspects such as frailty, LTC, H/O, Rx.



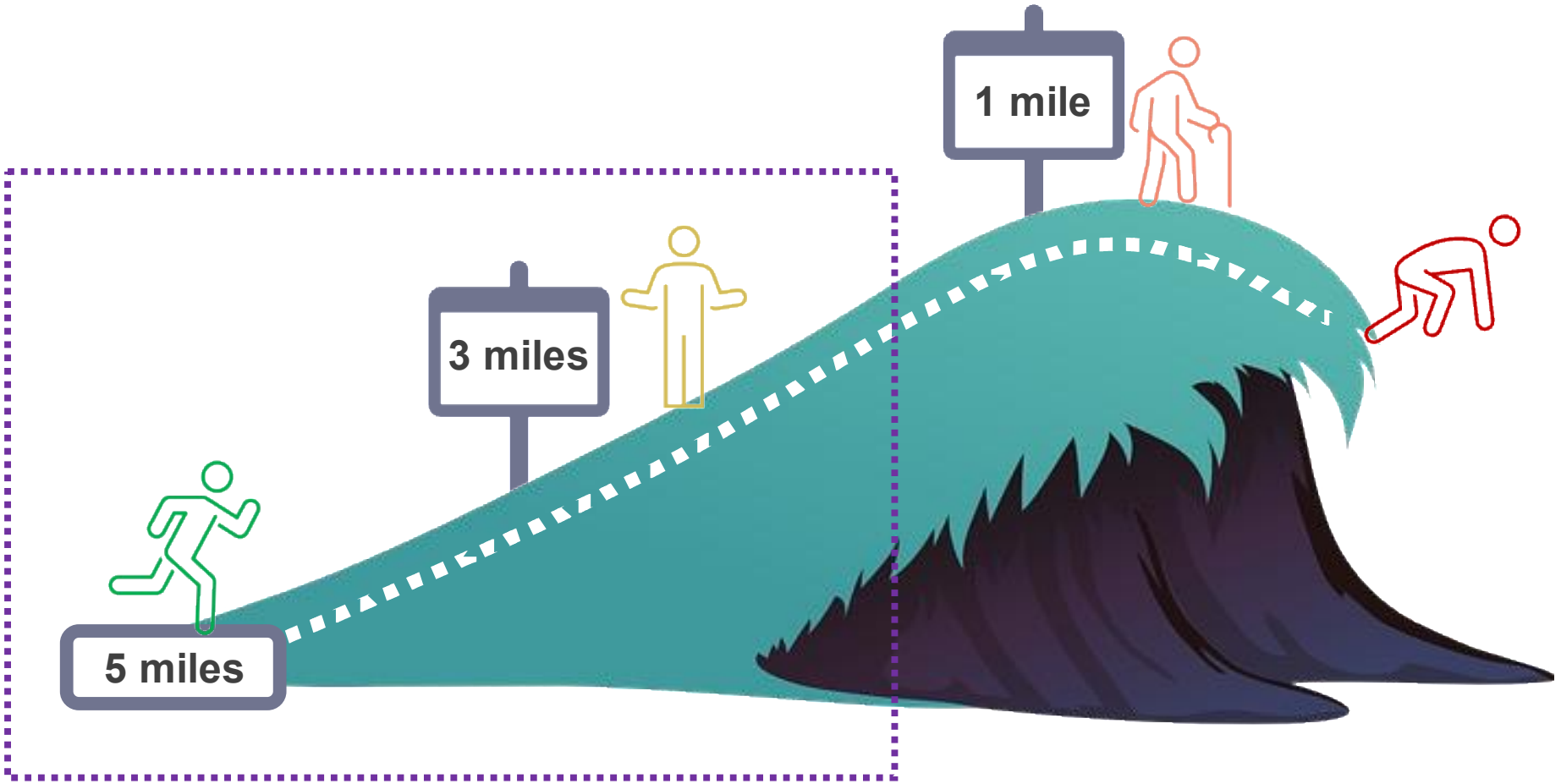
Year 1 profile of exactly the same population – two years ago

Year 2 profile of exactly the same population – one year ago

Year 3 profile of all over 65 who were admitted in hospital/attended A&E

There is a need to shift the focus towards early proactive prevention whilst equally supporting those at the other end of the scale

- Catching people at the '5-mile mark': there is a clear need to continue to shift focus towards early identification, proactive prevention and working with people holistically (health and social care).
- Equally, focusing on initiatives to support people when they are at the other end of the scale, looking at how we can proactively and reactively manage those living with frailty/ complexity.



The Ageing Well framework aligns with and helps meet the drivers and objectives of key national directives

Example national directives:		Examples of how the Ageing Well framework aligns
	British Geriatrics Society Blueprint for preventing managing frailty in older people (2023)	The framework delivers against the key BGS recommendations for the 'seven touchpoints' – from enabling independence and promoting wellbeing through to frailty-attuned hospital care
NHS	2025/26 NHS priorities and operational planning guidance	• Neighbourhood health services models to prevent admissions and improve access to care • Address inequalities and shift towards prevention
NHS England Neighbourhood Health Guidelines	Neighbourhood Health guidelines 2025/26	• Integrated working, reducing fragmentation, poor communication and siloed working. Increasing ability to self-care • Shifting focus from hospital to community and from treatment to prevention
	Fuller Stocktake Report 2022	• Providing more proactive, personalised care with support from a multi-disciplinary team • Helping people to stay well for longer and a focus on early identification and prevention • Streamlining access to care and advice
	Lord Darzi's independent investigation of the NHS in England (2024)	• Shifting spend from hospital to community • Listening and responding to the patient voice • Empowering patients • Multi-disciplinary teamwork and working.
	National Association of Primary Care: Creating Integrated Neighbourhood Teams. March 2025	• Engaging communities, citizens and patients • Start with staff and equip them to deal with the work • Simplify processes • Enlist hospital specialists

South East London Integrated Care System

NHS South East London

4.
What do our SEL residents and carers say?

Quotes captured from primary research and a range of SEL reports providing residents' feedback

HEALTH INTEGRATION PARTNERS

A range of parallel activities took place involving residents to ensure their voice is reflected in the framework

1. Distilling themes from SEL and Place - based engagement work done so far

SEL has done significant work around engagement across all age groups and communities in the past few years. It was important that we capture and distill key themes that needed to be incorporated in the framework.

2. Connecting with residents to understand what ageing well means for them

- Blackfriars Settlement
- Bexleyheath in Bexley
- Orpington in Bromley
- Southwark Carers

Connected with residents across SEL to understand what 'ageing well' means to them, their experience and expectations. The engagement is still ongoing and will convert into a graphic. The key themes will be woven into the framework and will influence our priorities for delivery

3. Attendance in co-design workshops

Representatives attended both workshops (1 and 2) to support the co-design of framework

4. Continued engagement at Place

While the framework is being established, there will be continued hyper local engagement at Place to ensure the model of care is defined locally in line with the needs of the local population

Residents highlight the need to destigmatise ageing. They want to feel like they count and are respected and trusted. They place importance on purpose, connection, resilience and independence

1. **Remaining resilient despite physical vulnerabilities. Preventing deconditioning: physical, functional and cognitive**
   Missing out on physical, social and cognitive activities decreases confidence, increases fear and intrinsic capacity to protect myself. Optimising social, physical, functional and cognitive avoids deconditioning.

2. **Hopes and dreams for ageing well**
   Wanting to do things for myself, getting support adds to ageing well, having a sense of purpose, being able to use my previous skills to help others and laughter ☺

3. **Help with how to set yourself up for success to age well**
   Trusted, professional information and advice. **Having peace of mind.**
   Not having to burden friends and family.

4. **Loneliness and participation**
   Need for true human connection and bond between friends and family and opportunities to be part of other groups

LAUGHTER is essential for ageing well, and to share in the laughter with others, and seeing others enables me to focus less on pain and ailments

"Dreams? I don't really have any because I'm just trying to stay alive. I want to be there for my grandkids, but some days I'm just counting the days, and I need to make the most of every day. If I could, I would love to travel and fly, but I can't because I'm immobile."

"For me, ageing well means being able to feel INDEPENDENT. And have the ability to take care of yourself."

"Pensioners aren't necessarily the frail and retiring types of popular imagination. I don't think many people my age (early 60s) will be interested in playing Bingo in our retirement."

"On the whole as people get older, they would prefer not to be seen as a 'category' but simply as themselves ... among all sorts of other humans ... being as active, intelligent, engaged, healthy, friendly and involved as possible. Many frailties and disadvantages and problems are shared across age groups"

Includes excerpts from SEL resident engagement papers e.g., Age Friendly engagement insights – SEL Ageing Well Strategy 2025

Resident voice … continued

5

Reduce fears and increase safety
Need for more police, level pavements fewer blocked pavements due to roadworks, fear of electric bikes as a hazard, easier access to public toilets, more disability toilets.

6

Joined up care, coordination and accurate navigation, seamless continuity and effective coordination
Accurate, consistent signposting and need for more connection / **communication between services** and settings. Ensuring seamless continuity of care and through co-ordination.

7

Primary Care
Need to see the same GP for continuity
Telephone and video calls not being as good as face to face.
Difficulties in getting an appointment, especially online triage.
Having to give their same medical history repeatedly, and not all doctors read it before their appointments

8

Housing
Ability to adapt or change housing to meet changing needs as you age

"There should be a database enabling older people to swap homes to get what they want"

"I was falling but told I couldn't join strength and balance classes because I needed to see a cardiologist. 6 months later I'm still waiting"

"I would like to get advice but it's too hard to navigate"

"Virtual GP appointments only work if I have a Carer with me, otherwise I don't feel seen or heard, I prefer face to face"

"I wanted to join the gym but couldn't get past the questions, form filling and documents required at reception"

"I would like to get advice but it's too hard to navigate"

"We're going to hand over our lives, probably to a white person or a South Asian person but there's no trust between us and those communities"

"When I phoned up on the day, the appointments have already gone. I can't tell you the last time I've actually seen my doctor face to face because I can't get an Appointment."

Resident voice … continued

9

Caring role

Access to more flexible, ad hoc support (including respite) instead of an 'all or nothing' arrangement.

Unpaid carers able to get a GP appointment quicker and at a time they need it. Pre-emptive planning for carer crisis – leading to peace of mind and the right action.

Advocacy and earlier respite for carers.

10

Respect and feeling heard

Considering the person's whole life not just seeing a health problem.

Feeling that you must lie and exaggerate to be seen.

Feeling judged and dismissed as a patient or carer.

"Someone to talk to mum about how to live better in her own home – keeping warm, paying bills, buying a hearing aid, checking for risk of financial abuse."

"Contacted NHS for an eye appointment, chased up for weeks without action....admin was not listening, when final action was taken, I was told that I should have come sooner, leaving me feeling that I can't win, when I tried everything in my power to be seen."

"I get exemplary support from my local GP and the Guys and St Thomas' NHS Trust…"

"I felt like I was dismissed and spoken down to as well. They were still offering me what I said I don't need so I thought it was more or less a box ticking exercise."

"There's also the systemic issue of structural racism. I'm very, very aware of it. I know that doctors are under pressure. I believe that the wider system does, either actively, sometimes disadvantage us or through negligence as Black people."

"Work needs to be done to close the wealth gap, as poorer residents have less positive experiences with ageing."

"You can tell the difference between a doctor who tells you what to do and the one that converses with you right? Someone who takes the time to explain things to you, who listens to you, you know, and takes into consideration your views."

"But being aware of the community that you serve. What does that community that you're serving look like? So then be more educated about them… about foods, about culture, about all those things, because you can then better support. Because when somebody is coming to you, you can show that understanding."

Feedback from unpaid carers highlights practical changes that would make a real difference to their quality of life

"Carers' organisations and carers carry no weight, they should be respected, they should mean something"

"No communication between organisations whatsoever – each has its own agenda and won't intervene with the other"

"I can't get my Mum to activities in the community if there is no reliable transport"

"What if the person I care for won't accept help from anyone else? I need an advocate to help free me up from the trap"

"I would have peace of mind as a carer if a plan was in place for what should happen if I am taken ill or go into hospital."

"When carers are coping they should still be allowed some respite; a chance to recharge the batteries. It will mean they can go on caring for longer – it's an investment"

"Staff need time to have proper conversations with carers who often know the answers more than anyone"

"Mum is not considered bad enough to get help, so I do everything! But something more flexible is needed; even if the voluntary sector helped me out half a day a week. But the current approach is more 'all or nothing"

"As a carer it should be easier for me to get a GP appointment. I should be a priority to enable me to keep on caring"

"My mother needs help with paying bills, making appointments, getting groceries online, sorting glasses and hearing aids, online banking, using parking apps, dealing with chatbots and having her questions answered."

An artist attended the sessions that we held with residents to understand what ageing well means to them – and their voices have been captured in a graphic

Four workshop sessions were held with residents and unpaid carers to understand what ageing well means to them and to capture their experience and expectations of services. The workshop sessions were as follows:

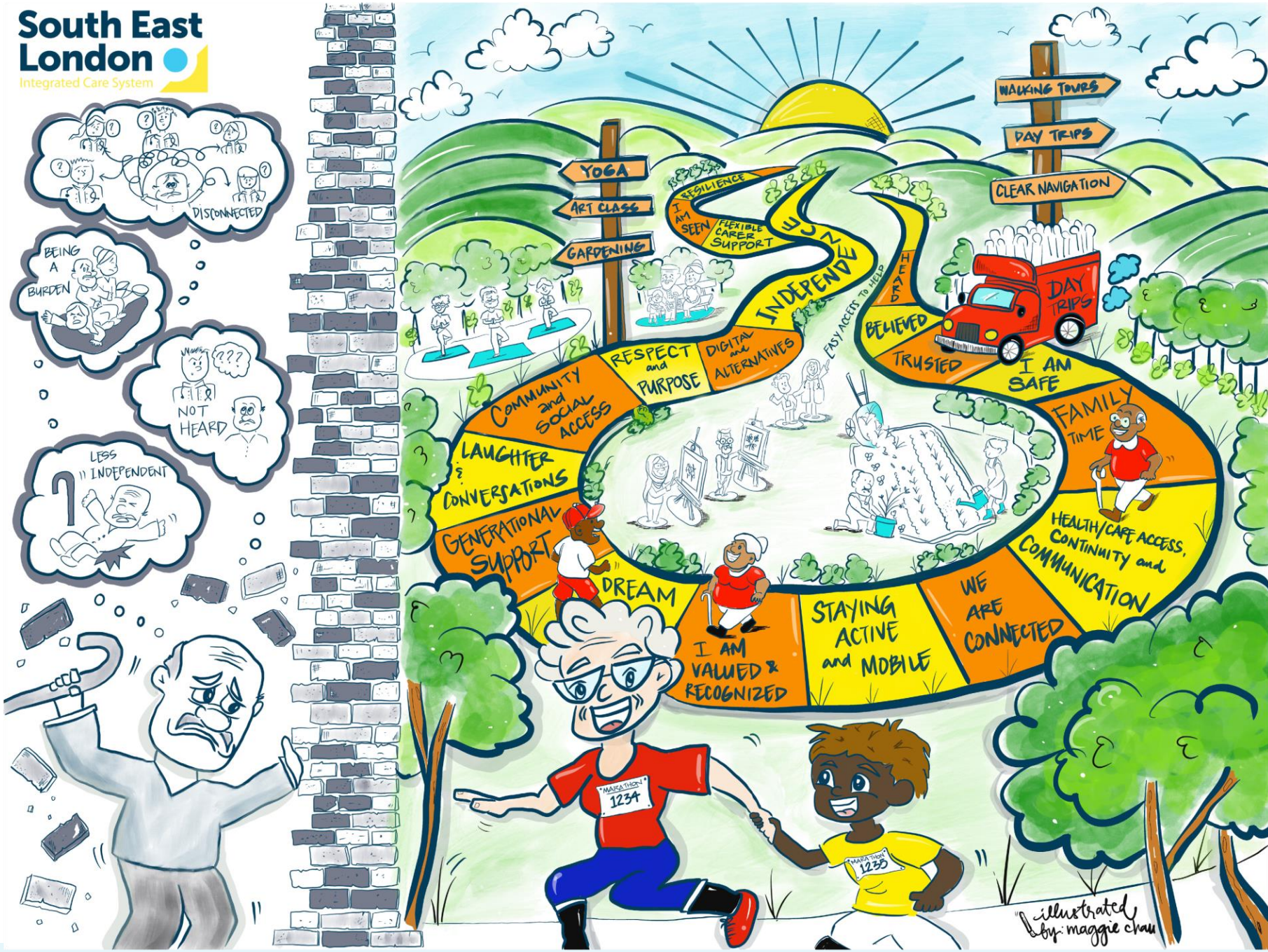
Borough	Resident/Carer organisation	Date of engagement
Southwark	Southwark Carers Cafe	21 February 2025
Southwark/Lambeth	Blackfriars Settlement	11 March 2025
Bromley	Orpington Methodist Church Art Class Group	13 March 2025
Bexley	Bexleyheath Geddes Place Church	10 March 2025

The key themes from the sessions have been woven into the framework to help inform the priorities for delivery. In addition, an artist has produced a graphic depicting the voice of residents and unpaid carers, which can be found on the following slide.

Resident voice

The left-hand side of the graphic captures some of the main challenges residents face when dealing with services.

The right-hand side of the diagram portrays the aspirations, hopes and dreams that residents have including what they like to do and how they would like to feel.



5.
‘Age without limits: You say, your way’
The SEL Ageing Well framework

150+ clinicians and professionals have been engaged and involved in developing the framework, at SEL and local levels - identifying key values and principles that underpin the framework, below

1. Early identification
Understanding who our older and frail population are and identifying them sooner

2. Seamless navigation
Visibility and clarity about what sits where across settings, enabling easier signposting, self-navigation (by problem) and movement between zones and real connection and dialogue between professionals

3. Hyperlocal VCFSE involvement
Stronger connection, Increased visibility, bigger role in healthcare, trust and financial security for VCFSE, especially grass roots offers

4. Improved Accessibility
Removing barriers to accessing amenities and services such as need for form filling, providing documents and overcoming travel, digital and language barriers. Providing alternatives to digital

5. Social Well-being
Fostering environments where people build and sustain lasting friendships and social connections to prevent the loneliness spiral

6. Personalised Care
What it means to the individual e.g., listening, understanding, believing, trusting and respecting. Seeing an active, whole life, not a health problem. Making nuanced decisions based on *'what matters to me'* and accepted shared risk with residents and families.

7. Active & Engaged Living
Focus on exercise, cognitive stimulation, nutrition, hydration, & self-care - enabling purposeful living that creates resilience, connection and independence

8. Positive Ageing
De-stigmatising ageing and promoting positive representations of older people as having a purposeful life to live and a strong contribution to make. Making amenities and services more age and culturally friendly.

9. 'Heating and eating'
Ensuring the basics are supported to set yourself up to age well such as heating, eating, paying bills, getting appointments, using on-line services

10. Equity
Independence and wellbeing of people is of equal importance regardless of setting. Care homes and home care are not separate ecosystems and require an integrated offer that enables equitable access.

11. Wider factors
Addressing the wider things that foster ageing well – e.g., feeling safe on the streets, level pavements, access to shops and public toilets, bus drivers being mindful of older people stepping onto buses

12. Activating self-help
Facilitating communities to help themselves e.g., via peer and expert support groups, volunteering, linking people up with people, allowing people to swap their homes

The Ageing Well framework comprises three inter-connected zones. People move easily in and between zones based on where they are on their journey

The emphasis of the framework is on early proactive prevention but also includes 'what good looks like' for those further along the frailty continuum.

1

Promoting independence and wellbeing- thriving at home

Working in partnership to create local age-friendly, compassionate and responsive communities that encourage and support people to age well, through supporting their health and wellbeing, independence and social participation. Improving the building blocks of ageing well such as safety, access and housing.

2

Proactive community care via integrated neighbourhood teams

Early identification of frailty and rising risk, working with people, their carers and networks to provide well-coordinated, community-based care that maintains resilience, delays and responds to exacerbation.

3

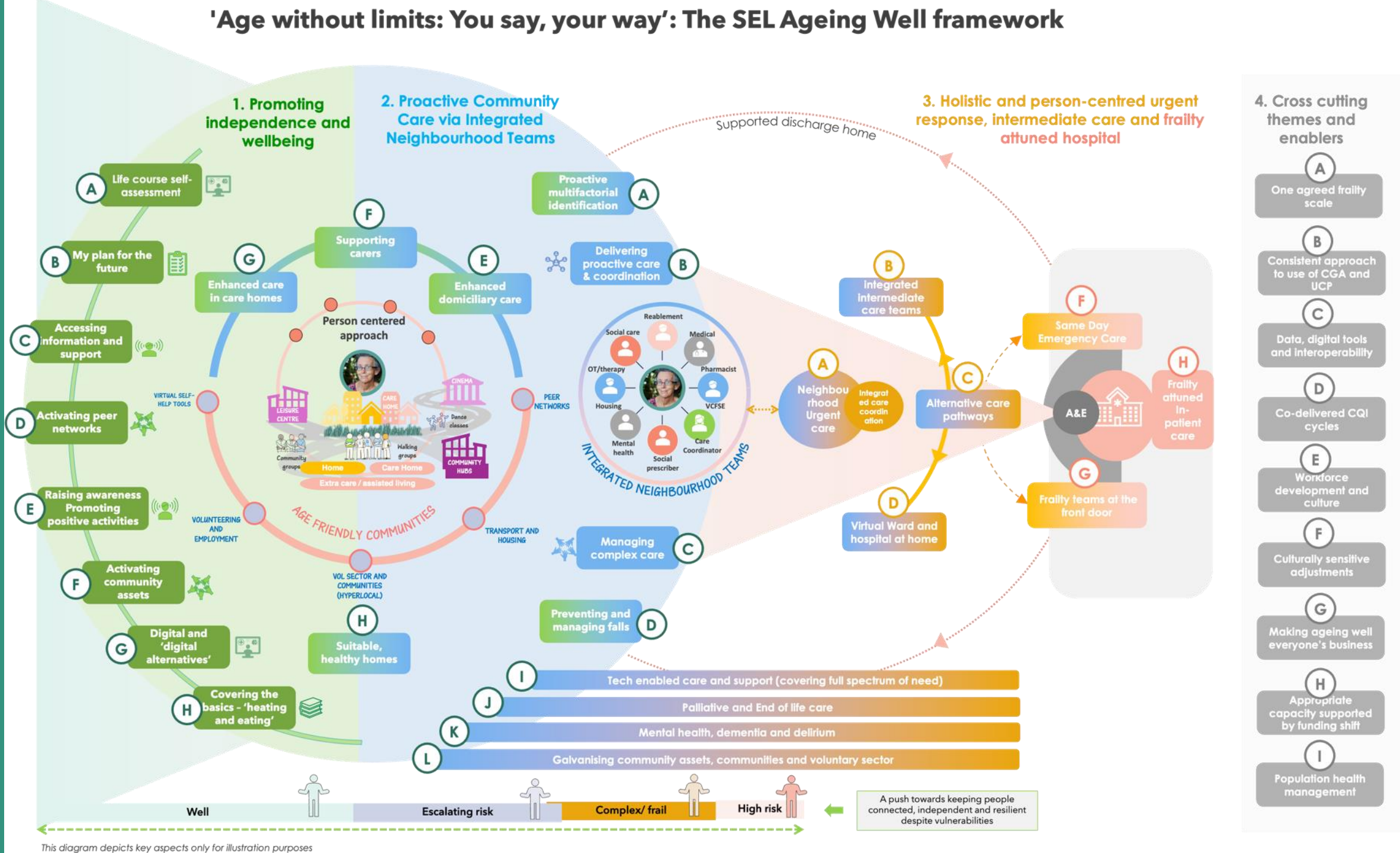
Holistic and person-centred urgent response, intermediate care and frailty attuned hospital

Working closely with zones 2 and 4 to provide holistic and person-centred urgent / timely step-up and step-down community care that helps to avoid unnecessary hospital attendance, admission or readmission and enables timely discharge.

Front door frailty team focused on identification of frailty and same day delivery of coordinated care so that people can be discharged back into the community or undertake a short stay in a frailty unit, avoiding admission where possible. Frailty-attuned hospital care and hospital discharge for those who are admitted.

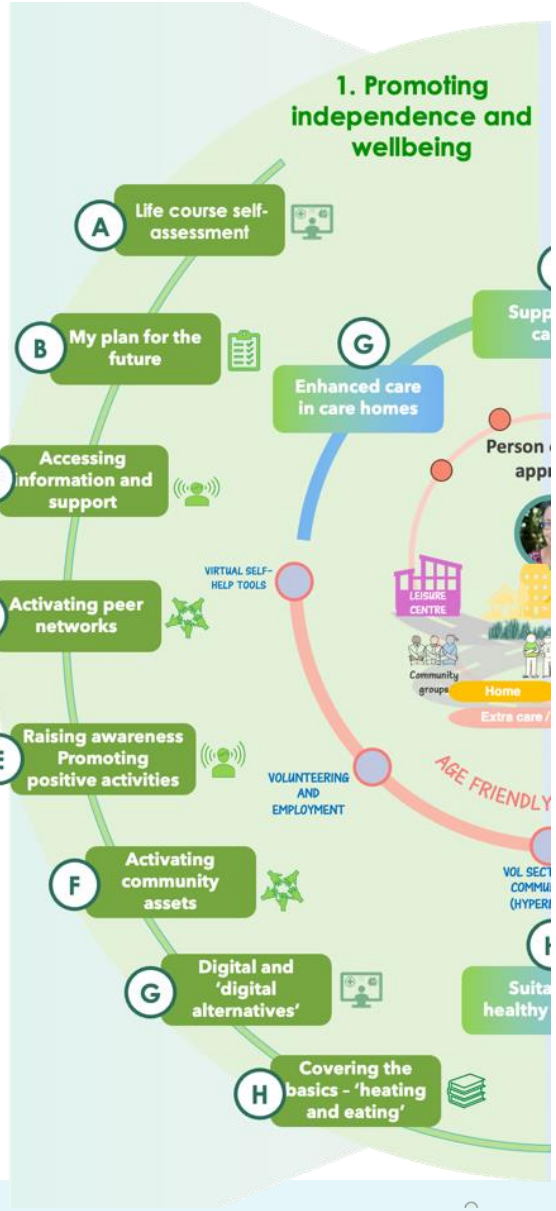
The SEL Ageing Well Framework

'Age without limits: You say, your way': The SEL Ageing Well framework



This diagram depicts key aspects only for illustration purposes

Zone 1: Promoting independence and wellbeing - thriving at home



Zone 1: Working in partnership to create local age-friendly, compassionate and responsive communities that encourage and support people to age well, through supporting their health and wellbeing, independence and social participation. Improving the building blocks of ageing well such as safety, access and housing.

This zone comprises of the following elements:

- Life course self-assessment, empowering people to self-identify goals and take holistic actions based on 'ageing well milestones' This feeds into 'My Plan for the Future' OR "Planning ahead for what matters to me?"
- 'My Plan for the Future', a self-led holistic tool and plan reflecting personal goals and informed by the ageing well milestones including actions I will take to maintain my health and wellbeing, e.g. adopting a healthy lifestyle and preparing for the future. Includes support and resources I will access, e.g. a community exercise programme or other support through voluntary, community, faith and social enterprise (VCFSE) such as managing money. Plan includes end of life. Can be generated digitally and produced with support from a community champion.
- An easily accessible one stop shop ('access hub') that provides and signposts people to information and knowledge about ageing well and helps them to access local services, support and VCFSE sector offers. Could be virtual/digital or walk-in, providing an alternative for those unable to access digital offers.
- Building and delivering local community peer support groups and networks that for example, provide opportunities for older people to contribute, share and learn new skills leading to improved social connections and reduced isolation, and that contribute to building age friendly environments. Inter-generational working e.g. bringing students into care homes/older people into schools and utilising industry e.g. professionals being role models or peer mentors to others.

Zone 1: Promoting independence and wellbeing - thriving at home

Zone 1: Working in partnership to create local age-friendly, compassionate and responsive communities that encourage and support people to age well, through supporting their health and wellbeing, independence and social participation. Improving the building blocks of ageing well such as safety, access and housing.

- Raising awareness of the factors that prevent, slow, and reverse frailty and enable ageing well such as exercise, hydration and nutrition (insights from blue zones). Raising awareness of, normalising and breaking down taboos associated with ageing and dying. Promoting a positive approach and positive representations of older people. Delivery of the above via hyperlocal social media/marketing, NHS App, smartphones as well as other non-digital media
- Incentivising and activating community assets to provide easy, affordable or free (off-peak) access to local activities, events and facilities (including gyms, cinema, yoga classes, leisure centres, education courses). Asset based community development in which communities do it for themselves. Systems taking an active role in local leadership to influence community developments according to local need.
- Improving the accessibility, knowledge and use of digital tools by residents. Supporting access equity where digital access is not achievable for individuals.
- Ensuring that the basic, minimum things are more easily accessible and in place to support wellbeing, prevent illness and assist recovery from illness such as a secure home, heating, cleaning, having access to food and that food is being eaten
- Addressing other wider factors that support independence such as ensuring decent housing, well-lit streets, level pavements and easy to read signage.

Zone 1: Promoting independence and wellbeing - thriving at home

A. Life course self-assessment	• The aim is to focus on prevention by doing the right thing at the right time. This can be enabled through supporting people to self-identify suitable goals and actions based on 'ageing well milestones'. The milestones create a shift in perception, empower people and strengthen understanding of actions that should be taken to 'age well'. This may include information such as "at age 75 focus on this type of exercise, diet and lifestyle to keep your bones healthy and reduce risk of falls". • Milestones will also flag national screening programmes such as the bowel cancer screening kit offered every 2 years for 50–74-year-olds and highlight local resources, e.g. how to access community exercise programmes. It can include continence care information for those over 50. • Milestones can also help educate younger people (e.g., men in their 40s and 50s to take earlier action to prevent issues as they age. • The milestones provide a guide to the production of 'my plan for the future'. This should not be a one-off assessment and can form part of the person's universal care plan (UCP).
B. My plan for the future	• A personalised plan, which is self-generated or co-produced with a 'wellness coach' or similar, that captures the person's self-identified goals and actions **they** will take to maintain wellbeing and stay healthy. • The life course self-assessment (above) will help inform and feed into the plan. • The plan will also encourage people to think through what matters most to them, and plan what they want to happen in future, for example if they become unwell – and prompt earlier action, e.g. around producing a lasting power of attorney (LPA) or deciding arrangements for care they may need, including what to do should a crisis be looming or occur, and preferences or arrangements for end of life. • Approach to recognise that changes with ageing can be stressful (e.g. retirement) and therefore be done with empathy.

Zone 1: Promoting independence and wellbeing - thriving at home

C. Accessing local information and support	• An easily accessible (to residents, carers and staff) one stop shop ('access hub') that provides and proactively signposts people to information and knowledge about holistic ageing well and helps them to understand and access local services, support and VCFSE offers. • Could be virtual/digital or walk-in, providing an alternative for those unable to access digital offers. The hub can be co-located with existing community services at Place, with a focus on local health promotion. Hub may also be able to aid professionals with navigation of local resources to support residents. • Public health involvement to promote prevention, working in partnership with residents and resident-facing professionals. • Sharing of information on different partner initiatives, across partners e.g. visibility between health and social care about ambitions, innovations and developments (e.g. falls prevention). A resource that enables staff to understand what is provided in the community and how it helps to get home from hospital earlier with better support or avoid unnecessarily going into hospital. • Sharing self-help information about falls, continence care, mental health and education around diet, hydration and exercise will have a significant impact on quality of life for residents. Practical advice e.g. how to get a hearing check, manage gas and electric, pay bills, get an optician appointment. • Information is sensitive to cultural and generational challenges. • Information be provided to the 'access hub' through people e.g. champions and networks. • Include simplifying existing websites, making them more accessible.

Zone 1: Promoting independence and wellbeing - thriving at home

D. Activating peer networks and intergenerational relationships	• Building local community peer support groups, improving social connections and reducing isolation (therefore improving mental health and reducing depression and anxiety) within the local community. • Utilisation of community champions and creating community networks which are of high value, providing support and resilience. • Creating intergenerational connections to reduce societal ageism barriers e.g. older people mentoring in schools, students volunteering via local VCSFE organisations. • Interventions and activities should be personally relevant (e.g. acceptable in different cultures).
E. Raising awareness and promoting positive activities	• Raising awareness, changing perceptions and activating people to prevent frailty as well as identifying signs of frailty at the earliest opportunity, hence implementing actions to reduce progression. • Early discussions and awareness of palliative care/death literacy. Promoting episodic symptoms support e.g. palliative care. • Raising awareness of the factors that prevent, slow, and reverse frailty (insights from blue zones). • Putting out key messages such as ‘come to us early to prevent illness’ or ‘do this for yourself to take charge of your health’ – or messaging to activate neighbours to look out for older people in their neighbourhood. • Delivery of the above via hyperlocal social media/marketing, NHS App, smartphones and other non-digital alternative media. • Changing the images and photos we use to portray older people, to more positive, breaking down stereotypes.

Zone 1: Promoting independence and wellbeing - thriving at home

F. Activating community assets

- Setting up and running social and exercise classes, including strength and balance training, tai chi, yoga, pilates, walking, circuit training, dance, spin, cheerleading, choir and swimming.
- Easy, affordable/free access to local activities such as leisure centres/cinema/ gyms to improve connections.
- Musical and dance activities from their era, keeping sighted different older people will have grown up in different years and cultures.
- 'Expert patients' teaching e.g. exercise groups, how to use gym equipment or other new skills such as DIY, gardening co-ops (e.g. building gardens in care homes or GP surgeries), men in sheds to maximise peer-peer influence and mentorship.
- Expert patients may also encompass specific co-morbidity and mental health peer support and identifying champions in key areas e.g. falls, hydration, continence, loneliness, hearing loss, etc. As well as death and technology literacy.
- Activating people to contribute to their communities by recognising their contributions and maximising volunteering opportunities and skills.
- Providing recognition, accreditation and awards for both those who lead and those who participate in exercise groups. e.g. NHS 'couch to 5k'.
- Local and community gyms and swimming pools promoting classes
- Corporate social responsibility: connecting with local corporate companies who can support people to age well e.g. local theatre, professionals providing peer mentorship, tapping into philanthropic opportunities.
- Having accessible transport links (volunteering opportunities around this).
- Community assets need to be dementia-friendly and mental health trained
- Consider adopting interventions such the 'paperweight armband'- an easy tool to help identify older people who are at risk of malnutrition, developed by Age UK Salford. Since the introduction of the paperweight armband, Age UK Salford has reported a reduction in hospital admissions, a 50% increase in reporting of underweight BMI in primary care after 1 year and a more appropriate prescribing of oral nutritional supplements).

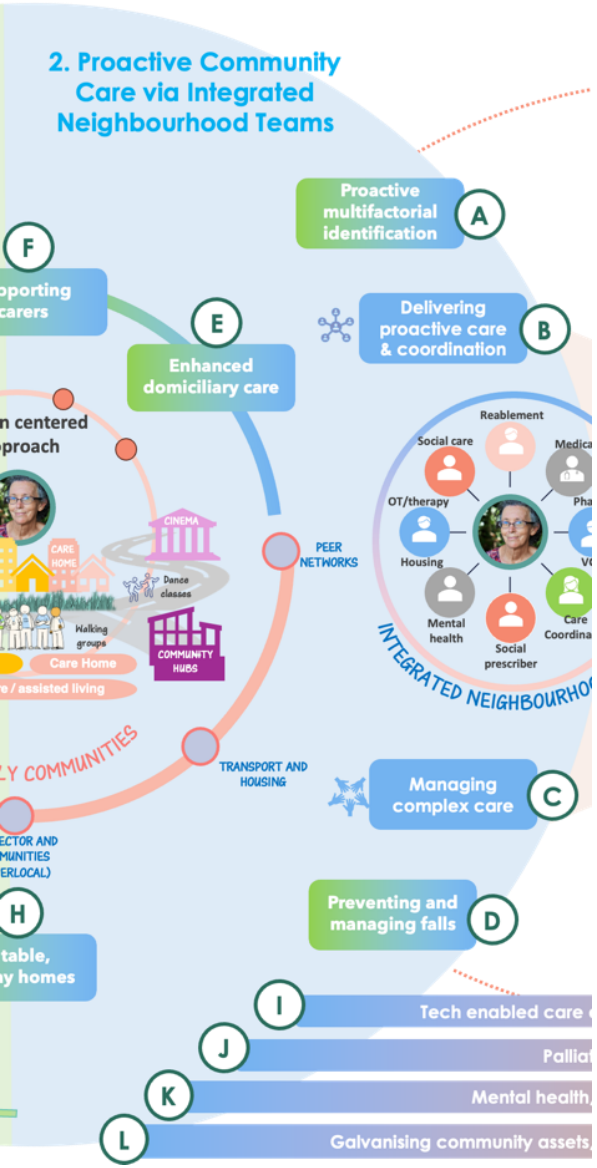
Zone 1: Promoting independence and wellbeing - thriving at home

G. Tapping into the digital world	• Improving accessibility, knowledge and use of digital tools by residents within the local community. This may be achieved through implementing digital 'drop-in' sessions within local libraries or community centres for instance, or that may be supported by local university student volunteers/peer mentors. • Supported by key FAQ leaflets. • Age friendly support available within libraries. • Providing alternatives to digital (e.g. appointment cards, paper diaries) for people with dementia/others who would benefit e.g. dementia, digital poverty, language barriers / others.
H. Covering the basics – 'heating and eating'	• Ensuring that the basic, minimum things are more easily accessible and in place to support wellbeing, prevent illness and assist recovery from illness • Examples include a secure home with working locks, minimising drafts, heating, cleaning, having access to suitable food and checking that suitable food is being eaten and managing money. • Whilst services exist that focus on these 'basics' for people with an identified need, the numbers of people living without them are significant and it is incumbent on all to be alert, identify gaps and problems and help address them, which may include being proactive and notifying VCFSE organisations that can support. • Consider an 'older person's' review in their home, "I want... I need.... I can... I can't..." • Consider what population health management (PHM) data we need and what we want to capture to address the 'basics.'

Zone 1: Promoting independence and wellbeing - thriving at home

Wider determinants	• Identifying changes that are required within the wider infrastructure to create an age friendly community (in reference to WHO age-friendly cities framework). • Addressing issues such as pavements, street lighting, access to clean and usable public toilets, access to outdoor seating, support with employment and better transport links. • Uptake of benefits, managing rising cost of living, financial advice and employment support. • Recognising and meeting people's spiritual beliefs, personal values and needs. • Ageing well cafes and death cafes. • Where people are in receipt of extra care, ensuring this is integrated with the wider social/community offer so it supports people to get out and join in rather than become isolated at home.

Zone 2: Proactive community care via integrated neighbourhood teams



Zone 2: Early identification of frailty and working with people, their carers and networks to provide well-coordinated, community-based care that maintains resilience, delays and responds to exacerbation.

Proactive community care focuses on delivering an integrated and coordinated primary and community care-based offer, which is holistic and personalised for people with frailty and/or at rising risk, enabling a good quality of life. Through understanding *who and what matters*, it prioritises what is important to the individual. Key components include:

- Proactive multifactorial identification of people living with frailty and/or at rising risk via consistent means
- A dedicated care team of multi-agency professionals formed within the neighbourhood, including specialists who provide a personalised and holistic approach, with multi-disciplinary team (MDT) interventions and support which includes facilitation of interventions beyond only health and social care.
- Robust, flexible support for unpaid carers, ensuring a carer's assessment is completed, regular reviews occur and signposting to appropriate resources takes place.
- Increased focus on hydration, nutrition, eyesight, hearing to tackle the modifiable risk factors for frailty and falls.
- Multifactorial assessment of frailty including falls and its prevention and continence promotion amongst others using a comprehensive geriatric assessment (CGA) framework for those with moderate/severe frailty.
- Managing people with frailty and escalating complexity via a named care coordinator i.e., someone to holds the case to enable pulling together and coordination of support.
- Enhanced and more integrated domiciliary care which is flexible, high quality and personalised, via well trained and supported staff.
- Defining elements that will improve the way ageing and frailty are managed in care homes, e.g. ensuring all residents have a CGA and proactive planning ahead including end of life.
- Easier access to responsive advice and guidance, with reduced bureaucracy.
- Developing and integrating the use of telecare and telehealth to enable people to stay at home where possible.
- Structured face to face medication reviews resulting in better patient understanding of medications and shared decision-making based on patient-oriented goals
- Increasing the role of VCFE organisations, including more formal, longer-term funding.

Zone 2: Proactive community care via integrated neighbourhood teams

A. Proactive multi-factorial identification	• Proactive multifactorial identification of frailty and its severity (mild, moderate, severe) with a uniform tool across health and social care, e.g. using the clinical frailty scale (CFS) to enable standardisation and one common language. • Using collective local intelligence (wider proactive community flag) to supplement the data e.g. from GP practices in which all system staff (regardless of host organisation) are trained to **help** identify frailty (with a united system language of what we mean by frailty) and connect with others to enable residents earlier access to CGA and help. Making all system interactions count to enabling holistic whole person approach, whether resident accesses help via their GP, secondary care, community pharmacists, social care, district nursing, carers, VCFSE, learning disabilities services, homeless and refugee services, housing, domiciliary care and pharmacy. All partners working together to deliver as an MDT. • No wrong door to an organisation approach. Move organisational navigation from the user to the access point. • Community information hub or 'access hub' to also report and raise concerns about vulnerable people. • Consider an in-reach team with an ageing well skill set (geriatrician, nurse, AHP), working with GPs, allocating whole day going into e.g., sheltered accommodation, Latino centre to test different 'out of the box' ways of finding and responding to people (see Lambeth approach) • Ensuring people with severe mental illness (SMI) and/or dual diagnosis, are not excluded. • Looking at the value of shared records, collected by all, to create a single, shared frailty register. • Use of data and/or artificial intelligence (AI) to identify people with frailty or at a rising risk.

Zone 2: Proactive community care via integrated neighbourhood teams

B. Delivering proactive care and coordination	• A dedicated care team of multi-agency professionals formed within the neighbourhood, including primary care, allied health professionals (AHPs), including speech and language therapists (SALT), physiotherapists, occupational therapists (OT), substance use, mental health, housing, community nursing and secondary care specialists. Consider establishing a specific frailty neighbourhood team as part of integrated neighbourhood teams (INT) that visits, conducts CGA/tests, plans, delivers and follows up care. • Frailty neighbourhood team to include CGA & frailty skilled workers working within their scope of practice with support, admiral nurses, social prescriber, pharmacist, council access (social care and housing) as well as geriatrician input feasible to context. • Focus on individual's holistic needs and preferences, established through 'talking to the person', carers and family on 'what matters to them', enabling nuanced decision-making, as well as and providing a personalised and holistic approach, with MDT interventions. • Consistent minimum core actions to be carried out at mild/moderate/severe stages of frailty. • Building a strong social prescribing resource/team who build relationships with individuals. • Seeing people who are teetering before they reach crisis point and galvanising holistic (not just health) interventions straight away before exacerbation occurs. • Above arrangements to include making reasonable adjustments for people with mental health needs and dementia or other characteristics that mean care or care pathways need nuance to facilitate equity.

Zone 2: Proactive community care via integrated neighbourhood teams

B. Delivering proactive care and coordination .. Cont'd	• Close liaison and optimal use of VCFSE organisations, including hyper local offers. • Definition of a strategy for medicines management and de-prescribing including proactive identification of most vulnerable patients with medication issues, structured face to face medication reviews based on shared decision-making and what matter to the person • Access to pharmacists for a second opinion (including via MDTs with social prescribers for non-drug options), • Clear links to community pharmacy to enable bi-directionally MDT working between primary care, frailty teams and community pharmacist to better identify non-concordance, better access to help, information and health education • Provision of help especially post-discharge (e.g., through the New Medicines Services and Discharge Medicines Service), information and education so that patients better understand their medications – and clear ownership of these elements so professionals know 'who does what'. • Existing examples that incorporate some of these aspects are the integrated clinical pharmacy services – GSTT Integrated Local Service Pharmacy team, Lewisham Integrated Medicines Optimisation Service (LIMOS), Bromley Integrated Medicines Optimisation Service (BIMOS).
C. Managing complex care	• Cohort may include homeless, asylum seekers and prisoners, as well as more obvious groups e.g. severe mental health disorders, care homes. • Manage people with frailty and escalating complexity via complex care coordination. • Bring specialist and acute input into the community MDT e.g. SALT, substance use, secondary care experts. • Strong role for social prescribing and use of VCSFE sector. • Explicit medicines management strategy for complex patients with MDTs including prescribers (e.g., GPs), pharmacists and specialists to make balanced decisions about polypharmacy and de-prescribing for complex patients. Guide by patient-oriented goals, so that complex decisions about stopping/starting medications are supported and made and in a timely way – and complex patients are supported with proactive help and advice to optimise concordance (e.g., via referral to community pharmacy to engage with and support complex patients).

Zone 2: Proactive community care via integrated neighbourhood teams

D. Preventing and managing falls	• Falls management model as part of proactive community care. Timely multifactorial assessment for falls addressing additional factors such as eyesight and hearing, for those that are complex and predisposed to falling. • Preventative measures such as activity, strength and balance exercises are highlighted in Zone 1 (Component F).
E. Supporting carers	• Unpaid carer's assessment completed and reviewed regularly. • Earlier, more flexible and episodic, ad hoc support (including respite) for carers (instead of an 'all or nothing' offer). • Unpaid carers able to get a GP appointment at a time they need it, recognising the importance of their role. • Signposting to appropriate services including financial advice and support groups within the community e.g. carers café. • Pre-emptive planning for carer crisis e.g. contingencies if the carer becomes unwell, leading to peace of mind and the right actions taken. • Carer identity card indicating where to find an 'emergency pack' so that urgent and emergency services know where to find everything in the event of a carer crisis. • Providing training for carers to increase their skill and resilience to managing older people with frailty.

Zone 2: Proactive community care via integrated neighbourhood teams

F. Enhanced domiciliary care

- For stable people at home, care which is flexible, high quality and focused on how to support people to achieve their full potential supported by a personalised care plan that is regularly reviewed.
- Redesign recognising the holistic opportunity to keep people at home for longer, prevent escalation and delay admission to a care home. Redesign aligned to the CQC framework.
- Moving from a 'task and time' approach to outcomes; optimising the person, increasing self-sufficiency and encouraging/supporting social engagement and participation.
- Establishing stronger partnership working between domiciliary care providers, informal carers and the health and care system so that issues are identified and acted upon earlier.
- Domiciliary care staff upskilled and supported in proactively identifying signs of deterioration early on and able to make direct referral to the resident's nominated coordinator and be involved in MDT meetings. Uniformity in training needs across the borough, to reduce the variation in care delivered by domiciliary care providers including in skills related to frailty to enable earlier escalation of concerns.
- Provision of coaches to support workers through oversight, giving advice, coaching and training e.g. in practical ways to optimise the person, identifying and managing concerns such as frailty, delirium and behavioural and psychological symptoms of dementia (BPSD).
- Training can be also attended by other formal/informal carers to create local support networks within communities to become the 'eyes and ears' of domiciliary care.
- Option for people to select their preferred wellbeing worker using summary info about their profile (experience, style of working).
- Health visitor role coordinated with domiciliary care to provide enhanced support.
- Ensuring clear expectations are set between wellbeing worker and client at outset e.g. 'I will use my mobile phone as part of my job whilst I am with you'.
- Paying workers the London living wage.

Zone 2: Proactive community care via integrated neighbourhood teams

G. Enhanced care in care homes (including sheltered supported housing and extra care housing)

- Care homes are not a separate ecosystem and residents are to receive equivalent care and support as those in other settings, recognising they are of equal importance and that the model may need nuance to enable equity of access. For example, ensure use of the life course self-assessment in care homes (see Zone 1), and use of CGA, UCP and ACP.
- Care home settings are often poorly understood by health teams. There is a need to shift to a positive approach, listening and championing care home staff and asking them what they most need. Consider a care home champion post per Place.
- Training and support to maintain competency are key, so that care home staff feel confident (recognising they sometimes do tasks infrequently so get out of practise e.g. using a syringe driver). Healthcare should play an active role in supporting health-related training, e.g. in falls prevention, wound care etc.
- Provision of training around early recognition of deterioration with supportive tools (e.g. RESTORE2) and 4AT (screening tool used to assess delirium and cognitive impairment).
- Consider establishing a care home support team (CHS) and/or primary care, to provide a transparent, uniform offer into care homes, supporting e.g. bedside training, clinical supervision (around topics such as falls prevention/management, tissue viability, polypharmacy reduction, nutrition and hydration) to build trust and dissipate fear (see Penninsula Practice, Greenwich as an example). This support to be provided to care home health care assistants (HCAs), not just registered staff.
- Consider a specific care home mental health/dementia team as part of the above provision, to provide training and support to e.g. mental health, dementia, delirium and BPSD.
- Consider a geriatrician in-reach model reaching into care homes to support MDTs, training and to visit specific residents to prevent admission (Whipps Cross Hospital model).

Zone 2: Proactive community care via integrated neighbourhood teams

G. Enhanced care in care homes (including sheltered supported housing and extra care housing) Cont'd	• Regular feedback to relatives regarding the resident's progress and proactively addressing any relative's concerns. • Care homes direct referral pathway to same day emergency care (SDEC). London Ambulance Service (LAS) transfer to SDEC, SDEC provide treatment and LAS return to care home). • Specifically ensure an Alzheimer's support worker supports transitions into care homes to settle the person and resolve issues. • Include care homes within a telecare and telehealth strategy, e.g. providing the opportunity for wearables to be utilised where this shows evidence-base to support its utility. • Involvement of activity coordinators within care homes to keep residents engaged with social activities and group activities and to promote self-help and independence and include accessing the community where possible. • Include a spell in care homes as part of student training, e.g. to enable deeper understanding of frailty. • Align with the national framework for enhanced health in care homes (EHCH).
H. Suitable homes	• Develop processes to swap social homes with others to get a home that meets changing needs and preferences as you grow older (e.g. moving from a high rise flat to a ground floor flat with a balcony if you develop knee problems and have a dream of having a place to sit outside). • Prioritising housing adaptations and changes for people with specific needs via making a link between health, social and housing services - working together to respond to people's changing needs in a coordinated way. • Influencing the design of new build housing and estate infrastructure so that it is suitable for older people's future needs.

Zone 2: Proactive community care via integrated neighbourhood teams

I. Technology enabled care and support (TECS)	• Consider development of an integrated telecare and telehealth strategy and approach that optimises the ability to keep people living with frailty safe and independent at home (aligned to virtual ward offer). • As part of strategy scan the market to identify new products to innovate the offer, move from analogue to digital and upgrade the user experience. • Examples of TECS include community alarms and detectors, door alarms, home activity detectors (e.g. falls), TECS supporting daily activities of living such as picture clocks with visual, audible clues, and wearables (e.g. blood pressure monitors), low tech items like walking sticks also included. • Consider same day TECS delivery to expedite timely discharge of people with frailty from hospital. • Consider VCSFE ability to directly source smaller items themselves to increase speed of response and source at cheaper prices. • Monitor clinical and cost effectiveness outcomes, satisfaction levels and benefits gained as part of rigorous evaluation process.

Zone 2: Proactive community care via integrated neighbourhood teams

J. Palliative and end of life care (PEoLC)

- The narrative should be focussed on what is right for the individual and include shared decision making, not on what is best for the system.
- Recognising 'ordinary dying' – palliative and end of life care should be everyone's business, not just that is the palliative care specialists.
- Build PEoLC skills within the neighbourhood teams to reduce over-dependence on specialists. Recognise the need for a personal navigator role at the end of life.
- Recognising that domiciliary care and district nursing play a vital role at the end of life, alongside GPs and community services.
- Social care plays a huge role in the holistic care for a person – palliative care is not just about medical care needs.
- Palliative care does not just happen at the end of life – it can be episodic and last a number of years.
- Creating a culture where people are more comfortable to talk about death and see it as part of the continuum of care, 'planning for the end'.
- Recognising that advanced care planning (ACP) is not a one-off conversation, rather should be ongoing and it is not the responsibility of a single role – it is everyone's responsibility.
- Embedding early advanced care planning as a standard, before a crisis happens, 'planning for the future is key', particularly for people living with dementia.
- Having difficult conversations regarding PEoLC earlier to enable care, and death, to happen in the person's place of preference, with family members/friends present.
- Outcome measures should be focussed on quality of advance care planning rather than preferred place of death, as well as learnings from national audit of care at the end of life (NACEL), and the emphasis on staff and bereaved carer feedback.
- Timely support to carers is key and gaps in bereavement services need to be filled and offers made more transparent (e.g., in a brochure). (Greenwich public health team undertaking pilot bereavement project).

Zone 2: Proactive community care via integrated neighbourhood teams

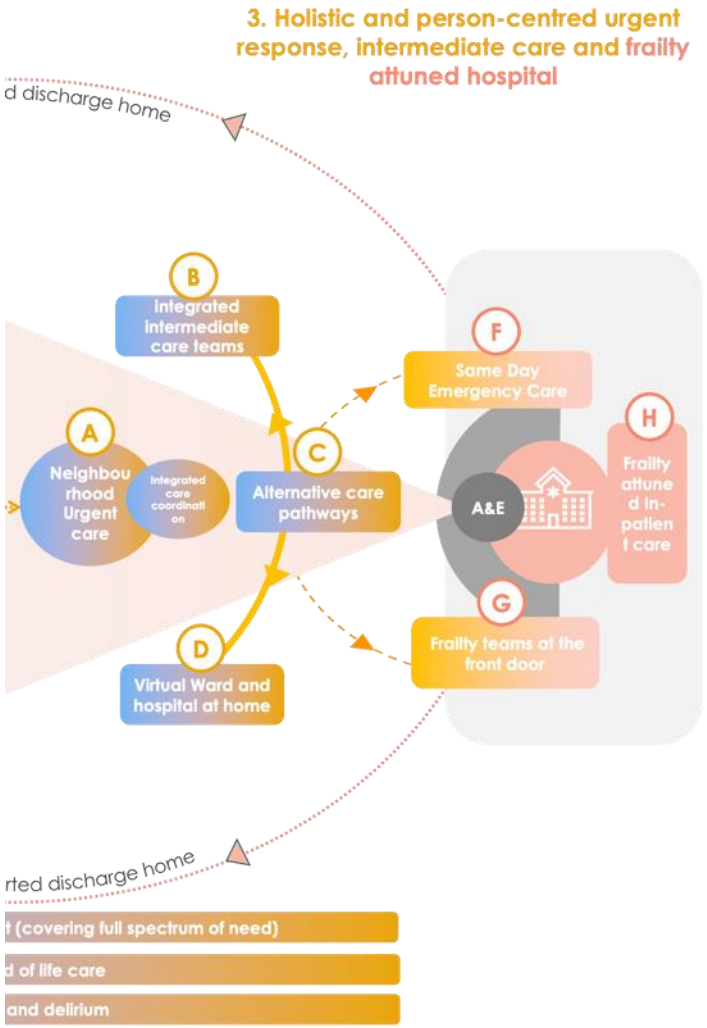
K. Mental health, dementia and delirium	• Please see the next slide that summarises some of the important elements across all zones regarding Mental Health/Dementia & delirium within the framework.
L. Galvanising community assets, communities and voluntary sector	• A key feature of the framework involves increasing partnership working between voluntary, community, faith and social enterprise (VCFSE) sector organisations and the wider system to improve health and care outcomes • Specifically, there is an opportunity to increase the role of voluntary sector organisations who often know residents better than other agencies, are more skilled in supporting their needs and can do so more effectively and efficiently than statutory services • To do this best, voluntary sector organisations need to be 'around the table' from the kick-off, involved in designing solutions and services and require more formalised roles supported by secure, longer-term funding. They also need to be part of the ongoing review and refinement of services • Places are at different points in this journey; effective starting points include helping to build a local collaborative of organisations supported by some practical governance (such as collaborative meeting points, clear leadership, etc.). Identifying a specific aim in terms of shifting budgets to the voluntary sector is also recommended • It is also important to ensure strong participation from hyper-local organisations, helping to build real local knowledge, goodwill and cooperation with residents and resident groups at neighbourhood level • The extent to which the above represents a change in culture and way of thinking is not to be underestimated, so continual challenge to change the status quo is to be encouraged.

Mental Health/Dementia & delirium within the framework

ZONE 1	ZONE 2	ZONE 3
• Knowing exactly who our population with mental health problems and dementia are • Equally promoting independence and wellbeing for people living with mental health problems and dementia ensuring parity of provision for these groups and reducing stigma. • Early identification: spotting and responding proactively to early signs of deterioration. • Supporting people to engage with their health, e.g. to address excessive drinking and resultant low mood. • Early support and advocacy to good decision-making about what to do e.g. post diagnosis • Supporting people to build resilience post-diagnosis • Understanding and acting upon carer risk	• Clear support post-diagnosis (instead of being sent all over the place) • Dementia care home team providing advice, training and coaching to staff e.g. managing BPSD, monitoring hydration, etc. • Upskill domiciliary care workers to reduce avoidable escalation and admission with earlier detection and action to deterioration and delirium. • Strong connections with social care link workers • Pre-planned crisis escalation support (including e.g. giving carers urine pots so testing can be expedited quicker). • Carers as full partners in decision making and effective carer support and respite • Managing behavioural issues associated with dementia (across zones). Understanding people's unmet needs and what they are trying to communicate via their behaviours to keep people in the least intensive setting. • Access to substance use specialists e.g. to take part in MDT discussions • Making reasonable adjustments e.g. providing paper appointment cards, using paper diaries (instead of automation).	• Timely step-up/step-down to intermediate care • Provision of specialist input e.g. speech, language, nutrition. • Integrated, wrap around offer (housing, homecare, domiciliary care). • Speedy return to normal place of residence • Skilled management of emergency presentations to avoid admission. • Timely identification and assessment of dementia/delirium in hospital (4AT). • Strong focus on nutrition, hydration and constipation checks at all stages of the journey. • Minimal ward moves and improving the patient experience • Nuanced decision-making based on what and who matters to the person. • Optimising the discharge process for people with mental health problems and dementia, so they experience parity. • Being more empathetic and proactive when appointments are missed, e.g. following up, taking time to explain and re-setting appointments. • Consider Admiral nurse as part of team to provide support to and help to navigate/coordinate and signpost care for people living with dementia (including support to carers).

Skills and knowledge to respond to mental health issues, dementia and delirium and the interplay between them.
Cohesion and effective communication between teams.
Data and digital interoperability.
Dementia-attuned environments.

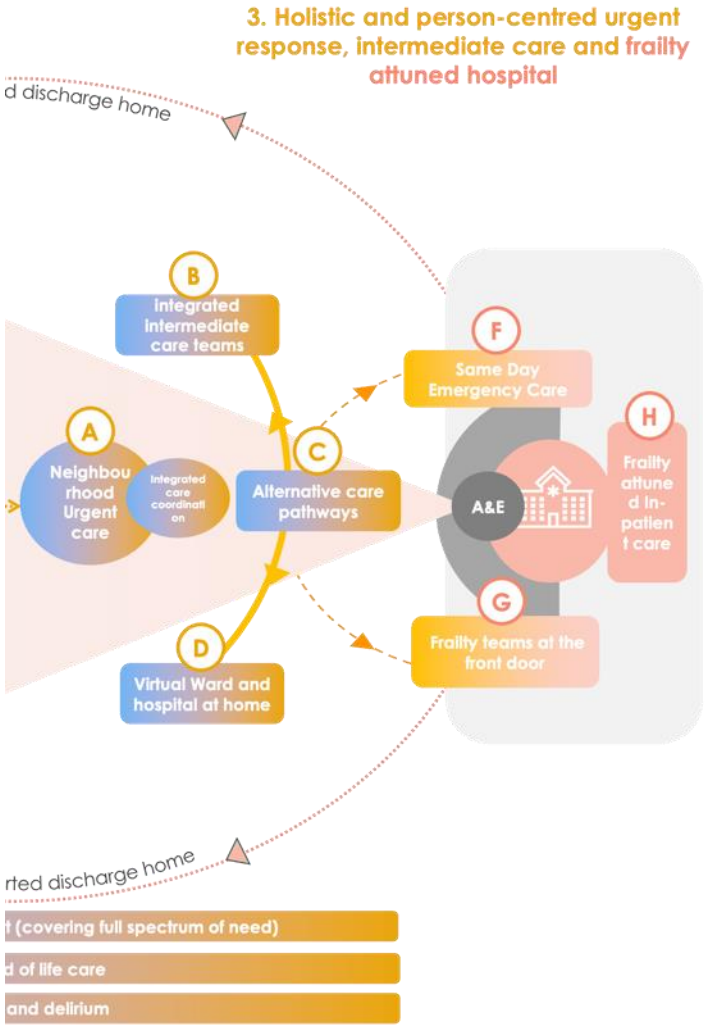
Zone 3: Holistic and person-centred urgent response, intermediate care and frailty attuned hospital



Zone 3 - working closely with zone 2 to provide:

- Neighbourhood-based urgent community care preventing escalation for those at home
- Integrated care coordination (hub) that provides a single point for remote assessment via MDT resulting in (1) advice, (2) direct booking or referral or (3) case holding – where appropriate.
- Step-up intermediate care and/or hospital@home helping to avoid unnecessary hospital attendance or admission.
- Step-down intermediate care and/or hospital@home for those at the hospital front door or who have been admitted, enabling timely discharge and avoidance of readmission.
- Strong focus on step-up provision to ensure fewer people are unnecessarily admitted to hospital in the first place.
- Simplified and coherent community escalation attuned to the holistic needs of older people and those living with frailty to keep people at home for as long as possible. Neighbourhood-based urgent care encapsulates a range of functionalities including urgent community response (UCR) and is directly connected with neighbourhoods (these are being developed and will be further refined).
- Provision of timely, strengths-based and coordinated intermediate care (recovery, reablement and rehabilitation) based on people's goals and focused on wellbeing and independence, for those who need a continued period of managed care in the community or following presentation at or admittance to hospital.

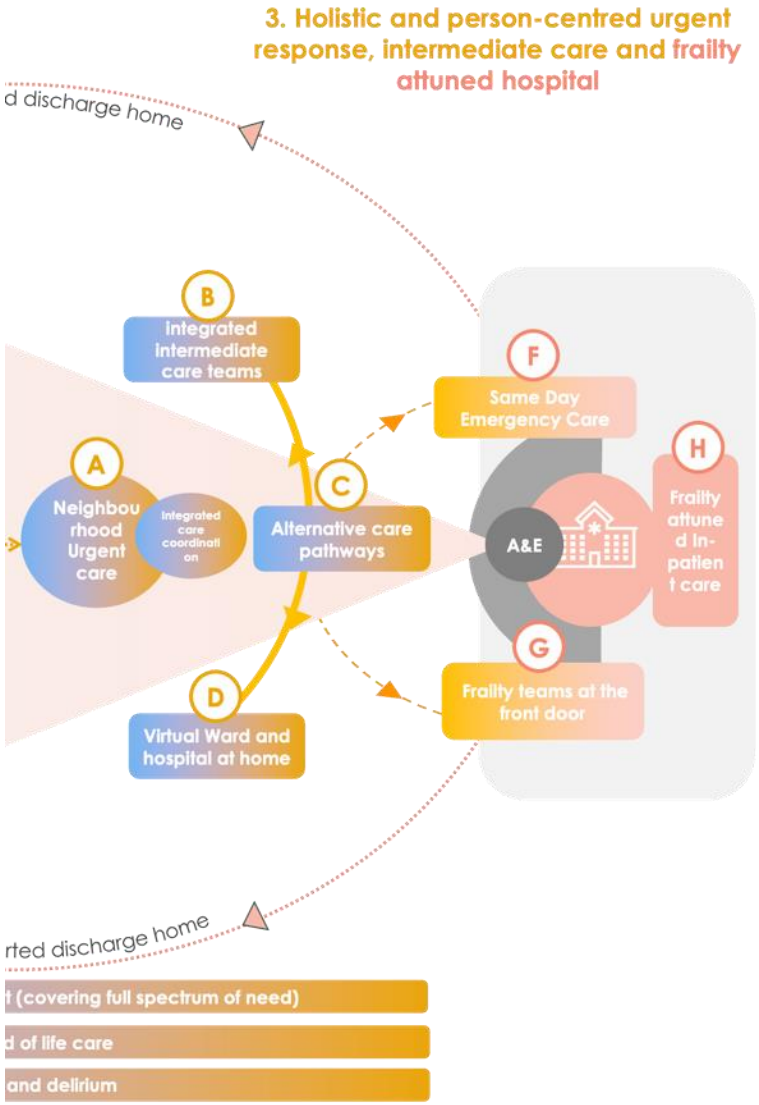
Zone 3: Holistic and person-centred urgent response, intermediate care and frailty attuned hospital



Zone 3 - working closely with zone 2 to provide:

- Intermediate care needs identified in the community or hospital front door escalated into a single point of access for advice or acceptance for rapid therapeutic transfer of care, including real time review of any existing package of care in place.
- Timely delivery of intermediate care and support without delay that would otherwise lead to deterioration at home or deconditioning in hospital, e.g. therapy starts immediately post discharge to avoid person becoming bed bound and to optimise independent living.
- Includes advice and support to help people manage life events such as bereavement, organising care requirements and planning lasting power of attorney.
- Ability to make direct referral to a virtual ward to prevent admission or expedite earlier discharge from hospital.
- Inclusive of direct access to medical support (including via advice and guidance) and a solid out of hours provision.
- The ability to align mental health resources to the more urgent mental health and dementia cases to ensure parity of care for people with mental health problems and dementia. For example, admiral nurse involvement to expedite swifter hospital discharge and provision of a short period of specialised support at home to enable earlier discharge for people with delirium.

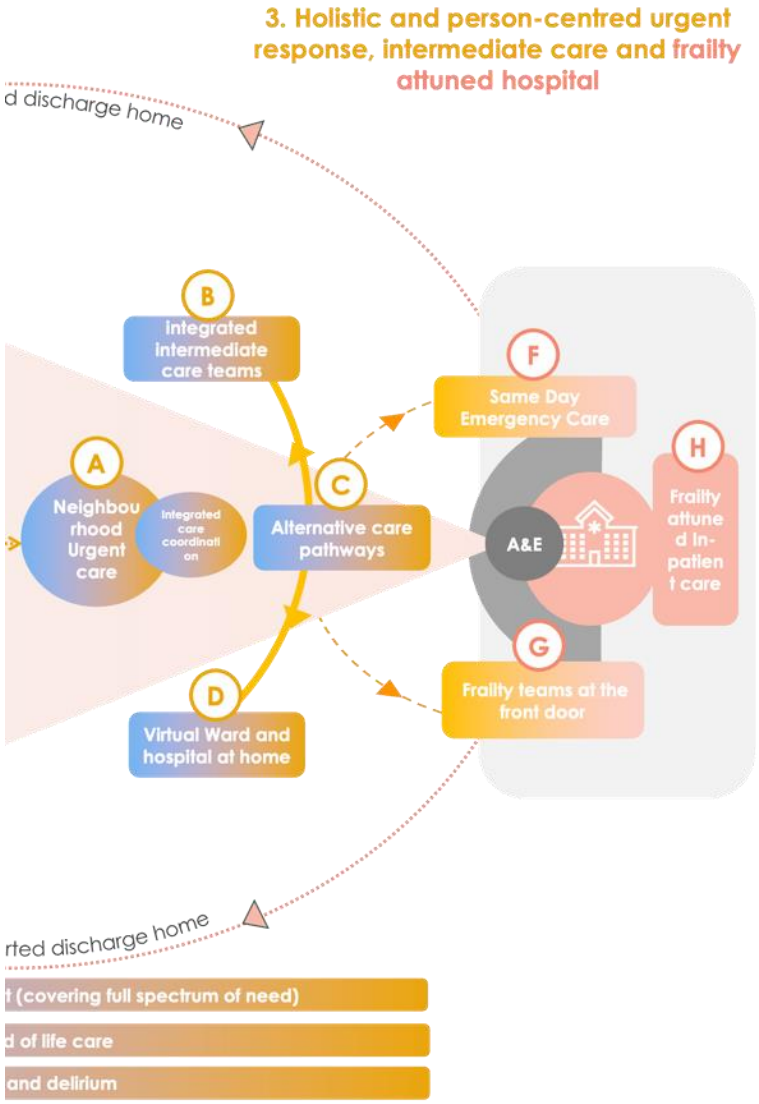
Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**



Front door frailty team focused on identification of frailty and same day delivery of coordinated care so that people can be discharged back into the community or undertake a short stay in a frailty unit, avoiding admission where possible. Frailty-attuned hospital care and timely hospital discharge for those who are admitted. Flexible boundaries and closer working between acute teams and integrated neighbourhood teams.

- Frailty team at the front door to proactively identify frail people, carry out holistic assessment and care planning and where possible transfer directly back to community-based care before the person becomes ‘medicalised’.
- Establishing realistic independence and activities of daily living (ADL) baseline and making nuanced decisions based on this and 'what and who matters to the person'.
- SDEC - assessment and care by specialist clinicians on the day of arrival to hospital as an alternative to admission, ensuring those that would not benefit from hospital admission are discharged back into the community.
- Acute frailty unit - a multidisciplinary assessment unit, to address the urgent medical needs for those that are frail and require a short stay (less than 3 days) in hospital.
- Fracture liaison service - identification of people who have suffered a fragility fracture, providing a bone health assessment to identify future falls risks and to reduce the risk of future fractures.
- An inpatient older people’s ward for those who require a longer inpatient stay due to medical reasons – including a focus on reablement, mobility, exercise and cognitive stimulation to reduce deconditioning during their stay.

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**



Front door frailty team focused on identification of frailty and same day delivery of coordinated care so that people can be discharged back into the community or undertake a short stay in a frailty unit, avoiding admission where possible. Frailty-attuned hospital care and timely hospital discharge for those who are admitted. Flexible boundaries and closer working between acute teams and integrated neighbourhood teams (cont'd)

- Transfer of care hub providing coordinated discharge back to the community, including taking actions from day of admission (as part of discharge planning) to expedite timely discharge without delay.
- Frailty and dementia/delirium skilled and attuned staff in all key hospital roles, so that for example, decision-making about care is more nuanced and driven by *what and who matters* to the person.
- Defined standards for frailty-attuned care for people in other settings such as surgery, oncology and other non-geriatrician led inpatient services.
- Consider use of summary acute medicine indicator table (SAMIT 75+) offering national comparative data for frailty at site level. Metrics cover demand, flow and outcome for both the admission and recovery phases of frailty care.

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**

A. Neighbourhood urgent care with integrated care coordination

- Neighbourhood-based urgent care encapsulates a range of functionalities including urgent community response (UCR) and is directly connected with neighbourhoods (these are being developed and will be further refined).
- Integrated care coordination (hub) that provides a single point for remote assessment via MDT resulting in (1) advice, (2) direct booking or referral or (3) case holding – where appropriate.
- Seamless flow and pathways between services and in-reach into neighbourhoods as a shared resource.
- Core MDT: An MDT approach consisting of paramedics, nurses, OT, dietician, social care professionals, advanced care practitioners and managers.
- Connected teams: Direct interface with health and social care provision such as GP, 111, pharmacy, INT, Virtual ward, LA front door, Housing,
- System collaboration: Access to other professionals including UEC, GP, hospital, mental health, housing, urgent response mental health placement etc
- System integration/technology: ensuring visibility of patients, access to shared records, data transfer between MDT and use of tele-monitoring/tele-care
- Care navigator/ co-ordinator with clear ownership of cases. Strong key relationships and conversations-with clear communication lines
- Holistic approach with focus on prevention, e.g. ensuring that lower-level or emerging social needs are not missed

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**

B. Integrated intermediate care teams	• MDT working to deliver a timely step-up and step-down service focused on recovery, wellbeing and independence • MDT comprising of medical, therapy, mental health, nursing, VCSFE, pharmacy, reablement, night carers, handyman service. • Access to extended MDT and/or advice including housing, geriatricians, cardiologists, etc. • Coordinated, proactive support, putting everything in place, working closely with a carer or family where present • Real time review and adjustment of support and ability to increase or decrease care to optimise outcomes • Access to existing CGA or ability to carry out a CGA, aligned to an urgent care plan • Specific liaison role with care homes to ensure proportional access and utilisation of service by care homes • Utilisation of service by specialist palliative care, hospice and end of life care teams • Timely access to equipment to ensure care and support commence rapidly.
C. Urgent community response and alternative care pathways	• Consistent UCR offer across SEL aligned to national standards and population health. Seamless flow/pathways into/in-between ACP :virtual wards, frailty units, SDEC • Intermediate care needs identified in the community, at the hospital front door or at discharge from hospital are escalated into the single point of access for advice, guidance or referral for a rapid, therapeutic transfer of care, including real time review of existing packages of care • Specifically for frailty, which is delivered at a place level, and may differ operationally between places based on local requirements. • Anyone can access and be signposted, including professionals working in zones 1 and 2, care homes, palliative care, etc. • Timely, direct access to reablement and rehabilitation via one and done process (no hand-offs). • A senior experienced clinician and social care led service, with authority and decision-making capabilities. • Rotation of staff within the system for care alignment and development. • Standardisation and simplification of proforma.

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**

D. Virtual ward and hospital at home	• Direct referral pathway from intermediate care teams, urgent community response teams, front door frailty teams, SDEC, discharge teams and transfer of care hub (TOCH) to virtual ward. • Virtual ward teams specifically skilled in frailty care and falls management.
F. Same day emergency care (SDEC)	• An MDT led frailty SDEC approach (geriatrician, advanced frailty practitioner, case manager, pharmacist). • Conduct investigations and delivery of short-term treatment e.g. iron infusion. • Assessment of acute issues referred from LAS, community teams, outpatients, care and nursing homes and front door frailty team • Direct link to virtual ward.
G. Frailty Teams at the Front Door	• Proactive screening and identification of frailty in ED through seeing all people age 65+ • Automatic CGA for CFS frailty score 6 and above and for those living in care homes. • An MDT approach: geriatrician, advanced frailty practitioner, physician associate, frailty pharmacist, frailty dedicated physiotherapist, social worker, community advanced nurse practitioner (ANP) and mental health representation. • Assessment and planning, including redirecting people back home, referral to community-based care, falls clinic, intermediate care, fast-tracking to the acute frailty unit or admission. • Providing advice to the ED team. • Geriatrician-led frailty advice line for GPs, community health services and ambulance service. • Good links to community teams, virtual ward, equipment services and voluntary sector (e.g. for meals, shopping, etc.).

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**

H. Frailty Attuned In-patient Care	• An acute MDT bed base utilised to address urgent medical needs for those that require assessment and/or a short stay (less than 3 days) in hospital. • Utilised by the frailty at front door team. • Direct and easy referral to intermediate (step down) care. • A dedicated environment providing patient-centred care (and continuity) via a frailty and dementia/delirium trained MDT (including a frailty consultant and access to mental health specialist) that focuses on the patient, carer(s) and families. • Routine screening for delirium (4AT). • Timely access to CGA e.g. to identify/avoid people being constipated, dehydrated, becoming delirious, resulting in falls. • Increased VCSFE involvement, expediting early action to support timely discharge such as making home ready for person to go home. • Focus on food and feeding and hydration. • A focus on reablement, mobility, exercise, continence care and cognitive stimulation on the ward to reduce deconditioning and hospital acquired disability (HAD), helping to minimise the need for packages of care once discharged. • Dementia support worker present with time to have the conversations and help plan and put support in place. • Focus on early discharge recognising every day in hospital has detrimental outcomes and leads to loss of independence.

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**

Supported Discharge Home

- Frailty attuned, therapeutic transfer of care processes, interfaces, proforma, assessment, out of area arrangements, etc.
- Link to discharge coordination.
- Direct interface with specialist older people's ward, care and nursing homes and intermediate care
- Live view of capacity for frailty-related services.
- Personal health budget in hub to enable discharging the person sooner/on time e.g. via provision of food, towels, and other items required, that were unforeseen or not addressed as part of a discharge plan
- Ability to refer directly e.g. to handyman services e.g. to fit key safe, repair locks or windows, fix the heating
- VCSFE support to unpaid carers/families at point of discharge to navigate the system and achieve a coordinated, timely and worry-free discharge.
- Full sharing and use of CGA and other information with care or nursing homes at point of transfer, recognising that going into a home is a major life event and that a 'discharge letter' is not sufficient to expedite this or achieve a person-centred, therapeutic transfer of care.

(this element does not appear as a numbered item in the overarching framework)

A range of enablers have been identified as critical to the delivery of the framework

The cross-cutting themes and enablers that will support the ageing well/frailty framework include the following:

- One agreed **frailty scale** to be used across the ICS.
- Consistent approach to use of **Clinical Geriatric Assessment** (CGA) and Universal Care Plan (UCP) - develop a technological solution to pull information from clinical systems such as EMIS in primary care into the UCP.
- **Digital tools** and data sharing - enabling digital solutions for patients and obtaining digital equality. Having required data sharing agreements in place to support collaboration
- **Continuous quality improvement cycles** – Formal QI methodology in place co-developed, owned and actioned across partners.
- **Workforce development and culture** – Achieving a universal minimum skill and competency level for ageing well and frailty (ideally including dementia and delirium) across all roles. Supporting the wellbeing of staff to prevent burnout and increase job satisfaction and staff retention. Developing 'employer of choice' status and attracting the best people with a passion for supporting older people to SEL. Achieving a shift in culture so that e.g., older people are respected, trusted and believed as equal citizens living full and well-rounded lives and with hopes and dreams. Supporting a cultural shift to increase pre-emptive thinking and genuine shared responsibility for prevention e.g., through talking to one another and triggering timely action in response to concerns or yellow/red flags, regardless of role. Co-location of teams to support building of strong, authentic teams and relationships
- **Culturally sensitive adjustments** – understanding the barriers to accessing services and wider amenities in the community, which could be real or perceived. Adjusting practices, processes, pathways, measures etc. in response to older peoples' experiences to create inclusion, encourage self-care and meet their needs. Health inequalities – look at how to tackle inequalities not only in access to services but also regarding preferences and limitations due to race, gender, etc.
- **Making ageing well everyone's business.** Ensuring that ageing well/frailty is "everyone's business" including raising awareness and upskilling the workforce to understand ageing well and recognise frailty and early signs of deterioration. Making it "every professional's responsibility" to input into the UCP. Supporting the upskilling and raised awareness of staff in care homes and domiciliary care
- Having a clear and overt strategy in place for **delivering the funding shift** needed to fulfil the ambitions of the framework, supported by a demand and capacity model that sits alongside the framework, pinpointing the capacity needed in each area to successfully deliver the required care and support
- **Population health management** (PHM) - using PHM capabilities such as predictive risk analytics to identify cohorts and further predict the risk of deterioration. Using alerts e.g., to indicate where patient reviews have been missed or need to be undertaken. Access to granular detail, e.g., to enable identification of people with frailty and at risk of deterioration.

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6.
How will we know if we are making a difference

Outcomes and measures

HEALTH INTEGRATION PARTNERS

Introduction

- The following slides outline a list of outcomes developed through engagement with stakeholders across all Places in SEL, encompassing a wide range of professions (e.g., clinical, social, managerial) and care settings (voluntary sector, local authorities) as well as residents.
- Please note that this list of outcomes is still "in development." Other outcome frameworks, such as those for LTC and neighbourhoods, have already been or are currently being developed. It is essential that we align these outcomes, and as such, the list will evolve alongside the development of other programs.
- The goal is to establish a unified set of outcomes across SEL that reflects progress and achievements at three levels: neighbourhood, Place, and South-East London. To ensure practicality and relevance, it is crucial to limit the number of indicators that effectively demonstrate overall impact in line with the aspirations of the ageing well framework.
- To keep it practical and meaningful, it is important that there is a finite number of indicators that can show the overall impact in line with the aspirations of the ageing well framework.
- The indicators should be SMART and, ideally, based on established data points that can be centrally extracted to support an automated dashboard across the system. This dashboard will be designed to filter by location, population segment, and severity of frailty (mild, moderate, severe). Developing this automated (or semi-automated) dashboard is a key part of the roadmap ahead and will require a task and finish group, including data experts, clinical/professional leads, and executive oversight.
- Considerations for dashboard development includes: (1) availability of and access to viable data points (such as in GP records, HES and LA datasets), (2) creation of repository of joined-up datasets, (3) assessment of data quality, (4) defining key algorithms and definitions, and (5) the development of the dashboard, which will involve testing, refining, and implementing through a quality improvement (QI) process.

How we will know if we are making a difference
Outcomes that will be used to monitor and evaluate

The following table outlines the key outcomes that were jointly developed with input from stakeholders. The outcomes aligns with the aim to improve outcomes and experience for people with a more sustainable health and care economy. The indicators will be refined further as part of implementation.

	Outcomes	What do we aim to understand from the indicators	Potential Indicators Long list at this stage - to be refined further
1	**Improvement in quality of life**	• Are we genuinely supporting in people to age well and thrive? • Are we making a difference to the quality-of-life outcomes of people (residents, patients and carers)?	**At system level:** • Priority: Healthy life span as a marker of ageing well * • Priority: Quality of life of people who use services (ASCOF) • Carer reported quality of life (ASCOF) • Mortality rate of >65 population * **At an individual / cohort level:** • EQ-5D patient reported outcomes-based quality of life score • Set of outcomes defined in INT at the time of care planning and then assessed at defined intervals 1. Achievement of goals defined at the time of care planning 2. Improvement in ADL from baseline (if relevant) 3. Reduction in reported loneliness (if relevant) 4. Improvement on overall mental wellbeing 5. Improvement in clinical outcomes (exact indicator will depend upon the clinical condition of the patient) • Self reported outcomes: Use of simple wellness star. Use of digital / telehealth to monitor wellness scores where possible

* Indicators that will show impact in the longer term

How we will know if we are making a difference
Outcomes that will be used to monitor and evaluate

The following table outlines the key outcomes that were jointly developed with input from stakeholders. The outcomes aligns with the aim to improve outcomes and experience for people with a more sustainable health and care economy. The indicators will be refined further as part of implementation.

	Outcomes	What do we aim to understand from the indicators	Potential Indicators Long list at this stage - to be refined further
2	**Supporting people to age well**	• Are we able to reduce risk for individuals and stop or slow their progression into higher frailty zones for e.g. mild to moderate and moderate to severe / reduce manifestations of growing frailty	• Priority: Reduction in number of admissions due to ACSC / avoidable admissions *(avoidable admissions codes to be confirmed locally and monitored against baseline or as a rate of population)* • Priority: Reduction in people with 10+ medications (poly-pharmacy) *(https://www.who.int/docs/default-source/patient-safety/who-uhc-sds-2019-11-eng.pdf)* • Priority: Reduction in people with self reported isolation (ASCOF) • Reduction in number of admissions due to falls *(measure against baseline or as a rate of population)* • Reduction in number of people requiring domiciliary care (new) • Reduction in people who are house-bound *
3	**System sustainability (value-based care)**	• Are we reducing demand from resource intensive areas such as hospital and long-term residential care and shifting focus of care into community	• Priority: Reduction in ED presentations for over 65 or those who are mild/mod/severe frail • Priority: Reduction in % of patients over 65 with a Length Of Stay of 21+ Days • Priority: Reduction in admissions into residential care (nursing and residential care homes) • Priority: Reduction in number emergency admissions to hospital and beddays (measure against baseline and as a rate of population) • Increased SDEC utilisation and reduction in ED utilisation for people with moderate to severe frailty with UCP in place • Reduction in care home conveyances to ED • Reduction in LAS conveyances to hospital

* Indicators that will show impact in the longer term

How we will know if we are making a difference
Outcomes that will be used to monitor and evaluate

The following table outlines the key outcomes that were jointly developed with input from stakeholders. The outcomes aligns with the aim to improve outcomes and experience for people with a more sustainable health and care economy. The indicators will be refined further as part of implementation.

	Outcomes	What do we aim to understand from the indicators	Potential Indicators Long list at this stage - to be refined further
4	**Improved resident / carer experience**	• Are the experience of our residents, patients and carers positive. Do they feel supported, seen, heard and respected in their interactions with health and care services. Do they have a positive experience of ageing.	**At system level:** • Priority: Proportion of people who use services who report having control over their daily life (ASCOF measure) • Priority: Social Isolation: Percentage of adult carers who have as much social contact as they would like (ASCOF) • Social Isolation: Percentage of adults who feel lonely often or always **At an individual / cohort level:** • To be delivered at service level such as people supported by Integrated neighbourhood teams • Qualitative survey (person feedback): List of 5 questions - could include aspects like 'ability to self manage', 'improved connectivity' and 'feeling trusted, heard and respected' • Real life stories through deep dive semi-structured interviews (for learning and CQI)

5	**Improved access to community assets**	• Are residents provided with opportunities to access support in the community to support them in ageing well.	• Priority: Proportion of people accessing the green and blue zone such as:
			  • Access into neighbourhood services (e.g. INT), community activities
			  • Access to community-based support and amenities (e.g. exercise classes)

6	**Reduced health inequalities**	• Are the outcomes the same in all resident/population groups ie gender, ethnicity, sexual orientation, deprivation level (IMD), mental health, LD and other exclusion groups such as homeless • Is access to community-based support and neighbourhood equitable	In addition to dissecting the data, survey and interviews above to identify any signs of inequality, the following additional objective measures to be considered: • Priority: Rate of NEL admissions in respective population cohorts • Priority: Access into neighbourhood services (e.g. INT), community activities and amenities (e.g. exercise classes) • Access to suitable housing • Rate of multi-morbidity (4 and more LTC) in respective population cohorts

* Indicators that will show impact in the longer term

How we will know if we are making a difference
Outcomes that will be used to monitor and evaluate

The following table outlines the key outcomes that were jointly developed with input from stakeholders. The outcomes aligns with the aim to improve outcomes and experience for people with a more sustainable health and care economy. The indicators will be refined further as part of implementation.

	Outcomes	What do we aim to understand from the indicators	Potential Indicators Long list at this stage - to be refined further
7	**Identification of people with escalating frailty**	Are we identifying people with escalating frailty or complexities before it is late	• Priority: Proportion of people with Moderate frailty who are identified and supported by INT • Dementia diagnosis rate for 65+ years old * • Proportion of people that have been enrolled in neighbourhood care that have been flagged by population health algorithms (future) • Consider: Increased coding of frailty status of population
8	**Positive dying**	Are the patient's wishes being included in their ACP, including their preferred place of death. Are we recognising 'ordinary dying'	• Priority: PPoC and PPOD from UCP correlated against actual place of care and death • Number of 'Plan for the future' achieved (tbc - % of total population over 65)
9	**Other**		• Priority: Proportion of UCP and CGA completed for people with frailty (mild, moderate and severe) • Number of SMR / polypharmacy reviews

* Indicators that will show impact in the longer term

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7.
How we implement the framework

HEALTH INTEGRATION PARTNERS

A recommended first principle is that the biggest proportion of effort in implementing the Ageing Well framework should be on people

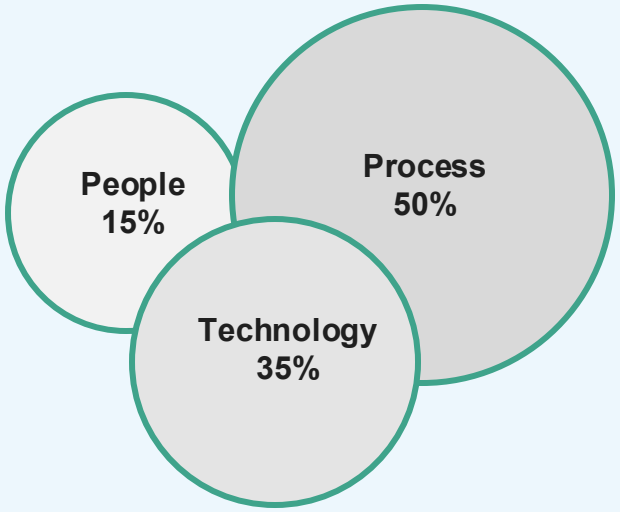
Nearly two thirds of healthcare change projects fail and less than 5% deliver what they are supposed to[1]

Common pitfalls include insufficient focus on:

- → Creating meaning and purpose
- → Engaging and taking people/partners on the journey
- → Having the right team, skills and knowledge for the job
- → Visible leadership championing the work
- → Tapping into values, feelings and attitudes
- → Creating trust, ownership and accountability
- → Tracking, reporting and promoting success
- → Project methods that drive delivery at scale and pace

Most healthcare transformations **under invest in the human dimension**

Proportion of effort showing less focus on people led change



Change dominated by process and technology only achieves around a 10% level of adoption [2]

1. *NCBI 2022*
2. *Ian Gotts. Common Approach, Uncommon Results 2007*

This recommended first principle then translates into some further recommendations for how SEL should approach implementation of the framework

Engagement	• Developing a strong 'brand' identity for the framework that conveys not just the 'tasks' bit also the 'spirit and emotion' behind the ambition and embedding this in each Place • Developing a robust approach to engagement at SEL and Place level including executive and front-line buy-in across all partners e.g., health providers, social care, Local Authority, Public Health, VCFSE, private providers e.g., domiciliary care and care homes • Patient, carer and family education, engagement and co-production.
Leadership, resources and skills	• Clarifying programme leadership and project management resources at SEL and Place levels (identifying inspirational leaders) • Putting the resources in place required to deliver the framework • Establishing a multi-professional training and job shadowing/rotational roles skills transfer framework for ageing well and frailty.
Delivery and change management	• Having clarity on what the ICB is doing and what Place is doing and ensuring the ICB provides the required practical support needed to Place (e.g., identifying and agreeing the deliverables that can be done 'once for SEL' that support standardisation, efficiency and avoidance of duplication such as the Life course self-assessment, My Plan for the Future, CGA, UCP, frailty identification/scoring tool and the enablers) • Developing a new, proactive and dynamic approach to change e.g., via establishment of a community of practice and champions to inspire and drive developments, capture and assimilate feedback etc. • Sharing good practice examples across SEL enabled by a single, easy to use communication channel.
Measurement and funding	• Developing clear success measures and minimum standards to be achieved by services and the implementation programme/project itself (and securing a signed agreement to these across providers) • Establishing a holistic, longer-term plan for funding versus a short-term or piecemeal approach • Planning the investment into ageing well and frailty jointly and openly with wider partners, around an approach emphasising people.

Implementation planning – key elements

Change initiation planning at Place

- Review of framework against current Place plans and initiatives underway
- Understanding of gaps and opportunities and what to prioritise from the framework
- Identifying the key interventions to be developed building from what is already underway
- Defining the *how* – including resources, change management approach, requirements for support from SEL
- Production of practical delivery plan of action including stages, phasing, QI cycles, etc.

SEL parallel review

- Parallel review of Place plans and understanding of what can be done at SEL level/practical support Places need from SEL
- SEL level planning (aligned to Place plans) and mobilisation of SEL-level resources to deliver
- Alignment and coordination of plans with wider SEL strategies and initiatives (INTs, LTCs etc.)
- Plans to include SEL level comms and engagement e.g., resident education, launch of brand, etc.
- Plans include laying foundations for investment shift e.g., to upstream prevention, longer term VCSFE funding, etc.

Engagement and mobilisation at Place (building on existing work underway)

- Identifying Place lead(s) who will drive delivery (overall leads and lead clinicians, professionals, etc.)
- Engaging and onboarding of partners/individual stakeholders at Place who will participate in and help lead design and delivery
- Set up of collaboration and sharing across Places e.g., community of practice, shared communication channel, best practice library, change management approaches, etc.
- Establishing/activating resident engagement and co-production approach
- Mobilising the Place-level resources and project to deliver, including comms, engagement, launch of the brand etc.

Implementation planning – key elements

Demand and capacity modelling

- Scoping and mobilising the D&C modelling – SEL and Place levels
- Marrying the modelling to Place plans e.g. Place assumptions, timings, phasing, etc.
- Gaining collaboration with wider partners e.g., agreeing principles/actions for resourcing, investment, investment shift, etc
- Building the SEL and Place level D7C model
- Gaining buy-in to the model across all stakeholders

Creating a dashboard

- Creating a SEL dashboard of outcome measures and KPIs
- Populating the dashboard with baseline assumptions (SEL and Place level)
- Quarterly reporting of progress and achievement of outcomes as change is delivered.

Enablers

- Scoping and detailed specification of enablers required to enable the framework
- Developing a specific plan for delivery of enablers to meet the requirements of the framework
- Aligning the specification and plan with existing work already underway on enablers and adjusting any existing specification and plans as required to ensure delivery meets Place requirements
- Mobilising delivery of enablers, prioritised against plans.

Roadmap for implementation

Stage 1: Establishing the vision and the framework to deliver it

SEL Ageing well framework

- Bringing system stakeholders together
- Resident voice
- Framework for ageing well

Demand and capacity modelling

- System baseline for frailty demand and capacity
- Utilisation hot spots and projections
- Overall shift in demand and capacity with new framework

Defining outcomes

- Key outcomes and indicators to know what we are making a difference
- Define system dashboard for frailty
- Establish data points and beta test live dashboard

Stage 2: Embedding the framework (SEL–Place-Neighbourhoods) Change initiation planning

1. Self assessment @ Place

- Map services against framework
- Map performance: What is working well & not
- Define - stay as is, scale, enhance

2. Analysis of opportunities

- Identify areas of improvement against framework
- Scope of development – SEL vs Place
- Impact (£, outcomes)

3. Priorities for delivery

- Prioritise based on potential impact, deliverability and strategic alignment
- Roadmap for implementation

6. Change management, OD and enablers

- Identify change leaders
- Engage, inspire, empower frontline
- Requirements; Digital/OD/training
- Change management

5. Demand and capacity

- Impact on baseline demand and capacity
- Identify shift in resources (Left shift)
- Upfront investment or business case (if req'd)

4. Operating model

- Engage – frontline / clinical / professional
- Define operational model
- Define who/what/how
- Trajectory of implementation

Key tenets of delivery

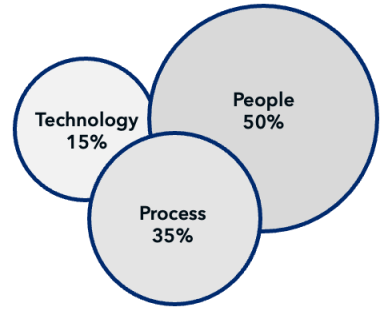
Regular touchpoints

System-wide cross learning workshops

System governance, oversight and review

Stage 3: Phased QI led implementation

Achieving the right focus for change



Phased implementation

- Robust program delivery team (representing system partners)
- Oversight and governance
- Clarity on SEL-level support to Places
- QI methodology and system-wide learn and share events
- Communication plan

- Continued QI cycle
- Test and titrate
- At scale delivery

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8.
Appendices
(circulated as a separate document)

HEALTH INTEGRATION PARTNERS

Appendices - contents

1. Project Plan
2. Summary of baseline positions at Place
3. Outputs from workshops
    a) Ambition and vision
    b) What must change?
    c) What else must change?
    d) Ageing well and frailty definitions
4. Governance
5. What ageing well and frailty mean in SEL
6. Mantra
7. Case Studies
8. List of stakeholders who participated in developing the framework

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Programme supported by:

HEALTH INTEGRATION PARTNERS

Bexley Wellbeing Partnership

Wednesday 22nd May 2025

Item: 6

Enclosure: E

Title:	**Lyndhurst Medical Centre Contract Variation**
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Executive Sponsor:	Diana Braithwaite, Place Executive Lead (Bexley), NHS South East London Integrated Care Board

Purpose of paper:	The purpose of this paper is to approve a variation to the contract of Lyndhurst Medical Centre to include Bursted Wood Surgery as a second (branch) site and transfer the registered patient list. Bursted Wood Surgery is the only time limited contract in Bexley, which ends on 31st March 2026. This variation will mean that Lyndhurst Medical Centre will be responsible for the operation of both practice sites and the associated registered list. This is a contractual change that will not change the services delivered but aims to improve the quality of care and patient outcomes in the longer term.	**Update / Information**	
		Discussion	
		Decision	***X***
Summary of main points:	The GP Practice at Bursted Wood Surgery (219 Erith Road, Barnehurst) is currently commissioned by the ICB as an Alternative Personal Medical Service (APMS) contract. In this case, there are few differences between the APMS contract and other more standard General Medical Service (GMS) or Personal Medical Service (PMS) contracts, apart from the fact that: (i) The contract is time limited – this particular contract was commissioned for a maximum of 15 years (5+5+5). (ii) The ICB pays a small risk based premium (£5 per patient) on top of the standard list-based allocations 'the Global Sum' which reflects the finite nature of the contract, and the 'risk' associated with investment into the practice by the contract holder during the lifetime of the contract. The contract was awarded to Bexley Health Neighbourhood Care (BHNC) CIC, the local GP Federation in 2018 and BHNC sub-contracts delivery of this contract to a Ltd company called 'Clocktower Healthcare'. Dr Clive Anggiansah and Dr Mehal Patel (Partners at Lyndhurst Medical Centre) are Directors of this company. The first 5-year term expired at the end of December 2024 and a variation has been issued to extend the contract,		

initially for a period of 15 months (01/01/24 to 31/03/26) to allow a suitable timeframe to consider and progress options.

There are no real advantages to continuing with an APMS contract for this practice, particularly in the context of the new Provider Selection Regime which largely limits competitive procurement for health services to circumstances where there are clear advantages in pursuing that approach for the commissioner and/or patients.

In this circumstance, there is also an existing and established working relationship between Bursted Wood Surgery and Lyndhurst Medical Centre (nearby practice) both from the perspective of clinical leadership, managerial leadership and a significant number of clinical staff that work across both sites including GP registrars. The two practices already have formal links as detailed in their Business Continuity Plans which have worked well in supporting recent power outages caused by theft and vandalism at the Bursted Wood site. They are also both members of the APL Primary Care Network.

Lyndhurst Medical Centre is a high performing and growing practice located approximately 0.5 miles from Bursted Wood Surgery. It is well regarded by patients, as reflected in the national GP Patient Survey 2024 (92% of patients surveyed rated the practice as good or very good, the highest scoring practice in Bexley) and performs well against a range of quality and performance indicators. It has also invested in improving and expanding its premises in recent years.

Following consideration of independent legal advice regarding options and procurement implications, commissioners propose to work towards effecting a merger of the two practices by allowing the Bursted Wood APMS contract to expire in 2026 and facilitating the assignment of patients to Lyndhurst Medical Centre. The Bursted Wood Surgery site would become a 'branch site' of Lyndhurst Medical Centre and the full suite of primary care services would continue to be provided at both sites, as now.

As with the Station Road Surgery/Sidcup Medical Centre scenario, patients would have the option to access primary care at both sites. There will be no loss or reduction in service provision.

The ICB engaged with Bexley GP Practices during February 2025 to inform them of the intention to progress the proposal to combine the two practices into a single practice list and invited alternative proposals. No alternative proposals were received. Support for the proposal was received from two other local practices that are part of the same Primary Care Network.

The practices continue to engage with their respective Practice Participation Groups, are gathering patient views via surveys and have plans for more extensive patient engagement once there is an agreed way forward.

All Bursted Woods patients would be written to, to inform them of the name change to their practice and options for changing their patient registration, should they wish to longer receive their general practices services from the combined Lyndhurst/ Bursted Wood practice. Should a patient not wish to remain with the practice, they would receive advice and support, appropriate to their needs, to register elsewhere.

There is no material change to the provision of primary care services to patients at either practice under this recommended contract variation and therefore formal public consultation does not apply in this instance.

Key information about the two practices is summarised below:

Practice Names	Bursted Wood Surgery	Lyndhurst Medical Centre

	Contract Types:	Alternative Personal Medical Services (APMS)	Personal Medical Services (PMS)
	Site Address(s):	219 Erith Road, Bexleyheath, DA7 6HZ	41 Lyndhurst Road, Bexleyheath, DA7 6DL
	List Sizes (as at 01/04/25):	6,431	12,304
	Contract Holder	BHNC but sub-contracted entirely to Clocktower Healthcare (2 GP Directors)	4 GP Partners
	Current Care Quality Commission Rating:	Good	Good
	Primary Care Network:	• APL Primary Care Network • 4 practices (includes Lyndhurst Medical Centre, Bursted Woods, Albion Surgery and Plas Meddyg) • Adjusted Network list size as at 1/1/25 is 39,513	
Potential Conflicts of Interest	There is a conflict of interest for all Primary Care Network Clinical Directors and the Chair as voting members of Bexley Wellbeing Partnership Committee. Consequently, there are several mitigations, which will be enacted to support the committee in its deliberations: (i) The Vice Chair and Independent Member of the committee will take over the Chair for this item. (ii) Primary Care Network Clinical Directors will not be permitted to vote on the item.		
Other Engagement	Equality Impact	An Equality Impact Screening Tool (see appendix 3) has identified a low overall impact for patients with protected characteristics. This has been reviewed by the Diversity & Inclusion team who have confirmed that they are satisfied with the mitigating actions being taken.	
	Financial Impact	There will be a small recurrent saving of £5 per patient equating to approximately £35k per year recurrently. There are no additional costs for the provision of services under the contract. The ICT system changes are estimated to be between £7,000 and £10,000 which will be picked up by the ICB.	
	Public Engagement	• The report sets out the patient engagement activities underway. • The stakeholder engagement event included Healthwatch, Local Medical Committee and any interested practices • Further patient and stakeholder communications will take place prior to the contract variation taking effect.	

	Other Committee Discussion/ Engagement	• Primary Care Delivery Group – 7th May 2025 • Stakeholder Engagement Event – 27th February 2025 • Primary Care Delivery Group (Part 1) – 5th February 2025 • Primary Care Delivery Group (Part 1) – 4th December 2024 • Bexley Wellbeing Partnership Committee (meeting in public – 23rd January 2025 • Primary Care Delivery Group (Part 2) – 4th December 2024 • Primary Care Delivery Group (Part 2) – 6th November 2024 • Primary Care Delivery Group (Part 2) – 6th March 2024
Recommendation:	The Primary Care Delivery Group recommends that the Bexley Wellbeing Partnership approves a variation to the Lyndhurst Medical Centre contract with effect from 1st April 2026, which will include: • The addition of the Bursted Wood surgery site as a location for the delivery of the contract (to remain open 8-6.30pm Monday to Friday) • The expansion of the Lyndhurst practice boundary to include the Bursted Wood catchment. • Allowing for the commissioner to safely assign patients to the Lyndhurst PMS contract (subject always to patient choice).	

Variation to the Lyndhurst Medical Centre contract to include Bursted Wood as second site and assigning the Bursted Wood list to the Lyndhurst Medical Centre

1. Background

1.1 The GP Practice at Bursted Wood Surgery (219 Erith Road, Barnehurst) is currently commissioned by the ICB as an Alternative Personal Medical Service (APMS) contract. In this case, there are few differences between the APMS contract and other more standard General Medical Service (GMS) or Personal Medical Service (PMS) contracts, apart from the fact that:

(iii) The contract is time limited – this particular contract was commissioned for a maximum of 15 years (5+5+5).

(iv) The ICB pays a small risk-based premium (£5 per patient) on top of the standard list-based allocations 'the Global Sum' which reflects the finite nature of the contract, and the 'risk' associated with investment into the practice by the contract holder during the lifetime of the contract.

1.2 The contract was awarded to Bexley Health Neighbourhood Care (BHNC) CIC, the local GP Federation in 2018 and BHNC sub-contracts delivery of this contract to a Ltd company called 'Clocktower Healthcare'. Dr Clive Anggiansah and Dr Mehal Patel (Partners at Lyndhurst Medical Centre) are Directors of this company. The first 5-year term expired at the end of December 2024 and a variation was issued to extend the contract, initially for a period of 15 months (01/01/24 to 31/03/26) to allow a suitable timeframe to consider and progress options.

1.3 In the lead up to the extension there was a comprehensive review of performance which showed that the practice was performing well evidenced by:

- A growing list
- Positive patient feedback
- Increases in Quality and Outcomes Framework (QOF) performance, REMOS/ GP Premium, Diabetes management, vaccination uptake rates and improved uptake of LD/SMI health checks
- An effective practice manager who has established a more stable non-clinical workforce
- A commitment to development of the future workforce and supporting workforce wellbeing

1.4 The areas where there was need for improvement identified included:

- the level of GP provision appearing low in the national workforce reporting tool and GP appointment data
- Clinical oversight given the number of complaints received in the last few months
- GP workforce changes limiting continuity of care

1.5 The review also demonstrated a strong and well-established working relationship with Lyndhurst Medical Centre, a practice less than half a mile away. This was shown through:

- Consistency in the clinical leadership- Dr Clive Anggiansah and Dr Mehal Patel (the two Directors responsible for Bursted Wood Surgery are also two of the four managing partners at Lyndhurst Medical Centre
- Clinical and management staff that work across both practices
- A joint clinical supervision structure across both sites of GP Registrars
- Formal links as detailed in their Business Continuity Plans which have worked well in supporting recent power outages caused by theft and vandalism at the Bursted Wood site
- Both members of APL Primary Care Network

1.6 The options appraised in March 24 included:

- Option 1: Extend for 5 years on the same terms
- Option 2: Extend on re-negotiated terms
- Option 3: Terminate the contract and disperse the list

- Option 4: Merger of Bursted Wood Surgery and Lyndhurst Medical Centre
- Option 5: Re-procure the List

1.7 The preferred option was option 2, to extend the contract on re-negotiated terms but was also recognised that another option may well need pursuing that provided greater longevity and security of the contract. From the review of performance, it was evident that the lead GPs were more vested in Lyndhurst (providing 6 - 8 sessions there each week) and it generally performed better with a more stable workforce and a strong model of continuity of care provided by the four partners. Exploratory conversations began on what their longer-term vision was for the two practices and whether they saw any benefit in operating as a single organisation and the mechanisms by which this could be achieved.

1.8 From a commissioner perspective, the APMS incurs an additional £5 per patient risk premium and while there had been evident improvement during the first 5 years of the contract, there were opportunities for improvements to be made to reach the Lyndhurst standard. This is not uncommon for APMS contracts that are time-limited and of a relatively small list size.

1.9 Through the summer of 2024 it became apparent that the introduction of the Provider Selection Regime in January 2024 presented new opportunities and approaches to consider in determining the future of APMS contracts. Elsewhere there were examples of where APMS practices became branch sites of a GMS/PMS contract providing advantages to patients and commissioners including:

- Removing the need to ever have to reprocure the APMS contract which is resource intensive
- Improving recruitment and resilience challenges through greater list sizes and the economies of scale that provides.
- Making a recurrent annual saving from no longer having to pay the time-limited premium
- Securing long term continuity of care for this population from a local provider.

1.10 In November 2024 a two-stage approach was agreed whereby:

- the APMS contract was extended for 15 months to the 31st March 2026
- there was support for pursuing options and securing legal advice to determine the best method for Bursted Wood becoming a branch site from 1st April 2026.

1.11 This approach would facilitate the long-term expansion of high quality integrated primary care at scale that delivers demonstrable improvement in patient outcomes.

1.12 A legal advice note was supplied by Hill Dickinson in January 2025 in relation to the possible options for the future of Bursted Wood Surgery after the extended APMS contract comes to an end in March 2026. Hill Dickinson were asked to advise whether the ICB could consider “merging” the APMS with the nearby Lyndhurst Medical Centre (a four GP partner, PMS contract.) whilst complying with the ICBs duties under the Provider Selection Regime (PSR). The rationale for Lyndhurst Medical Centre taking the Bursted Wood list is due to a detailed assessment of the anticipated quality improvements that this change would deliver.

1.13 Following this legal advice, engagement first happened at the Primary Care Delivery Group meeting in February and subsequently a stakeholder event took place on 27th February that was widely publicised to all Bexley practices and local organisations.

1.14 This event provided an overview of:

- the primary care landscape in Bexley
- details about Bursted Wood Surgery, the site development plans and the wider Primary Care Network geography
- An overview of performance and quality

- A proposal for the future of the contract that involved it becoming a branch of Lyndhurst Medical Centre and the benefits this would afford patients, the practice and the commissioner
- An opportunity for other practices and stakeholders to ask questions about the proposal
- An explanation of the process if any other GMS/PMS contract holders wished to submit a counter proposal for running the branch surgery
- The governance that would follow.

1.15 During the session, the PPG Chair of Bursted Wood Surgery spoke positively about the changes made to the surgery over the previous 5 years and that he was supportive of it becoming under the management and leadership of Lyndhurst Medical Centre. The practice manager also spoke positively about the proposal.

1.16 The Local Medical Committee (LMC) raised some concerns about the process being followed but these were responded to and addressed and the LMC is working closely with Bursted Wood providing constructive advice to the process of managing this change. The ICB is managing the risks and taking mitigating actions as set out formally in our risk register.

1.17 No counter proposals were received by the deadline of 7th March. Two nearby practices (Plas Meddyg and Albion Surgery) who are also members of APL PCN emailed in their support for the proposal.

1.18 Since the stakeholder engagement session, both practices have undertaken their own patient engagement activities to gather feedback from patients. Currently posters are up in the surgeries with a link to an online survey. This engagement activity will increase to reach more people over the next few months to ensure views are captured. The Practices are making sure that feedback is representative and ensure vulnerable groups, including those with learning disabilities, the housebound and those with language barriers have the opportunity to feedback.

2. Practice Profiles

Bursted Wood Surgery

2.1 Bursted Wood Surgery is a single practice site with a registered list of 6,431 (April 24) which has been steadily growing. The list size was 5,363 when the contract commenced 5 years ago so has increased by over 1,000 patients within that initial term.

2.2 The list has grown by 202 patients in the last year (3.2% increase) which is in the top 5 of fastest growing practices in the borough.

2.3 The surgery has a mixed patient demographic being in an area where there are lots of family homes and it is only 0.3 miles from Barnehurst train station with direct links to central London. The current surgery is located in a suburban setting, adjacent to woodlands, down a quiet road and is adjacent to the former CCG headquarters that were vacated in 2017.

2.4 The practice has invested in the building through securing two Local Improvement Grants in 2022/23 and 23/24 which has provided an additional consulting room, reconfiguration of administrative space, replacing fire doors, new sinks and new waiting room seating. The building was identified as having significant extension potential from the ICB estates review that was undertaken in 2022.

2.5 The practice forms part of a wider site that is soon to be redeveloped. There is a planning application for 121 residential units which is expected to gain planning approval imminently. The landlord has developed plans to extend the current building by two additional rooms, should section 106 be secured as part of the site development plans. There is also potential for internal reconfiguration of waiting area to provide an additional clinical room.

2.6 While waiting for the development to get planning approval, the surgery has been left isolated on a largely vacant site and has faced three power outages in the past year due to repeated vandalism of the adjacent abandoned maternity hospital. These outages have caused major disruption to the practice, including the emergency relocation of £30k in vaccines in September

and the loss of £12k in vaccines during a more recent incident in November. The relocation of services to Lyndhurst as part of the business continuity plan has helped minimise the impact and disruption to patient care

2.7 Approximately 25% of Bursted Wood's patients are from ethnic minority groups. It also has a relatively low level of deprivation with approx. 3.7% of the registered list being within the 20% most deprived nationally. The practice describe that the list has become younger over the last five years with the older generations passing away and new registrations being received from families and newborns.

Lyndhurst Medical Centre

2.8 Lyndhurst Medical Centre is a practice of c.12,304 patients run by four partners, from a single site at Lyndhurst Road in Barnehurst, Bexleyheath.

2.9 The list has grown by 586 patients in the last year (5% increase) making it the fastest growing list in the borough. This growth is largely driven by families with children moving to the area and patients moving their registrations from other practices.

2.10 The practice looks after two local older people care homes so have a high proportion of residents over the age of 85.

2.11 Approximately 30% of Lyndhurst's patients are from ethnic minority groups. It also has a relatively low level of deprivation with less than 3.2% of the registered list being within the 20% most deprived nationally.

2.12 The premises is owned by the GP partners. The practice secured a Local Improvement Grant in 23/24 which enabled them to complete a ground floor extension providing three additional clinical rooms.

2.13 Lyndhurst is a large training practice which typically has between 4 to 6 GP Registrars at any one time. They also host nursing, Physician Associate and medical students and support physiotherapists to become prescribers. This demonstrates that they play a key role in training and developing the future workforce which many practices do not have the capacity or space to do.

3. Key Quality & Performance Indicators

3.1 List size data shows that both practices have a strong and steady growth that is at a rate much higher than most Bexley practices.

3.2 Workforce data shows that both practices are well resourced compared to national benchmarks and far in excess of the average levels seen in South East London which are low relative to national averages for primary care workforce. Both practices have a strong nursing workforce team and have a high level of non-clinical workforce.

3.3 The two practices do have a different level of GP resource with Lyndhurst having 0.49 FTE GPs per 1000 population compared to Bursted Wood having 0.25 FTE per 1000 patients. The GP clinical capacity increased at Bursted Wood by 0.6 FTE to 1.6FTE in the last year so while it may be below the average level in Bexley (0.49 FTE/1000), the high levels of nursing and other clinicians (e.g. paramedics) offsets this. Both practices have a generally younger GP workforce than is typical for the borough so succession planning is not an issue and the mixed workforce profile shows there are no resilience concerns. Lyndhurst is a training practice, so supervises a number of GP registrars.

3.4 Lyndhurst has 4 GP partners which is more than most practices in Bexley. Patients are assigned to the partners to strengthen the continuity of care that the practice offers. Evidence suggests that continuity of care with a General Practitioner (GP) leads to improved health outcomes, reduced healthcare costs, and better patient satisfaction bringing benefits to patients, GPs and the wider system.

3.5 Both practices' Quality Outcome Framework[1] (QOF) performance is relatively high and far in excess of England averages. There has been a slight drop this year due to the Synnovis cyberattack in June 2024 which is a trend seen across the whole of south east London. Lyndhurst performs higher than Bursted Wood which is likely due to offering a high level of continuity of care.

Table 1 – 5 Year QOF Performance

	Lyndhurst	Bursted Wood	England
Financial Year	Percentage of points achieved	Percentage of points achieved	Points achieved (England average)
2024-25	97.40%	94.75%	Not yet known
2023-24	98.47%	97.60%	93.03%
2022-23	98.40%	94.33%	90.40%
2021-22	98.98%	93.14%	91.80%
2020-21	100.00%	96.71%	96.20%

3.6 Both practices have performed well above the average on Learning Disability (LD) and Serious Mental Illness (SMI) health checks consistently for the last 5 years. There have been steady improvements year on year and showing no sign of the Synnovis cyber attack impacting performance. The 24/25 performance shows both practices to be well in excess of the national target and the Bexley average. Table 2 and 3 below show this performance.

Table 2: Annual health checks for patients with a Learning disability

	Lyndhurst	Bursted Wood	Target	Bexley average
Financial Year				
2024-25	84%	91%	75%	79%
2023-24	65%	75%	75%	68%
2022-23	66%	70%	75%	62%
2021-22	61%	82%	75%	57%
2020-21	67%	70%	75%	56%

Table 3: Annual health checks for patients with a serious mental illness

	Lyndhurst	Bursted Wood	Target	Bexley average
Financial Year				

[1] Quality Outcome Framework indicators are agreed as part of the GP contract negotiations every year. These indicators have points and corresponding funding attached that are given to a GP practices based on how they are performing against these measures.

2024-25	77%	70%	60%	63%
2023-24	70%	54%	60%	62%
2022-23	43%	48%	60%	44%
2021-22	36%	46%	60%	33%
2020-21	9%	24%	60%	28%

3.7 Neither practice has concerning levels of NHS 111 and Urgent Treatment Centres activity.

3.8 The most recent GP patient survey results (2024) showed Lyndhurst to be the highest performing practice in Bexley for overall experience with 92% of patients survey rating the practice as good or very good. For Bursted Wood, the survey results showed a drop in overall experience by 4% compared the previous year (80% to 76%) but this was still well above the SEL ICB average (71%). Confidence and trust had declined, dropping by 5% (95% to 90%) while Lyndhurst was at 99% the highest in the borough. The provider is expecting this to improve when the next survey results get published in July. The practice was less well-resourced at the time of the survey.

3.9 The practice friends and family data for Bursted Wood has ranged from a high of 97.3% in January 25 to a low of 83% in March 24 but generally hovering at around ~90% for patients reporting their experience as positive. In comparison Lyndhurst has been no lower than 92% and some months 10% higher than Bursted Wood, averaging around ~97%. The Bexley average has been 89% in the last year.

3.10 There was 100% performance for both Bursted Wood and Lyndhurst in the first 9 months of the GP premium. Full reconciliation is yet to be completed and reported on.

3.11 A quality impact assessment has been completed which has highlighted the positive impact that this contractual change will have upon patient care. This is still awaiting review by the quality team.

4. Fundamentals of the Contract variation to Lyndhurst Medical Centre

4.1 The proposed variation will create a large single practice entity in the borough, in excess of 18,000 patients. This practice size is not unusual for the borough with four other practices already at this scale (Bexley Medical Group, Sidcup Medical Centre, Lakeside, Belvedere). Lyndhurst Medical Centre would become the 4th largest practice with further list growth predicted over the next few years from new housing planned in Barnehurst and Crayford. Bursted Wood is currently the third smallest practice in Bexley.

4.2 The Lyndhurst PMS contract will be varied to take effect from 1st April 2026. This variation will include:

- The addition of the Bursted Wood surgery site as a location for the delivery of the contract (to remain open 8-6.30pm Monday to Friday)
- The expansion of the Lyndhurst practice boundary to include the Bursted Wood catchment (see appendix 1)

4.3 In the lead up to the assignment of patients to the Lyndhurst list, all patients will receive a letter making them aware that this will take place and will be reminded of patient choice requirements. They will be made aware of what other practices are in the vicinity and encouraged to change practice before the assignment process happens if they do not wish to continue to have primary care services from the Lyndhurst/ Bursted Wood practices. No patients will be deregistered.

4.4 There are two other practices in the APL Primary Care Network, Albion Surgery and Plas Meddyg. They have both confirmed their support to the proposal to bring the running of both surgeries under the partnership pf Lyndhurst Medical Centre.

4.5 From 1st April 2026 patients will be able to attend either the Lyndhurst or Bursted Wood site and be offered a greater choice of appointments in terms of timing, appointment type, location and healthcare professional. There will be access to a broader range of skills and expertise and greater flexibility in what a larger practice can offer.

4.6 Currently there is no intention to change enhanced access appointments which forms part of the PCN Network DES with appointments available:

- 6.30pm to 8.00pm Monday to Friday excluding bank holidays
- 9.00am to 5.00pm on Saturdays (this rotates location within the PCN)

4.7 Upon approval by the Bexley Wellbeing Partnership, the contract variation will be issued to Lyndhurst Medical Centre to provide future security over the addition of the Bursted Wood patient list to enable them to progress the operational management and staffing changes to effectively operate as one surgery not two.

4.8 The ICB will also be required to publish a transparency notice within 30 days of issuing the contract variation.

5. Project management through the mobilisation phase

5.1 Combining the lists of two practices can be a complex process involving legal, operational, clinical, and financial considerations. It requires careful planning to integrate systems, align governance, communicate with patients, and ensure the continued delivery of high-quality care. Key technical aspects include ensuring data compatibility, aligning staffing structures, reviewing financial and contractual obligations, and meeting regulatory standards.

5.2 The timeline allows a 10-month mobilisation period where all HR, lease, IT and communication related activities are planned for and undertaken in a timely way. A detailed mobilisation plan has been prepared to ensure all tasks are completed in a timely manner so patient care is not disrupted and the transition to becoming a single practice happens smoothly.

5.3 Set up regular meetings with Clocktower Healthcare Directors to ensure the process and requirements of this contract variation would be in line with the Primary Medical Care Policy and Guidance Manual (PGM) including patient engagement and communication activities.

5.4 To date there have been regular meeting with the practice but upon approval of the contract variation a more regular meeting structure will be established with wider members of the team. This also helps to safeguard that the needs of vulnerable patients are met throughout the transition.

5.5 The risks associated with this contractual change process are recognised in the primary care risk register.

6. Benefits

6.1 The move towards a neighbourhood health service and integrated teams requires a model of continuity and long-term certainty to provide the necessary conditions that facilitates long-term investment in workforce and estates to improve population health outcomes. Whilst PMS and GMS contract are not ideal, they provide long term certainty in the way that APMS contracts do not. There has increasingly been a move away from ICBs commissioning time-limited APMS contracts, to provide greater stability and a focus on long-term care quality from general practice.

6.2 Both Lyndhurst and Bursted Wood are both outward looking practices that have a track record of working closely with community organisation and system partners. They are currently working with BVSC to mobilise a volunteer-led, community-driven intervention model that champions key social determinants of health, focusing on combatting social isolation, enhancing mental wellbeing, bridging digital divides, and preventing long-term conditions. The aim of this work is to

empower individuals, reduce unnecessary health service utilisation, and foster a sense of belonging and self-efficacy among patients.

6.3 A key advantage of bringing these two practices together would be the 'pooling' of staff. This means greater ability for staff to provide cover for unexpected absences or to cover each other when releasing staff for training and development becomes easier. The Bursted Wood patients could access a greater pool of clinicians with specialist knowledge or interests in particular conditions.

6.4 Lyndhurst and Bursted Wood Surgery are two very high performing practice with a proven track record of delivering patient-centric holistic care. While their patient lists have been growing, they have also been expanding their workforce and extending their estates capacity. This contractual change will allow them to further invest in their workforce, estate, digital tools and evolve their model of care that prioritises continuity and the proven health outcomes that this delivers for their population.

6.5 In summary the benefits are summarised opposite:

To patients	To staff/ the practices	To commissioner
• Access to a broader range of clinical professionals and hence expertise • Greater continuity of care • Improved patient experience • Improved access by greater appointment choice and availability at both sites • Expanded service offer and potential to offer more personalised care making use of staff specialities	• Greater long-term security of the contract • Economies of scale and improved efficiencies • Greater development opportunities that a larger organisation offers, contributing to recruitment and retention • Ability to expand and strengthen the services for this community	• An expanded population receiving an improved level of care • Stronger more resilient primary care for the population of Barnehurst and surrounding communities • Securing a provider who can offer greater commitment/investment to the branch in the long-term • Financial saving of the time limited risk premium (£5/patient) on the Bursted Wood list

7. Recommendation

7.1 The Bexley Wellbeing Partnership is asked to approve a variation to the Lyndhurst Medical Centre contract with effect from 1st April 2026, which will include:

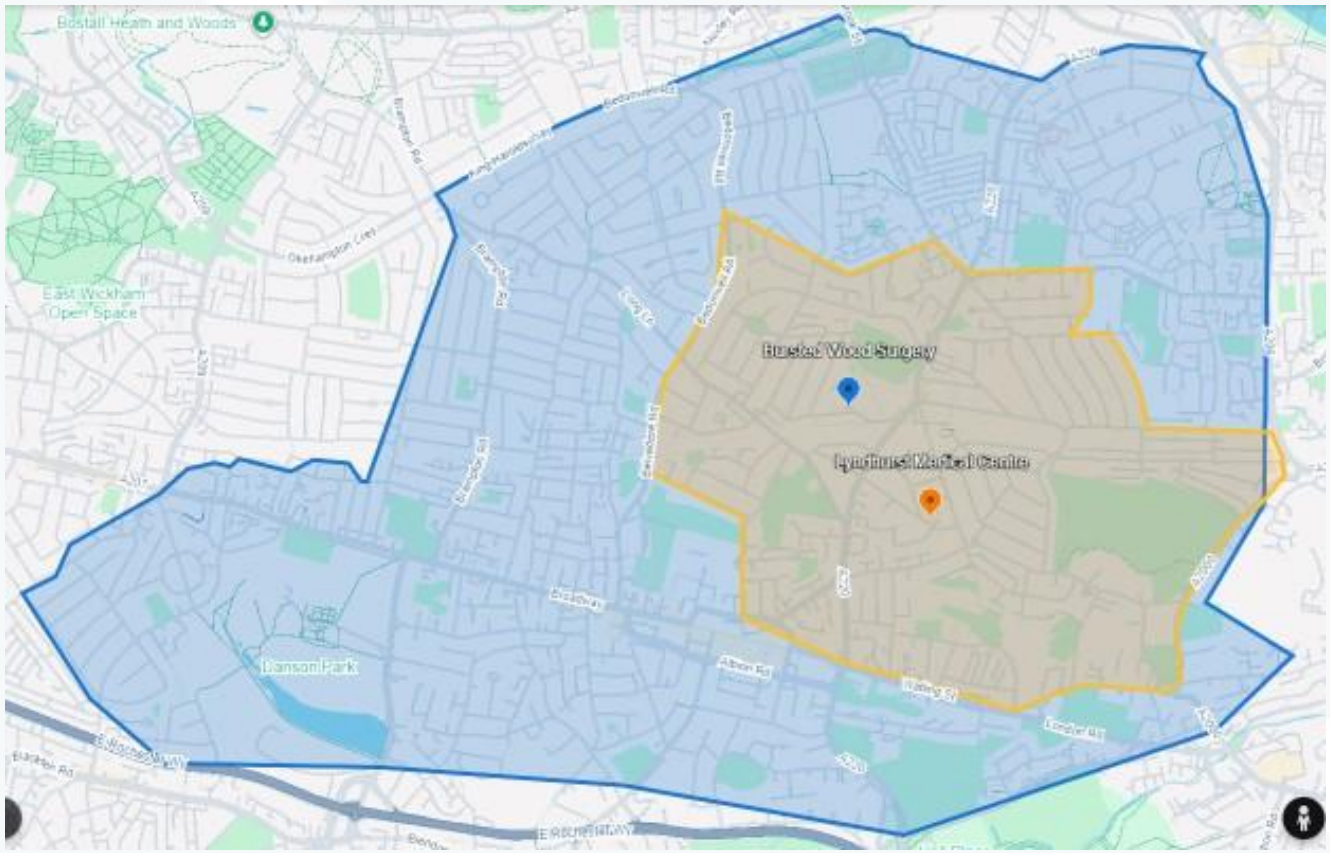
(i) The addition of the Bursted Wood surgery site as a location for the delivery of the contract (to remain open 8-6.30pm Monday to Friday)

(ii) The expansion of the Lyndhurst practice boundary to include the Bursted Wood catchment (See Appendix 1)

(iii) Allowing for the commissioner to safely assign patients to the Lyndhurst PMS contract (subject always to patient choice)

Practice boundary

- The merged practice will take on the current boundary of both practices which is the entirety of the current Bursted boundary plus the furthest easterly area that falls within Lyndhurst's boundary.
- No change to current boundaries



Bexley Wellbeing Partnership Committee

Thursday 22nd May 2025

Item: 7

Enclosure: F

Title:	**Primary Care Delivery Group Business Update Report – Q4 2024/25**
Author/Lead:	Graham Tanner, Associate Director Primary and Community Based Care (Bexley), NHS South East London Integrated Care Board
Executive Sponsor:	Diana Braithwaite, Place Executive Lead (Bexley), NHS South East London Integrated Care Board

Purpose of paper:	The Bexley Primary Care Delivery Group (PCDG) is established as a sub-group of the Bexley Wellbeing Partnership (BWP) Committee. Under adopted Terms of Reference, the PCDG has two main functions that support the Bexley Wellbeing Partnership Committee in enacting the delegated function of Primary Care services: (i) Supporting the Bexley Wellbeing Partnership Committee by considering all contractual matters relating to Primary Medical Service, (PMS), General Medical Service (GMS) and Alternative Primary Medical Service (APMS) contracts, together with the Primary Care Network (PCN) Network Direct Enhanced Service Contract, local premiums/incentives, locally commissioned services and contracts (delivered through Primary Care), out of hours GP services, Primary Care estate issues, Primary Care business continuity and contingency planning and all financial/budgetary issues relating to Primary Care. (ii) Supporting the delivery of the vision for integrated primary care as defined by the Next steps for integrated Primary Care, (Fuller Report). In line with the proposal endorsed by the BWP Committee at its meeting on 25th May 2023, the business of PCDG will be reported quarterly to the Committee, highlighting any decisions taken by the Place Executive Lead in line with their delegated authority within the ICB and/or endorsements or recommendations requiring	**Update / Information**	***X***
		Discussion	
		Decision	

	formal consideration and approval by the Committee	
Summary of main points:	The enclosed paper details all items of business discussed and transacted by the Primary Care Delivery Group during Q4 2024/25 at its meetings held on: • 8th January 2025 • 5th February 2025 • 5th March 2025 All the above meetings were Quorate in line with the adopted Terms of Reference. All decisions noted were approved by the Place Executive Lead in line with their delegated authority.	
Potential Conflicts of Interest	This report is for information only.	
Other Engagement	Equality Impact	None directly relating to this report.
	Financial Impact	All items with financial implications are discussed and agreed in conjunction with the Associate Director of Finance.
	Public Engagement	None directly relating to this report.
	Other Committee Discussion/ Engagement	This report highlights business transacted by the Primary Care Delivery Group, in consultation with the Local Medical Committee and Local Pharmaceutical Committee where applicable.
Recommendation:	The Bexley Wellbeing Partnership Committee is requested to note the report and to highlight any items for further clarification and/or future reporting to the Committee.	

Primary Care Delivery Group Business Update Summary

Q4 2024/25

Date of Meeting	Part 1 or 2	Title and purpose of the paper	Recommendation(s)	Decision/Assurance
8th January 2025	**Part 1**	**Bexley Primary and Community Based Care Estates Strategy Update** - to provide a high-level update in relation to progress made in relation to the Primary and Community Based Care estates priorities in the borough at a Local Care Network level, together with an update on the capital schemes pipeline last discussed at Primary Care Group in September 2023, following completion of Local Care Network estates workshops during that summer.	The Primary Care Delivery Group was requested to note the report and opportunities as highlighted and to provide further comment, insight and clarification to support the proposed SEL ICB PCN Estates Strategy refresh in the Spring of 2025.	Item for discussion and assurance only.
	Part 2	**Merger request between Station Road Surgery (G83047) and Sidcup Medical Centre (G83066**) - to support consideration of a Business Case submitted by the Partners of Station Road Surgery and Sidcup Medical Centre, requesting a merger of their respective lists with effect from 1 April 2025. The paper sought Primary Care Delivery Group's endorsement of the proposal, prior to final consideration and determination by the Bexley Wellbeing Partnership Committee on 23 January 2025.	In consideration of the options, the recommendation was that the Primary Care Delivery Group endorse the merger of Station Road Surgery and Sidcup Medical Centre at a date to be finalised within the 25/26 financial year. The recommendation was subject to conditions.	Bexley Wellbeing Partnership Committee *approved in principle* the merger between Station Road Surgery and Sidcup Medical Centre with the following caveats and conditions: (i) A date for the enactment of the merger to be agreed by the Place Executive Lead once the pre-requisite criteria set out in 9.1 has been

Date of Meeting	Part 1 or 2	Title and purpose of the paper	Recommendation(s)	Decision/Assurance
				satisfactorily addressed. The submission of a Quality Improvement Plan by the Contractor and the Contractor's acceptance of the additional conditions.
5th February 2025	**Part 1**	**Bursted Wood Surgery APMS** 0 A presentation was provided to update PCDG on the current and future intentions for the Bursted Woods APMS contract following the review that took place by the Primary Care Delivery Group (Part 2) committee during 2024.	Primary Care Delivery Group was asked to note the update.	Item for discussion and assurance only.
	Part 1	**Continuation of the Bexley Care Homes Supplementary Network Service (SNS) Specification for Nursing & Residential Care Homes for a minimum of 12 months, to commence 1st April 2025**	The paper sought endorsement from the Primary Care Delivery Group that the current Care Homes Supplementary Network Service (SNS) specification be continued for a minimum of 12 months from 1st April 2025 until 31st March 2026.	Recommendation endorsed. Progressed under Place Executive Lead Delegated Authority.
	Part 1	**Bexley Erectile Dysfunction (GPwER) Service – Options Paper** - to propose options following the expiry of a locally commissioned 'GP With Extended Role' (GPwER) service for Erectile Dysfunction delivered by Dr. Adagra on 31 March 2025.	Primary Care Delivery Group was recommended to endorse the decommissioning of the current service whilst utilising the Training Hub and Dr Adagra's expertise to provide training and support to GP practices during 25/26.	Recommendation endorsed. Progressed under Place Executive Lead Delegated Authority.
	Part 2	**Littleheath Surgery Business Case Discussion and Recommendations** - to provide a framework for discussion in relation to the business case submitted and presented by Dr Davies concerning her planned purchase of the Littleheath Surgery site from the current landlord	The Primary Care Delivery Group was recommended to consider the presentation by Dr Davies and accompanying business case and provided adequate assurances were received, to endorse, in principle, the purchase of the building and associated lease.	Recommendation endorsed. Progressed under Place Executive Lead Delegated Authority.

Date of Meeting	Part 1 or 2	Title and purpose of the paper	Recommendation(s)	Decision/Assurance
		and the ICBs approval of a new lease between A F DAVIES & SONS PROPERTIES LIMITED and Dr Davies as Partner.		
	Part 2	**Belvedere Family Centre – High Level Options** - to provide Primary Care Delivery Group with information and high level options regarding a potential health 'hub' at the Belvedere Family Centre site provided by Bexley Co in Lower Belvedere.	The Primary Care Delivery Group was asked to consider the options outlined in the report and to identify the preferred option for responding to this opportunity.	Item for discussion and assurance only.
	Part 2	**Delivery of Diabetes Structured Education in Bexley from 1st April 2024** - to update Primary Care Delivery Group concerning the ongoing commissioning of its Structured Diabetes Education programme following previous endorsement of a recommendation to vary the provision the Oxleas contract and subsequent representations received from the incumbent provider.	In consideration of the information provided within the report, the recommendation was that Primary Care Delivery Group reverse its previous endorsement of a recommendation to re-provide the service through an alternative ICB contract and instead, for BHNC to continue the service as part of its wider service contract through to 31 March 2027. The recommendation was subject to ongoing satisfactory service delivery and consideration of any external factors that may impact on requirements during the lifespan of the contract.	Recommendation endorsed. Progressed under Place Executive Lead Delegated Authority.
5th March 2025	**Part 1**	**GP Premium 2025/26 Proposed Changes and Specification** - To provide an update on proposed changes to the GP Premium for the 2025/26 Financial Year	Subject to clinical views and feedback from GP voting members and considering any formal LMC response, Primary Care Delivery Group was asked to endorse the GP Premium changes for the 2025/26 financial year, as summarised within the paper and included within the proposed GP Premium Year 3 specification.	Recommendation endorsed. Progressed under Place Executive Lead Delegated Authority.

Date of Meeting	Part 1 or 2	Title and purpose of the paper	Recommendation(s)	Decision/Assurance
	Part 1	**Hypertension and First Contact Physios (2023/24 GP Premium reinvestment proposal)** - to present a proposal and business case to reinvest 2023/24 Bexley GP Premium funding into a PCN led proposal to improve the borough's hypertension performance and increase access to First Contact Physios.	Subject to feedback at the meeting, the recommendation was to allocate the available 2023/24 GP Premium funding to the four Bexley PCNs in support of these proposals.	Recommendation endorsed. Progressed under Place Executive Lead Delegated Authority.
	Part 1	**getUBetter App Business Case (24/25 SDF Residual Funding) -** to present a proposal and business case to invest residual 2024/25 Primary Care Service Development Funding into an 'App' which would provide a digital first approach to supporting Bexley residents to prevent the onset of musculoskeletal pain or to self-manage when pain arises.	Primary Care Delivery Group was recommended to progress funding Option 1 on the basis that the Digital Change Manager and other ICB colleagues will be able to support the engagement and mobilisation across practices.	Recommendation endorsed. Progressed under Place Executive Lead Delegated Authority.
	Part 1	**Bexley Training Hub Update -** to provide an update on Bexley Training Hub led initiatives during 2024/25, including those supported through 2024/25 System Development Funding.	Primary Care Delivery Group was asked to note the report and update.	Item for discussion and assurance only.
	Part 1	**Primary Care Risk Register (Part 1) -** This paper is presented as a regular standing item at Primary Care Delivery Group and is intended to track and monitor any identified risks which have the potential to negatively impact the delivery of universal and good-quality Primary Care within Bexley in the short, medium and long term. The scope will reflect delegated commissioning and contracting functions within the Integrated Care System (ICS).	The Primary Care Delivery Group is asked to: i. Note the recorded risks and mitigations and agree scores. ii. Discuss whether recorded risks should remain as a substantive risks within the Register and/or whether they have been fully mitigated and can be removed. iii. Recommend any other risks for inclusion and	Item for discussion and assurance only.

Date of Meeting	Part 1 or 2	Title and purpose of the paper	Recommendation(s)	Decision/Assurance
			consideration within the Risk Register. iv. Agree any risks for inclusion on the wider SEL ICB Risk Register via the Datix system.	
	Part 2	**Primary Care Risk Register (Part 2) -** This paper is presented as a regular standing item at Primary Care Delivery Group and is intended to track and monitor any identified risks which have the potential to negatively impact the delivery of universal and good-quality Primary Care within Bexley in the short, medium and long term. The scope will reflect delegated commissioning and contracting functions within the Integrated Care System (ICS).	The Primary Care Delivery Group is asked to: i. Note the recorded risks and mitigations and agree scores. ii. Discuss whether recorded risks should remain as a substantive risks within the Register and/or whether they have been fully mitigated and can be removed. iii. Recommend any other risks for inclusion and consideration within the Risk Register. Agree any risks for inclusion on the wider SEL ICB Risk Register via the Datix system.	Item for discussion and assurance only.

Bexley Wellbeing Partnership Committee

Thursday 22nd May 2025

Item: 8

Enclosure: G

Title:	**Place Risk Register**
Author/Lead:	Rianna Palanisamy, Partnership Business Manager, NHS South East London Integrated Care Board
Executive Sponsor:	Diana Braithwaite Place Executive Lead (Bexley), NHS South East London Integrated Care 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 12 open risks specifically relating to borough activities. The risk register has been reviewed for the new financial year. The risks principally arise due to the following issues: 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 monthly. The Board reviews the Board Assurance Framework at each meeting and is provided with an update on actions taken by other committees in relation their specialty associated risks.
Recommendation:	This report is for information and assurance to the Bexley Wellbeing Partnership Committee setting out the risks and associated mitigations.	

Bexley Place Risks – Report to the Bexley Wellbeing Partnership Committee

Thursday 22nd May 2025

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 12 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 12 risks on the Place based risk register:
    - **One** risk is rated as “extreme risk” (red) after mitigations are put in place
    - **Eleven** risks is rated as “high” (amber) 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
- GP Collective Action resulting in reduced primary care access and provision resulting in pressures on the acute sector.

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

13th May 2025

South East London Integrated Care System

Bexley Wellbeing Partnership

Bexley Place Risk Register

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.	12	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.	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.	8
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	9	Budget monitoring and continuous review of efficiency plans. SEL process for approval of fee uplift requests. Robust 1;1 review process, Potential savings schemes amounting to £915k developed for internal CIP audit March 2025	Unable to control incoming high cost cases, Limited control of fee uplift requests from providers	6
550	There is a risk that system partners will fail to deliver on one or more of the areas for priority action from the SEND inspection and that required improvements are not made so that the local authority and ICB fail to meet their statutory duties and children and young people with Special Educational Needs and Disabilities do not receive the support they require.	9	The T&F has generated a project plan to address therapy gaps	9	Progress report to Board, all Priority Action Plan actions Red Amber Green rated and updated monthly, SEND assurance now shared with Integrated Care Board Accountable Officer, Recent SEND PAP stocktake with NHS England and Dept for Education, Project manager in place and programme manager due to start in December, SEND transformation manager and project manager both started full time at beginning of December. Tracker to monitor delivery and impact of all PAP now populated and Board will review in December, Positive deep dive by DfE/NHSE with clear actions for continued improvement 22/01/25, SEND hub being rolled out- which will provide child level data and show where therapy gaps exist, SEND Board being assured that actions will be completed by the end of June 2025 and the evidence to support those actions is increasing weekly through the roll out of the SEND hub and collation of survey and audit results, SEND Hub is now producing real time information on gaps in therapy services in	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	4
582	There is a risk that inadequate immunisation coverage may increase the risk of outbreaks of vaccine-preventable diseases, especially measles and whooping cough.	12	The Borough Immunisation Coordinator works closely with practices to support improvement in uptake., Raising awareness on programme changes & signposting to associated supporting resources & toolkits	12	Communications - To ensure parents can make informed decisions about vaccinations, systems need to provide clear and up-to-date information about vaccines, including any potential side-effects as well as information on the diseases vaccines protect against., Doing the basics well - Robust call & recall processes, a range of clinics & appointments, easy registration processes for new families/patients, timely follow-up of DNA's by suitably trained staff alongside the offer of another appointment., Learning and review - Regular review by GP practices (individually and collectively) of their data and processes to understand their progress with vaccine uptake and identify training gaps and areas for development., Engagement and co-production - Seeking support from local stakeholders and community champions on how communities with lower uptake can be better served., Making Every Contact Count - Making immunisation everyone's business so a wide cohort of staff are equipped to have effective conversations with parents.	All key childhood 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%.	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.	Evidence of post pandemic vaccination 'fatigue' within the target population.	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	Despite significant challenges resulting from the Synnovis cyber attack, Bexley GP practices have recovered to a 24/25 year end position of 63% which is ahead of the national target of 60%.	In the last 12 months 63% of people with SMI have had physical health check vs an SEL operating plan target of 70% (24/25)	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 80% over a 2 year time period (i.e. by end March 2026). This approach has been agreed by the PELs., Additional investment agreed by Primary Care Delivery Group in 25/26 targeted at rapid improvement to reach mid / upper 60% by May/June 2025 and achievement of the SEL 80% target by the end of March 2026.	15	Clear plans in place to recover position to target by 31 March 2026, including rapid improvement to reach mid / upper 60% by end of Q1 25/26 and 80% by end of March 2026., All practices to identify a dedicated team (champions) and Lead GP to take charge of hypertension management and set criteria/ priorities to recall relevant patients., A Care Coordinator will ensure appropriate patients are contacted, follow-ups arranged, missed appointments rescheduled, and continuous engagement through phone calls or digital platforms.	Current data shows 63% of patients with hypertension are treated to NICE guidance vs a 24/25 target of 70%.	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.	12	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	4
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.	9	There is a clear understanding of the strategic objective of Bexley place to deliver its efficiency plan. The risks on this is well discussed at the senior management team/executive meetings. Recovery/mitigation actions will be put in place as necessary.	None	3
588	There is a risk that Bexley does not fulfil the recommendations of the Better Care Fund Support Programme received in March 2025 so that required improvements to patient flow and discharge are not made in the local acute system	9	SRO's drawn from key partner organisations, SRO from LGT leading creating leadership capacity and alignment with UEC improvement plan, SRO from Oxleas leading on hub implementation, SRO from LBB leading on agreement of system wide metrics and and dashboard, SRO from RBG leading on OD programme and shared escalation system	9	Plan on a page agreed with system leaders, SRO's supported by project managers provided by partners, Engagement event to discuss review outputs planned	Review outputs not yet shared with wider partnership	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	12	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	Data interoperability and data sharing across organisations, Variable capacity and resourcing across providers, Dependencies on voluntary sector engagement and capacity, Public engagement and buy-in relating to preventative and self-care initiatives, Limited real-time impact data especially in new models of care	6

South East London Integrated Care System

Bexley Wellbeing Partnership

Bexley Wellbeing Partnership Committee

Thursday 22nd May 2025

Item: 9

Enclosure: H

Title:	**Finance Report Month 12**
Author/Lead:	Asad Ahmad, Associate Director of Finance (Bexley), NHS South East London Integrated Care Board
Executive Sponsor:	Diana Braithwaite, Place Executive Lead (Bexley), NHS South East London Integrated Care Board David Maloney, Director of Corporate Finance, NHS South East London Integrated Care Board

Purpose of paper:	**This paper is to provide an update on the financial position of Bexley (Place) as well as the overall financial position of the Integrated Care Board (ICB) and the Integrated Care System (ICS) as at month 12 (March 2025) 2024/25.**	**Update / Information**	*X*
		Discussion	
		Decision	

Summary of main points:

Bexley place financial position

	Annual Budget	Full Year Outturn	Full Year Variance
	£'000s	£'000s	£'000s
Acute Services	4,893	4,886	7
Community Health Services	22,678	22,527	151
Mental Health Services	10,660	10,462	198
Continuing Care Services	26,139	25,680	458
Prescribing	37,448	38,433	(985)
Other Primary Care Services	3,439	3,482	(42)
Other Programme Services	1,199	1,199	-
Delegated Primary Care Services	45,720	45,757	(38)
Corporate Budgets	3,037	2,756	281
Total	**155,213**	**155,182**	**31**

- **At Month 12 (March 2025) the borough has reported a year end position of £31k underspend against its control total of £155,213k.**
- Prescribing reported an overspend of £985k. Prescribing data is provided two months in arrears, therefore the year end position includes an estimate for this period. The primary driver for the overspend is significant growth in medicines aimed at preventing complications and optimise the management of long-term conditions. The position moved adversely over the last couple of months driven by prescribing in relation to infections, cardio vascular disease (CVD), central nervous system (CNS), respiratory, endocrine (including the impact of NICE approval for Mounjaro for treating obesity and diabetes) and the expanded use of Freestyle Libre continuous glucose monitoring.
- CHC reported an underspend of £458k. The overall underspend in continuing care is due to the implementation of efficiency plans,

particularly in CHC reviews, personal health budget refunds and improved payment practices with CHC providers.

- Community Health Services reported an underspend of £151k, this was primarily due to efficiency delivery within various contracts.
- Mental Health reported an underspend of £198k, this was due to underspends against several budget lines within both adults and CYP.
- Primary care services reported minor overspends for the year.
- Corporate budgets reported an underspend of £281k due to several vacancies through out the year which are now mostly filled.
- Efficiency plans were delivered in full for the year.

South East London ICB Summary

- As at month 12, the ICB is reporting an **£87k surplus position against its revenue resource limit (RRL).** This represents an overspend of **£38,871k** against the ICB's planned surplus. Agreement was reached across all NHS organisations in SEL regarding the achievement of the 2024/25 ICS control total, and the month 12 position of each organisation, including the ICB , reflects this. The ICB delivered in full its annual savings requirement.
- Due to the usual time lag in receiving current year information from the PPA, the ICB has received ten months of prescribing data, with an estimate made for the last two months. The ICB is reporting an overspend of **£5,233k** which was an adverse movement in-month for all boroughs. Details of the drivers and actions are set out later in the report.
- The expenditure run-rate for continuing healthcare (CHC) services is above budget **(£3,376k),** a deterioration from last month. Lewisham **(£4,028k),** Bromley **(£837k)** and Greenwich **(£49k)** boroughs are particularly impacted, with the other boroughs reporting small underspends.
- All boroughs delivered year-end financial positions in line with their agreed targets of breaking even.
- In reporting this month 12 position, the ICB has delivered the following financial duties:
    - Underspend of **£87k** against the revenue resource limit (RRL).
    - Underspend of **£4,158k** against its management costs allocation **(£35,908k)**, with the monthly cost of staff at risk being charged against programme costs in line with the relevant definitions;
    - Delivering all targets under the **Better Practice Payments code**;
    - Delivery of spend in line with the capital resource limit **(£554k);**
    - Subject to the usual annual review, delivered its commitments **(exceeded the target by £1,717k)** under the **Mental Health Investment Standard**; and
    - Delivered the **month-end cash position**, well within the target cash balance – **a year-end cash balance of £834k, against a target of £4,963k.**

South East London ICS Summary

	• The ICS had an agreed financial plan for 2024/25 of a **£100.0m deficit**. In year, the ICS was allocated **non-recurrent deficit support funding** of **£100.0m** to enable a **break-even** plan to be set. • The ICS is reporting an overall **£0.5m** surplus for the financial year 2024/25, against this break-even plan. • 4 out of 5 providers reported a surplus, offsetting the £33.7m deficit reported at King's. • The system has delivered **£247.2m** of efficiencies for the year against a plan of £270.0m. **£164.6m (65%)** of the efficiencies were delivered **recurrently.** • At year end, the system **underspent** its annual **capital allocation** by **£7.5m** due to an underspend on capital related to IFRS 16.	
Potential Conflicts of Interest	There are no conflicts of interest as a consequence of this report.	
Other Engagement	Equality Impact	None, all Bexley residents have the same levels of access to healthcare.
	Financial Impact	There is no known risk to these numbers as they have now been published.
	Public Engagement	The finance reports are reported to public borough-based board meetings and also the position is reported by SE London ICB at the public Governing Body Meetings.
	Other Committee Discussion/ Engagement	The finance reports are discussed at SE London level at the Planning and Delivery Group, locally, it has been discussed at Bexley SMT and the LCP Executive.
Recommendation:	The Bexley Wellbeing Partnership Committee is recommended to: (i) Note the month 12 (March 2025) financial position for Bexley Place. (ii) Note the NHS South East London ICB and NHS South East London ICS financial position at month 12 (March 2025).	

South East London Integrated Care System

Bexley Wellbeing Partnership Committee

Finance Report – Month 12

Thursday 22nd May 2025

V1.0

Bexley Wellbeing Partnership

Contents

Bexley

NHS South East London

Overall Position

	Annual Budget	Full Year Outturn	Full Year Variance
	£'000s	£'000s	£'000s
Acute Services	4,893	4,886	7
Community Health Services	22,678	22,527	151
Mental Health Services	10,660	10,462	198
Continuing Care Services	26,139	25,680	458
Prescribing	37,448	38,433	(985)
Other Primary Care Services	3,439	3,482	(42)
Other Programme Services	1,199	1,199	-
Delegated Primary Care Services	45,720	45,757	(38)
Corporate Budgets	3,037	2,756	281
Total	**155,213**	**155,182**	**31**

- At Month 12 (March 2025) the borough has reported a year end position of £31k underspend against its control total of £155,213k.
- Prescribing reported an overspend of £985k. Prescribing data is provided two months in arrears, therefore the year end position includes an estimate for this period. The primary driver for the overspend is significant growth in medicines aimed at preventing complications and optimise the management of long-term conditions. The position moved adversely over the last couple of months driven by prescribing in relation to infections, cardio vascular disease (CVD), central nervous system (CNS), respiratory, endocrine (including the impact of NICE approval for Mounjaro for treating obesity and diabetes) and the expanded use of Freestyle Libre continuous glucose monitoring.
- CHC reported an underspend of £458k. The overall underspend in continuing care is due to the implementation of efficiency plans, particularly in CHC reviews, personal health budget refunds and improved payment practices with CHC providers.
- Community Health Services reported an underspend of £151k, this was primarily due to efficiency delivery within various contracts.
- Mental Health reported an underspend of £198k, this was due to underspends against several budget lines within both adults and CYP.
- Primary care services reported minor overspends for the year.
- Corporate budgets reported an underspend of £281k due to several vacancies through out the year which are now mostly filled.
- Efficiency plans were delivered in full for the year.

Bexley Wellbeing Partnership

South East London Integrated Care System

Appendix A

SEL ICB Abridged Finance Report

Month 12 2024/25

Bexley Wellbeing Partnership

1. Key Financial Indicators

NHS South East London

- The below table sets out the ICB's performance against its key financial duties as at the end of 2024/25. As highlighted below in the Executive Summary, the ICB is reporting an overspend against plan of £38,871k which represents an overall **£87k surplus position against the revenue resource limit (RRL) excluding the historic surplus.**
- The table below shows the in-year allocations, excluding the historic surplus figure.
- In reporting this month 12 position, **all financial duties have been achieved by the ICB for the financial year 2024/25.**
- The draft annual accounts for 2024/25 are now subject to the usual external audit process.

	Target	Actual		
	April 24 to March 25 (£'000's)	April 24 to March 25 (£'000's)		
Agreed Surplus	-	87		Achieved
Expenditure not to exceed income	4,947,140	4,947,053		Achieved
Operate Under Resource Revenue Limit	4,885,531	4,885,444		Achieved
Not to exceed Running Cost Allowance	35,908	31,750		Achieved
Operate under Capital Resource Limit	554	554		Achieved
95% of NHS creditor payments within 30 days	95.00%	100.00%		Achieved
95% of non-NHS creditor payments within 30 days	95.00%	99.10%		Achieved
Mental Health Investment Standard	469,778	471,495		Achieved

2. Executive Summary

NHS South East London

- This report sets out the month 12 financial position of the ICB. The financial reporting is based upon the final June plan submission. This included a **planned surplus of £40,769k** for the ICB which was adjusted due to the impact of the deficit support funding by £1,811k, to give a revised surplus of **£38,958k.**
- The ICB's final financial allocation as at month 12 is **£4,885,531k.** In month, the ICB received an additional **£50,756k** of allocations. These related mainly to the following - £43,286k for system pressures and support funding, £3,635k depreciation funding, £1,094k public dividend capital (PDC) for GSTT, plus other minor allocations.
- As at month 12, the ICB is reporting an **£87k surplus position against its revenue resource limit (RRL).** This represents an overspend of **£38,871k** against the ICB's planned surplus. Agreement was reached across all NHS organisations in SEL regarding the achievement of the 2024/25 ICS control total, and the month 12 position of each organisation, including the ICB , reflects this. The ICB delivered in full its annual savings requirement.
- Due to the usual time lag in receiving current year information from the PPA, the ICB has received ten months of prescribing data, with an estimate made for the last two months. The ICB is reporting an overspend of **£5,233k** which was an adverse movement in-month for all boroughs. Details of the drivers and actions are set out later in the report.
- The expenditure run-rate for continuing healthcare (CHC) services is above budget **(£3,376k),** a deterioration from last month. Lewisham **(£4,028k),** Bromley **(£837k)** and Greenwich **(£49k)** boroughs are particularly impacted, with the other boroughs reporting small underspends.
- All boroughs delivered year-end financial positions in line with their agreed targets of breaking even.
- In reporting this month 12 position, the ICB has delivered the following financial duties:
    - Underspend of **£87k** against the revenue resource limit (RRL).
    - Underspend of **£4,158k** against its management costs allocation **(£35,908k)**, with the monthly cost of staff at risk being charged against programme costs in line with the relevant definitions;
    - Delivering all targets under the **Better Practice Payments code**;
    - Delivery of spend in line with the capital resource limit **(£554k);**
    - Subject to the usual annual review, delivered its commitments **(exceeded the target by £1,717k)** under the **Mental Health Investment Standard**; and
    - Delivered the **month-end cash position**, well within the target cash balance – **a year-end cash balance of £834k, against a target of £4,963k.**

3. Budget Overview

	M12 YTD							
	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Budget								
Acute Services	4,893	7,559	7,220	1,188	1,322	85	2,504,585	**2,526,853**
Community Health Services	22,678	91,350	39,125	28,230	29,343	36,424	262,486	**509,638**
Mental Health Services	10,660	14,862	8,593	23,166	7,696	10,257	547,968	**623,201**
Continuing Care Services	26,139	27,128	29,220	34,616	23,056	19,760	-	**159,919**
Prescribing	37,448	51,047	37,290	42,666	42,599	35,112	1,837	**247,998**
Other Primary Care Services	3,439	2,390	2,364	4,141	2,468	1,462	19,730	**35,995**
Other Programme Services	1,199	-	1,000	-	3,329	796	38,509	**44,833**
Programme Wide Projects	-	-	-	-	26	259	12,750	**13,034**
Delegated Primary Care Services	45,720	65,515	58,167	89,271	67,006	71,460	(2,446)	**394,692**
Delegated Primary Care Services DPO	-	-	-	-	-	-	222,706	**222,706**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	-	**-**
Corporate Budgets	3,037	3,480	3,503	4,012	3,146	3,480	47,045	**67,704**
Total Year to Date Budget	**155,213**	**263,331**	**186,482**	**227,291**	**179,990**	**179,096**	**3,655,170**	**4,846,573**

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Actual								
Acute Services	4,886	7,355	7,230	978	775	93	2,505,063	**2,526,379**
Community Health Services	22,527	90,094	37,697	28,702	27,874	34,750	262,986	**504,631**
Mental Health Services	10,462	15,655	9,545	23,911	7,135	12,204	547,335	**626,247**
Continuing Care Services	25,680	27,965	29,269	33,579	27,084	19,196	522	**163,295**
Prescribing	38,433	51,353	38,887	42,602	44,342	36,411	1,203	**253,231**
Other Primary Care Services	3,482	2,280	2,248	3,730	2,017	1,446	19,911	**35,114**
Other Programme Services	1,199	-	-	-	0	-	19,892	**21,091**
Programme Wide Projects	-	-	(7)	-	757	325	72,082	**73,157**
Delegated Primary Care Services	45,757	65,525	58,316	90,094	67,018	71,477	(3,139)	**395,049**
Delegated Primary Care Services DPO	-	-	-	-	-	-	221,754	**221,754**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	4,825	**4,825**
Corporate Budgets	2,756	3,097	3,289	3,682	2,983	3,151	41,712	**60,670**
Total Year to Date Actual	**155,182**	**263,325**	**186,475**	**227,278**	**179,985**	**179,053**	**3,694,146**	**4,885,444**

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Variance								
Acute Services	7	204	(10)	210	547	(7)	(478)	**473**
Community Health Services	151	1,256	1,428	(471)	1,469	1,674	(500)	**5,007**
Mental Health Services	198	(793)	(953)	(745)	561	(1,947)	632	**(3,047)**
Continuing Care Services	458	(837)	(49)	1,037	(4,028)	565	(522)	**(3,376)**
Prescribing	(985)	(306)	(1,597)	64	(1,744)	(1,299)	634	**(5,233)**
Other Primary Care Services	(42)	109	116	412	452	15	(181)	**881**
Other Programme Services	-	-	1,000	-	3,329	796	18,617	**23,742**
Programme Wide Projects	-	-	7	-	(731)	(66)	(59,332)	**(60,123)**
Delegated Primary Care Services	(38)	(10)	(149)	(823)	(13)	(17)	693	**(357)**
Delegated Primary Care Services DPO	-	-	-	-	-	-	952	**952**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	(4,825)	**(4,825)**
Corporate Budgets	281	383	214	330	163	329	5,334	**7,034**
Total Year to Date Variance	**31**	**6**	**7**	**12**	**5**	**44**	**(38,976)**	**(38,871)**

- At month 12, the ICB is reporting an overspend against plan of £38,871k and a **£87k surplus against the RRL**. This position reflects prescribing and continuing care overspends, with offsetting underspends in other budgets.
- The ICB is reporting a **£5,233k overspend** against its **prescribing position**. This is based on ten months actual data. Savings schemes have mitigated the growth, but there continued to be pressures, the impact of which was differential across boroughs. This is detailed in the next slide.
- Overall Mental Health budgets were underspent by **£3,047k** at year-end. The main area of financial pressure has been in cost per case activity, where the overspending was differential across boroughs - with Bromley, Greenwich, Lambeth and Southwark being the most impacted. Right To Choose ASD and ADHD assessments have also seen significant increases in activity across all boroughs.
- The final **continuing care** financial position was an overall **£3,376k overspend.** Underlying pressures were variable across the boroughs with Lambeth, Southwark and Bexley showing underspends whilst Bromley, Lewisham and Greenwich reported overspends - which are explained on slide 6.
- As described previously, the ICB is continuing to incur pay costs for staff at risk following the consultation process to deliver the required 30% reduction in management costs. The ICB's business case no longer requires DHSC approval and the ICB has issued notice and has now made most of the redundancy payments. The additional cost in-year was £4,836k.
- **As at month 12, all boroughs delivered final year-end financial positions in line with their agreed targets of breaking even.**

4. Prescribing – Overview

NHS South East London

- The month 12 prescribing position was based upon month 10 2024/25 data (as the information is provided two months in arrears) plus an estimate for February and March. **In month, the rate of overspend increased and all boroughs were adversely impacted despite the impact of the ongoing savings programme.** The ICB is reporting a PPA prescribing position of a **£7,093k overspend**. In addition, the non PPA budgets were underspent by **£1,860k** giving an **overall year-end overspend of £5,233k.**

M12 Prescribing	Total PMD (Excluding Cat M & NCSO)	Cat M & NCSO	Central Drugs	Flu Income	Independent Prescribing Pathfinder	Cat M Clawback	Total 24/25 PPA Spend	M12 YTD Budget	YTD Variance - (over)/under	Annual Budget
	£	£	£	£	£	£	£	£	£	£
BEXLEY	37,258,988	213,608	1,242,414	(310,420)	(7,059)		38,397,531	37,205,018	(1,192,513)	37,205,018
BROMLEY	49,802,163	348,397	1,659,388	(579,084)	(9,438)		51,221,426	50,804,582	(416,843)	50,804,582
GREENWICH	37,473,741	261,747	1,249,915	(192,302)	(7,159)		38,785,942	37,000,001	(1,785,941)	37,000,001
LAMBETH	41,274,852	376,237	1,377,244	(315,103)	(7,889)		42,705,341	42,588,181	(117,160)	42,588,181
LEWISHAM	42,298,204	479,009	1,418,683	(265,695)	(8,152)		43,922,049	41,913,282	(2,008,767)	41,913,282
SOUTHWARK	35,022,366	351,140	1,173,153	(347,223)	(6,718)		36,192,718	34,752,075	(1,440,643)	34,752,075
SOUTH EAST LONDON						251,464	251,464	120,000.00	(131,464)	120,000
Grand Total	**243,130,314**	**2,030,137**	**8,120,797**	**(2,009,826)**	**(46,416)**	**251,464**	**251,476,471**	**244,383,140**	**(7,093,331)**	**244,383,139**

- The table above shows that of the overspend, approximately **£2,030k** is related to Cat M and NCSO (no cheaper stock) pressures. An additional **£3,303k** relates to a local growth in prescribing.
- The growth has been identified as partly relating to NICE recommendations for new and existing drugs, which are mandatory for the NHS. Specifically, key elements of the growth relate to hormone replacement therapy, medicines for attention deficit hyperactivity disorder, melatonin (sleep disorder), antibiotics, catheters, wound care, and promethazine. The chapters which are the largest drivers of increased costs in 2024/25 are Infections, CVD, CNS, Respiratory and Endocrine which correlate with the key elements of growth highlighted above.
- There has also been a higher number of repeat prescriptions being issued which is impacting both activity and costs.
- The financial position is differential per borough and is in part determined by local demographics and prescribing patterns.

5. NHS Continuing Healthcare

NHS South East London

- **As of Month 12**, the Continuing Healthcare (CHC) financial position reflects a **£3,376k overspend**, showing a **£970k deterioration** from the previous month, the drivers of which include updating the year end provision for retrospective claims, together with increased activity and costs. Cost pressures remain uneven across boroughs, with **Lewisham, Bromley, and Greenwich reporting overspends**, while the **other three boroughs** collectively show an **underspend of £2,060k.**
- **Lewisham (£4,028k overspend)** remains the largest contributor, primarily due to the full-year impact of late 2023 activity pressures (£1,445k), particularly among Learning Disability (LD) clients. Actions to address this include weekly meetings led by the Place Executive Lead to monitor savings plans and an ongoing client database review, which has improved the underlying monthly run rate during the year. However, at month 12 the costs increased due to additional clients being included in the database which totalled circa £396k.
- **Bromley (£837k overspend)** continues to face financial pressure due to expanded bed capacity, higher staff costs from new contracting arrangements, and settlements for retrospective cases, which are under review to assess why Bromley remains an outlier compared to other local boroughs.
- **Greenwich (£49k overspend)** has maintained the improved position, primarily due to database updates and regular client reviews by CHC teams, bringing the borough close to break-even. Additionally, all funds allocated for inflationary pressures have been released in year, further supporting financial improvement. Other boroughs have strengthened their financial positions through ongoing service and database reviews.
- **To address provider price increases**, an ICB panel has met during the year to review requests exceeding 1.8%, meeting weekly to maintain consistency across SE London and mitigate significant cost escalations. Boroughs initially budgeted for a 4% inflationary uplift, and reserves were released in Month 7 where agreements were below budget. At month 12, all reserves in respect of inflationary uplifts were released as agreements with almost all providers have now been reached and are included in the costs being reported in financial positions.
- **On savings initiatives,** all boroughs have made progress on CHC savings plans, with three exceeding their targets. However, rising activity levels and high-cost patients continue to exert financial pressure on the CHC budget.

South East London Integrated Care System

Appendix B

SEL ICS Abridged Finance Report

Month 12 2024/25

Bexley Wellbeing Partnership

Executive Summary

- The values in this report are draft as final year-end figures are not confirmed until after the usual external audit process is completed. Only high-level information is reported due to detailed information not yet being available.
- The ICS had an agreed financial plan for 2024/25 of a **£100.0m deficit**. In year, the ICS was allocated **non-recurrent deficit support funding** of **£100.0m** to enable a **break-even** plan to be set.
- The ICS is reporting an overall **£0.5m** surplus for the financial year 2024/25, against this break-even plan.
- 4 out of 5 providers reported a surplus, offsetting the £33.7m deficit reported at King's.
- The system has delivered **£247.2m** of efficiencies for the year against a plan of £270.0m. **£164.6m (65%)** of the efficiencies were delivered **recurrently.**
- At year end, the system **underspent** its annual **capital allocation** by **£7.5m** due to an underspend on capital related to IFRS 16.

I&E summary

System Revenue

Organisation	Surplus / (Deficit) - Adjusted Financial Position							
	Plan YTD £000	Actual YTD £000	Variance YTD £000	Variance YTD %	Plan Year Ending £000	Outturn Year Ending £000	Variance Year Ending £000	Variance Year Ending %
South East London ICB	38,958	87	(38,871)	(0.8%)	38,958	87	(38,871)	(0.8%)
Guy'S And St Thomas' NHS Foundation Trust	0	12,655	12,655	0.4%	0	12,655	12,655	0.4%
King'S College Hospital NHS Foundation Trust	(40,004)	(33,662)	6,342	0.3%	(40,004)	(33,662)	6,342	0.3%
Lewisham And Greenwich NHS Trust	-	9,061	9,061	1.1%	-	9,061	9,061	1.1%
Oxleas NHS Foundation Trust	1,036	2,779	1,743	0.3%	1,036	2,779	1,743	0.3%
South London And Maudsley NHS Foundation Trust	10	9,569	9,559	1.5%	10	9,569	9,559	1.5%
ICS Total	0	489	489	0.0%	0	489	489	0.0%

- The ICS reported an outturn position of a **£0.5m surplus** against a break-even plan. As highlighted on the previous slide, this is after the receipt of deficit support funding of £100.0m. This position is now subject to the usual external audit process.
- The ICB reported a **break-even** position with the surplus held in the ICB for planning purposes delivered by the provider sector.
- KCH delivered a **£33.7m deficit**, a £6.3m better position than planned. This £33.7m deficit was offset by surpluses delivered across the 4 other providers.

System capital expenditure

- The **total system capital allocation for 2024/25, including impacts of IFRS 16, is £306.7m**, made up of £303.3m provider allocation and £3.4m ICB primary care allocation.
- In 2024/25 the system **underspent** its allocation by **£7.5m,** driven by providers not requiring the total £53.1m of allocation related to IFRS 16.

Capital spend against system capital allocation

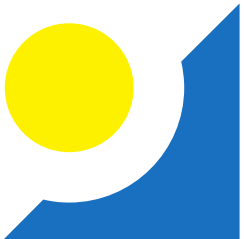
	Full-year (FY)		
	Plan	Forecast	Variance
	£m	*£m*	*£m*
GSTT	124.7	124.6	0.1
KCH	50.4	48.4	2.0
LGT	44.9	46.6	(1.7)
Oxleas	17.2	11.6	5.6
SLAM	63.4	64.7	(1.4)
SEL Providers	**300.5**	**295.9**	**4.6**
SEL ICB	**3.3**	**3.3**	**0.0**
Total	**303.8**	**299.2**	**4.6**
Capital envelope analysis			
Provider allocation	**303.3**		**7.3**
ICB allocation	**3.4**		**0.1**
System allocation	**306.7**		**7.5**

Agenda Item: 13
Enclosure: I

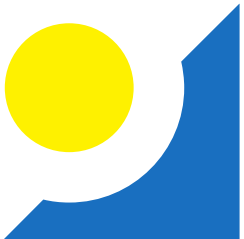
Bexley Wellbeing Partnership Committee

Glossary of NHS Terms

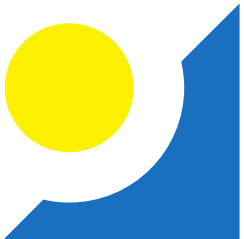
A&E	Accident & Emergency
AHC	Annual health Checks
AAU	Acute Assessment Service
ALO	Average Length of Stay
AO	Accountable Officer
APMS	Alternative Provider Medical Services
AQP	Any Qualified Provider
ARRS	Additional Roles Reimbursement Scheme
ASD	Autism Spectrum Disorder
BAME	Black, Asian & Minority Ethnic 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